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.)

BILL: CS/SB 1508

SPONSOR: Banking and Insurance Committee and Senator Brown-Waite

SUBJECT: Health maintenance organizations

DATE: April 4, 2000 REVISED: _____ _____ _____ _____

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Deffenbaugh | Deffenbaugh | BI | Favorable/CS |
| 2. | | | HC | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |

## I. Summary:

The Florida Legislature in 1999 authorized the Executive Director of the Agency for Health Care Administration (AHCA) to establish the Advisory Group on the Submission and Payment of Health Claims to prepare recommendations on prompt payment of health claims and related issues. The Advisory Group issued its report and recommendation on February 1, 2000. The bill makes the following changes, based on these recommendations:

- Requires HMOs to pay a hospital service claim or referral service claim for treatment that was authorized by a physician empowered by the HMO to authorize or direct the patient's utilization of health care services and that was also authorized in accordance with the HMO's current and communicated procedures, unless the service is not covered, the subscriber was ineligible at the time of service, or the physician provided information to the HMO with the willful intention to misinform.

- Creates the Statewide Provider and Managed Care Organizations Claim Dispute Mediation Panel. AHCA must contract with independent resolution organizations to recommend to the agency an appropriate resolution of disputes between a managed care organization and providers with regard to claim disputes in violation of the prompt payment statute, s. 641.3155, subject to a final agency order.

- Requires HMOs to have the capability to provide treatment authorization 24 hours a day, 7 days a week. Requests for treatment authorization may not be held pending by the HMO unless the requesting provider contractually agrees to take a pending or tracking number.

- Strengthens the "balance billing" prohibitions in s. 641.315, F.S., by prohibiting a provider from collecting or attempting to collect from a subscriber any money for services covered by an HMO; specifying that the statute applies to non-contract providers providing covered services; prohibiting a provider from billing the subscriber during any ongoing dispute

resolution process; and requiring referral of a violation by a physician to the Board of Medicine for final disciplinary action.

- Provides that the responsibility for claims payment to providers rests with the HMO and not with any party to which the HMO has delegated the functions of claims or management claims processing.

-Limits the requirement for an HMO to pay claims within 35 days of receipt, to a "clean claim" or any portion of a "clean claim" filed by a contract provider. "Clean claim" is defined for institutional providers and other providers with reference to specific forms and the bill authorizes the Department of Insurance to adopt rules revising the definition of clean claim to be consistent with federal claim filing standards for health care plans.

- Clarifies that the requirement for an HMO to notify the provider within 35 days if the HMO denies or contests the claim, applies if the HMO denies or contests "any portion of a claim."

- Clarifies that the current 10 percent interest penalty on overdue payments for a clean claim or for any uncontested portion of a clean claim begins to accrue on the 36th day after the claim has been received, and requires that the interest be payable with the payment of the claim.

- Requires providers to implement electronic billing in accordance with the implementation schedule established by the federal Health Insurance Portability and Accountability Act, subject to variances authorized by the Department of Insurance.

- Entitles providers who bill electronically to electronic acknowledgment of receipts of claims within 48 hours.

- Provides that the time limit for recouping or collecting outstanding claims may not exceed 1 year for either a contracted or a noncontracted provider.

This bill substantially amends the following sections of the Florida Statutes: 408.7057, 641.315, 641.3155, and 641.495. The bill creates s. 408.7057, Florida Statutes.

## II. Present Situation:

**HMO "Prompt Payment" Statute (s. 641.3155, F.S.)**

In 1998, the Legislature enacted s. 641.3155, F.S., requiring health maintenance organizations (HMOs) to pay claims within certain time frames. (Ch. 98-79, L.O.F.; CS/SB 1584) This statute (referred to as the "prompt payment" law) requires an HMO to reimburse any claim 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. If the claim is contested by the HMO, the HMO must notify the contract provider, in writing, within 35 days after receipt of the claim, identify the contested portion of the claim and the specific reason for contesting or denying the claim. This notice may also 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. Within 45 days after receipt of the information requested, the HMO must pay or deny the contested claim or portion of the contested claim.

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.

