

## **PROMPT-PAY INSURANCE LAWS A CONTINUING “HOTBED OF ACTIVITY”**

**Errol J. King, Esq.**

With 49 states and the District of Columbia now having enacted prompt-pay insurance laws,<sup>i</sup> mostly applicable to the payment of the claims of health care providers, enforcement of the laws by regulators and legal action by providers against health plans continues to be a “hotbed of activity” across the nation. According to a survey of state medical societies, payment problems consistently top the list of complaints from physicians and hospitals. Meanwhile, regulators have stepped-up enforcement actions against health plans under state prompt-pay laws and plaintiffs are asserting tried and used, as well as new, causes of action nationwide. This article will identify the types of state laws that are found from state-to-state regarding the prompt payment of health care claims.<sup>ii</sup> This article will also discuss recent enforcement actions by regulators, causes of action being asserted by plaintiffs against insurers and defenses to provider prompt-pay lawsuits.

### *State Laws Regarding Prompt Payment Of Health Care Claims.*

The practitioner must begin by distinguishing between “clean claim laws” and “prompt-pay laws.” While “clean claim laws” and “prompt-pay laws” are both intended to compel health insurers to be prompt in their reimbursement of health care providers, there is a difference. The difference is that clean claim laws generally define what information the insurer or health plan may request in order to process the benefit claim. Prompt-pay laws usually define a clean claim and specify the amount of time an insurer or health plan has in which to consider a claim before paying it. Clean claims not paid within a certain amount of time are usually subject to the payment of interest on the balance owed, or other penalties. A “clean” claim is generally a claim that is promptly submitted on either a UB92 or HCFA1500 claim form and which possesses all of the information the insurer requires to assess its obligation and for which there is no dispute regarding the amount owed.

While prompt-pay laws are varied, as can be expected, key provisions usually found are: (1) the number of days in which claims must be investigated and paid; (2) distinction between written or paper claims and electronic claims; (3) statutory penalties in the form of interest or dollar payments; (4) those claims which are excluded from coverage under the statute; and (5) other provisions, such as recoupment provisions or notices to be provided to insureds. Of the 49 states with such laws, 45 states and the District of Columbia have adopted interest penalties. Most states that have adopted interest penalties include penalties as high as 18% annually on unpaid or untimely paid claims. In addition, administrative fines are assessed by 15 states and 7 states currently require restitution.<sup>iii</sup>

As mentioned above, most prompt-pay statutes exclude certain types of coverage, such as claims submitted under a Medicare plan, from the provisions of the statute. Another area that most state prompt-pay statutes address is what conditions a health plan can pend a claim or not pay the claim. These are commonly referred to as “statutory exceptions.” Exceptions in which a plan can adjudicate the claim outside the time constraints of the prompt-pay statute without penalty are varied. The most common, is that the health plan has reasonable justification or just and reasonable grounds to believe that the claim is inappropriate and subject to review. Fourteen states have fraud exceptions allowing the health plan not to pay the claim if there is some evidence of fraud or misrepresentation.<sup>iv</sup>

Other notable statutory exceptions involve eligibility determination disputes, disputes regarding coverage liability or damages, a court order regarding the non-payment of the claim, premiums not being paid and matters beyond the control of the insurer. Where there is a dispute on the payment of a claim, many statutes require the insurer to notify the provider of the dispute and state in writing the basis of the dispute and to pay the undisputed portion, if existent.

### *Enforcement Of Prompt-Pay Laws By Regulators.*

It has been publicly stated by regulators that causes for prompt-pay violations by insurers fall into four broad categories: (1) plan growth through mergers or acquisitions which result in computer system problems; (2) downstream risk to provider entities; (3) plans may view prompt-pay compliance as a low priority; and (4) lack of resources or commitment. Unexpected inventory growth and system and manual coding errors are also areas

mentioned by regulators as sub-areas of concern. Some states have established compliance rates, which require plans to pay a certain percentage of their claims within a certain amount of time from receipt. For instance, Texas has a 98% compliance rate whereas Mississippi and Florida have established compliance rates of 95%. Significantly, the Federal Government holds itself to a 95% compliance rate for prompt-payment of Medicare claims, rather than the 100% compliance rate often suggested by provider groups. This is recognition by our Government that there is a valid need to review a small percentage of claims more closely while continuing to pay the vast majority of claims quickly.

