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's 706 and 2234

SPONSOR: Banking and Insurance Committee and Senators Laurent and Saunders

SUBJECT: Health maintenance organizations

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

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

I. Summary:

CS/SB's 706 and 2234 makes the following changes to the laws relating the HMOs and the payment of provider claims:

- Requires HMOs to: (1) maintain on-line or telephone services 24 hours, 7 days a week for confirming subscriber eligibility and authorization of services.

- Provides that an HMO is bound by, and required to make payment for an eligible subscriber upon receipt of authorization as required by s. 641.495(4), (which requires HMO authorization and confirmation of eligibility within 60 minutes of the request), for covered medical services ordered by a provider and entered on the patient's medical record or covered medical services ordered by the HMO's employee or by an entity contracting with or acting on behalf of the HMO.

- Requires an HMO to notify the provider within 14 days after receipt of a claim whether it is deficient in any way, whether the patient receiving the service is an eligible subscriber, or if the service is not authorized. Failure to do so constitutes a complete waiver of the HMO's right to deny any part of the claim.

- Requests for treatment authorization may not be held pending. Requires the HMO to confirm, by FAX or electronically, subscriber eligibility and authorization within 60 minutes of the request.

- Requires an HMO to disclose to contract providers the mailing or electronic address where claims should be sent for processing; the telephone number a provider may call for questions; and the address of any separate claims processing centers for specific types of services. The HMO must provide written notice to contract providers at least 30 days prior to any change in this information.

- Applies the prompt payment statute, s. 641.3155, F.S., to claims by non-contract providers.

- Applies the requirements of the prompt payment statute (s. 641.3155) to a "clean claim," defined as determined under Department of Insurance rules, submitted by institutional providers on specified claim forms.

- Allows the provider to charge the HMO the reasonable costs of copying and providing any additional information requested by the HMO, including reasonable staff time.

- Provides that a claim shall be considered received by the HMO, if the claim has been electronically transmitted, when receipt is verified electronically; or if the claim is mailed to the address disclosed by the HMO, on the date indicated on the return receipt. Providers must wait 45 days before resubmitting a duplicate claim.

- Increases the penalty for overdue payments: an overdue payment, either after 35 days for clean, uncontested claims, or after 120 days for all other claims, reverts to the provider's billed charges. The failure of the HMO to pay or claim in a timely manner constitutes a waiver of the discount agreed to by the provider and the HMO.

- Authorizes the Department of Insurance to assess a penalty of between $750 and $1,000 for each non-willful violation, and between $2,500 and $10,000 for each knowing and willful violation of ss. 641.3901, 641.3903 (all current and new unfair trade practices), or 641.3155 (prompt payment). Each claim not paid in accordance with s. 641.3155 shall constitute a separate violation.

- Prohibits "take backs" of overpayments through reduction of current payments, which would be an unfair trade practice subject to department sanctions; and repeals current s. 641.3155(4) which requires take-backs to be reconciled to specific claims.

- Creates the Statewide Provider and Managed Care Organization Claim Dispute Mediation Program. AHCA must establish a program to assist contracting and noncontracting providers and managed care entities to assist providers whose claims are not resolved to their satisfaction and a managed care entity that seeks to recover an overpayment.

The provisions related to the claims dispute medicate program contain exemptions from public meetings and records laws, which must, constitutionally, be contained in a separate bill.

This bill substantially amends the following sections of the Florida Statutes: 641.31, 641.315, 641.3155, 641.495, and 641.3909. 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.

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

Problems related to claims filed with HMOs for emergency care and treatment led to the enactment of legislation requiring 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 1927 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*
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

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

(p. 19)

E) Balance and Duplicate Billing

Enforcement of Balance Billing Prohibition -- The appropriate authorities to enforce the

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.

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

2. *Medical Necessity*
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

conditions. (p. 20)

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

Non-Participating Providers -- Current s. 641.315, F.S., is ambiguous because the

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

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

Restriction on Referral to Credit Agencies -- It is inappropriate for providers to refer

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

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:

Section 1 creates s. 408.7057, F.S., relating to the statewide provider and managed care organization claim dispute mediation program. AHCA must establish a program to assist contracting and noncontracting providers and "managed care entities" with regard to claim disputes that are not resolved by the managed care entity to the satisfaction of the provider and to provide assistance to managed care entities that seek to recover an alleged overpayment to a provider. The program must consist of one or more panels that meet as often as necessary to review and hear grievances and recommend to AHCA and the Department of Insurance any actions that should be taken. [However, some of the provisions refer only to the "agency" (AHCA) issuing a final order following the panel's recommendation, as summarized below.]

