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****AS PASSED BY THE LEGISLATURE****
CHAPTER #: 2002-389, Laws of Florida

HOUSE OF REPRESENTATIVES

HEALTH PROMOTION
FINAL ANALYSIS

BILL #: HB 37-E (PASSED AS SB 46-E)

RELATING TO: Health Care/Health Flex Plans

SPONSOR(S): Representative(s) Diaz-Balart and Fasano & others

TIED BILL(S): HB 43-E, 3rd Eng.

ORIGINATING COMMITTEE(S)/COUNCIL(S)/COMMITTEE(S) OF REFERENCE:

(1) CALENDAR
(2)
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I. SUMMARY:

THIS DOCUMENT IS NOT INTENDED TO BE USED FOR THE PURPOSE OF CONSTRUING STATUTES, OR TO BE CONSTRUED AS AFFECTING, DEFINING, LIMITING, CONTROLLING, SPECIFYING, CLARIFYING, OR MODIFYING ANY LEGISLATION OR STATUTE.

HB 37-E: creates a pilot program, designated health flex plans, to provide health care coverage for low-income uninsured persons under the oversight of the Agency for Health Care Administration and the Department of Insurance.

Establishes the Florida Alzheimer's Center and Research Institute at the University of South Florida and a not-for-profit corporation for the governance and operation of the center and institute.

Revises various provisions relating to certain health insurers, health maintenance organizations, and health providers, specific to dispute resolution, claim submission, processing, payment, and processing of claims for overpayment. Revises the types of entities eligible to utilize the statewide provider and managed care organization claim dispute resolution program, adds new requirements, and re-designates the program title. Substantially revises prompt payment requirements. Specifies that an HMO contracting with certain entities transferring the obligation to pay providers remain responsible for any violations of specified statutes by those entities. Redefines the term "administrator" relating to the regulation of insurance administrators. Provides requirements relating to HMO third-party risk contracts. Modifies circumstances under which a provider knows that an HMO is liable for reimbursement.

Authorizes an HMO primary care physician to solely make referral decisions regarding ophthalmology services needs of subscribers.

Removes referrals for diagnostic clinical laboratory services related to renal dialysis from the list of orders, recommendations, or plans of care that are excluded from the definition of "referral" for purposes of the prohibitions and exceptions contained in the "Patient Self-Referral Act of 1992." The bill adds an exclusion from the definition of referral for a health care provider whose principal professional practice consists of treating patients in their private residences for services to be rendered in the private residence.

Revises various provisions relating to the Employee Health Care Access Act. Allows small employer carriers to rate small employer groups of 1 employee separately from groups of 2 to 50 employees. Permits an increase in the rate applicable to small employer groups of 1 employee, subject to a rate cap. Provides for an interim rate cap. Specifies that laws restricting or limiting to deductibles, coinsurance, copayments, or annual or lifetime maximum payments must be made expressly applicable to small employer group plans or policies.

Provides for statutory construction of laws enacted at the 2002 Regular Session in relation to this Act.

Provides for an October 1, 2002, effective date, with exceptions.

SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes []	No [X]	N/A []
2.	Lower Taxes	Yes []	No []	N/A [X]
3.	Individual Freedom	Yes []	No []	N/A [X]
4.	Personal Responsibility	Yes [X]	No []	N/A []
5.	Family Empowerment	Yes [X]	No []	N/A []

For any principle that received a "no" above, please explain:

Less Government: The bill provides that violation of various timeframes for payment of claims is a violation of the Florida Insurance Code and that each violation is a separate offense, thus increasing enforcement authority for the Department of Insurance. The Department of Insurance has added responsibilities relating to auditing an HMO's or health insurer's compliance with prompt payment of claims requirements and must determine and utilize a permissive error ratio of 5 percent.

The bill establishes a new institute on Alzheimer's research which promotes the ability of elderly Floridians and their families to maintain self-sufficiency.

Family Empowerment: The bill eliminates an exemption from the Patient Self-Referral Act, thereby reducing a physician's discretionary decision making as it relates to patient treatment options.

B. PRESENT SITUATION:

The Florida Health Insurance Study

In 1998, the Legislature created the Florida Health Insurance Study (FHIS) to be conducted by the Agency for Health Care Administration and the University of Florida. This multi-year project was intended to provide a detailed understanding of the exceedingly complex issues of uninsurance and health insurance coverage.

In its first year the study was composed of three major elements. The primary focus was a large-scale telephone survey of Floridians under the age of 65. From March to September of 1999, the research team surveyed over 14,000 households representing more than 37,000 individuals. The interviews emphasized health insurance coverage, health care utilization, employment, income, family structure, and demographic characteristics. In addition to the telephone survey, the first year, the FHIS included: a study to determine the number, location, and characteristics of community subsidized safety net organizations that provide health care to people without insurance; and 1,000 in-person interviews conducted in communities that are economically disadvantaged and known to have incomplete telephone coverage.

In 1999, the Legislature continued to build on the initial research generated by the FHIS by commissioning additional research. The FHIS was directed to evaluate the impact of welfare reform and the WAGES (Work and Gain Economic Self-Sufficiency) program on the number of medically indigent individuals in Florida. The FHIS team was asked to estimate or identify:

- The number of individuals who will lose their Medicaid coverage as they transition from welfare to work;
- The number of former welfare recipients who will lose their Medicaid coverage and fail to obtain adequate health insurance for themselves and/or their families; and
- The major barriers preventing these individuals from obtaining health insurance coverage, and make recommendations to address these issues including, but not limited to, the feasibility of implementing a Medicaid buy-in program.

On March 23, 2000, the agency released the results of one of the FHIS studies. This was the first such state-level study conducted in the nation to pinpoint who is not covered by health insurance. The FHIS study revealed that 2.1 million people in the state did not have health insurance in 1999, identified those areas of the state where there is a need for such coverage, and showed a significant decrease in the number of the non-insured population.

The two-phase study, which involved extensive data interpretation, culminated an extensive effort to pinpoint the uninsured population according to income, employment status, ethnicity, and region of the state, as well as the impact of the WAGES program on the uninsured. Of Florida's major metropolitan areas, Tampa, Orlando, Jacksonville, Palm Beach, and Ft. Lauderdale were all identified as below the statewide average of uninsured. Rural areas, especially around Lake Okeechobee and Immokalee, and metropolitan Dade County, where over 450,000 residents are not insured, were also identified as an area of concern.

The general findings of the study included:

- Uninsured - The number of uninsured Floridians in 1999 was placed at 2.1 million, down 560,000 from 1993 when a previous survey was taken. The state's population grew by nearly 2 million people during the same time.
- Income - Nearly half (938,527) of the uninsured earn less than 150 percent of the Federal Poverty Level (FPL), which currently is $26,475 for a family of four.
- Employment Status – 50 percent of the uninsured work full or part-time and 62 percent of Floridians gain access to health insurance through their employer. A majority of the working uninsured (89 percent) says they do not have health insurance because their employer does not offer it, or they are not eligible, or they cannot afford it.
- Size of employer - Employers with one to nine employees have the highest rate of uninsured (24.6 percent), compared to companies with 100 or more employees (4.78 percent).
- Ethnicity - Hispanics make up nearly one-fourth (492,154) of Florida's uninsured population. The rate of non-insurance for Hispanics (28.59 percent) is more than twice the rate of white non-Hispanics (13.2 percent) and almost 50 percent greater than the rate of African Americans (19.6 percent).
- Regional difference - The rates of uninsurance vary widely across the state, ranging from a high of 25.5 percent in District 13 (DeSoto, Glades, Hardee, Hendry, Highlands, Okeechobee, and Monroe counties) and 24.6 percent in District 17 (Dade County), to a low of 11.8 percent in District 6 (Lake, Osceola and Seminole counties) and 12.1 percent in District 4 (Duval County).

Governor's Health Care Summit

On September 21-22, 2000, a conference entitled, "The Florida Governor's Summit on Health Care: Solutions for the Uninsured," was held in Miami Beach, Florida. The summit was hosted by the Agency for Health Care Administration, with primary funding from the Robert Wood Johnson Foundation, as part of an existing grant to the state in support of the development and analysis of

insurance coverage expansion proposals, and in response to the Florida Health Insurance Study. The purpose of the summit was to stimulate thinking about Florida's options for health care policy, especially concerning methods to improve access, affordability, and availability of health coverage. A variety of national speakers, representing a variety of perspectives, addressed the several hundred people in attendance at the conference.

As a keynote speaker at the conference, Governor Jeb Bush highlighted health care accomplishments of this administration to date. He also identified specific issues of concern, including: too many uninsured forced to access the health care system in inappropriate ways, such as emergency room use; eroding quality of care; issues regarding who are the uninsured, and who needs access to care (based on Florida Health Insurance Study)--specific rural communities, especially around Lake Okeechobee, Hispanics and African Americans, and employees of small businesses. He also identified guiding principles to be followed in crafting solutions, including: recognizing, and not forgetting, that 17 percent of the uninsured will not opt into health insurance, even when available; avoiding harm and unintended consequences; striking a delicate balance between access, affordability, and quality; rewarding personal initiative (financial incentives); and recognition that basic insurance is better than no insurance (flexibility in coverage).

Among the major challenges identified by the Governor were making an affordable insurance product available for targeted groups, and enhancing the state's health care safety net. Specific issues of note included recognition that the uninsured need to seek care at more appropriate times and places, not the emergency room, and the fact that the insurance cost of Florida's 51 mandated health benefits adds 15-20 percent to the cost of health insurance.

The Governor indicated his desire to look at the uninsured and structure a basic insurance product that meets their needs on a geographic specific basis—which he referred to as "health flex communities." Such products would be:

- Free of mandates;
- A basic flexible policy for the uninsured in a community with a large volume of uninsured;
- Subject to minimum regulation;
- Offered by insurers recruited, or provider service networks specifically recruited, to offer this flexible product; and
- Catastrophic coverage, with some primary care coverage as a coverage option.

Health Insurance Regulation

A person or entity must obtain a certificate of authority (COA) from the Department of Insurance (department) in order to transact health insurance in this state. The department may not grant a COA if it finds the management, officers, or directors to be incompetent or untrustworthy or so lacking in insurance company managerial experience as to make the proposed operation hazardous to the insurance-buying public; or so lacking in insurance experience, ability, and standing as to jeopardize the reasonable promise of successful operation; or which it has good reason to believe are affiliated with any person whose business operations are to the detriment of policyholders, stockholders, investors, or of the public, by manipulation of assets, accounts, or reinsurance, or by bad faith. The department may deny a COA if any person who exercises or has the ability to exercise effective control of the insurer, or who has the ability to influence the transaction of the business of the insurer, has been found guilty of, or has pleaded guilty or nolo contendere to, any felony. In addition, the following conditions must be met:

- Before an insurer may be issued an original COA, it must maintain a minimum of surplus as to policyholders, equivalent to a net worth requirement. [s. 624.407, F.S.]