In 1999, the prompt payment statute was amended to address the issue of HMOs deducting past overpayments from a provider's claim, commonly referred to as "take backs." (Ch. 99-393, L.O.F.; CS/HB's 1927 and 961) Section 641.3155(4), F.S., requires any retroactive reduction of payments or demands for refund of previous overpayments to be reconciled to specific claims unless the parties agree to other reconciliation methods and terms. This also applies to providers who make retroactive demands for payment due to underpayments or nonpayment. The look-back period may be specified by the terms of the contract.

**Balanced Billing Prohibition (s. 641.315, F.S.)**

In 1988, the Legislature enacted amendments to s. 641.315, F.S., which provide that no subscriber of an HMO is liable to any provider of health care services for any services covered by the HMO. This law also prohibits a provider of services from collecting or attempting to collect from an HMO subscriber any money for services covered by an HMO. This statute is interpreted by the Department of Insurance and the Agency for Health Care Administration as applying to both contract and non-contract providers in those cases where services are covered by the HMO. For example, if a subscriber obtains a covered service at a contract hospital from a non-contract physician, the HMO is liable and the physician may not bill the subscriber. However, some providers argue that the statute is limited to balanced billing by contract providers, due to the heading of the statute that reads, "Provider contracts." There are no appellate court decisions on this point.

**The Statewide Provider and Subscriber Assistance Program**

The Statewide Provider and Subscriber Assistance Program is authorized by s. 408.7056, F.S., under the administration of the Agency for Health Care Administration. The program is designed to assist subscribers and policyholders of managed care entities and providers whose grievances are not resolved by the managed care entity to the satisfaction of the subscriber or provider. The agency refers grievances to panels that hold hearings on the grievance and issue recommendations to the agency or to the Department of Insurance for a final order. However, the program does not provide assistance for grievances related to providers unless it is related to the quality of care provided to a subscriber. Also, the program does not provide assistance for a grievance for "unpaid balances." Therefore, the program does not typically provide assistance for grievances related to provider disputes for late payments or underpayments.

**HMO Claims for Emergency Care and Treatment**

CS/SB 1508 does not specifically address claims filed with HMOs for emergency care and treatment, but problems in this area led to the enactment of legislation that is relevant to the issue of prompt payment. Florida law requires HMOs to provide coverage for emergency services and care without prior authorization or referral. This requirement encompasses coverage for emergency care and treatment at non-contract hospitals in emergency situations not permitting treatment through the HMO's providers. [ss. 641.31(12), 641.47(7)-(8), and 641.513 F.S.]

In summary, an *emergency medical condition* is defined as a medical condition manifesting itself by acute symptoms of sufficient severity, such that the absence of immediate medial attention could reasonably be expected to result in serious jeopardy to the health of a patient, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

When a subscriber is present at a hospital seeking emergency services and care, the determination of whether an emergency medical condition exists must be made by a physician of the hospital or, to the extent permitted by law, by other appropriate licensed professional hospital personnel under the supervision of the hospital physician. The HMO must compensate the provider for screening, evaluation, and examination reasonably calculated to assist the health care provider in making this determination (even if the provider determines that an emergency medical condition does not exist). If the provider determines that an emergency medical condition does exist, the HMO must also compensate the provider for *emergency services and care*, which are defined to include the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition within the service capability of a hospital.

Further language in the current law requires the hospital to make a reasonable attempt to notify the subscriber's primary care physician or HMO, if known, and prescribes certain time frames for such notice, but the law provides that an HMO may not deny payment for emergency services and care based on a hospital's failure to comply with the notice requirements.

A subscriber may be charged a reasonable copayment, up to $100, for the use of an emergency room. Net of this copayment, an HMO must reimburse a non-contract provider for emergency services and care at the lesser of: (a) the provider's charges; (b) the usual and customary provider charges for similar services in the community where the services were provided; or (c) the charge mutually agreed to by the HMO and the provider within 60 days of submittal of the claim.

