



# The Council for Affordable Health Insurance's ISSUES & ANSWERS

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## *Dirty Little Secrets about Clean Claims Laws*

When consumers make credit card purchases, they incur the obligation to pay for those purchases. Occasionally, a questionable item appears on a credit card bill. When that happens, the cardholder simply notifies the card's issuer and withholds payment until the issuer has time to resolve the question.

Similarly, when medical providers treat insured patients, they usually send a bill to the patients' insurer. When the insurance company or health plan gets the bill, it is obligated to pay — just like the credit cardholder. But at times the provider submits incomplete information, leaves off salient data, miscodes procedures, or even makes a mistake in the patient's name, time of treatment or medical condition.

When this happens, the insurer has to recheck the information. And like the credit cardholder, the insurer needs the right to challenge a bill. Historically, they have had it. But recently, some states have passed — and others have begun considering — legislation undermining that right. The new laws obligate an insurer to pay even questionable bills or face a heavy fine.

For the insurer, this is equivalent to discovering a mysterious \$10,000 credit card charge, being forced to pay it before it is verified, then waiting to be reimbursed. The insurance company may be able to prove the charge invalid, but if it has already paid the claim, then it must wait and hope for timely reimbursement from the patient or medical provider.

**What Are "Clean Claims" Laws?** So-called clean claims laws are attempts to get health insurers and health plans to issue prompt payments. They are a result of medical community allegations that most health plans and insurance companies routinely delay claims reimbursements for six months or more.

Supporters of the legislation define a clean claim as a completed standard claim form, *regardless of whether it includes all of the information the insurer needs to determine its liability*. Critics of the legislation contend that when a claim appears incomplete or otherwise inaccurate, the insurer cannot always tell right away whether or to what extent it is liable for the claim. Thus they define a clean claim as one that includes all the information the insurer needs to assess its obligation.

Even the federal government recognizes that some claims take longer to process. The Medicare definition of a clean claim is one "that has no defect, impropriety, lack of any required substantiating data, or particular circumstances requiring special treatment that prevents a timely payment." (The citation is 42 CFR 422.500.)

**Who Supports Clean Claims Legislation?** A coalition of some 20 health care organizations including the American Medical Association, the American College of Physicians, the American Society of Internal Medicine and the Medical Group Management Association is pushing clean claims legislation at both the federal and state levels. The coalition's stated goal is

### Fraud Happens!

Dr. Abdul Rashid Baluch will be spending the next five years in prison, followed by three years of supervised release and repaying the government \$4 million. What did the West Texas physician do wrong? According to a BNA article, "Baluch pleaded guilty to one count of health care fraud and one count of money laundering in connection with an alleged scheme to defraud Medicaid, Medicare, and the Federal Employees Health Benefits Program."

According to the U.S. Attorney's office:

- Baluch electronically filed medical claim forms for tests that he never performed and prepared phony progress reports in the event that Medicaid or Medicare would request supporting documentation when reviewing claims.
- He also ordered his staff to select 13 to 15 patient files each week and to use them to bill Medicaid for services and treatment he never provided.

All of this fraud cost taxpayers roughly \$4 million.

Who knows whether he was doing the same thing to health insurers, who would have had to pay at least 85 percent of each claim within 45 days under Texas' clean claims law. Fortunately, the federal government isn't bound by Texas law. Otherwise, the doctor might still be bilking taxpayers — and insurers.

Source: Bureau of National Affairs, BNA's Health Care Daily Report, Volume 7, Number 210, Wednesday, October 30, 2002.

“to put a stop to some of the evasive actions taken by health insurance carriers to put off paying claims.”

Unfortunately, that statement hides some dirty little secrets about clean claims laws.

**Dirty Secret #1: The Medical Community Wants to Be Paid First and Asked Questions Later.** In 1999, the Texas Legislature passed a bill calling for the “prompt payment of clean claims.” The subsequent regulations, which went into effect in August 2000, require carriers to pay all clean claims within 45 days. The regulations allow carriers to take longer to audit a claim — so long as they pay 85 percent of the claim amount within 45 days. No exceptions are allowed.

