L.D. 897

DATE: 4-30-03 (Filing No. S-90)

INSURANCE AND FINANCIAL SERVICES

Reported by:

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STATE OF MAINE
SENATE
121ST LEGISLATURE
FIRST REGULAR SESSION

COMMITTEE AMENDMENT " " to S.P. 292, L.D. 897, Bill, "An Act Concerning Health Insurance Reimbursement and Contracting Practices"

Amend the bill by striking out everything after the enacting clause and before the summary and inserting in its place the following:

'**Sec. 1. 24 MRSA §2332-E,** as enacted by PL 1993, c. 477, Pt. D, §5 and affected by Pt. F, §1, is amended to read:

§2332-E. Standardized claim forms

~~On or after December 1, 1993, all~~ All nonprofit hospital or medical service organizations and nonprofit health care plans providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed physician or chiropractor must accept the current standardized claim form for professional services approved by the Federal Government. ~~On or after December 1, 1993, all~~ All nonprofit hospital or medical service organizations and nonprofit health care plans providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form for professional or facility services, as applicable, approved by the Federal Government. A nonprofit hospital or medical service organization or nonprofit health care plan may not be required to accept a claim submitted on a form other than the applicable form specified in this section.

Sec. 2. 24-A MRSA §1912, as enacted by PL 1993, c. 477, Pt. D, §8 and affected by Pt. F, §1, is amended to read:

§1912. Standardized claim forms

~~On or after December 1, 1993, all~~ All administrators who administer claims and who provide payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed physician or chiropractor must accept the current standardized claim form for professional services approved by the Federal Government. ~~On or after December 1, 1993, all~~ All administrators who administer claims and who provide payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form for professional or facility services, as applicable, approved by the Federal Government. An administrator may not be required to accept a claim submitted on a form other than the applicable form specified in this section.

Sec. 3. 24-A MRSA §2436, sub-§2-A, as enacted by PL 2001, c. 569, §1, is amended to read:

2-A. ~~For~~ Except as provided in this subsection, for purposes of this section, an "undisputed claim" means a timely claim for payment of covered health care expenses under a policy or certificate providing health care coverage that is submitted to an insurer on the insurer's standard claim form using the most current published procedural codes with all the required fields completed with correct and complete information in accordance with the insurer's published claims filing requirements. After January 1, 2005, for a provider with 10 or more full-time-equivalent employees, an "undisputed claim" means a timely claim for payment of covered health care expenses under a policy or certificate providing health care coverage that is submitted to an insurer in the insurer's standard electronic data format using the most current published procedural codes with all the required fields completed with correct and complete information in accordance with the insurer's published claims filing requirements. This subsection applies only to a policy or certificate of a health plan as defined in section 4301-A, subsection 7.

Sec. 4. 24-A MRSA §2436, sub-§3, as amended by PL 1999, c. 256, Pt. I, §1, is further amended to read:

3. If an insurer fails to pay an undisputed claim or any undisputed part of the claim when due, the amount of the overdue claim or part of the claim bears interest at the rate of 1 1/2% per month after the due date. Notwithstanding this subsection,

the superintendent may adopt rules that establish a minimum amount of interest payable on an overdue undisputed claim to a health care provider before a payment must be issued. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

Sec. 5. 24-A MRSA §2680, as repealed and replaced by PL 1999, c. 609, §18, is amended to read:

§2680. Standardized claim form

Administrators providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed physician, chiropractor or licensed hospital shall accept the current standardized claim form for professional or facility services, as applicable, approved by the ~~federal Health Care Financing Administration~~ Federal Government. An administrator may not be required to accept a claim submitted on a form other than the applicable form specified in this section.

Sec. 6. 24-A MRSA §2753, as enacted by PL 1993, c. 477, Pt. D, §10 and affected by Pt. F, §1, is amended to read:

§2753. Standardized claim forms

~~On or after December 1, 1993,~~ All insurers providing individual medical expense insurance on an expense-incurred basis providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed physician or chiropractor must accept the current standardized claim form for professional services approved by the Federal Government. ~~On or after December 1, 1993, all~~ All insurers providing individual medical expense insurance on an expense-incurred basis providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form for professional or facility services, as applicable, approved by the Federal Government. An insurer may not be required to accept a claim submitted on a form other than the applicable form specified in this section.

Sec. 7. 24-A MRSA §2823-B, as enacted by PL 1993, c. 477, Pt. D, §11 and affected by Pt. F, §1, is amended to read:

§2823-B. Standardized claim forms

~~On or after December 1, 1993, all~~ All insurers providing group medical expense insurance on an expense-incurred basis providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed physician or chiropractor must accept the current standardized claim form for

professional services approved by the Federal Government. ~~On or after December 1, 1993, all~~ All insurers providing group medical expense insurance on an expense-incurred basis providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form for professional or facility services, as applicable, approved by the Federal Government. An insurer may not be required to accept a claim submitted on a form other than the applicable form specified in this section.