When assessing fines to plans, state regulators have publicly stated reasons or causes for the fines. Those reasons have included the following:

- Failure to pay interest on incorrectly paid claims or late paid claims.
- Failure to reprocess claims by a specific date.
- Using an incorrect fee schedule.
- Not monitoring the functions of subcontractors, such as an IPA or Administrative Service Provider.
- Failure to comply with an earlier order of the regulator's office.
- In certain states, using unapproved reimbursement rates in contracts.<sup>v</sup>
- Failure to maintain proper complaint files/records.
- Failure to maintain proper procedures for handling claims payment or rejected claims.

There is no doubt that the state regulators have become more aggressive in dealing with prompt-payment issues. Particularly, state insurance regulators in Georgia, New York, New Jersey, Maryland, Texas and Florida have been particularly active. In some cases, fines have run into the hundreds of thousands of dollars.<sup>vi</sup>

#### ***Causes Of Action/Claims Asserted Against Health Plans.***

A myriad of claims have been asserted by plaintiffs against health plans pertaining to the slow payment, late payment or under-payment of claims. Most obviously, a cause of action can be asserted under the prompt-pay law itself if a private right of action is allowed. Some state statutes do not provide for a private right of action, leaving enforcement up to the regulator.<sup>vii</sup> Where a private action is allowed, it may also be that violation of the prompt-pay law may give rise to violation of another statute, such as an unfair trade practices statute, or one that prevents the unfair settlement of claims. Generally, these types of claims are "lumped together" by plaintiffs. Most attempts at private enforcement of prompt-pay laws have taken the form of sweeping class actions against health plans, in which prompt-pay claims are sometimes joined with other causes of action, such as alleged violations of the Federal Racketeering Influenced Corrupt Organizations Act.<sup>viii</sup> However, the use of class action litigation has had its share of problems. First, extensive procedural disputes over the propriety of class certification are more than likely. Second, few class action settlements have actually been entered into that deliver significant compensation for providers.

Plaintiffs are also asserting claims of breach of contract, where a contract exists. Courts have routinely held that state law breach of contract claims are not ERISA claims. In contracts cases, plaintiffs are usually entitled to pre-judgment interest on liquidated debts from the date of default until payment is made. Such interest may be more than the interest provided by a prompt-pay law. Other developing claims that have been asserted by plaintiffs in lawsuits around the nation are as follows:

- Claims of improper downcoding and the bundling of CPT codes, which is an area somewhat related to breach of contract, has been alleged in a number of lawsuits across the nation.
- Unjust enrichment, which is a cause of action most likely used where a provider does not have a written contract with the health plan. By performing a service for the insurer's member, the provider has rendered a benefit and the plan is obliged to pay a reasonable value for the benefit.
- Mismanagement of the affairs of others, in that the health plan has allegedly mismanaged the provider's affairs.
- Claims of intentional misrepresentation and/or detrimental reliance/estoppel.
- General state law claims of negligence.

However, rather than engaging in expensive and time-consuming litigation, providers ought to seek opportunities to make the payment process easier, quicker and more accurate. Such solutions by providers can, for example, include the increasing electronic submission of claims, eliminating submission of duplicate claims and simplifying and standardizing the service coding process.

### *Health Plan Defenses To Provider Prompt-Pay Attacks.*

While health plans publicly recognize the legitimate interest of health care providers in being paid quickly, disputes will nonetheless erupt and sometimes spill over into the judicial arena. When engaged in the defense of prompt-pay lawsuits, a number of positions are available to be asserted by the health plans. First and foremost, review the language of the statute. Is it applicable to the coverage at issue? If the patient in question is a Medicare Advantage member, then the statute will be preempted or simply will not be applicable. Moreover, the prompt-pay law in question may not apply to all lines of coverage (e.g., disability plans, limited benefit plans).

As mentioned above, does the statute in question provide a private cause of action for providers? In making this determination, a three-part test has been used by courts to determine if a private right of action exists:

1. Is the plaintiff a member of the class for whose benefit the statute was enacted?
2. Is there any evidence of a legislative intent, either to create or deny a private remedy?
3. Is a private remedy consistent with the legislative scheme?<sup>ix</sup>

Another viable defense commonly asserted is that there was a prudent reason for delaying or denying payment of the claim. Many statutes contain a “reasonable and prudent business person” standard that can be utilized by health plans. Many claims do require extra time to review, either because of their complexity or to consider possible errors or fraud. Health plans and the public, and even providers themselves, have a legitimate interest in these types of review.

Where defending breach of contracts claims that involve prompt-pay laws, many such contracts will require a binding arbitration provision, sometimes preceded by required mediation. On some occasions, there may be a statute of limitations or contractual time limitations applicable to the claims at issue, thus providing a limited defense of cutting off the measure of damages being sought by the provider.