**Federal HIPAA Requirements for "Clean Claims" and Electronic Billing**

The federal Health Insurance Portability and Accountability Act (HIPAA) requires the Health Care Financing Administration (HCFA) to identify and implement standard electronic formats for health insurance transaction, including claims, eligibility and payment. There have been problems and delays with the implementation of HIPAA. An industry group working on the implementation, the National Uniform Billing Committee (NUBC) recently agreed to a definition of an institutional clean claim. A parallel group, the National Uniform Claims Committee (NUCC) is expected to agree to an equivalent definition of a practitioner clean claim. Both of these committee recommendations, and other administrative simplification recommendations, will be submitted to the federal Secretary of Health and Human Services for adoption and implementation.

**Florida Advisory Group on the Submission and Payment of Health Claims**

The health care provider community has voiced concerns about delays in payment of HMO claims, underpayment of claims, and difficulty in obtaining authorization for treatment from HMOs. The providers assert that the current prompt payment law is not being observed. Estimates generated by the Florida Hospital Association show that as of May 1999, 16.1 percent of outstanding claims dollars had been in accounts receivable for 120 days or more. A 1999 survey by the South Florida Hospital and Healthcare Association found that the average age of HMO receivables in the hospitals in question were over 70 days old, with about 30 percent of the receivables being over 60 days old. However, none of this information has been independently verified or assessed for accuracy.

The Agency for Health Care Administration performed an emergency room claims payment survey. The summary of its survey indicates that 4924 emergency room claims (commercial claims; not Medicaid) from 26 HMOs were reviewed and that 32 claims were improperly denied or not paid. (AHCA Emergency Room Claims Payment Survey Summary, March 23, 2000)

On March 30, 2000, the Department of Insurance issued a Notice and Order to Show Cause ("Order") to each of two HMOs, resulting from a target examination of their claims payment practices. Each of the Orders finds that the HMO failed to pay, contest, or deny claims within the 35 days, as required by s. 641.3155, F.S., and failed to pay the 10 percent penalty for late payments as required under that section, among other allegations. The Orders include notice that the department intends to impose administrative penalties of $100,000 against one HMO and $75,000 against the other HMO.

The managed care community disputes the magnitude of this problem and maintains that most delays in payment are caused by provider's failure to include essential and accurate information with their claims.

In response to these concerns and divided opinions, the Florida Legislature in 1999 authorized the Executive Director of the Agency for Health Care Administration (AHCA) to establish the Advisory Group on the Submission and Payment of Health Claims to prepare recommendations on prompt payment of health claims and related issues. (Ch. 99-393, L.O.F.; CS/HB's 927 and 961). The Advisory Group issued its report and recommendation on February 1, 2000 ("Advisory Group Report").

**Summary of Advisory Group Report**

The following is a committee staff summary of the recommendations of the Advisory Group Report, with the page number of the report where the recommendation is contained. The staff summary uses the term "HMO," rather than "MCOs" or managed care organizations, as used in the report, which are synonymous terms (as stated on page 1 of the report).

*Issues and Recommendations: Non-Emergent Treatments*

*A) Authorization to Treat*

1. *24-Hour Service* -- HMOs should have the capability to provide authorization 24 hours a day, 7 days a week for all services for which pre-authorization is required. (p. 16)

2. *Binding Authorization of Services* -- If a provider follows authorization procedures and applicable laws, and receives authorization for a covered service for an eligible employee, then the plan is bound by its authorization to pay and the service is deemed medically necessary. (p. 16)

3. *Pend Numbers* -- It is inappropriate for HMOs to respond to pre-authorization requests with pending or tracking numbers that do not constitute a substantive response to the request. Such policies are only acceptable when the requesting provider contractually agrees to take a pending or tracking number. (p.16)

*B) Electronic Billing and Clean Claims*

1. *Definition of Clean Claim* -- Recommend adoption of the recently adopted National Uniform Billing Committee (NUBC) definition of institutional clean claim. However, no national definition has yet been agreed on for non-institutional claims, and the Advisory Group made no recommendation for them. (p. 17)

2. *HIPAA Standards* (Federal Health Insurance Portability and Accountability Act) -- The federal HIPAA law includes requirements for electronic filing of claims, but these provisions have not yet been implemented. It is believed that implementation will take place within the next 3 years. Recommendation that Florida adopt the expected federal schedule for implementation of HIPAA Administrative Simplification standards and that the standards be applied to all HMOs and providers. AHCA staff estimate the costs of HIPAA implementation in Florida to average between $24,000 and $30,000 per office practice. (p. 17)