- The maximum amount of insurance that an insurer may write is controlled by its surplus as to policyholders. [s. 624.4095, F.S.]
- Insurers that issue health insurance policies in Florida are required to file their forms and rates for approval with the Department of Insurance, subject to specified conditions. [ss. 627.410 and 627.411, F.S.] [Note: These requirements apply to individual and group health insurance policies, Medicare Supplement policies, and long-term care policies.]
- Certain rating laws are designed to prohibit so-called "death spiral" rating practices. [s. 627.410(6)(d)-(e), F.S.]
- Health insurers must make an annual rate filing demonstrating the reasonableness of its premium rates in relation to benefits. [s. 627.410(7), F.S.]
- An insurer that issues individual health insurance policies is permitted to use a loss ratio guarantee as an alternative method for meeting rate filing and approval requirements. [s. 627.410(8), F.S.]
- The primary grounds for disapproval for health insurance rates are if the policy "provides benefits which are unreasonable in relation to the premium charged, contains provisions which are unfair or inequitable or contrary to the public policy of this state or which encourage misrepresentation, or which apply rating practices which result in premium escalations that are not viable for the policyholder market or result in unfair discrimination in sales practices." [s. 627.411(1)(e), F.S.]

In addition, the department has adopted rules that establish minimum loss ratio requirements for all types of health insurance policy forms. [4-149, F.A.C.]

Third Party Administrators

A TPA or Third Party Administrator is a professional organization hired to provide certain administrative services to employee benefit plans such as:

- Benefit processing and adjudication;
- Communication of benefits (consult and educate employers and participants);
- Stop loss coverage placement;
- Risk management (design, implement, administer and monitor all managed care programs);
- Provide sales support and related services;
- Consolidated billing services; and/or
- Outsourcing services (COBRA, HIPAA & other needed plan services).

Section 626.88, F.S., defines "administrator" and "insurer" as related to insurance administrators or TPAs.

Health Maintenance Organization Regulation

Health maintenance organizations (HMOs) provide a comprehensive range of health care services for a prepaid premium. Such organizations stress preventive care and make efforts to avoid unnecessary hospitalization and expensive tertiary care. Subscribers must surrender certain freedom of choice selections of health care providers and health care related services. Subscriber choice is typically restricted to a "gatekeeper" physician (primary care physician) or other health care professional that is either an employee of, or has contracted to provide professional services on behalf of, the subscriber's HMO. Furthermore, subscribers are restricted in their choice of hospitals and other health care delivery facilities that they may utilize.

Under present law, the Department of Insurance regulates HMO finances, contracting, and marketing activities under part I of ch. 641, F.S., while the Agency for Health Care Administration

(AHCA) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a COA from the department, an HMO must receive a Health Care Provider Certificate from AHCA. Any entity that is issued a certificate under part III of chapter 641 and that is otherwise in compliance with the licensure provisions under part I, may enter into contracts in Florida to provide an agreed-upon set of comprehensive health care services to subscribers in exchange for a prepaid per capita sum or prepaid aggregate fixed sum.

For HMO contracts, the department may disapprove rates that are excessive, inadequate, or unfairly discriminatory, which may be defined by rule of the department, in accordance with generally accepted actuarial practice as applied by HMOs. The department may also disapprove a rate if the rating methodology followed by the HMO is determined by the department to be inconsistent, indeterminate, ambiguous, or encouraging misrepresentation or misunderstanding. [s. 641.31(2), F.S.]

Subscriber Protections

HMO subscribers are statutorily provided certain subscriber protections as specified in s. 641.185, F.S., as follows:

- Access to health care services under reasonable standards of quality of care that are, at a minimum, consistent with the prevailing standards of medical practice in the community [ss.641.495(1) and 641.51, F.S.];
- Access to quality health care from a broad panel of providers, including referrals, preventative care, emergency screening and services, and second opinions [ss. 641.402(1), 641.31(12), 641.51, and 641.513, F.S.];
- Assurance that the HMO has been independently accredited by a national review organization and is financially secure as determined by the state [ss. 641.512, 641.221, 641.225, and 641.228, F.S.];
- Continuity of health care, even after the provider is no longer with the HMO [s. 641.51(8), F.S.];
- Access to timely, concise information regarding the HMO's reimbursement to providers and services [ss. 641.31 and 641.31015, F.S.];
- Flexibility to transfer to another Florida HMO regardless of health status [ss. 641.228, 641.3104, 641.3107, 641.3111, 641.3921, and 641.3922, F.S.];
- Eligibility for coverage without discrimination against individual participants and beneficiaries of group plans based on health status [s. 641.31073, F.S.];
- Coverage for preexisting conditions, guaranteed renewable of coverage, notice of cancellation, extension of benefits, conversion on termination of eligibility, and access to conversion contracts [ss. 641.31071, 641.31074, 641.3108, 641.3111, 641.3921, and 641.3922, F.S.];
- Receipt of timely and, if necessary, urgent grievances and appeals within the HMO [ss. 641.228, 641.31(5), 641.47, and 641.511, F.S.];
- Requires HMO to receive timely and, if necessary, urgent review by an independent state external review organization for unresolved grievances and appeals [ss. 641.228, 641.31(5), 641.47, and 641.511, F.S.];
- Written notice at least 30 days in advance of a rate change either by the HMO or the employer [s. 641.31(3)(b), F.S.]; and
- A copy of the applicable HMO contract, certificate, or member handbook specifying: all the provisions, disclosures, and limitations of HMO contract requirements; the covered services, including statutorily specified services, medical conditions, and providers; and where and in what manner services may be obtained [ss. 641.31(1) and (4), 641.31, 641.31094, 641.31095, 641.31096, 641.51(11), 641.513, and 641.31(4), F.S.].

Section 641.185, F.S., specifies that the section does not create a civil cause of action by any subscriber or provider against any HMO.

Payment Obligation

Section 641.3154, F.S., relating to balance billing, provides that if an HMO is liable for services rendered to a subscriber by a provider, regardless of whether a contract exists between the organization and the provider, the organization is liable for payment of fees to the provider and the subscriber is not liable for payment of fees to the provider. In addition, the section also defines when an HMO is liable for purposes of the statute. The section also provides that:

- An HMO is liable for services rendered to an eligible subscriber by a provider if the provider follows the HMO's authorization procedures and if the HMO receives authorization for a covered service for an eligible subscriber, unless the provider provided information to the health maintenance organization with the willful intention to misinform the health maintenance organization.
- Prohibits a provider or any representative of a provider, regardless of whether the provider is under contract with the HMO, from collecting or attempting to collect money from, maintain any action at law against, or report to a credit agency a subscriber of an organization for payment of services for which the organization is liable, if the provider in good faith knows or should know that the organization is liable.
- Specifies that this prohibition also applies during the pendency of any claim for payment made by the provider to the organization for payment of the services and any legal proceedings or dispute resolution process to determine whether the organization is liable for the services if the provider is informed that such proceedings are taking place.
- Creates a presumption that a provider does not know and should not know that an HMO is liable unless:
    - The provider is informed by the organization that it accepts liability;
    - A court of competent jurisdiction determines that the organization is liable; or
    - The Department or AHCA make a final determination that the HMO is required to pay for such services subsequent to a recommendation made by the Statewide Provider and Subscriber Assistance Panel pursuant to s. 408.7056, F.S.

Quality Assurance Program

Section 641.51, F.S., relating to quality assurance, among other provisions, requires that if a contracted primary care physician and the HMO determine that a subscriber requires an examination by a licensed ophthalmologist for medically necessary, contractually covered services, the organization must authorize the contracted primary care physician to send the subscriber to a contracted licensed ophthalmologist.

Health Risk Contracts

Health risk contracts are contracts between the health maintenance organization (HMO) and individual health care providers and institutional health care providers. Typically, the HMO contracts with a third party to provide to the HMO's subscribers, specified services offered by the HMO at a lump sum flat rate. The third party contracts with the health care providers and/or institutional health care providers to provide the contracted services and, typically, also provides such services as: medical management; centralized credentialing; claims processing; cost and utilization reporting; and provider relations.

Prompt Payment Of Claims

Other States

With health care providers complaining that laws requiring prompt payment of claims have not resulted in insurers and health maintenance organizations (HMOs) actually paying claims promptly, nine states, Florida among them, in their 2000-2001 legislative sessions revised their laws to tighten deadlines, stiffen fines, or attempt to close other loopholes that providers say allow plans to evade state-mandated time limits. According to a June 4, 2001, *American Medical Association News Report,* even more states are likely to consider further revisions to their prompt pay statutes and regulations in their next regular legislative sessions.

Currently, forty-eight states have put HMOs and/or health insurers on notice to pay clean claims in a timely fashion or face possible penalties and fines. The term "clean claim" generally means a claim that has no defect or impropriety or particular circumstance requiring special treatment. Most states require insurers to pay clean claims within 45 days, however state requirements range from 15 days (Georgia) to 60 days (Michigan). Under Georgia law, insurers are required to pay 18 percent interest on claims not paid within 15 days. Although Georgia's law is considered to be the strictest, Hawaii requires that claims filed electronically be paid within 15 days. The trend in the most recent state "prompt-pay" legislation is to adopt the Medicare standard of 95 percent clean claims paid within 30 days and all claims approved or denied within 30 days.

During their 2001 sessions, five states passed "prompt-pay" laws with specified interest requirements. Typically, these standards are similar, if not identical, to the Medicare 30-day prompt pay requirement.

State	Prompt-Pay Deadline	Interest Rate
Arizona	30 days	Rate equal to state legal rate
Kansas	30 days	1% per month
Kentucky	30 days	12% for up to 60 days and 21% after 90 days
Minnesota	30 days	1.5% per month
New Mexico	45 days	1.5 times state legal rate

Typical of the newly adopted "prompt-pay" laws is the Minnesota law, which requires all health plan companies and third-party administrators to pay or deny clean claims within 30 calendar days of receiving the claims, or face an interest penalty of 1.5 percent per month. The act defines "clean claim" to mean "a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or a particular circumstance requiring special treatment that prevents the timely payment from being made on a claim under this section." This is very similar to the definition for Medicare claims. The Minnesota act applies not only to health plan companies but also to third-party administrators. This act applies to all health care providers except pharmacists. The health plan company or third-party administrator must itemize any interest payment separately from other payments being made for services provided. The health plan company or third-party administrator may, at its discretion, require the health care provider to bill the health plan company or third-party administrator for the interest required under this section before an interest payment is made.

Health Insurers

Section 627.613, F.S., relating to time of payment of health insurer claims, requires health insurers to pay claims under a health insurance policy within 45 days after receipt of the claim by the health

insurer. If a claim or a portion of a claim is contested by the health insurer within the 45 days, then the insured or the insured's assignees must be notified, in writing, that the claim is contested or denied. Upon receipt of the additional information, a health insurer must pay or deny the contested claim or portion of the contested claim within 60 days. All claims must be paid or denied no later than 120 days after receiving the claim. Overdue payment of a claim accrues a simple interest rate penalty at the rate of 10 percent per year. Health insurance policies typically covered by this section include: Medicare supplemental policies, disease specific policies such as cancer policies, and long-term disability policies.