"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, or an exclusive provider organization certified under s. 627.6472, F.S.

The panel would not hear grievances for a claim that is $5,000 or less for institutional claims or, in the aggregate, $500 or less for physician claims. The panels would also not hear any claim that was filed before the provider or the managed care entity made a good-faith effort to resolve the dispute. Other exceptions include disputes based on any action that is pending in state or federal court, and exceptions related to Medicare and Medicaid claims.

The panel must be composed of eight members, consisting two medical directors of health maintenance organizations holding a certificate of authority in Florida; a physician licensed under chapter 458 or 459 (allopathic or osteopathic); a physician licensed under chapter 460 (chiropractor); a physician licensed under chapter 461 (podiatrist); a member who represents a hospital; an employee of AHCA; and an employee of the department. The Governor appoints the six members of the panel who are not employed by the agency or department. Each member must be proficient in coding methodology.

AHCA would be required to review all requests for claims dispute resolution within 30 days after receipt and make a determination whether the dispute shall be heard. Once all parties are notified, the panel must hear the claims dispute within 60 days after the date the claims dispute was filed, unless waived by all parties. The panel may take testimony under oath and request certified copies of documents. The panel must issue a written recommendation, supported by finding of fact, to the provider and the managed care entity within 30 days after the hearing. The proceedings of the panel are not subject to chapter 120, F.S. The agency, upon receiving patient authorization, may request medical records from a health care provider or managed care entity who must provide such records within 10 working days, subject to a $500 fine for failure to do so.

The panel must make a recommendation to AHCA which may include specific actions the managed care entity must take to comply with state laws or rules, including payment of the unpaid portion of any claim or the provider's billed charges. For claims disputes filed by a managed care entity seeking recovery of an overpayment, the panel's recommendation may include requiring the provider to refund any overpayment.

Within 30 days after the issuance of the panel's recommendation, AHCA may adopt the panel's recommendation or findings of fact in a final order as provided in chapter 120, issued to the managed care entity and the provider. The final order may require payment of the unpaid portion of any claims or the provider's billed charges, which must bear interest at a rate of 10 percent from the 36th day after the date the managed care entity received the claim. For claims disputes filed by a managed care entity seeking recovery of an overpayment, the final order may require the provider to refund any overpayment. The agency or the department may modify all or apart of the panel's recommendation as provided in s. 120.57, F.S. (The bill is not consistent in referring to "the agency" or "the agency or the department" with regard to issuance of orders subsequent to the recommendations of the panel.)

Meetings of the panel are open to the public unless the provider, managed care entity, or the agency determines that information of a sensitive personal nature which discloses a subscriber's medical treatment or history; information which constitutes a trade secret; or information relating to internal risk management programs may be revealed at the panel meeting, in which case that portion of the meeting during which such information is discussed is exempt from the open meetings provisions of s. 286.011, F.S., and the public records and meetings requirements, s. 24(b), Art. I of the State Constitution. (See Constitutional Issues, below.)

Section 2 amends s. 641.315, F.S., relating to provider contracts. The bill provides that an HMO is bound by, and required to make payment for an eligible subscriber upon receipt of authorization as required by s. 641.495(4), (which requires HMO authorization and confirmation of eligibility within 60 minutes of the request), for covered medical services ordered by a provider and entered on the patient's medical record or covered medical services ordered by the HMO's employee or by an entity contracting with or acting on behalf of the HMO.

The statutory cross-reference, cited above, is to the bill's requirement that each HMO maintain on-line or telephone service 24 hours, 7 days a week, for confirming subscriber eligibility and authorization of services. If prior authorization is required by the HMO-provider contract, the HMO must confirm, by facsimile or electronic transmission, subscriber eligibility and authorization of services within 60 minutes of the request. It is not clear if the bill means that the *failure* of the HMO to confirm or deny subscriber eligibility or authorization of services within 60 minutes would bind the HMO for covered medical services ordered by the provider, for which authorization was requested but not obtained. It is also unclear whether the HMO could deny coverage, in any event, on the grounds that a subscriber was not eligible, due to the reference to this term on page 6, line 18.