*C) Late Payments*

1. *Interest Payments* -- Section 641.3155 should be clarified to indicate that interest on the late payment of a claim begins to accrue when the payment is overdue, i.e., 35 days after the receipt of a clean claim. The statute should also clarify that the accrued interest must automatically be included with any late payment of a claim. This revised statute should apply equally to payment to contracted and non-contracted providers. (p. 18)

2. *Venue for Complaints and Dispute Resolution* -- Florida needs to institute and supervise a mechanism for resolving claims disputes that are not satisfactorily resolved by the plans' internal provider appeals processes. This mechanism should be available to both contracted and non-contracted providers. The scope and procedures of such a mechanism need to be carefully defined so as not to be invoked in an enormous volume of disputes and not to create incentives for frivolous or unmerited appeals. (p. 18)

3. *Sub-Contractor Processing and Payment of Claims* -- In instances where an HMO delegates authority for issuing authorization or processing or paying claims to a third-party subcontractor, the current policy of the Department of Insurance is to hold the licensed HMO

financially and legally responsible for all actions or failures to act of the third-party subcontractor. The Advisory Group and the Agency support this policy. (p. 19)

*D) Claims Review*

1. *Eligibility Determination* -- Insurers should not be permitted to deny claims because of member ineligibility more than 1 year after the date of service. Employers should be required to notify insurers of changes in eligibility status within 30 days. (p. 19)

2. *Receipts* -- Providers who submit claims electronically should be entitled to electronic acknowledgment of receipts of claims. Providers who receive acknowledgment of receipts of claims should be prohibited from sending a duplicate bill for 45 days. (p. 19)

3. *Take Backs* -- Take backs should be treated as claims made by an HMO to a provider. Insurers should provide written notice to providers of all over-payments, and providers should have a standard amount of time to return such payments or appeal the insurer's determination. The time period and penalties for repayment should be the same as for initial payment, 35 days to pay or contest, then so many days to resolve the conflict, etc. Only after all the requirements concerning notification and correspondence are satisfied, which can take as long as 120 days, can the insurer reduce payments to compensate for prior overpayments. (p. 19)

*E) Balance and Duplicate Billing*

1. *Enforcement of Balance Billing Prohibition* -- The appropriate authorities to enforce the prohibition against balance billing by professionals are the Board of Medicine and other state professional boards, and such boards shall enforce the prohibition. AHCA, in its role as investigatory agency, shall refer cases of repeated balance billing to professional boards. Balance billing by facilities shall be referred to AHCA in its role of assuring health facility compliance. Providers should be prohibited from balance billing a subscriber for covered services. Providers may not balance bill patients while billing disputes are going through any future state supervised dispute resolution process. (p. 20)

2. *Medical Necessity* -- Except in emergency situations, if an HMO denies authorization for a service on the grounds that it is not medically necessary, then the treatment is not covered by the HMO, and the provider is entitled to bill the patient for the service. It is important to educate the subscriber that he or she will be responsible for payment of services under these conditions. (p. 20)

3. *Non-Covered Services* -- Providers have a right to bill patients for non-covered services. (p. 20)

4. *Non-Participating Providers* -- Current s. 641.315, F.S., is ambiguous because the heading refers to provider contracts, but the language says no provider is permitted to balance bill. The Advisory Group recommends eliminating this ambiguity by changing the heading of the statute. Non-participating providers should not bill patients (beyond HMO copayments) if they are billing the HMO, going through a dispute resolution process to

secure payment from an HMO or have accepted HMO payment for this specific service. (p. 20)

5. *Restriction on Referral to Credit Agencies* -- It is inappropriate for providers to refer patients to credit agencies for failing to pay bills that are illegal balance bills, as clarified by the above recommendations.