During the legislative session, carriers unsuccessfully objected that requiring 100 percent compliance (i.e., paying all bills, even disputed ones, within 45 days) was both unreasonable and bad policy. One obvious problem is that a provider filing questionable or fraudulent claims might settle for 85 percent of the amount billed and refuse to cooperate when a carrier sought to audit the claims.

The National Healthcare Anti-Fraud Association estimates that up to 10 percent of all claims made by providers contain fraudulent elements. The organization estimates that each year, insurers and consumers are bilked out of more than \$1.1 billion. Even the Texas insurance commissioner testified in 2001 that it takes his *own* department up to two years to complete a fraud investigation. So how are insurance companies supposed to do their investigations in 45 days?

By forcing insurers to pay claims first and ask questions later, Texas law encourages the submission of sloppy, incomplete and even fraudulent claims.

**Dirty Secret #2: The Problem Arose from a Few Health Insurance Carriers.** Some state legislatures treat all insurers and health plans as if they were chronic late payers. Yet the National Association of Insurance Commissioners (NAIC) years ago created prompt payment legislation for both the individual and group markets, and that legislation has been adopted in virtually every state in the country. The Employee Retirement Income Security Act (ERISA), federal law that covers large employers who self-insure, now requires a benefit determination within 30 days of receipt of a claim, and many states have gone well beyond the NAIC and ERISA models.

**Dirty Secret #3: Clean Claims Legislation Drives Up Health Insurance Costs.** Processing claims is expensive, but it is much *more* expensive when the forms are incomplete or the information inaccurate. The insurer may need extra time and thus incur extra expense, for example, if the claimant’s coverage lapsed because he or she stopped paying premiums or for some other reason, or if a preexisting condition the claimant denied has come to light.

The insurer also incurs greater expense if the claimant has another carrier with which it must coordinate benefit payments.

Other abuses also require time-consuming, costly oversight. When providers bill insurers, they use Current Procedural Terminology (CPT) codes. Many are global codes that encompass

a number of procedures. Some providers fail to use the appropriate global CPT code. Instead, they “unbundle” claims by using a series of individual codes in order to maximize charges. This technique can turn a \$5,000 charge into one for \$10,000, maximizing the doctor’s profits while needlessly reducing the amount of insurance payout left on the policy. Confronted with such a claim, the insurer needs time to detect the impropriety, rebundle the claim and process the correct payment. Of course time is precisely what clean claims legislation denies.

When an insurer fails to meet the legal timeline, it faces a fine. Last year, Texas insurers that failed to pay all claims within 45 days were fined a total of \$10 million. One company that processed more than 45,000 claims over a 20-month period paid all but 17 on time. For the 0.04 percent paid late, the Texas Department of Insurance fined the company \$60,000!

So who really ends up paying the passed-along costs of such unreasonable clean claims laws? The state’s consumers — the very ones these laws are alleged to protect.

**Dirty Secret #4: A Good Alternative to Clean Claims Legislation Already Exists.** Many claims have indeed been paid late. Reasons why include the complexity of the health insurance system and insurance laws, requirements that vary from state to state, and attempts by a few providers to game the system.

It also may be true that some insurers and HMOs delay reimbursements as part of their business model.

But all of these problems can be solved with prompt pay laws. A good alternative to clean claims legislation, prompt pay laws require a health insurance company to pay or deny a claim promptly, once the medical provider submits all the necessary information. Texas is the only state that requires and enforces 100 percent payment of all claims within the allotted time. Mississippi and Florida have established a more reasonable standard of 95 percent — providing insurers with some leeway to question and investigate when necessary.

**Conclusion.** Health insurance carriers have a fiduciary obligation to handle all claims promptly, but they also have an obligation to refuse claims for which they are not liable, since those costs translate into higher premiums.

Credit cardholders can challenge questionable claims. Insurers should have the same right.

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