There is also the tested and tried defense of ERISA preemption. The ERISA analysis, in conjunction with prompt-pay litigation, could comprise an article in itself. While some state statutes define “insurer” to exclude self-insured health plans subject to ERISA,<sup>x</sup> the real battle comes in regard to insured plans qualified as ERISA plans. If the plaintiff is proceeding by an assignment of benefits of the member, most likely in a non-participating provider situation, the argument would be that the provider is seeking additional remedies other than those allowed by ERISA, such that the prompt-pay statute is completely preempted. ERISA provides the exclusive enforcement mechanism for a benefit claim.<sup>xi</sup> If not completely preempted, the statute may be conflict-preempted, which would require a Kentucky Association of Health Plans analysis to determine whether the statute in question is saved from preemption under ERISA as a state law regulating insurance.<sup>xii</sup>

Finally, recently it has been alleged that prompt-pay insurance laws have fueled health care fraud. At times the health plan will be caught between timeframes in which to promptly pay a claim and, at the same time, suspecting a fraudulent claim and not being able to “stop the clock” on payment in order to properly investigate the claim. Once an insurer pays a fraudulent claim, it is extremely difficult to recover the money. According to the National Health Care Anti-Fraud Association (“NHCAA”), a consortium of insurers and state and federal law enforcement officials, in 2001 59 of the NHCAA’s member insurance companies collectively recovered or prevented fraudulent payments totaling approximately \$356 million. Still, it is estimated that this is only a small fraction of the total amount lost annually to fraudulent claims. While the many types of fraud perpetuated in the system are beyond the scope of this article, it is apparent that if a “clean” claim is correctly filled-out and submitted, the claim will not be rejected on this basis, even though it could potentially be fraudulent.

Prompt-pay laws are here to stay, having been adopted by 49 states and the District of Columbia. The issue for the industry now is enforcement of those laws and problems inherent in enforcement actions by both regulators and

providers. Therefore it is expected that at least for the next few years, activity in this area, both from a regulatory and a judicial perspective, will increase and perhaps a legislative solution will soon be sought on a national level.

- 
- <sup>i</sup> Idaho is the lone exception. To evidence how quickly this industry issue has grown, consider that at the end of 1998, 17 states had prompt-payment laws. By the end of 2003, the number had grown to 47 states.
- <sup>ii</sup> While this article focuses primarily on the payment of health care claims, some state laws are not limited only to health care insurance, in that they cover all types of insurance.
- <sup>iii</sup> Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Medicare Advantage requirements supercede all state laws and regulations, except those relating to licensure and plan solvency. As concerns the payment of claims, written agreements between Medicare Advantage organizations and providers must contain a prompt-payment provision, the terms of which are to be developed and agreed-to by both the Medicare Advantage organization and the provider. As concerns the Medicaid Managed Care Arrangement, §1932(f) of the Social Security Act addresses prompt-payment and mirrors the Medicare rule.
- <sup>iv</sup> The 14 states with fraud exceptions are: Alabama; California; Colorado; Connecticut; Kentucky; Massachusetts; Minnesota; Mississippi; New Hampshire; New York; Rhode Island; Virginia; Washington; and West Virginia.
- <sup>v</sup> Not all State Departments of Insurance require that a health plan's contractual reimbursement rates with its providers be filed and approved.
- <sup>vi</sup> It has been estimated that between 1999 and 2003, insurers across the United States paid a collective \$54 million in fines and restitutions to health care providers. Source: The Hygeia Corporation, 2005.
- <sup>vii</sup> See, Delaware's law at Code of Del. Regs. §18-1300-1310(8) as an example.
- <sup>viii</sup> 18 U.S.C. §1961, *et seq.* The most infamous of these Class Action suits is the multi-district litigation (MDL) currently pending in Florida District Court.
- <sup>ix</sup> See, as an example, *Solomon v. United States Healthcare Systems of Pennsylvania, Inc.*, 797 A.2d 346 (Pa.Super.Ct. 2002), *appeal denied*, 808 A.2d 573 (Pa. 2002), where the court applied this analysis.
- <sup>x</sup> See, as an example, Georgia, Arkansas and Iowa.
- <sup>xi</sup> In the recently decided case of *Jacobsen v. Humana Insurance Company*, N.D.Ill. No. 05 C 1011, 6/6/05, where the court held that a provision of the Illinois Insurance Code allowing a plaintiff to recover substantial statutory penalties akin to punitive damages was held to be completely preempted by ERISA.
- <sup>xii</sup> See, *Kentucky Association of Health Plans v. Miller*, 538 U.S. 329 (2003).