*F) Non-Participating Providers*

Recommends that when a physician empowered by an HMO (through formal delegation of authority) to make referrals and authorize treatment refers a patient to another provider, then the HMO is obligated to reimburse that other provider for the authorized services. (p. 21)

*G) Fraud and Abuse*

1. *Automated Recoding of Claims* -- Systematic downcoding by payors or upcoding by providers, which are distinct from bundling, when the only information available is the original code, are clearly inappropriate. The Department of Insurance has already issued a Statement to that effect. (p. 22)

2. *Incentives for Billing Agent to Submit Fraudulent Claims* -- Florida should follow the same policies as Medicare. Under current Medicare regulations, billing agents who receive a percentage of charges or receipts are prohibited from collecting payments. This policy may or may not be strengthened, revised or enforced more stringently by the Health Care Financing Administration in the near future. Similarly, if Medicare implements a policy against percentage incentives for HMO audit or credit collection firms, the Advisory Group recommends that Florida do likewise. (p. 22)

3. *Reporting Liability of Additional Payors* -- The Advisory Group urges all providers to ascertain and report liability of additional payors besides commercial HMOs. (p. 22)

4. *Auditing of Claims* -- Providers should not charge HMOs for auditing claims on site as long as there are no copying costs or significant demands on provider staff time. If there are such costs, the provider can charge them to the HMO, but still should not add an extra charge for HMO staff reviewing provider records. (p. 22)

5. *Civil Liability of Whistleblowers* -- Requested the Department of Insurance to research and determine whether there needs to be additional immunity for private individuals or private sector employees who report or investigate suspected fraud. (p. 22)

*Issues and Recommendations: Emergency Treatments*

1. *Hospital Code System* -- The Advisory Group acknowledges AHCA's review of Medicaid standards concerning the coding of hospital emergency department treatments. The group recommends that AHCA look into redoing the Florida Medical Quality Assurance Inc. (FMQAI) study of hospital emergency room coding in light of the objections to that study that have been presented to the group. (p. 26)

2. *Availability of Specialized Physicians for Emergency Treatment* -- In cases where hospitals or other providers have difficulty finding contracted specialists or other needed providers who are affiliated with a specific HMO, the hospital should notify the HMO as soon as possible. If a serious problem persists, the provider experiencing difficulty should notify the AHCA Bureau of Managed Care, which assesses HMO network adequacy. Access to emergency care is addressed in s. 395.1041. This law gives the Agency comprehensive and detailed responsibility for assuring that all parts of the state have an adequate emergency care network and that all persons have access to the emergency care they need. (p. 26)

## III. Effect of Proposed Changes:

CS/SB 1508 contains many of the recommendations of the Report of the Advisory Group on the Submission and Payment of Health Claims, established by AHCA.

**Section 1** amends s. 641.315, F.S., which currently provides that no subscriber of an HMO is liable to any provider of health care services for any services covered by the HMO, and prohibits a provider from collecting or attempting to collect from an HMO subscriber any money for services covered by an HMO.

The bill specifies that the balanced billing prohibitions apply to either a contracted or non-contracted provider who provides covered services to an HMO subscriber. This is a clarification of the current law, as read literally and interpreted by the department and agency. The bill changes the heading of this section from "Provider contracts" to "Provider billing," to further clarify that the statute applies to non-contract providers.

The bill prohibits a provider from billing the subscriber during any ongoing dispute resolution process. A provider would be specifically prohibited from reporting a subscriber to a credit agency for unpaid claims due from an HMO for covered HMO services. A violation of the balanced billing prohibitions by a physician must be referred to AHCA for investigation and to the Board of Medicine for final disciplinary action. A violation by an institutional provider must be referred to AHCA for investigation as part of its Consumer Assistance Program.

The bill also provides that the responsibility for claims payment to providers rests with the HMO and not with any party to which the HMO has delegated the functions of claims or management claims processing. The language of the bill applies this provision to an "HMO/MCO" which is not defined or spelled out. The term "MCO" apparently refers to a managed care organization, but there is no definition of this term. This section would appear to have no application to any entity other than an HMO.