Health Maintenance Organizations

In 1999, the Legislature authorized the director of the Agency for Health Care Administration in ch. 99-393, L.O.F., to establish an advisory group on the submission and payment of health claims. The advisory group was composed of eight members, with three members from HMOs licensed in Florida, one representative from a not-for-profit hospital, one representative from a for-profit hospital, one representative who was a licensed physician, one representative from the Office of the Insurance Commissioner, and one representative from the Agency for Health Care Administration. The advisory group was required to study and make recommendations concerning timely and accurate submission and payment of health claims; electronic billing and claims processing; the form and content of claims; and measures to reduce fraud and abuse. The advisory board made its recommendations to the Legislature and Governor on February 1, 2001. The advisory board made the following recommendations for changes of the prompt payment of claims requirements:

- Clarification of the statute on the inclusion of interest with late payments.
- Development of a state-supervised mediation mechanism for both providers and managed care organizations for hearing and resolving claims disputes promises to help resolve serious disputes, including disputes over reimbursement for emergency care, and without the parties resorting to civil litigation or the termination of their contracts and service relationships.
- Clarification of the balance billing prohibition to make it easier to enforce this consumer protection statute.
- Adoption of the National Uniform Billing Committee definition of institutional clean claim and the endorsement.
- Adoption of the HIPAA Administrative Simplification process to expedite the standardization of claims forms and the automated processing of claims.
- Adoption of electronic claims processing by providers and insurers, as soon as possible.
- Require managed care organizations to pay for pre-authorized services except under very limited circumstances.
- Require a receipt for claims submitted electronically.

In the 2000 legislative session, s. 641.3155, F.S., relating to payment for claims requirements of health maintenance organizations (HMO), was substantially revised as part of ch. 2000-252, L.O.F. That law included the following:

- Deleted provisions relating to provider billings, revised provisions relating to provider contracts, provided for disclosure and notice, and required procedures for requesting and granting authorization for utilization of services.
- Provided for HMO liability for payment for services rendered to subscribers, and prohibited certain provider billing of subscribers.
- Defined the term “clean claim” in the institutional and non-institutional setting, and specified the basis for determining when a claim is to be considered clean or not clean.
- Required the Department of Insurance to adopt rules to establish a claim form and requirement for the form and granted discretionary rulemaking authority for coding standard.

- Provided for payment, denial, and contesting of clean claims or portions of clean claims, and provided for interest accrual, payment of interest, and an uncontestable obligation to pay a claim.
- Required HMOs to make a claim for overpayment; prohibited an HMO from reducing payment for other services and provided exceptions.
- Required providers to pay a claim for overpayment within a specified timeframe and procedures, timeframes for overpayments were specified, and created an uncontestable obligation to pay a claim for overpayment.
- Specified when an electronically transmitted or mailed provider claim is considered received; mandated acknowledgement of receipt for electronically submitted provider claims; prescribed a timeframe for an HMO to retroactively deny a claim for services provided to an eligible subscriber; and provided for treatment authorization and payment of claims for emergency services subject to specified provisions of law.
- Provided that downcoding with intent to deny reimbursement by an HMO is an unfair method of competition and an unfair or deceptive act or practice.
- Authorized the Department of Insurance to issue a cease and desist order for a payment-of-claims violation, and revised provisions relating to treatment-authorization capabilities.
- Established a statewide claim dispute resolution program for providers and managed care organizations for all claims for services rendered after October 1, 2000, submitted by a provider or managed care organization 60 days after a certain date, and provided the Agency for Health Care Administration specific rulemaking authority for the program. [s. 408.7057, F.S.]
- Authorized administrative sanctions against a hospital's license for improper subscriber billing and violations of requirements relating to claims payments.
- Provided that certain actions by a provider are punishable, and expanded a provision of law relating to fraud against hospitals to include health care providers.

Statewide Provider and Managed Care Organization Claim Dispute Resolution Program

In the 2000 legislative session, CS/CS/CS/SB 1508, created s. 408.7057, F.S., relating to the Statewide Provider and Managed Care Organization Claim Dispute Resolution Program. The bill required the Agency for Health Care Administration (agency) to contract with an independent third-party organization to resolve claims payment disputes between managed care organizations and providers, with the organization's final determination adopted by agency order.

The program provides for an independent mediator to hear disputes regarding amounts paid for services. The program requires that physicians have at least $500 in disputed claims to enter the process, hospitals must have $25,000 for inpatient treatment and $10,000 for outpatient services they believe they are owed. In addition, HMOs are also able to initiate the process after meeting the same $500 monetary threshold as physicians. In each case, the loser would pay the cost for the mediation. Submitted claims must be for dates of service after October 1, 2000.

On February 27, 2001, the Agency signed a two-year contract with Maximus to resolve claims disputes. Maximus was selected from eight firms through a competitive bid process. The Reston, VA-based firm has contracted since 1986 with the federal government to resolve Medicare beneficiary disputes with their managed care plans. The program became operational on May 1, 2001. On August 18, 2001, the Agency received 6 claims (1 was a duplication). According to a recent e-mail from Maximus, the company responsible for the independent mediation, only one health plan has responded to the mediation process. According to provider representatives, providers are hesitant to participate in the program due to its lack of public records exemption for its confidential and proprietary information and the potential costs associated with the review process to the non-prevailing party. The Agency issues final orders based on the recommendation by the

resolution organization and tracks compliance by the non-prevailing party. All review costs are borne by the parties involved in the dispute and fines can be levied for unpaid review costs.

The Employee Health Care Access Act

In 1992, the Legislature enacted the Employee Health Care Access Act (the act). [Section 627.6699, F.S.] An express purpose of the act is to promote the availability of health insurance coverage to small employers (i.e., under the act, at least 1 but not more than 50 eligible employees) regardless of their claims experience or their employees' health status. The components of the act applied toward this purpose are group rating through the use of "Modified Community Rating," comparability of policies through the formulation and approval of "standard" and "basic" plans and limited benefit (or "street") plans that reduce the impacts of mandated health benefits, and guarantee-issue to any small employer seeking coverage.

According to the Department of Insurance, as of December 31, 2001, there were 28 carriers offering small employer health benefit plans with additional withdrawals pending. This number reflects a continuing drop in recent years in the number of carriers offering small employer benefit plans in Florida. In 1997, there were 116 carriers offering small employer benefit plans in Florida. In 1998, there were 90 small employer carriers. While there has been a reduction in the number of carriers offering small employer group coverage, the market may nonetheless be competitive at current or lower levels of carrier participation. Some of the reduction in active small employer carriers may result from de-listing inactive small employer carriers and some consolidation in the health market generally.

According to recent membership surveys by the Florida Chamber of Commerce, 77 percent of employers offered health insurance benefits to their employees in fall of 2001. Earlier editions of the survey indicated that 86 percent of employers offered these benefits in 2000 and 91 percent offered them in 1999.

<u>Rates</u>

Application and Adjustment

The small employer carrier's rate, approved by the Department of Insurance, is applied to the pool of small employer policies written by the carrier collectively, not individually. On an individual policy basis, a small group carrier may adjust a small employer's rate from the approved rate by plus or minus 15 percent, based on health status, claims experience, or duration of coverage. Accordingly, any increase in small employer's individual rate should be offset by a reduction in the rate of other small employers in the pool. Also, the small employer's renewal premium may be adjusted up to 10 percent annually (up to the total 15 percent limit) of the carrier's approved rate, based on the same factors.

Rating Method

Modified Community Rating is a variation on Community Rating. Community Rating is a method of developing health insurance rates taking into account the medical and hospital costs in the entire community or area to be covered. Individual characteristics of the insured employer are not considered. Under Modified Community Rating, small employer carriers are permitted to additionally consider age, gender, family composition, tobacco usage, and geographic location. [s. 627.6699(3)(n), F.S.]

Alzheimer's Disease

Background

Alzheimer's Disease is a progressive, irreversible brain disorder with no known cause or cure. Symptoms of the disease include memory loss, confusion, impaired judgment, personality changes, disorientation, and loss of language skills. Always fatal, Alzheimer's Disease is the most common form of irreversible dementia. How rapidly it advances varies from person to person, but it eventually causes confusion, personality and behavior changes and impaired judgment. Communication becomes difficult as the affected person struggles to find words, finish thoughts, or follow directions. Most people with Alzheimer's Disease become unable to care for themselves. There is no known treatment that will cure Alzheimer's Disease. For those who are currently suffering with the disease, medications can help control symptoms or slow the progression of the disease.

Demographics

Alzheimer's Disease is the most common cause of dementia among people age 65 and older. Scientists estimate that up to 4 million people currently suffer with the disease, and the prevalence (the number of people with the disease at any one time) doubles every 5 years beyond age 65.

It is a major public health problem because of its enormous impact on individuals, families, the health care system, and society as a whole. Each year in the U.S., approximately 100,000 victims die and 360,000 new cases are diagnosed. It is also estimated that approximately 360,000 new cases (incidence) will occur each year and that this number will increase as the population ages (Brookmeyer et al., 1998). By 2050, experts predict that 14 million Americans will be living with the disease.

In every nation where life expectancy has increased, so has the incidence of Alzheimer's Disease. Similarly, as Florida's population has aged, the incidence of Alzheimer's has risen.

The Cost of Alzheimer's Disease

Alzheimer's Disease places an economic burden on society. A recent study estimated that the annual cost of caring for one Alzheimer's patient is $18,408 for mild Alzheimer's Disease, $30,096 for moderate Alzheimer's Disease, and $36,132 for severe Alzheimer's Disease (Leon et al., 1998). The annual national direct and indirect costs of caring for Alzheimer's patients are estimated to be as much as $100 billion (Ernst and Hay, 1994; Ernst et al., 1997; Huang et al., 1988).

Research

Alzheimer's research began to make significant progress with the 1990 discovery by a British research team of the first gene linked to the disorder. The next year, the University of South Florida recruited the leader and several other members of that team. Within a few years, the second gene linked to Alzheimer's Disease was discovered at USF. Other research at USF has led to the discovery of links with brain blood vessels and brain inflammation and of links between Alzheimer's Disease and Down's syndrome. The development by USF of a strain of mice that carry two genes that cause Alzheimer's, and that develop symptoms quickly, has accelerated research into a vaccine.

One of the most pressing current issues is determining possible differences in Alzheimer's Disease risk, incidence, and prevalence among various racial and ethnic groups. These differences are

important to study for several reasons. One is that the percentage of non-Caucasians in the older U.S. population is growing rapidly (by the year 2050, the percentage of the population over the age of 65 that is non-Caucasian will have increased from 16 percent to 34 percent). Another is that the variations in prevalence may give us important future insights into the different roles that particular genetic and environmental factors play in the development of Alzheimer's Disease. Recent research has shown that African Americans and Hispanic Americans may have a higher overall risk of Alzheimer's Disease than do Caucasians (Tang et al., 1998), although other studies have found conflicting results (Fillenbaum et al., 1998).

