SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based only on the provisions contained in the legislation as of the latest date listed below.)

Date: April 7, 1998 Revised: _____ _____ _____ _____

Subject: Health Maintenance Organizations

	Analyst	Staff Director	Reference	Action
1.	Johnson	Deffenbaugh	BI	Favorable/CS
2.				
3.				
4.				
5.				

I. Summary:

The bill requires a health maintenance organization (HMO) to reimburse all claims or any portion of any claim made by a contract provider for services or goods provided under a contract with the HMO which the HMO does not contest or deny within 35 days after receipt of the claim by the HMO. If the claim or a portion of a claim is contested by the HMO, the HMO is required to formally notify the contract provider within 35 days after receipt of the claim by the HMO. Such notification must identify the contested portion of the claim and the specific reason for contesting or denying the claim, and may include a request for additional information.

If the HMO requests additional information, the provider must provide the information within 35 days of the receipt of such request. Upon receipt of the additional information requested from the contract provider, the HMO must pay or deny the contested claim or portion of the contested claim within 45 days after receipt of the information.

In any event, an insurer must pay or deny any claim no later than 120 days after receiving the claim. Payment of the claim is considered made on the date the payment was received or electronically transmitted or otherwise delivered. An overdue payment of a claim bears simple interest at the rate of 10 percent per year.

This bill creates section 641.3155, Florida Statutes.

II. Present Situation:

Payment Requirements for Health Insurers and Commercial HMOs

Section 627.662, F.S., requires group health insurers to reimburse all claims or any portion of any claim from the insured or insured's assignees, for payment under a group health insurance policy, within 45 days after receipt of the claim by the health insurer. If the claim or a portion of a claim is contested by the health insurer, the insured or the insured's assignees must be notified within 45 days after receipt of the claim by the health insurer. Upon receipt of the additional information requested from the insured or the insured's assignees must pay or deny the contested claim or portion of the contested claim within 60 days. In any event, an insurer must pay or deny any claim no later than 120 days after receiving the claim.

Presently, s. 641.3903(5)(c), F.S., provides that it is an unfair or deceptive act for an HMO to fail to affirm or deny coverage of claims upon written request of the subscriber within a reasonable time not to exceed 30 days after a claim or proof-of-loss statements have been completed and documents pertinent to the claim have been requested in a timely manner and received by the HMO. The Department of Insurance, under the provisions of Rule 4-191.066, F.A.C., requires an HMO to pay within 30 days after receipt of all valid (clean) claims from subscribers or providers, except as provided below:

- Each HMO is required to pay all valid and undisputed (clean) claims with 30 days of receipt by the HMO of the claim from the provider, except as otherwise authorized by Medicare and Medicaid regulations. If additional information is needed, the HMO is required to request the additional information in writing within 30 days of receipt of the claim and must maintain that request in the claim file. If additional information is requested, the HMO must affirm and pay any valid claim within 30 days of receipt of the additional information.

- Each HMO must pay all valid (clean) claims for emergency services within 30 days from receipt of the claim unless additional information is requested to evaluate the claim. Each HMO must affirm and pay any valid claim within 30 days of receipt of the additional information, or deny coverage of the claim within the same 30-day period. If the claim is denied, the HMO must provide written justification for the denial to both the subscriber, including the right to appeal, and to any provider involved.

Payment Requirements for Medicaid HMOs

Medicaid is a medical assistance program that pays for health care for the poor and disabled. The program is jointly funded by the federal government, the state, and the counties. The federal government, through law and regulations, has established extensive requirements for the Medicaid Program.

Recently the federal Balanced Budget Act of 1997, revised the payment provisions under 42 U.S.C. s.1396a, entitled, Social Security - Grants to States for Medical Assistance Programs, to require a Medicaid HMO receiving payments under a state medical assistance program, to provide for claims payment procedures which 1) ensure that 90 percent of claims for payment (for which no further written information or substantiation is required in order to make payment) made for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims and that 99 percent of such claims are paid within 90 days of the date of the receipt of such claims; and 2) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program.

