SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

BILL: SB 46-E

SPONSOR: Senators Saunders, Pruitt, and Lee

SUBJECT: Health Care

DATE: April 30, 2002 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Harkey	Wilson	HC	Favorable
2.				
3.				
4.				
5.				
6.				

I. Summary:

The bill creates a pilot program to provide health care coverage, referred to as health flex plans, for uninsured persons who have a family income equal to or less than 200 percent of the federal poverty level. The Agency for Health Care Administration and the Department of Insurance may approve health flex plans in the three areas of the state having the highest number of uninsured persons and in Indian River County. The plans would be exempt from the requirements of the Insurance Code.

The bill 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, under an agreement with the State Board of Education. The affairs of the corporation are to be managed by a board of directors which must appoint a chief executive officer of the institute to serve at the pleasure of the board. The board of directors must also establish a council of scientific advisors to review programs and recommend research priorities and initiatives to maximize the state's investment in the institute.

The bill substantially revises requirements and procedures for the payment of claims by health insurers and HMOs and standardizes all time periods for such entities to pay, deny, or contest any claim, or portion of a claim, to 20 days for "electronic" submitted claims and 40 days for "nonelectronic" submitted claims. Failure to pay or deny a claim within 120 days for electronic or 140 days for nonelectronic claims creates an "uncontestable obligation" for the insurer or HMO to pay the claim. The bill limits the applicability of the prompt pay provisions to major medical expense health insurance policies offered by an individual or group health insurer, including preferred providers and exclusive provider organizations, or an individual or group contract that provides direct payments to dentists for enumerated dental services.

The bill provides procedures and time frames for "overpayment" claims by insurers and increases the interest rate penalties for "overdue" payments of claims from 10 to 12 percent a year. The bill mandates that the prompt pay provisions apply to HMO subscribers who submit claims under an HMO contract and provides that the prompt pay provisions may not be waived, voided, or nullified by contract.

The bill specifies time frames and procedures for the Statewide Provider and Managed Care Organization Claim Dispute Resolution Program (Program) under the Agency for Health Care Administration (AHCA), redesignates the Program title to reflect "health plan" rather than "managed care organization," and expands the Program to include major medical expense health insurance policies offered by an individual or group health insurer, including preferred provider organizations. The bill further provides sanctions for health plans which fail to comply with the time frames and requires AHCA to determine if there is a "pattern of noncompliance" by health plans or providers as to claims payments and to report such findings to licensure or certification entities.

The bill deletes the requirement that the HMO (in addition to the primary care physician) determine that a subscriber requires examination by an ophthalmologist for medically necessary, contractually covered services, in order for the subscriber to be referred to a contracted ophthalmologist.

The bill 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 contained in the "Patient Self-Referral Act of 1992." Thus, a health care provider would be prohibited from referring patients for diagnostic laboratory services related to renal dialysis to a clinical laboratory in which the referring provider had a financial interest. 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.

The bill allows small group carriers to rate one-life groups, separate from the rating pool for groups with 2-50 employees, but not to exceed 150 percent of the rate for groups of 2-50 employees. All health plan policies offered to a small employer are exempt from laws limiting deductibles, coinsurance, co-payments, and maximum lifetime and annual benefits.

This bill amends ss. 408.7057, 456.053, 626.88, 627.651, 627.662, 627.6699, 641.185, 641.234, 641.30, 641.3154, 641.3155, and 641.51, F.S., and the bill creates s. 627.6131, F.S., and three undesignated sections of law.

II. Present Situation:

Prompt Payment of Claims

National Perspective

The submission and payment of health insurance claims is a critical component of the health care economy. In recent years a total of forty-seven states, including Florida, have enacted legislation

to require HMOs and insurers to promptly pay their claims.[1] During the 2000-2001 legislative session, nine states, Florida among them, revised their laws to tighten deadlines, stiffen fines, and attempt to close other loopholes that health care providers say allow plans to evade state-mandated time limits. Such laws put HMOs and 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.[2]

Most states require insurers to pay clean claims within 30 to 45 days, however state requirements range from 15 days (North Dakota) to 60 days (Michigan and Nevada). 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 requiring 95 percent of clean claims to be paid within 30 days and all claims approved or denied within 60 days from the date of the request, with time tolled for supplying additional information. Medicare defines a "clean claim" as a claim that has no defect or impropriety, including lack of required substantiating documentation or particular circumstances requiring special treatment, which is the same language as is in current Florida law.[3] Medicare also has authority to audit the billing practices of providers and has strict fraud provisions incorporating civil and criminal penalties, which include requiring the offender to pay restitution and investigative costs.

During their 2001 legislative 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

Even given the above referenced reforms, some health care providers continue to complain that the laws requiring prompt payment of claims have not resulted in insurers and HMOs actually paying claims promptly. Health providers assert that HMOs in particular are chronically paying claims late. According to a June 4, 2001, American Medical Association News Report, more states are likely to consider further revisions to their prompt pay statutes and regulations in their next regular legislative sessions.

However, insurers and HMOs dispute the alleged magnitude of payment problems and assert that the overwhelming majority of claims have been paid on time. Further, these entities argue that

[1] The American Medical Association Report, July 2001. The three states which do not presently have prompt pay provisions are Idaho, Nebraska and South Carolina.
[2] See s. 641.3155, F.S.
[3] S. 641.3155, F.S.

the recent prompt pay laws need to be given time to work. In many cases, the time health plans spend processing claims is used to protect consumers from fraud, thereby keeping health care costs down.

