Governor Michael L. Parson
State of Missouri

Missouri Department of
Commerce & Insurance
Chlora Lindley-Myers, Director

September 25, 2019

Mr. Matthew Aug, President
Cox Health Plans
P.O. Box 5750
Springfield, MO 65801-5750

RE: Expedited Request for No-Action Letter, August 7, 2019

Dear Mr. Aug:

Cox Health Systems Insurance Company ("CHSIC") submitted an expedited request for a no-action letter to Angela Nelson, Director of the Division of Market Regulation of the Department of Commerce and Insurance ("Department") on August 7, 2019. In this request for a no-action letter, CHSIC requests that "the Department issue a no-action letter affirming that due to the payment grace period of 90 days under the Affordable Care Act Marketplace, for members that qualify, if the member hasn't paid the premium due, this circumstance would be considered "particular circumstance requiring special treatment that prevents timely payment" as defined under RSMo. Section 376.383-384 for a "clean claim." If the definition of a "clean claim" is met other than the circumstance noted above, at the time the member pays the premium that is due, any claims that have been accumulated for the specified time period would be considered "clean claims" and subject to RSMo. Section 376.383-384."

<u>Section 374.018</u>

The Missouri Department of Commerce and Insurance has authority under section 374.018, to issue no-action letters related to the business of insurance in the state. A no-action letter is defined as "a letter that states the intention of the department not to take enforcement actions under section 374.046 with respect to the requesting insurer, based on the specific facts then presented and applicable law, as of the date a no-action letter is issued." 374.018.1. A no-action letter is not considered a statement of general applicability that would require promulgation by rule. The insurer seeking a no-action letter from the department has an affirmative obligation to make a full, true, and accurate disclosure of all information related to the request for the no-action letter.

<u>Regulatory Background</u>

Prompt Pay

In 1998, the Missouri General Assembly enacted section 376.383, which created a requirement that health insurers pay or deny claims within 45 days of receipt, unless the insurer needed additional information in order to pay the claim. If additional information was needed, the insurer had to pay or deny the claim within 10 days of receipt of the additional information. If an insurer failed to pay a claim or provide notice of and reason for a denial within the time limits

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specified in the statute, the insurer was required to pay interest at the rate of one percent per month.

In 2001, the General Assembly amended section 376.383. With these amendments, the legislature created a framework for prompt pay that allowed a health insurer to have the option to suspend the payment of a claim, specifying a reason for the suspension based on grounds listed in the contract between the insurer and the health care provider. Health insurers were still required to pay, deny, or suspend a claim within 40 processing days from receipt of the claim and if they failed to do so, were subject to a penalty and interest charges.

Finally, in 2010, section 376.383 was amended again by the General Assembly. This amendment reflects the law as it exists today. Notably, the 2010 amendment defines a new term, "clean claim" as "a claim that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment." In addition, the 2010 amendment removes the definition of the term "suspends the claim" and requires health insurers to pay a claim, deny a claim, or request additional information. Finally, a penalty in the amount of one percent of the claim per day is added, in addition to the existing one percent per month interest if the claim is not paid within the timelines specified in the statute.

Grace Periods

Under Missouri law, insurers must provide a 31-day grace period for individual health insurance products such as the one at issue here. Section 376.777.1(3). During the grace period, the statute requires that the "policy shall continue in force." Therefore, during the grace period, the health insurer is still obligated to pay claims incurred during that 31-day period. At the end of the 31-day period, the insurer is allowed to terminate the individual's coverage.

There is also a grace period requirement under federal law, which applies to policies held by individuals who receive advance payment of the premium tax credit. Pursuant to 45 CFR §156.270, an insurer must provide a grace period of three consecutive months for individuals who receive advance payments of the premium tax credit. During the grace period, the insurer must pay claims for service rendered during the first month of the grace period. An insurer "may pend claims for services rendered to the enrollee in the second and third months of the grace period." 45 C.F.R. §156.270(d)(1). Insurers are required to notify HHS that the enrollee has not paid premiums, and to notify providers of the possibility of denied claims when an enrollee is in the second and third months of the grace period. The insurer is also required to provide notice to the enrollee of their premium payment delinquency. If the enrollee fails to pay the delinquent premium by the end of the third month of the grace period, the insurer must terminate coverage retroactive to the last day of the first month of the grace period.