**Section 2** amends s. 641.3155, F.S., the HMO "prompt payment" statute. The bill limits the requirement for an HMO to pay claims within 35 days of receipt, to a "clean claim" or any portion of a "clean claim" filed by a contract provider. "Clean claim" is defined as a completed claim submitted by institutional providers on a UB-92 claim form or by other providers on a HCFA 1500 claim form for medical care or health care services under a health care plan. The Department of Insurance is authorized to adopt rules revising the definition of clean claim, to be consistent with federal claim filing standards for health care plans as required by the Health Care Financing Administration.

If a claim or a portion of a claim meets the definition of "clean claim" the HMO would be required to *pay* the claim within 35 days if it does not contest or deny the claim. However, the HMO would still be required to notify a provider within 35 days if the HMO *contests or denies* a claim, regardless of whether the claim is a "clean claim" or not, (because the bill uses the term "claim" in this provision.) The bill clarifies that the requirement for an HMO to notify the provider within 35 days if the HMO denies or contests the claim, applies if the HMO denies or contests "any portion of a claim."

The bill does not impose additional penalties for late payments of claims by HMOs, but clarifies when the interest begins to accrue. Interest on overdue payments for a clean claim or for any uncontested portion of a clean claim would begin to accrue on the 36th day after the claim has been received. Interest is payable with the payment of the claim.

Interest on overpayments to providers begins to accrue on the 36th day after the provider receives notice of overpayment and HMOs may offset any interest due against future claims. Upon the 36th day, HMOs must be allowed to offset any interest payment due against future claims.

The bill requires providers to implement electronic billing in accordance with the implementation schedule established by the Health Insurance Portability and Accountability Act, (but the implementation schedule is reportedly delayed and has not been definitively established.) The Department of Insurance would be authorized to grant special consideration and variance to the implementation schedule to rural hospitals and physician's practices. In context, these electronic billing requirements appear to be conditions of triggering an HMO's requirements under the prompt payment statute, rather than a requirement that would trigger sanctions by any state agency if violated, but this is not clear. The bill does state that providers who bill electronically are entitled to electronic acknowledgment of receipts of claims within 48 hours.

The bill provides that the time limit for recouping or collecting outstanding claims may not exceed 1 year for either a contracted or a non-contracted provider. This is the only provision that would be applied to non-contract providers. The rest of the section would continue to be limited to claims by contract providers.

**Section 3** creates section 641.3156, F.S., related to treatment authorization and payment of claims. The bill requires HMOs to pay a hospital service claim or referral service claim for treatment that was authorized by a physician empowered by the HMO to authorize or direct the patient's utilization of health care services and that was also authorized in accordance with the HMO's current and communicated procedures. An HMO could not retroactively deny such authorized claims, *unless* the service is not covered, the subscriber was ineligible at the time of service, or the physician provided information to the HMO with the willful intention to misinform.

**Section 4** amends s. 641.495, F.S., related to requirements for the issuance and maintenance of an HMO certificate of authority. The bill requires HMOs to have the capability to provide treatment authorization 24 hours a day, 7 days a week. Requests for treatment authorization may not be held pending by the HMO unless the requesting provider contractually agrees to take a pending or tracking number.

**Section 5** creates s. 408.7057, F.S., related to the statewide provider and managed care organization claim dispute mediation panel. AHCA must establish a program to provide assistance to contracting and noncontracting providers and managed care organizations for those claim disputes that are in violation of the prompt payment statute (s. 641.3155) and are not resolved by the provider and the managed care entity. AHCA would be required to contract with a qualified independent third-party claims dispute resolution organization to review and consider claims disputes and to recommend to the agency an appropriate resolution of those disputes.

"Managed care entity" is defined as this term is currently defined in s. 408.7056, F.S., related to the statewide provider and subscriber assistance panel, to mean an HMO or prepaid health clinic certified under chapter 641, a prepaid plan [for Medicaid] authorized under s. 409.912, F.S., or an exclusive provider organization certified under s. 627.6472, F.S.

The panels would not hear disputes for a claim that is $5,000 or less for a claim against an institution or $1,000 or less for a claim against a physician. Another significant exception is that the panels would not hear any claim that is subject to a binding claims dispute resolution process provided by contract between the provider and the managed care entity. Other exceptions include claims related to interest payments; disputes based on any action that is pending in state or federal court, and exceptions related to Medicare and Medicaid claims.