The Agency for Health Care Administration is the single state agency responsible for the Florida Medicaid Program. The statutory provisions for the Medicaid Program appear in ss. 409.901 through 409.920, F.S. Pursuant to s. 409.907, F.S., the Agency for Health Care Administration contracts with each provider through a voluntary agreement, in which the provider agrees to comply with all laws and rules pertaining to the Medicaid program. The agency is authorized to adopt, and include in the provider agreement, other requirements and stipulations on either party as the agency finds necessary to properly and efficiently administer the Medicaid program.

The current Medicaid HMO contract requires that a contractor provider's claim, (if properly documented) must be paid within 35 calendar days of receipt. The contract authorizes AHCA to impose the following sanctions against a Medicaid HMO if it determines that the HMO has violated any provision of the contract: (1) suspension of the plan's acceptance of applications for Medicaid enrollment; (2) suspension or revocation of payments to the plan for Medicaid recipients enrolled during the sanction period; (3) suspension of all marketing activities to Medicaid recipients; (4) imposition of fines, up to $2,500 per violation (not to exceed an aggregate amount of $10,000); (5) termination of the contract; or (6) nonrenewal of the contract.

In response to concerns regarding the timeliness of processing and payment of claims, AHCA recently audited claims provided by some hospital contract providers. As a result of the audit, AHCA determined that many hospital claims were denied as a result of the hospital not obtaining authorization, the patient being ineligible, and other reasons.

In November 1997, the Agency for Health Care Administration and the Department of Insurance created a Prompt Payment Task Force for all interested stakeholders to explore the problems associated with prompt payment. The Task Force identified five major problems: authorization of services related to emergency rooms, access to emergency room services, medical records administration, timeliness of payment, and balanced billing by providers, and is working with the industry to address the issues.

Health maintenance organizations are licensed under chapter 641, F.S. The Department of Insurance regulates HMO finances, contracting, and marketing activities under parts I and II of

chapter 641, F.S. The Agency for Health Care Administration regulates the quality of care provided by HMOs under part III of chapter 641, F.S.

III. Effect of Proposed Changes:

Section 1. Creates s. 641.3155, F.S., relating to provider contracts and payment of claims, to require a health maintenance organization (HMO) to reimburse all claims or any portion of any claim made by a contract provider for services or goods provided under a contract with the HMO which the HMO does not contest or deny within 35 days after receipt of the claim by the HMO. If the claim or a portion of a claim is contested by the HMO, the HMO is required to formally notify the contract provider within 35 days after receipt of the claim by the HMO. Such notification must identify the contested portion of the claim and the specific reason for contesting or denying the claim, and may include a request for additional information.

If the HMO requests additional information, the provider must provide the information within 35 days of the receipt of such request. Upon receipt of the additional information requested from the contract provider, the HMO must pay or deny the contested claim or portion of the contested claim within 45 days after receipt of the information.

In any event, an insurer must pay or deny any claim no later than 120 days after receiving the claim. Payment of the claim is considered made on the date the payment was received or electronically transmitted or otherwise delivered. An overdue payment of a claim bears simple interest at the rate of 10 percent per year.

Section 2. The act takes effect October 1, 1998.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The 10 percent interest penalty, coupled with statutorily required 35-day turnaround (or 120 days total resolution time) for the payment or denial of a contract provider's claim may an HMO to resolve the payment or denial of a claim in a timely manner. Also, if an HMO violates the provisions of the statute, the department may determine that the HMO is not operating in compliance with part I of chapter 641, F.S., and impose such administrative penalties authorized by ss. 641.23 and 641.25, F.S., which authorizes fines of up to $2,500 for each nonwillful violation and up to $20,000 for each willful violation.

C. Government Sector Impact:

None

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill does not address the payment of out-of-network service providers.

VIII. Amendments:

None.