Florida's Alzheimer's Disease Initiative

As part of Florida's Alzheimer's Disease Initiative, s. 430.502, F.S., establishes memory disorder clinics at each of the three medical schools in the state, plus ten additional memory disorder clinics in other medical settings. The purpose of these clinics is to conduct research and training in a diagnostic and therapeutic setting for persons with Alzheimer's Disease, conduct research, and develop caregiver-training materials. Individuals diagnosed with or suspected of having Alzheimer's Disease are eligible for memory disorder clinic services. Memory disorder clinics are located at:

Mayo Clinic in Jacksonville;
The University of Florida in Gainesville;
East Central Florida Memory Disorder Clinic in Melbourne;
Orlando Regional Healthcare System in Orlando;
University of South Florida in Tampa;
North Broward Medical Center in Pompano Beach;
University of Miami in Miami;
Mount Sinai Medical Center in Miami Beach;
West Florida Regional Medical Center in Pensacola;
St. Mary's Medical center in West Palm Beach;
Tallahassee Memorial Health Care in Tallahassee;
Lee Memorial Memory Disorder Clinic in Ft. Myers; and
Sarasota Memorial Hospital in Sarasota.

The memory disorder clinics have developed extensive educational programs targeted at doctors, medical students, caregivers, and nursing home staff. In fiscal year 2000-2001, memory disorder clinics served approximately 5,600 clients, and provided training to 21,500 individuals. Memory disorder clinics receive a state General Revenue appropriation of $189,000 each. Clinics report that the state funds and the designation as a memory disorder clinic allow them to leverage additional funds which support the bulk of their operations. The Alzheimer's Disease Initiative Advisory Committee at the Department of Elder Affairs is required to evaluate the need for additional memory disorder clinics in the state.

Four model day care programs have been established in conjunction with memory disorder clinics to test therapeutic models, provide training, and deliver day care services to persons with Alzheimer's Disease and related disorders. Model day care centers receive a state General Revenue appropriation of $125,510 each.

Florida has established an Alzheimer's brain bank at Mt. Sinai hospital which collects brain tissues from deceased individuals from around the state (often clients of memory disorder clinics) whose families have consented to participate in research. The brain bank provides a definitive diagnosis of the disease for families and referring physicians, and maintains a neuropathology database which contains information about the pathology of the tissue, and the demographics and history of the individual. The brain bank stores brain tissue for research purposes, and distributes tissue

samples to researchers for ongoing studies. The brain bank performs between 60 and 90 autopsies per year and receives $130,000 in General Revenue funding.

The department provides respite care services to relieve the families of persons with Alzheimer's Disease and related disorders from the burden of caregiving. The Alzheimer's respite program receives approximately $7.8 million in General Revenue funding and serves approximately 3,800 clients annually. Also, some people receive respite care from other Senior-related programs, such as the R.E.L.I.E.F. program (s. 430.071, F.S.) and the volunteer-staffed Senior Companion program.

Kidney Dialysis

Background

There are limited numbers of treatments available to patients with end stage renal disease: hemodialysis; peritoneal dialysis; and kidney transplantation.

Hemodialysis cleans and filters blood using a machine to temporarily rid the body of harmful wastes, extra salt, and extra water and helps control blood pressure and keeps the body blood chemistry in proper balance. Patients receive hemodialysis treatments usually three times a week with each treatment lasting from 3-5 hours. To determine whether dialysis is removing enough urea, the clinic periodically tests a patient's blood to measure dialysis adequacy.

There are four major End Stage Renal Disease (ESRD) clinical laboratories providing services to dialysis patients in Florida: Fresenius Medical Care; DaVita Inc.; Gambro Healthcare, Inc.; and ESRD Laboratories.

The federal government is the primary payor of health services of patients with ESRD. Eligibility for Medicare, for patients with ESRD, is not based on age, but rather on diagnosis. Medicare reimburses health providers for dialysis services based on a composite rate, which includes both the dialysis and some clinical blood test.

Prior to eligibility for Medicare benefits, some patients with ESRD qualify as Medicaid recipients. In 1995, the Legislature amended s. 409.905, F.S., mandatory Medicaid services, to include the treatment for ESRD services. Similar to Medicare reimbursement methodologies, Medicaid reimburses dialysis services at a capped rate that includes some laboratory tests. Medicaid regulates both the number and types of tests that are routinely preformed on patients with end stage renal disease.

According to AHCA, there are approximately 400 Medicaid funded Florida ESRD patients out of approximately 17,000+ total ESRD patients in Florida. In fiscal year 1999-2000, Florida spent approximately $113,000,000 in Medicaid dollars to treat patients diagnosed with end stage renal disease. This amount represents all costs associated with treatment, hospitalization, transportation, clinical laboratory charges, and pharmaceuticals. Of that amount, only $4-5 million was spent for clinical dialysis services and laboratory costs.

Legislative History

The 1999 Legislature, pursuant to, required the Agency for Health Care Administration (AHCA), in conjunction with other agencies as appropriate to:
"…conduct a detailed study and analysis of clinical laboratory services for kidney dialysis patients in the State of Florida. The study shall include, but not be limited to, an analysis of the past and

present utilization rates of clinical laboratory services for dialysis patients, financial arrangements among kidney dialysis centers, their medical directors, any business relationships and affiliations of clinical laboratory services for dialysis patients in Florida; and the average annual revenue for dialysis patients for clinical laboratory services for the past 10 years." (chapter 99-356, section 4, Laws of Florida, and chapter 99-397, section 187, Laws of Florida) The Agency was directed to report its findings to the Legislature by February 1, 2000. Subsequently, the agency issued the report, which concluded that additional time and investigative resources were necessary to adequately respond to the legislative directives.

Therefore, during the 2000 Session, the Legislature specified that: "…the sum of $230,000 from the Agency for Health Care Administration Tobacco Settlement Trust Fund is appropriated to the Agency for Health Care Administration to contract with the University of South Florida to conduct a review of laboratory test utilization, any self-referral to clinical laboratories, financial arrangements among kidney dialysis centers, their medical directors, referring physicians, and any business relationships and affiliations with clinical laboratories, and the quality and effectiveness of kidney dialysis treatment in this state." (chapter 2000-318, section 19, Laws of Florida)

The USF 2000 study identified several "hot button" issue areas for potential fraud and abuse: vertical integration system issues, dialysis center issues, clinical laboratory issues, and medical director issues. The USF study concluded that: "Pursuant to our study and the AHCA Dialysis Report, the proprietary nature of the financial and contractual data required ascertaining the laboratory utilization rates and financial relationships, as requested by the Legislature, preclude a more detailed assessment than either effort achieved. Without mandatory reporting requirements, the Legislature's concerns cannot be completely and accurately addressed."

Overview of Kidney Dialysis Studies, Committee on Health Regulation

In July 2001, Speaker Feeney directed the Committee on Health Regulation to re-examine the 1999 and 2000 studies and clarify the multiple issues surrounding the delivery of end stage renal disease services to patients in Florida and to determine if the state is at a financial risk due to fraud or abuse within the Medicaid system. The 2001 interim study reviewed:

- Published reports from the Agency for Health Care Administration (AHCA) and the University of South Florida (USF);
- ESRD industry in the State of Florida as it exists;
- Current remedies for fraud and abuse in health care;
- Existing state and federal regulation of ESRD Providers;
- Department of Justice action against ESRD providers in Florida and the subsequent settlement agreements;
- Patient Self-Referral Act of 1992;
- Federal Stark Amendment as it relates to end stage renal disease; and
- The need, if any, for additional legislative action.

In evaluating the studies conducted by AHCA and USF, staff concluded that the USF Study drew conclusions based upon "potential opportunities for fraud and abuse" without a discussion of existing remedies in place to prevent fraud and abuse., and noted the following findings:

- **Fraud and Abuse -** Both the Medicare and Medicaid programs are highly regulated by the state and federal governments as demonstrated in this report. In the event there is fraud and abuse within a practicing facility, there are clear and defined remedies to investigate, fine and prosecute such abuse as demonstrated by the Operation Restore Trust Project by the federal government's office of Program Integrity for Medicare and Medicaid.

Enforcing the regulations that exist through ACHA is a clearer and more definitive avenue to address any concerns of fraud and abuse than creating additional programs or government authority as recommended in the USF Report.

- **Antitrust Violations -** In the event it is suspected that a monopoly exists within the health care industry, there are clear and definitive remedies under the Attorney General's office through the enforcement of the antitrust statutes. When the Attorney General's office investigates an industry for a monopoly and there is found no cause for concern, no legal action is taken and therefore this information is considered confidential and is not publicly disclosed. If such an investigation has occurred within Florida, the Attorney General's office is not at liberty to disclose such an investigation. However, through the no-action antitrust statues, an industry may ask the Attorney General's office to issue an opinion as to whether a monopoly exists, which is made public.

- **Feasibility of divestiture of clinical laboratory and clinical dialysis services** - Currently, clinical dialysis facilities operate in tandem with their corresponding laboratory. A patient that is treated in a Gambro, Fresenius, or DaVita clinic has the blood work sent directly from the clinic to the laboratory. All patient registration/financial information and medical records are obtained on the clinical side. In order to bill for laboratory work done on the patient specimen, the laboratory is dependent on the clinic to provide all patient financial information.

  The selection of the use of a laboratory, absent any third party payor restrictions, has historically been at the discretion of the physician or facility providing the service. The decision is based on the reliability of service that the lab provides, and this decision is considered an important decision-making process in overall patient care. Only when there is substantial risk to patient care should the state intervene in making medical decisions concerning the delivery of patient care. The divestiture of such services, absent any direct risk to patient care, is not recommended.

In conclusion, it was reported that:

> "there is convincing evidence that mechanisms are already in place to address allegations of fraud and abuse in the Medicaid industry without creating additional programs or government authority. Additionally, regulations already exist to address concerns of Antitrust violations. Further, it is concluded that repealing the nephrologist's exemptions in the Patient Self-Referral Act will not increase competition or provide opportunities for competition, but instead would eliminate provisions that are obsolete in today's renal dialysis market.
>
> It is therefore recommended, by the Committee on Health Regulation's Interim Report "Overview of Kidney Dialysis Studies", October 2001, " that no legislative action is needed to address the concerns regarding monopoly, over-utilization of services to patients with ESRD, or the divestiture of vertically integrated services within the ESRD industry.
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> To clarify any concerns regarding a monopoly, it was recommended that through the Florida Health Care Community Antitrust Guidance Act, codified at s. 408.18, F.S., under the investigation of the Attorney General's office that one or all four major corporations seek guidance from the Attorney General's office for a public determination as to whether a monopoly exists in the dialysis industry."

Prohibitions on Patient Self-Referral

Section 456.053, F.S., cited as the "Patient Self-Referral Act of 1992" (Patient Self-Referral Act or act), prohibits the referral of patients by a health care provider for specified services or treatments when the referring health care provider has a financial interest in the service or treatment to be provided. The prohibition against patient self-referral originated from an economic concern: a physician with a personal financial involvement in a diagnostic facility or clinical laboratory might prescribe more tests, or more costly tests, than he or she might prescribe without the personal financial incentive, thus driving up the cost of health care. The intent of the Patient Self-Referral Act was "to provide guidance to health care providers regarding prohibited patient referrals between health care providers and entities providing health care services and to protect the people of Florida from unnecessary and costly health care expenditures" (subsection (2)).