AHCA would be required to adopt rules to establish a process for the consideration by the resolution organization of claims disputes, which must include the issuance of a written recommendation, supported by findings of fact, to AHCA within 60 days after receipt of the claims dispute submission. Within 30 days after receipt of the recommendation of the resolution organization, AHCA must issue a final order subject to the provisions of chapter 120. The bill does not specify the allowable scope of the recommendations by the review organization, other than to recommend "an appropriate resolution of the dispute." The bill also does not specify what actions or penalties may be ordered by AHCA against either the managed care entity or the provider. In addition to penalties authorized under current law for statutory penalties for violations, the bill may be interpreted to allow the agency to order managed care entities to pay claims, but this is not clear.

The entity that does not prevail in the agency's order must pay a review cost to the review organization as determined by agency rule with must include an apportionment of the fee in those cases where both parties may prevail in part. The failure of the nonprevailing party to pay the ordered review cost within 35 days of the agency's order subjects the nonpaying party to a penalty of not more than $500 per day until the penalty is paid.

**Section 6** creates an unnumbered section authorizing AHCA to adopt rules necessary to administer this act.

**Section 7** provides an effective date of October 1, 2000, and applies to all requests for claim dispute resolution which are submitted by a provider or managed care entity 60 days after the effective date of the contract between the resolution organization and the agency.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

The bill is entitled, "An act relating to health maintenance organizations," but the provisions of Section 5 apply to additional entities which are within the definition of "managed care entity" on page 8, line 23.

## V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill creates additional protections for all parties to an HMO contract, including providers, subscribers, and HMOs which should help alleviate claims disputes and clarify legal requirements.

Providers who do not currently bill electronically will incur costs to implement electronic billing. AHCA staff estimate the costs of HIPAA implementation of electronic billing requirements for physicians in Florida to average between $24,000 and $30,000 per office practice.

Managed care entities and providers will incur fees to fund the activities of the claims dispute resolution organization. The provider or managed care entity that does not prevail in the agency's order must pay a review cost to the review organization as determined by agency rule. AHCA would also be authorized to issue a final order subsequent to the recommendation of the review organization, but the bill does not specify the allowable scope of the order. In addition to penalties authorized under current law for statutory penalties for violations, the bill may be interpreted to allow the agency to order managed care entities to pay claims.

HMOs would incur costs from the requirement to be able to provide treatment authorization 24 hours a day, 7 days a week.

C. Government Sector Impact:

AHCA would incur costs in contracting with independent claims dispute resolution organizations, but the bill provides that the provider or managed care entity that does not prevail in the agency's order must pay a review cost to the review organization as determined by agency rule. So, it is unknown to what extent this cost would be apportioned between AHCA and private parties, but it could possibly be borne entirely by the private parties. AHCA would incur costs related to issuing orders following receipt of recommendations by the resolution organization, which costs have not been estimated. [Previous estimates by AHCA for operating an agency (in-house) claims dispute panel was $895,474 for the first year and $773,239 annually thereafter, based on an estimated 13.5 new FTE positions and an estimated 40 hearings per month.]

## VI. Technical Deficiencies:

The language of the bill on page 2, lines 15 and 19, and on page 7, line 25 applies certain provisions to an "MCO" which is not a defined term or otherwise spelled out. The term "MCO" apparently refers to a managed care organization, which is synonymous with HMO as used in the Advisory Group Report (see page 1). Also, part I of chapter 641, F.S., in which such references to "MCO" are placed, has no application to any entity other than an HMO.

On page 8, line 21, and on page 9, lines 3, 8, 13, and 31, the term "managed care organization(s)" is used which should, instead, refer to "managed care entity (entities)" which is the term defined on page 8, line 23. (Newly created s. 408.7057, F.S., related to dispute resolution, applies to HMOs and other entities within the definition of "managed care entities," unlike the rest of the bill's provisions which are in chapter 641, F.S., and apply only to HMOs.)

## VII. Related Issues:

CS/SB's 706 and 2234 by Banking and Insurance Committee and Senators Laurent and Saunders, addresses similar issues to those addressed in CS/SB 1508, but is not consistent with this bill.

## VIII. Amendments:

None.