Another issue, which appears to be contrary to the original bill sponsors' intent, is raised by the absence of a semicolon (;) on page 6, line 15, after the word, "record." (Original drafts of this amendment inserted a semicolon.) Without the semicolon, the condition of "receipt of authorization as required in s. 641.495(4)," modifies the requirement that the HMO pay for covered medical services ordered by the HMO's employee or by an entity contracting with or acting on behalf of the HMO. It was the apparent intent of the original bill sponsors to have this requirement stand alone without being modified by receipt of authorization. But that, in itself, would be unclear with regard to whether it would be intended to require an HMO to pay for any covered services ordered by a contract physician as one who is "an entity contracting with or acting on behalf of the HMO."

The bill requires an HMO to disclose to contract providers: (a) the mailing address or electronic address where claims should be sent for processing; (b) the telephone number a provider may call to have questions; and (c) the address of any separate claims processing centers for specific types of services. The HMO must provide written notice to contract providers at least 30 days prior to any change in this information.

Section 3 amends s. 641.3155, F.S., related to the provider contracts and payment of claims, often referred to as the "prompt payment" statute.

"Clean claim" is defined as a completed claim, as determined under Department of Insurance rules, submitted by institutional providers on a UB-92 claim form or by other providers on a HCFA 1500 claim form. The department must use the most recently adopted format adopted by the National Uniform Billing Committee (NUBC) for institutional providers and by the National Uniform Claims Committee (NUCC) for all other providers. (A definition has been adopted by the NUBC, but has not yet been adopted by the Health Care Financing Agency. No definition has yet been adopted by the NUCC. See Constitutional Issues, below.)

The bill substitutes the term "clean claim" for most uses of the term "claim" in s. 641.3155, F.S., which requires HMOs to pay, contest, or deny claims within 35 days and related time frames. It would appear to be the general intent to require an HMO to pay a clean claim within 35 days. However, the bill also limits the HMO's requirement to deny or contest a "clean claim" within 35 days, implying that if a claim is not a clean claim, there is no obligation on the HMO to contest or deny the claim within any specific time period, which may not be the sponsors' intent.

However, the bill also requires an HMO to notify the provider within 14 days after receipt of a claim (not a "clean claim") whether it is deficient in any way, whether the patient receiving the service is an eligible subscriber, or if the service is not authorized. Failure to do so constitutes a complete waiver of the HMO's right to deny any part of the claim. This requirement is in addition to the requirement that an HMO contest or deny a clean claim within 35 days of receipt.

The bill allows the provider to charge the HMO the reasonable costs of copying and providing the additional information, including the cost of reasonable staff time, as provided in ss. 395.3025 and 455.667, F.S. The first cited section allows licensed facilities to charge up to $1 per page, and up to $2 for non-paper records, including sales tax and actual postage. A fee of up to $1 may be charged for each year of records requested. Under the latter section, individual physicians and other specified health care professionals may charge no more than the actual cost of copying, including reasonable staff time, or the amount specified in administrative rule by the appropriate board, or the Department of Health when there is no board.

The bill requires HMOs to pay the provider the uncontested portion of a claim as a condition of contesting a portion of a clean claim. (As noted above, this requirement would not appear to apply to an HMO contesting a portion of a claim that did not meet the definition of a clean claim.) The failure to pay the uncontested portion of a claim would constitute a complete waiver of the HMO's right to deny any part of the claim.

The bill deletes the current 10 percent penalty for late payments and provides that overdue payments, either after 35 days for complete, uncontested claims, or after 120 days for all other

claims, revert to the billed charges for hospitals and to the usual and customary charges for other providers. In such a case, the HMO must waive any discount contractually agreed to by the

The bill provides that a claim shall be considered received by the HMO, if the claim has been electronically transmitted, when receipt is verified electronically; or if the claim is mailed to the

receipt. Providers must wait 45 days before resubmitting a duplicate claim.

The bill repeals current s. 641.3155(4). F.S., which requires any retroactive reduction of payment parties agree to other methods and terms. See Section 5 of the bill, below which prohibits take practice subject to department sanctions.

amends s. 641.495, F.S., related to requirements for issuance of a certificate of

hours, 7 days a week, for confirming subscriber eligibility and authorization of services. If prior electronic transmission, subscriber eligibility and authorization of services within 60 minutes of confirm eligibility or authorization within 60 minutes, which is unclear.)

amends s. 3903, F.S., related to unfair methods of competition and unfair or deceptive unfair trade practices for an HMO:

641.315(2) (which requires payment for covered medical services ordered by a provider and contracting with or acting on behalf of the HMO under certain conditions). (See Section 1 for

- downcoding of a provider's claim without seeking additional information or documentation;