The act provides definitions for purposes of its requirements relating to financial arrangements between referring health care providers and providers of health care services. The act defines designated health services to mean clinical laboratory services, physical therapy services, comprehensive rehabilitative services, diagnostic-imaging services, and radiation therapy services. Referral is defined to mean any referral of a patient by a health care provider for health care services which includes: the forwarding of a patient by a health care provider to another health care provider or to an entity which provides or supplies a designated health service or any other health care item or service; or the request or establishment of a plan of care by a health care provider, which includes the provision of a designated health service or other health care item or service. Health care provider means any physician licensed under chapter 458, 459, 460, or 461, F.S., or any health care provider licensed under chapter 463 or 466, F.S. Thus, allopathic, osteopathic, chiropractic, and podiatric physicians, and optometrists and dentists are health care providers for purposes of the act.

The act provides exceptions to the prohibited referrals, which include any order, recommendation, or plan of care by:

- A radiologist for diagnostic-imaging services;
- A physician specializing in the provision of radiation therapy services for such services;
- A medical oncologist for drugs and solutions to be prepared and administered intravenously to such oncologist's patient, as well as for the supplies and equipment used in connection with treating such a patient for cancer and related complications;
- A cardiologist for cardiac catheterization services;
- A pathologist for diagnostic clinical laboratory tests and pathological examination services, if furnished by or under the supervision of such pathologist pursuant to a consultation requested by another physician;
- A health care provider who is the sole provider or member of a group practice for designated services or other health care items or services that are prescribed or provided solely for such referring health care provider's or group practice's own patients, and that are provided or performed by or under the direct supervision of such referring health care provider or group practice;
- A health care provider for services provided by an ambulatory surgical center licensed under chapter 395, F.S.;
- A health care provider for diagnostic clinical laboratory services where such services are directly related to renal dialysis;
- A urologist for lithotripsy services;
- A dentist for dental services performed by an employee of or a health care provider who is an independent contractor with the dentist or group practice of which the dentist is a member;

- A physician for infusion therapy services to a patient of that physician or a member of that physician's group practice; and
- A nephrologist for renal dialysis services and supplies.

In addition to the allowable exemptions by service type, as found in s. 456.053(3), F.S., s. 456.053(5), F.S., creates an exemption which allows physicians to have an investment interest in a publicly traded corporation, when specified conditions are met. A physician my refer a patient to a health care entity in which there is an investment interested provided that:

- The provider's investment interest is in registered securities purchased on a national exchange or over-the-counter market and issued by a publicly held corporation; and
- The shares are traded on a national exchange or on the over-the-counter market; and
- The total assets at the end of the corporation's most recent fiscal quarter exceeded $50 million.

Furthermore, a physician's referral of a patient to a health provider in which he or she has an investment interest is permissible when each of the following criteria are met:

- No more than 50 percent of the value of the investment interests are held by investors who are in a position to make referrals to the entity;
- The terms under which an investment interest is offered to an investor who is in a position to make referrals to the entity are no different from the terms offered to investors who are not in a position to make such referrals;
- The terms under which an investment interest is offered to an investor who is in a position to make referrals to the entity are not related to the previous or expected volume of referrals from that investor to the entity.
- There is no requirement that an investor makes referrals or be in a position to make referrals to the entity as a condition for becoming or remaining an investor.

Florida's Patient Self-Referral Act is similar to a federal prohibition of patient self-referral under 42U.S.C. § 1395nn. The law, popularly know as Stark II, prohibits a physician from referring patients to an entity for the furnishing of designated health services if there is a financial relationship between the referring physician or an immediate family member of the physician and the entity. The federal law provides certain exemptions to the prohibition, including an exemption for clinical laboratory services furnished in an ESRD facility. While Stark II governs services that are federally funded, Florida's Patient Self-Referral Act applies to all health care services provided in Florida.

C. EFFECT OF PROPOSED CHANGES:

HB 37-E addresses several issues relating to health care. These include:

- Health flex plan pilot projects;
- Florida Alzheimer's Center and Research Institute;
- Prompt payment of a variety of health care claims;
- Provider referral of patients for certain health care services;
- The small-employer Employee Health Care Access Act;
- Definitional issues relating to third-party administrators and health risk contracts; and
- Referral of an HMO subscriber by an HMO primary care physician for certain vision services.

The bill also provides for construction of laws enacted at the 2002 Regular session in relation to this act.

See the SECTION-BY-SECTION ANALYSIS which follows for additional detail.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Authorizes "health flex plans," as follows:

Subsection (1) provides the Legislative intent for health flex plans, with an emphasis on:

- Affordability and availability of health care coverage;
- Alternative approaches to traditional health insurance;
- Basic and preventative health care services; and
- Coordination with existing local service programs.

Subsection (2) provides definitions for the terms: "agency," "Department," "enrollee," "health care coverage or health flex plan coverage," "health flex plan," and "health flex plan entity."

Subsection (3) creates the pilot program. The Agency for Health Care Administration (agency) and the Department of Insurance (department), are directed to each approve or disapprove health flex plans which provide health care coverage for eligible participants residing in the three areas of the state having the highest number of uninsured residents, as identified in the Florida Health Insurance study conducted by the agency, and in Indian River County. The plans are authorized to:

- Limit or exclude mandated benefits;
- Cap the annual total amounts of claims paid;
- Limit enrollment; or
- May take any combination of the above actions.

Paragraph 3(a) requires the agency to develop guidelines for the review of applications for the plans and to disapprove or withdraw approval of plans that do not meet or no longer meet the minimum standards.

Paragraph 3(b) requires the department to develop guidelines for the review of the plan applications and to disapprove or withdraw approval of plans that:

- Contain any ambiguous, inconsistent, or misleading provisions, or exceptions or conditions that deceptively affect or limit the benefits purported to be assumed in the general coverage provided by the plan;
- Provide benefits that are unreasonable in relation to the premium charged, contains provisions that are unfair or inequitable or contrary to the public policy of this state or that encourage misrepresentation, or result in unfair discrimination in sales practices; or
- Cannot demonstrate that the plan is financially sound and the applicant has the ability to underwrite or finance the benefits provided.

Paragraph 3(c) grants the agency and the department rulemaking authority as needed to administer this section.

Subsection (4) provides that plans approved under this section are not subject to the licensing requirements of the Florida Insurance Code or chapter 641, F.S., relating to health maintenance

organizations, unless expressly made applicable. However, provides that for the purposes of prohibiting unfair trade practices, plans are considered insurance subject to the applicable provisions of part IX of chapter 626, F.S., except as otherwise provided in this section.

[Note: Insurance companies and self-insurance plans are governed by Chapters 624 through 632, 634, 635, 638, 642, 648 and 651 ("Florida Insurance Code") of the Florida Statutes. HMOs are governed by parts I and III of ch. 641 of the Florida Statutes and are exempt from the Florida Insurance Code, except for provisions specifically made applicable to HMOs. Insurance companies must be licensed by the department to do business in Florida. Self-insurance plans are not licensed by the department.**]**

Subsection (5) provides eligibility criteria. Eligibility to enroll in an approved health flex plan is limited to residents of this state who:

- Are 64 years of age or younger;
- Have a family income equal to or less than 200 percent of the federal poverty level;
- Are not covered by a private insurance policy and are not eligible for coverage through a public health insurance program such as Medicare or Medicaid, or other public health care program, including, but not limited to, Kidcare; and have not been covered at any time during the past six months; and
- Have applied for health care coverage through an approved plan and agree to make any payments required for participation, including periodic payments or payments due at the time health care services are provided.

Subsection (6) provides requirements for record keeping. Every plan entity shall maintain reasonable records of its losses, expenses, and claims experience and is required to make such records reasonably available to enable the department to monitor and determine the financial viability of the plan, as necessary. Provider networks and total enrollment by area shall be reported to the agency biannually to enable the agency to monitor access to care.

Subsection (7) provides notice requirements. The denial of coverage by a plan, or the nonrenewal or cancellation of coverage, must be accompanied by the specific reasons for denial, nonrenewal, or cancellation. Notice of nonrenewal or cancellation must be provided at least 45 days in advance, except that 10 days' written notice must be given for cancellation due to nonpayment of premiums. Provides that if the plan fails to give the required notice, the plan must remain in effect until notice is appropriately given.

Subsection (8) specifies that the coverage under a plan is not an entitlement and that no cause of action shall arise against the state, local governmental entity, or other political subdivision of this state, or the agency, for the failure to make coverage available to eligible persons under this section.

Subsection (9) requires the agency and the department to evaluate the pilot program and its effect on: the entities that seek approval as health flex plans; the enrollees; and on the scope of the health care coverage offered under a health flex plan. Requires an assessment of the plans and their potential applicability to other settings and requires that the agency and department must jointly submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2004.

Subsection (10) provides that this section shall stand repealed on July 1, 2004.

Section 2. Creates the Florida Alzheimer's Center and Research Institute, as follows:

Subsection (1) provides that the Florida Alzheimer's Center and Research Institute (institute) is established at the University of South Florida (USF).

Subsection (2) requires the State Board of Education to enter into an agreement with USF for the utilization of the facilities on the USF campus, to include all furnishings, equipment, and other chattels used in the operation of the facilities, with a Florida not-for-profit corporation organized solely for the purpose of governing and operating the institute. The corporation is authorized to:

- Act as an instrumentality of the state, govern and operate the institute in accordance with the terms of agreement with the State Board of Education and the corporation.
- With prior approval from the State Board of Education, create not-for-profit corporate subsidiaries to fulfill its mission.
- With its subsidiaries, receive property and money from private, local, sate, and federal sources, as well as technical and professional income generated or derived from practice activities of the institute for the benefit of the institute and the fulfillment of its mission.

The Corporation is to be managed by a board of directors (BOD) who shall serve without compensation. The BOD shall consist of: the President of the University of South Florida and the chair of the State Board of Education, or their designees; five representatives of the state universities; and no fewer than nine nor more than 14 representatives of the public who are neither medical doctors nor state employees. Each director who is a representative of a state university or of the public shall serve a term of three years. The Chair of the BOD shall be selected by a majority vote of the directors. Each director shall have one vote.

Requires the initial BOD to consist of the President of the University of South Florida or his/her designee; the Chair of the State Board of Education or his/her designee; the five university representatives, one of whom shall be appointed by the Governor, two by the President of the Senate, and three by the Speaker of the House of Representatives. Upon the expiration of the initial appointed directors, all directors subject to the 3-year term shall be elected by a majority vote of the directors and the board may be expanded to include additional public representative directors up to the maximum allowed. Any vacancy in office shall be filled for the remainder of the term by a majority vote of the directors. Any director may be reelected.