Sec. 8. 24-A MRSA §4235, as enacted by PL 1993, c. 477, Pt. D, §12 and affected by Pt. F, §1, is amended to read:

§4235. Standardized claim forms

~~On or after December 1, 1993, all~~ All health maintenance organizations providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed physician or chiropractor must accept the current standardized claim form for professional services approved by the Federal Government. ~~On or after December 1, 1993, all~~ All health maintenance organizations providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form for professional or facility services, as applicable, approved by the Federal Government. A health maintenance organization may not be required to accept a claim submitted on a form other than the applicable form specified in this section.

Sec. 9. 24-A MRSA §4303, sub-§§9 and 10 are enacted to read:

9. Notice of amendments to provider agreements. A carrier offering a health plan in this State shall notify a participating provider of a proposed amendment to a provider agreement at least 60 days prior to the amendment's proposed effective date. If an amendment that has substantial impact on the rights and obligations of providers is made to a manual, policy or procedure document referenced in the provider agreement, such as material changes to fee schedules or material changes to procedural coding rules specified in the manual, policy or procedure document, the carrier shall provide 60 days' notice to the provider. After the 60-day notice period has expired, the amendment to a manual, policy or procedure document becomes effective and binding on both the carrier and the provider subject to any applicable termination provisions in the provider agreement, except that the carrier and provider may mutually agree to waive the 60-day notice requirement. This subsection may not be construed to limit the ability of a carrier and provider to mutually agree to the proposed change at any time after the provider has received notice of the proposed amendment.

10. Limits on retrospective denials. A carrier offering a health plan in this State may not impose on any provider any retrospective denial of a previously paid claim or any part of that previously paid claim unless:

A. The carrier has provided the reason for the retrospective denial in writing to the provider; and

B. The time that has elapsed since the date of payment of the previously paid claim does not exceed 18 months. The retrospective denial of a previously paid claim may be permitted beyond 18 months from the date of payment only for the following reasons:

(1) The claim was submitted fraudulently;

(2) The claim payment was incorrect because the provider or the insured was already paid for the health care services identified in the claim;

(3) The health care services identified in the claim were not delivered by the provider;

(4) The claim payment was for services covered by Title XVIII, Title XIX or Title XXI of the Social Security Act;

(5) The claim payment is the subject of adjustment with another insurer, administrator or payor; or

(6) The claim payment is the subject of legal action.

For purposes of this subsection, "retrospective denial of a previously paid claim" means any attempt by a carrier to retroactively collect payments already made to a provider with respect to a claim by requiring repayment of such payments, reducing other payments currently owed to the provider, withholding or setting off against future payments or reducing or affecting the future claim payments to the provider in any other manner. The provider has 6 months from the date of notification under this subsection to determine whether the insured has other appropriate insurance that was in effect on the date of service. Notwithstanding the terms of the provider agreement, the carrier shall allow for the submission of a claim that was previously denied by another insurer because of the insured's transfer or termination of coverage.'

SUMMARY

The amendment replaces the bill. The amendment requires health carriers to give providers 60 days' notice of substantive amendments to provider agreements with certain exceptions. The parties may waive the notice requirement by mutual agreement. The amendment further requires limits on health insurers' retrospective denials of previously paid claims to 18 months from the date of payment with certain exceptions. The amendment permits carriers to refuse to accept claims not submitted on standardized claim forms approved by the Federal Government. The amendment requires that providers with 10 or more full-time-equivalent employees file claims electronically in order to claim interest, pursuant to the statute requiring health insurers to pay interest if an undisputed claim is not paid within 30 days of submission, beginning in 2005. Finally, it permits the Superintendent of Insurance to adopt rules that set a minimum amount of interest payable to health care providers, pursuant to the statute requiring health insurers to pay interest if an undisputed claim is not paid within 30 days of submission, before a payment must be issued.

FISCAL NOTE REQUIRED
(See attached)

Approved: 04/22/03 mac

121st Maine Legislature
Office of Fiscal and Program Review

LD 897
An Act Concerning Health Insurance Reimbursement and Contracting Practices

LR 1576(02)
Fiscal Note for Bill as Amended by Committee Amendment A S-90
Committee: Insurance and Financial Services
Fiscal Note Required: Yes

Fiscal Note

Minor cost increase - Other Special Revenue Funds

Fiscal Detail and Notes

Any additional costs to the Department of Professional and Financial Regulation can be absorbed by the Department utilizing existing budgeted resources.