Discussion and Conclusion

The amendments made to section 376.383 in 2001 and 2010 are critical to the analysis of the question presented. As outlined above, the General Assembly made significant changes to the statute in both 2001 and 2010, reflecting different policy goals and changing how insurers do business. When the General Assembly enacts an amendment, changing the language of a statute,

it is presumed that the change effects existing law, and the General Assembly's act is not meaningless. *Kelly v. Marvin's Midtown Chiropractic, LLC*, 51 S.W.3d 833, 835 (Mo Ct App. 2011).

This request for a no-action letter contemplates a situation where an enrollee who is the recipient of advanced payment of premium tax credits has not paid their health insurance premiums during the second and third months of the grace period described in federal law. CHSIC has asked for confirmation from the Department that for such an individual, non-payment of premiums in months two and three of the federal grace period would be considered a "particular circumstance requiring special treatment that prevents timely payment," thus deeming such a claim to not be a clean claim as defined in section 376.383.1(2).

While this interpretation is plausible based solely on the plain language of the current statute, enacted in 2010, the fact that the statute was amended to remove provisions that allowed for a claim to be suspended calls into question this interpretation. The "suspend the claim" language in the 2001 version of the statute outlined a scenario in which a claim could be suspended for a specified reason, including grounds set forth in the contract between the health care provider and the health insurer. This language was removed from the statute when it was amended in 2010. If nonpayment of premium is considered a "particular circumstance requiring special treatment" under the current statute, then there is no requirement in the current statute that a claim be paid or denied within a certain period of time. As a result, the time limitations of the current prompt pay law would not apply to the claims of certain individuals. In essence, such an interpretation would effectively reinstate the concept of "suspending the claim," despite its removal from the statute in 2010. This would create uncertainty for health insurers, health care providers, and enrollees, and would not effectuate the intent of the General Assembly in amending section 376.383 in 2010.

The amendments to section 376.383 enacted in 2010 allow for another solution. The statute requires the health insurer to pay the claim, deny the claim and provide a reason for the denial, or ask for more information. Ultimately, after receipt of more information, the insurer must either pay or deny the claim and must do so within 45 processing days of the receipt of the claim. The treatment of claims during the first month of the grace period is the same under both state and federal law – if an enrollee fails to pay their premium, any claims they incur during that first month must be paid by the insurer. After the first month, only the federal requirements remain applicable and only for recipients of advanced payments of the premium tax credits. At that point, if the enrollee has not paid their premium and 45 processing days have elapsed from the time a claim has been submitted, the health insurer can, under the provisions of section 376.383, deny the claim. If the enrollee subsequently pays their delinquent premium amounts, the health care provider can re-submit the claim for payment.

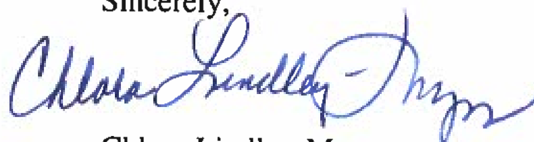
For all of the reasons stated above, the Department declines to issue a no-action letter to CHSIC affirming that the non-payment of premiums during the second and third month of the federal 90-day grace period constitutes a "particular circumstance requiring special treatment that prevents timely payment."

However, the Department states it will not bring an action against CHSIC under section 374.046, RSMo, under the following circumstances:

- CHSIC denies a claim submitted on behalf of an enrollee who receives advanced payment of premium tax credits;
- Such enrollee is in the second or third month of the grace period afforded under federal law;
- The denial meets all other requirements for notice and timeliness set forth in sections 376.383 and 376.384;
- The reason for the denial is the enrollee's nonpayment of premiums; and
- CHSIC implements processes to ensure that claims resubmitted after delinquent premium is paid are not denied as being a duplicate and are processed pursuant to sections 376.383 and 376.384, RSMo.

The Department expects CHSIC to comply with all of the conditions outlined above in order to take advantage of the regulatory relief described herein.

Sincerely,



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