Subsection (3) requires that the agreement between the State Board of Education and the Corporation must include the following:

- Approval by the State Board of Education of the articles of incorporation of the corporation.
- Approval by the State Board of Education of the articles of incorporation of any subsidiary created by the corporation.
- Utilization of hospital facilities and personnel by the corporation and its subsidiaries for mutually approved teaching and research programs conducted by USF or other accredited medical schools or research institutes.
- Preparation of an annual post audit of the corporation's financial accounts and the financial accounts of any subsidiaries to be conducted by an independent certified public accountant. The report shall include management letters and shall be submitted to the Auditor General and the State Board of Education for review. The State Board of Education, the Auditor General, and the Office of Program Policy Analysis and Government Accountability shall have the authority to require and receive from the corporation and any subsidiaries or from their independent auditor any detail or supplemental data relative to the operation of the corporation or subsidiary.

- A provision by the corporation and its subsidiaries of equal employment regardless of race, color, religion, sex, age, or national origin.

Subsection (4) provides that the State Board of Education is authorized to secure a comprehensive general liability protection (insurance), including professional liability protection for the Corporation and its subsidiaries, pursuant to s. 240.213, F.S., relating to securing liability insurance.

Subsection (5) provides that in the event the agreement between the State Board of Education and the corporation is terminated for any reason, the State Board of Education shall assume governance and operation of the facilities.

Subsection (6) provides that the institute shall be administered by a chief executive officer who shall be appointed by and serve at the pleasure of the BOD of the corporation and who shall have the powers and duties, subject to the approval of the BOD, relating to: the mission of the institute; establishment of academic programs; budget and dollars appropriated or donated to the institute and technical and professional income generated or derived from practice activities; appointment of representatives of the institute, as well as determining compensation, benefits, and terms of service and concurrent appointments of institute representatives; the use and assignment of space and equipment; administrative structure; reporting relationship to the Commission of Education; and an annual report.

Subsection (7) provides that the BOD of the corporation shall create a council of scientific advisers to the chief executive officer comprised of leading researchers, physicians, and scientists. The council shall review programs and recommend research priorities and initiatives to maximize the state's investment in the institute. The members of the council shall be appointed by the BOD, except for the five members appointed by the State Board of Education. Each member of the council shall be appointed for a two-year term and may be reappointed to the council.

Subsection (8) specifies that in carrying out the provisions of this section, the corporation and its subsidiaries are not agencies within the meaning of s. 20.03(11), F.S.

Section 3. Amends s. 408.7057, F.S., relating to the statewide provider and managed care organization claim dispute resolution program. The program is redesignated as the statewide provider and health plan claim dispute resolution program.

Subsection (1), defining the terms used in the section, is amended as follows:

Adds paragraph (a), to define "agency" to mean the Agency for Health Care Administration.

Redesignates paragraph (a) as (b) and amends, to define the term "health plan" rather than "managed care organization," and expand the definition to include a major medical expense health insurance policy (s. 627.643(2)(3), F.S.), offered by a group or individual health insurer licensed pursuant to chapter 624, F.S., including preferred provider organizations (s. 627.6471, F.S.).

Redesignates paragraph (b) as (c), relating to "resolution organization."

Amends subsection (2), to update references, replacing "Agency for Health Care Administration" with "agency" and "managed care organizations" with "health plans."

Adds paragraph (e), to require those seeking dispute resolution to submit supporting documentation within specified timeframes. Authorizes the resolution organization to extend timeframes. Provides

that failure to submit supporting documents within the timeframe results in the dismissal of the claim of the submitter.

Adds paragraph (f), to require the resolution organization to require the respondent to submit all documentation in support of its position within 15 days after receiving a request from the dispute resolution organization for supporting documentation. Authorizes the resolution organization to extend the time, if appropriate. Provides that failure to submit the requested documentation within the timeframe will result in a default against the health plan or provider. Provides that, in the event of default, the resolution organization must issue its written recommendation to the agency that a default be entered against the defaulting entity. The written recommendation must include a recommendation to the agency that the defaulting entity pay the entity submitting the claim the full amount of the claim dispute, plus all accrued interest, and must be considered a nonprevailing party for the purposes of this section.

Adds subparagraph (g)1., to require the agency, if it has reason to believe that a pattern exists on the part of a particular health plan or provider, to evaluate the cases to determine whether there is evidence of a pattern of violations, and report its findings and evidence to the appropriate licensure or certification entity.

Adds subparagraph (g)2., to require the agency to prepare an annual report to the Governor and the Legislature by February 1 of each year , listing the following: claims dismissed; defaults issued; and failures to comply with agency final orders under this section.

Amends subsection (3), to update terminology and to specify that the agency's rules establishing the process to be used by the resolution organization must specify that the written recommendation must be submitted to the agency within 60 days after the requested information is received by the resolution organization, and prohibits the extension of the timeframes from exceeding 90 days following the receipt of the initial claim dispute.

Adds subsection (5), to require the agency to notify within 7 days the appropriate licensure or certification entity whenever there is a violation of the final order issued by the agency pursuant to this section.

Section 4. Amends s. 626.88, F.S., relating to insurance administrators, as follows.

Subsection (1) is amended to expand the application of the definition for "administrator" to include any person who, through a health risk contract (as defined in s. 641.234, F.S., relating to administrator, provider, and management contracts), with an insurer or health maintenance organization that provides billing and collection services to health insurers and health maintenance organizations on behalf of health care providers.

Adds paragraph (1)(o), to exclude from the definition any provider or group practice (as defined in s. 456.053, F.S., relating to financial arrangements between referring health care providers and providers of health care services) which provides services under the scope of the license of the provider or member of the group practice.

Adds paragraph (1)(p) to exclude from the definition any hospital providing billing, claims, and collection services solely on its own and its physicians' behalf and providing services under the scope of its license.

Requires a person who provides billing and collection services to health insurers and health maintenance organizations on behalf of health care providers to comply with the provisions of prompt payment of claims requirements, and requirements relating to adverse determinations.

Section 5. Creates s. 627.6131, F.S., relating to payment of claims by health insurers, as follows:

Subsection (1) requires health insurance policy contracts to contain specific language relating to payment notice requirements.

Subsection (2) provides a definition of "claim" for institutional and noninstitutional providers, delivered to the insurer's designated location, as follows:

- Noninstutional providers: A paper or electronic billing instrument consisting of the HCFA 1500 data set, or its successor, with all mandatory entries for a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 463, or a psychologist licensed under chapter 490, or other appropriate billing instrument with all mandatory entries for any other noninstitutional provider.
- Institutional providers: A paper or electronic billing instrument consisting of the UB-92 data set or its successor, with entries stated as mandatory by the Uniform Billing Committee.

Subsection (3) specifies for all claims for payment or overpayment, electronic or nonelectronic, the following:

Paragraph (a) specifies when claims for payment or overpayment are considered received.

Paragraph (b) specifies that claims for payments must be mailed or electronically transferred to the primary insurer within 6 months after: discharge for inpatient services or the date of service for outpatient services, and the provider has been furnished with the correct name and address of the patient's health insurer.

Requires that all claims for payment, must be mailed or electronically transferred to the secondary insurer within 90 days after the final determination by the primary insurer. Provides that a provider's claim is considered submitted on the date it is electronically transferred or mailed.

Paragraph (c) prohibits the submission of a duplicate claim unless it is determined that the original claim was not received or is otherwise lost.

Subsection (4) specifies requirements for electronically submitted claims, as follows:

Paragraph (a) requires that within 24 hours of the beginning of the next business day after the receipt of the claim electronic acknowledgement of the receipt of the claim be provided to the electronic source submitting the claim.

Paragraph (b) requires that within 20 days of the receipt of the claim, the insurer must pay the claim or notify the provider or designee if the claim is denied or contested. Notice of the insurer's action on the claim and payment of the claim is considered to be made on the date notice or payment was mailed or electronically transferred.

Subparagraph (c)1. requires that notification of a contested claim must be accompanied by an itemized list of additional information or documents reasonably necessary for the insurer to process the claim.

Subparagraph (c)2. requires that a provider must submit the requested additional information or documentation within 35 days of receipt of the notification. Submission of additional information is considered made on the date electronically transferred or mailed. Provides that an insurer may not request duplicate documents.

Paragraph (d) requires, for the purposes of this section, that electronic means of transmission of claims, notices, documents, forms, and payment must be used to the greatest extent possible by the health insurer and the provider.

Paragraph (e) requires a claim to be paid or denied within 90 days of the receipt of the claim. Provides that failure to pay or deny a claim within 120 days after the receipt of the claim creates an uncontestable obligation to pay the claim.

Subsection (5) specifies requirements for nonelectronically submitted health insurer claims, as follows:

Paragraph (a), effective November 1, 2003, requires the insurer to provide acknowledgement of the receipt of the claim to the provider within 15 days of receipt of the claim or provide a provider within 15 days of receipt with electronic access to the status of a submitted claim. [Note: The November 1, 2003, effective date only applies to this paragraph.]

Paragraph (b) requires that within 40 days of receipt of the claim, the insurer must pay the claim or notify the provider or the provider's designee that the claim is denied or contested. Notification of a claim or payment of a claim is considered to have been made on the date the notice or payment was mailed or electronically transferred.

Subparagraph (c)1. requires notification of the insurer's determination of a contested claim to be accompanied by an itemized list of additional information or documents reasonably necessary for the insurer to process the claim.

Subparagraph 2. requires a provider to submit the requested additional documentation or information within 35 days of receipt of the notification. Provides that submission of additional information is considered made on the date it is electronically transferred or mailed. Provides that the health insurer may not request duplicate documents.

Paragraph (d) requires for the purposes of this subsection, electronic means of transmission of claims, notices, documents, forms, and payment to be used to the greatest extent possible by the health insurer and provider.

Paragraph (e) requires a claim to be paid or denied within 120 days of receipt of the claim. Provides that failure to pay or deny a claim with 140 days of receipt of the claim creates an uncontestable obligation to pay.

Subsection (6) requires an insurer to make a claim for overpayment to the provider's designated location if it determines that an overpayment has occurred. Requires an insurer to give the provider a written or electronic statement specifying the basis for the retroactive denial or payment. Requires the insurer to identify the claim or claims, or overpayment claim portion of the claim.

Paragraph (a) requires that in the case where an overpayment determination is the result of a retroactive review or audit of coverage decisions or payment levels not related to fraud, the health insurer must do the following:

- Submit the claim for overpayment to the provider within 30 months after the insurer's payment of the claim. The provider must pay, deny, or contest the claim for overpayment within 40 days of the receipt of the claim. Requires all contested claims for overpayment to be paid or denied within 120 days of the receipt of the claim. Failure to pay or deny the claim for overpayment within 140 days of receipt creates an uncontestable obligation to pay the overpayment claim.
- Providers that deny or contest a claim for overpayment or any portion of the claim for overpayment must notify the insurer, in writing, within 35 days after the provider received the claim. The provider's notice that the overpayment claim is being denied or contested must include a request for additional information. The provider's notice must identify the contested portion of the overpayment claim and the specific reason for contesting or denying the overpayment claim. If contested, the notice must include a request for additional information. If the insurer submits the additional information, the insurer must provide the information within 35 days after the receipt of the request and must mail or electronically transfer the information to the provider within that time. The provider must pay or deny the overpayment claim within 45 days after receipt of the information. Notice is considered made on the date the notice is mailed or electronically transferred by the provider.
- An insurer is prohibited from reducing payment to a provider for other services unless the provider has agreed to the reduction in writing or has failed to respond to the insurer's overpayment claim, as required by this paragraph.
- Payment of an overpayment claim is considered made on the date the payment was mailed or electronically transferred. An overdue payment of a claim bears simple interest of 12 percent per year. Interest begins to accrue when the claim should have been paid, denied, or contested.