- failing to promptly provide a reasonable explanation in writing to the provider of the basis in

The bill also specifies that the current unfair practices related to claims settlements applies to

See Section 6, below for penalties for violation of this section.

amends s. 641.3909, F.S., related to cease and desist and penalty orders. The bill adds a violation that would authorize a cease and desist order and penalty under this section. This section

also applies to any commission of an unfair trade practice by an HMO, as amended by Section 5 of the bill, above. The bill authorizes the Department of Insurance to assess a penalty of between $750 and $1,000 for each non-willful violation, and between $2,500 and $10,000 for each knowing and willful violation, notwithstanding s. 641.25, F.S. Each claim not paid in accordance with s. 641.3155 shall constitute a separate violation. (There is no cap for all violations arising out of the same action.)

Currently, under ss. 641.25 and 641.23, F.S., if the department finds that an HMO is not operating in compliance with part I of chapter 641, the department may impose a fine for a nonwillful violation not to exceed $2,500 per violation, not to exceed an aggregate amount of $25,000 for all nonwillful violations arising out of the same action. with respect to any knowing and willful violation, the department may impose a fine not to exceed $20,000 for each violation, not to exceed $250,000 for all willful violations arising out of the same action.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

Section 1 of the bill provides exemptions from the open meeting laws in s. 286.011, F.S. and from the public records and meetings requirements of s. 24(b), Art. I of the State Constitution. Such requirements must be contained in a separate bill, due to the provisions of Article I, s. 24(b) of the Florida Constitution which states, "Laws enacted pursuant to this subsection shall contain only exemptions from the requirements of subsections (a) or (b) and provisions governing the enforcement of this section and shall relate to one subject."

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 1 apply to additional entities which are within the definition of "managed care entity" on page 2, line 1.

Section 3 of the bill requires the Department of Insurance to adopt rules that use formats adopted by specified national committees, which formats have not yet been adopted and may be deemed to be an unconstitutional delegation of legislative authority.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

HMOs would be expected to incur additional expenses due to the following provisions of the bill: (1) requiring HMOs to pay for services ordered by a provider upon providing authorization (or possibly failing to provide authorization within certain time frames), or ordered by the HMO's employee or by an entity contracting with or acting on behalf of the HMO; (2) requiring HMOs to pay claims if they fail to notify the provider within 14 days after a claim has been received that the claim is deficient in any way, that the patient is no longer an eligible subscriber, or that the service was not authorized; (3) providing that the failure to pay the uncontested portion of a claim would constitute a waiver of the HMO's right to deny any part of the claim; (4) providing that overdue payments revert to the provider's billed charges and that the HMO must waive any contractual discount; (5) being potentially liable for an administrative penalty of up to $750 and $1,000 for each non-willful violation, and between $2,500 and $10,000 for each knowing and willful violation, (with no cap for all violations arising out of the same action) for current and new unfair or deceptive acts of practices; (6) requiring each HMO to maintain on-line and telephone services 24 hours, 7 days a week for confirming subscriber eligibility and authorization of services, and prohibiting an HMO from giving a provider a pending authorization. Such additional costs to HMOs would be expected to be passed on in higher premiums to subscribers.

Many of the above provisions would operate to the economic benefit of health care providers providing covered services to HMO subscribers. The bill may also benefit subscribers by expediting the payment of claims and ensure prompt treatment authorization.

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.

The bill allows the provider to charge the HMO the reasonable costs of copying and providing additional information requested by the HMO about a claim, including the cost of reasonable staff time, as provided in ss. 395.3025 and 455.667, F.S. The first cited section allows licensed facilities to charge up to $1 per page, and up to $2 for non-paper records, including sales tax and actual postage. A fee of up to $1 may be charged for each year of records requested. Under the latter section, individual physicians and other specified health care professionals may charge no more than the actual cost of copying, including reasonable staff time, or the amount specified in administrative rule by the appropriate board, or the Department of Health when there is no board.

C. Government Sector Impact:

AHCA has not estimated the cost of implementing the state panel for resolving claims disputes between managed care entities and providers. However, AHCA estimated the costs for implementing a similar panel established by original SB 706, which the agency estimated would require 13.5 new positions with an initial funding of $1,052,513 and $773,239 in annual recurring funding. The cost will be funded by increased rates of assessment against managed care entities for payment into the Health Care Trust Fund. The cost will be borne directly by the managed care entities, and indirectly by the subscribers through increased premium payments.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.