Paragraph (b) prohibits claims for overpayment beyond 30 months after the insurer's payment of a claim, unless the provider has been convicted of fraud pursuant to s. 817.234, F.S., relating to false and fraudulent insurance claims.

Subsection (7) provides that payment of a claim is considered made on the date the payment was mailed or electronically transferred. Provides than an overdue payment bears simple interest at a rate of 12 percent per year. Interest on an overdue payment for a claim or for any portion of claim begins to accrue when the claim should have been paid, denied, or contested. Requires the interest to be paid with the payment of the claim.

Subsection (8) requires, for all contracts entered into or renewed on or after October 1, 2002, an insurer's internal dispute resolution process related to a denied claim not under active review by a mediator, arbitrator, or third-party dispute entity to be finalized within 60 days of the receipt of the provider's request for review or appeal.

Subsection (9) prohibits providers or provider's designee from billing an insured or attempting to collect money, maintain a cause of action, or report to a credit reporting agency when the health insurer contests or denies a provider's claim or portion of a claim and specifies the time of the prohibition not to exceed 60 days. Specifies that this subsection does not prohibit the collection by the provider of co-payments, coinsurance, or deductible amounts due the provider.

Subsection (10) prohibits the provisions of this section from being waived, voided, or nullified by contract.

Subsection (11) prohibits retroactive denial of a claim due to insured ineligibility more than 1 year after the date of the payment of the claim.

Subsection (12) requires the health insurer to pay a contracted primary care or admitting physician, pursuant to the contract, for providing inpatient services in a contracted hospital to the insured if the services are determined by the insurer to be medically necessary and covered.

Subsection (13) requires an insurer, upon written notification by an insured, to investigate any claim of improper billing by a provider. Requires the insurer to determine if the insured was properly billed. If the insured was improperly billed, the insurer must notify the insured and the provider and must reduce the amount of the payment to the provider by the amount which was improperly billed. If a reduction is made due to the insured's notification, the insurer must pay the insured 20 percent of the amount of the reduction up to $500.

Subsection (14) specifies a permissive error ratio of 5 percent for the purposes of determining claims payment violations. Specifies method of calculation of error ratio, with fines for violations and such violations create an uncontestable obligation to pay a claim. Prohibits the department from assessing a fine for a violation which the department determines was due to circumstances beyond the insurer's control.

Subsection (15) limits the applicability of this section to major medical expense health insurance policies, as defined by statute, or individual health insurers licensed pursuant to statute, including specified preferred provider policies, exclusive provider organizations and group or individual insurance contracts that only provide direct payments to dentists for enumerated dental services.

Subsection (16) provides that notwithstanding paragraph (4)(b), relating to payment of electronic claims, an electronic pharmacy claim submitted to a pharmacy benefits manager acting on behalf of a health insurer must either pay the claim or notify a provider or designee if a claim is denied or contested within 30 days. Notice of the insurer's action on the claim and payment of the claim is considered to be made on the date the notice or payment was mailed or electronically transferred.

Subsection (17) provides that notwithstanding paragraph (5)(a), relating to payment of nonelectronic claims, a nonelectronic pharmacy claim submitted to a pharmacy benefits manager acting on behalf of a health insurer must provide acknowledgment of receipt of the claim within 30 days after receipt of the claim to the provider or provide the provider within 30 days after the receipt of the claim electronic access to the status of the submitted claim.

Section 6. Amends s. 627.651(4), F.S., relating to group contracts, to correct a cross-reference.

Section 7. Amends s. 627.662, F.S., relating to other provisions applicable to group health insurance, blanket health insurance, and franchise health insurance, to make applicable to such coverage the payment of claims requirements specified in the bill.

Section 8. Amends s. 641.185, F.S., relating to health maintenance organization subscriber protections, expanding the protections to include the receipt of prompt payment from the organization pursuant to s. 641.3155, F.S., relating to health maintenance organizations' prompt payment of claims.

Section 9. Adds subsection (4) to s. 641.234, F.S, relating to health care service programs administrative, provider, and management contracts, as follows:

Requires an HMO which, through a health care risk contract, transfers the HMO's obligation to pay any provider for any claims arising from services provided to or for the benefit of any subscriber of the HMO to any entity to remain responsible for any violations of the requirements related to payment of claims (s. 641.3155, F.S.) and requirements related to adverse determinations (s.

641.51(4), F.S.). Applies the provisions of ss. 624.418-624.4211, F.S., relating to various provisions of the Florida Insurance Code, to such violations. Provides the following definitions:

- "Health care risk contract" means a contract in which an entity receives compensation in exchange for providing to the HMO a provider network or other services. Such services may include administrative services.
- "Entity" means a person licensed as an administrator under s. 626.88, F.S., and does not include any provider or group practice (s. 456.053, F.S.), providing services under the scope of the license of the provider or the members of the group practice, nor a hospital providing billing, claims, and collection services solely on its own and its physicians' behalf and providing services under the scope of its license.

Section 10. Amends subsection (1) of s. 641.30, F.S., relating to HMO contract construction and relationship to other laws, to delete obsolete language and provide a cross-reference relating to HMO claim forms pursuant to s. 641.3155, F.S.

Section 11. Adds paragraph (d) of subsection (4) of s. 641.3154, F.S., relating to HMO liability and timeframes of the prohibition from collecting money from a subscriber, maintaining a cause of action against a subscriber, or reporting to a credit agency of a subscriber, adding to the existing presumptions of a provider to know that an HMO is liable when the agency issues a final order of the claim dispute resolution organization requiring the HMO to pay for services pursuant to s. 408.7057, F.S.

Section 12. Substantially rewrites s. 641.3155, F.S., relating to HMO payment of claims, as follows:

Subsection (1) provides definition of "claim" for institutional and noninstitutional providers, delivered to the HMO's designated location, as follows:

- Noninstutional providers: A paper or electronic billing instrument consisting of the HCFA 1500 data set, or its successor, with all mandatory entries for a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 463, or psychologists licensed under chapter 490, or other appropriate billing instrument with all mandatory entries for any other noninstitutional provider.
- Institutional providers: A paper or electronic billing instrument consisting of the UB-92 data set or its successor that has entries stated as mandatory by the Uniform Billing Committee.

Subsection (2) specifies for all claims for payment or overpayment, electronic or nonelectronic, the following:

- Specifies when claims for payment are considered received or the date a claim for overpayment is received by the primary provider at its designated location.
- Specifies that claims for payments must be mailed or electronically transferred to the primary HMO within 6 months after: discharge for inpatient services or the date of services for outpatient services; and the provider is provided the correct name and address of the patient's HMO. Specifies that all claims for payment must be mailed or electronically transferred to the secondary organization within 90 days after final determination by the primary HMO and that a provider's claim is considered submitted on the date it is electronically transferred or mailed.
- Prohibits submission of duplicate claims unless it is determined that the original claim was not received or is lost.

Subsection (3) specifies requirements for electronically submitted HMO claims, as follows:

Paragraph (a) requires that within 24 hours of the beginning of the next business day after the receipt of the claim electronic acknowledgement of the receipt of the claim be provided to the electronic source submitting the claim.

Paragraph (b) requires that within 20 days of the receipt of the claim, the HMO must pay the claim or notify the provider or designee if the claim is denied or contested. Notice of the HMO's action on the claim and payment of the claim is considered to be made on the date notice or payment was mailed or electronically transferred.

Subparagraph (c)1. requires that notification of a contested claim must be accompanied by an itemized list of additional information or documents reasonably necessary for the HMO to process the claim. Requires that submission of additional information is considered made on the date it is electronically transferred or mailed. Provides that the health maintenance organization may not request duplicate documents.

Paragraph (d) requires, for the purposes of this subsection, that electronic means of transmission of claims, notices, documents, forms, and payment must be used to the greatest extent possible by the HMO and the provider.

Paragraph (e) requires a claim to be paid or denied within 90 days of the receipt of the claim. Provides that failure to pay or deny a claim within 120 days after the receipt of the claim creates an uncontestable obligation to pay the claim.

Subsection (4) specifies for nonelectronically submitted HMO claims, as follows:

Paragraph (a), effective November 1, 2003, requires the HMO to provide acknowledgement of the receipt of the claim to the provider within 15 days of receipt of the claim or provide a provider within 15 days of receipt with electronic access to the status of a submitted claim. [Note: The November 1, 2003, effective date only applies to this paragraph.]

Paragraph (b) requires that within 40 days of receipt of the claim, the HMO must pay the claim or notify the provider or the provider's designee that the claim is denied or contested. Notification of a claim or payment of a claim is considered to have been made on the date the notice or payment was mailed or electronically transferred.

Subparagraph (c)1. requires notification of the HMO's determination of a contested claim to be accompanied by an itemized list of additional information or documents reasonably necessary for the HMO to process the claim.

Subparagraph 2. requires a provider to submit the requested additional documentation or information within 35 days of receipt of the notification. Provides that submission of additional information is considered made on the date it is electronically transferred or mailed. The HMO may not request duplicate documents.

Paragraph (d) requires for the purposes of this subsection, electronic means of transmission of claims, notices, documents, forms, and payment to be used to the greatest extent possible by the HMO and provider.

Paragraph (e) requires all claims to be paid or denied within 120 days after receipt of the claim. Creates an uncontestable obligation to pay the claim if the claim is not paid or denied within 140 days after the receipt of the claim.

Subsection (5) requires an HMO to make a claim for overpayment if it determines that an overpayment has occurred. Requires an HMO to give the provider a written or electronic statement specifying the basis for the retroactive denial or payment. Requires the HMO to identify the claim or claims, or overpayment claim portion of the claim.

Paragraph (a) requires that in the case where an overpayment determination is the result of a retroactive review or audit of coverage decisions or payment levels not related to fraud, the HMO must do the following:

- Submit the claim for overpayment to the provider within 30 months after the HMO's payment of the claim. The provider must pay, deny, or contest the claim for overpayment within 40 days of the receipt of the claim. Requires all contested claims for overpayment to be paid or denied within 120 days of the receipt of the claim. Failure to pay or deny the claim for overpayment within 140 days of receipt creates an uncontestable obligation to pay the overpayment claim.
- Providers that deny or contest a claim for overpayment or any portion of the claim for overpayment must notify the HMO, in writing, within 35 days after the provider received the claim. The provider's notice that the overpayment claim is being denied or contested must include a request for additional information. The provider's notice must identify the contested portion of the overpayment claim and the specific reason for contesting or denying the overpayment claim. If contested, the notice must include a request for additional information. If the HMO submits the additional information, the HMO must provide the information within 35 days after the receipt of the request and must mail or electronically transfer the information to the provider within that time. The provider must pay or deny the overpayment claim within 45 days after receipt of the information. Notice is considered made on the date the notice is mailed or electronically transferred by the provider.
- An HMO is prohibited from reducing payment to a provider for other services unless the provider has agreed to the reduction in writing or has failed to respond to the HMO's overpayment claim, as required by this paragraph.
- Provides that a payment for an overpayment claim is considered made on the date the payment was mailed or electronically transferred. Provides that an overdue payment for a claim for overpayment bears a simple interest rate of 12 percent per year. Provides that interest begins to accrue on an overdue payment for a claim on the date when the claim should have been paid, denied, or contested.

Paragraph (b) prohibits claims for overpayment beyond 30 months after the HMO's payment of a claim unless the provider has been convicted of fraud pursuant to s. 817.234, F.S., relating to false and fraudulent insurance claims.

Subsection (6) provides that payment of a claim is considered made on the date the payment was mailed or electronically transferred. Provides than an overdue payment bears simple interest at a rate of 12 percent per year. Interest on an overdue payment for a claim or for any portion of claim begins to accrue when the claim should have been paid, denied, or contested. Requires the interest to be paid with the payment of the claim.

Paragraph (7)(a) requires, for all contracts entered into or renewed on or after October 1, 2002, an HMO's internal dispute resolution process related to a denied claim not under active review by a mediator, arbitrator, or third-party dispute entity to be finalized within 60 days of the receipt of the provider's request for review or appeal.

Paragraph (b) requires all HMO claims begun after October 1, 2000, which are not under active review by a mediator, arbitrator, or third-party dispute entity, to have a final decision on the clam by

the HMO by January 2, 2003, for the purposes of the statewide provider and health plan claim dispute resolution program pursuant to s. 408.7057, F.S.

Subsection (8) prohibits providers or provider's designee from billing a subscriber or attempting to collect money, maintain a cause of action, or report to a credit reporting agency when the HMO contests or denies a provider's claim or portion of a claim and specifies the time of the prohibition not to exceed 60 days. Specifies that this subsection does not prohibit collection by the provider of co-payments, co-insurance, or deductible amounts due to the provider.

Subsection (9) prohibits the provisions of this section from being waived, voided, or nullified by contract.

Subsection (10) prohibits retroactive denial of a claim due to subscriber ineligibility more than 1 year after the date of the payment of the claim.

Subsection (11) requires the HMO to pay a contracted primary care or admitting physician, pursuant to the contract, for providing inpatient services in a contracted hospital to the subscriber if the services are determined by the HMO to be medically necessary and covered.

Subsection (12) specifies a permissive error ratio of 5 percent for the purposes of determining claims payment violations. Specifies method of calculation of error ratio, with fines for violations and such violations create an uncontestable obligation to pay a claim. Prohibits the department from assessing a fine for a violation which the department determines was due to circumstances beyond the HMO's control.

Subsection (13) specifies that this section applies to all claims or portion of claims submitted by an HMO subscriber under an HMO subscriber contract for payment.

Subsection (14) provides that notwithstanding paragraph (3)(b), relating to payment of electronic claims, an electronic pharmacy claim submitted to a pharmacy benefits manager acting on behalf of an HMO must either pay the claim or notify a provider or designee if a claim is denied or contested within 30 days. Notice of the HMO's action on the claim and payment of the claim is considered to be made on the date the notice or payment was mailed or electronically transferred.

Subsection (15) provides that notwithstanding paragraph (4)(a), relating to payment of nonelectronic claims, a nonelectronic pharmacy claim submitted to a pharmacy benefits manager acting on behalf of an HMO must provide acknowledgment of receipt of the claim within 30 days after receipt of the claim to the provider or provide the provider within 30 days after the receipt of the claim electronic access to the status of the submitted claim.

Section 13. Amends subsection (12) of section 641.51, F.S., relating to quality assurance programs, to eliminate the requirement that an HMO contracted primary care physician's decision regarding the referral of a subscriber to a contracted ophthalmologist be made in conjunction with the HMO.

Section 14. Amends s. 456.053(3)(o)3., F.S., relating to the definition of the term "referral" specific to the financial arrangements between referring health care providers of health care services as part of the "Patient Self-Referral Act of 1992," and exceptions to such definitions, as follows:

Deleting subsubparagraph h, pertaining to a health care provider ordering diagnostic clinical laboratory services where such services are directly related to renal dialysis, thus excluding such services from the current exemption.

Renumbers subsequent subsubparagraphs.

Adds language to subsubparagraph (k) that will not allow referral exclusion for nephrologists ordering laboratory services related to renal dialysis.

Inserts subsubparagraph (l), to add as an exclusion from "referral" those health care providers whose principal professional practice consists of treating their patients in their private residences for services to be rendered in such private residences, except for services rendered by a home health agency licensed under ch. 400, F.S. For purposes of the subsubparagraph, the term "private residence" includes patient's private homes, independent living centers, and assisted living facilities, but does not include skilled nursing facilities.

Section 15. Amends portions of s. 627.6699, F.S., relating to the Employee Health Care Access Act (small employer insurance provisions), as follows:

Amends paragraph (b) of subsection (6) to:

- Incorporate a technical change to subsubparagraph 1.

- Add subparagraph 8.a., authorizing a carrier to separate the experience of small employer groups with less than 2 eligible employees from the experience of small employer groups with 2-50 eligible employees for purposes of determining an alternative modified community rating.

- Add subparagraph 8.b., requiring carriers who separate the experience of small employer groups as provided above, to limit the rate charged to the small employer groups of less than 2 eligible employees to not more than 150 percent of the rate determined for small employer groups of 2-50 eligible employees. Authorizes the carrier to charge the excess losses of the experience pool consisting of the small employer groups with less than 2 eligible employees to the experience pool consisting of small employer groups with 2-50 eligible employees so that all losses are allocated and the 150-percent rate limit on the experience pool for small employer groups with less than 2 eligible employees is maintained. Provides, that notwithstanding the requirements of s. 627.411(1), F.S., relating to grounds for disapproval of rate filings, the rate charged to small employer groups of fewer than 2 eligible employees, insured as of July 1, 2002, may be up to 125 percent of the rate determined for small employer groups of 2-50 eligible employees for the first annual renewal and 150 percent for subsequent annual renewals.

Amends subsection (15) to specify that any law restricting or limiting deductibles, coinsurance, copayments, or annual or lifetime maximum payments does not apply to any health plan policy, including the standard or basic health benefit plan policy or contract, offered or delivered to a small employer unless specifically made applicable to the policy or plan. Provides that every small employer carrier must offer to eligible small employers the standard benefit plan and the basic benefit plan, as required, as such plans have been approved by the Department of Insurance pursuant to subsection (12) of this section.

Section 16. Provides that any law that is amended by this act was also amended by a law enacted at the 2002 Regular Session of the Legislature, such laws are to be construed as if they had been enacted at the same session of the Legislature, and full effect should be given to each if that is possible.

Section 17. Provides that this act shall take effect October 1, 2002, except that this section and sections 1, 2, and 16 of this act shall take effect July 1, 2002.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

N/A

2. Expenditures:

The Department of Insurance will incur costs relating to monitoring activities related to the prompt pay claims requirements.

According to the Agency for Health Care Administration, the bill has a direct fiscal impact on the agency because the bill permits all health insurers licensed under chapter 627, F.S., to access the Statewide Provider and Health Plan Claim Dispute Resolution Program. Currently, only managed care organizations licensed under Chapter 641, F.S., can access the program. The agency is responsible for issuing final orders for all claim disputes submitted to the Statewide Provider and Health Plan Claim Dispute Resolution Program. While the current caseload has been very low and far below the expectations of the agency, the inclusion of additional health insurance providers under this program may increase the caseload.

Fiscal Impact on the Agency for Health Care Administration

Expenditures – Non-Recurring	**Amount Year 1 (FY 02-03)**	**Amount Year 2 (FY 03-04)**
Expense	$ 2,59	$0
OCO	$ 1,389	$0
Total Non-Recurring Expenditures	**$ 4,048**	**$0**
Expenditures – Recurring		
1 Senior Attorney (PG 230)		
(Lapsed for 10/01/02 effective date)		
Salaries	$45,386	$60,515
Expense (Agency standard package)	$ 8,293	$11,057
Total Recurring Expenditures	**$53,679**	**$71,572**
Subtotal Non-Recurring Expenditures	$ 4,048	$0
Subtotal Recurring Expenditures	$53,679	$71,572
Total Expenditures	**S57,727**	**$71,572**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

N/A

2. Expenditures:

N/A

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

To the extent that health care providers currently refer patients for clinical laboratory services at facilities the referring provider owns, these private health care providers could be affected negatively. Clinical laboratories that are not owned by these providers could receive more business, if such referrals are prohibited.

The newly created exclusion for a health care provider whose principal professional practice consists of treating patients in their private residences for services to be rendered in the private residence would benefit providers of such services.

D. FISCAL COMMENTS:

According to the Agency for Health Care Administration, the bill has a fiscal impact on health insurers and HMOs by shortening payment timeframes and implementing stricter penalties for any violation of the prompt pay provisions.

The bill appears to have a direct fiscal impact on the Department of Insurance. Under the provisions of this bill, the department is required to expand its monitoring activities. In addition, the bill provides for a permissive error rate of 5 percent which can only be determined by department monitoring of insurers and HMOs, thereby requiring additional enforcement activities by the department.

The provisions of this bill relating to the Patient Self-Referral Act should not have any financial impact on state government. Medicare is the most prevalent source of funding for laboratory services related to dialysis services. The federal government establishes the payment amounts. Following a similar reimbursement methodology, Medicaid reimburses for services on a composite (bundled rate) and changes within the provision of the self-referral act will not reduce the cost of service for Medicaid patients.

III. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take actions requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that municipalities or counties have to raise revenues in the expenditure of funds.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of state tax shared with counties or municipalities.

IV. COMMENTS:

A. CONSTITUTIONAL ISSUES:

N/A

B. RULE-MAKING AUTHORITY:

N/A

C. OTHER COMMENTS:

The provisions of the bill amending the Patient Self-Referral Act may have an effect on the corporate renal dialysis industry. However, the provisions of law in s. 456.052, F.S. may continue to allow a physician to refer a patient to an entity in which the physician has an investment interest as long as the provider meets the provisions within this section of law, regardless of amending the definition of referral as it exists in s. 456.053, F.S.

V. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

N/A

VI. SIGNATURES:

FINAL ANALYSIS PREPARED BY THE COMMITTEE ON HEALTH PROMOTION:

Prepared by:	Staff Director:
Tonya Sue Chavis/Lisa Maurer	Phil E. Williams