Florida Prompt Payment Laws Applicable to Health Maintenance Organizations

In February 2000, the Florida Advisory Group on the Submission and Payment of Health Claims issued its report and recommendations to the Legislature on prompt payment of health claims and related issues affecting health care providers and managed care organizations (MCOs), specifically health maintenance organizations (HMOs)[4]. Subsequently, legislation was enacted during the 2000 Session based on those recommendations and subsequent discussions among the affected parties (ch. 2000-252, L.O.F.; s. 641.3155, F.S. et al. - other sections were also amended by the law). That law included the following provisions:

- Required HMOs to pay a claim for treatment if a provider followed the HMO's authorization procedures and received authorization for a covered service for an eligible subscriber, unless the provider submitted information to the HMO with the intent to misinform the HMO.
- Created the Statewide Provider and Managed Care Organization Claim Dispute Resolution Program. The Agency for Health Care Administration must contract with independent resolution organizations to recommend to the agency an appropriate resolution of disputes between a managed care organization and a provider with regard to claim disputes in violation of the prompt payment statute, s. 641.3155, F.S., subject to a final agency order.
- Required HMOs to provide treatment authorization 24 hours a day, 7 days a week. Requests for treatment authorization would not be held pending by the HMO unless the requesting provider contractually agreed to take a pending or tracking number.
- Clarified the "balance billing" provisions by prohibiting a provider from collecting from a subscriber any money for services authorized by an HMO; specified that the prohibition applies to both contract and noncontract providers rendering covered services; prohibited a provider from billing the subscriber during the pendency of any claim; prohibited a provider from reporting a subscriber to a credit agency for unpaid claims due from an HMO; and required referral of violations by physicians and facilities to the appropriate regulatory agency for final disciplinary action.
- Applied the prompt payment requirements of s. 641.3155, F.S., to claims made by either contract or noncontract providers. The requirement for an HMO to pay claims within 35 days of receipt was limited to a "clean claim" or any portion of a "clean claim" filed by a provider. A "clean claim" is defined until such time as the Department of Insurance adopts a revised definition, consistent with federal standards.
- Clarified that the current 10 percent annual simple interest penalty on a claim against an HMO begins to accrue on the 36th day after the clean claim has been received, and requires that the interest be payable with the payment of the claim.

[4] The 1999 Florida Legislature authorized the Director of the Agency for Health Care Administration (AHCA) to establish the Advisory Group. A health maintenance organization (HMO) is considered to be the prototype managed care organization and such entities are issued certificates of authority and approved by the Department of Insurance and AHCA.

- Required an HMO to file a claim against a provider for an overpayment and prohibited the HMO from reducing payment to the provider (termed a "take back"), unless the provider agrees to the reduction or fails to respond to the HMO's claim pursuant to specified time frames and requirements, which are the same requirements that apply to provider claims against an HMO.
- Entitled providers who bill electronically to electronic acknowledgment of receipts of claims within 72 hours.
- Prohibited an HMO from retroactively denying a claim due to subscriber ineligibility more than 1 year after the date of payment of the clean claim.
- Prohibited as an unfair claim settlement practice, an HMO committing or performing with such frequency as to indicate a general business practice, systematic downcoding with the intent to deny reimbursement otherwise due.
- Authorized AHCA to impose fines against hospitals and other regulated facilities for a violation of the "balance billing" prohibitions of s. 641.3154, F.S.
- Provided that in addition to any other provision of law, systematic upcoding by a provider, with the intent to obtain reimbursement otherwise not due from an insurer is punishable by fines in amounts the same as those that may be imposed against an HMO for a violation of chapter 641, F.S.

The above provisions were in addition to the 1998 and 1999 legislative changes requiring HMOs to pay claims within certain time frames. (See ch. 98-79, L.O.F.; CS/SB 1584 (1998) and ch. 99-393, L.O.F.; CS/HBs 1927 and 961 (1999) - s. 641.3155, F.S.)

In summary, the provisions of s. 641.3155, F.S., relating to prompt payment of claims, require HMOs to pay claims for services provided under contract with the provider within 35 days after receipt of the claim. For contested claims, the HMO must notify the contract provider, in writing, within 35 days after receipt of the claim, and identify the contested portion of the claim and the specific reason for contesting or denying the claim. In the event the HMO requests additional information, the provider must provide the information within 35 days, and within 45 days after receipt of the information requested, the HMO must pay or deny the contested claim or portion of the contested claim. In any event, all claims must be paid or denied no later than 120 days after the HMO receives the claim. Overdue payment of a claim accrues a simple interest penalty at the rate of 10 percent per year.

Florida Prompt Payment Laws Applicable to Health Insurers

The 2000 legislation, outlined above, focused on prompt payment of claims by HMOs. The current law requires health insurers to pay claims under a health insurance policy within 45 days after receipt of the claim by the health insurer under s. 627.613, F.S. 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 penalty at the rate of 10 percent per year.

Enforcement of Prompt Payment Laws by the Florida Department of Insurance

The Department of Insurance has jurisdiction to examine the affairs, transactions, accounts, and business records of both insurers[5] and HMOs,[6] to investigate such entities and assess fines,[7] seek injunctive relief,[8] and sanction them for unfair or deceptive trade practices.[9] In an effort to monitor the effectiveness of the HMO prompt pay law enacted in 2000, the department issued a special data call to the 24 HMOs operating in Florida and requested records as to all claims paid in the second quarter of 2001. After identifying the claims, which were paid more than 35 days after receipt of the claim or were paid beyond the uncontestable period of 120 days (i.e., late claims), the department picked a random sample of 100 such claims from each HMO to review and requested the particular HMO to explain why there was a delay in paying the claim. Ultimately the department found that 15 of the 24 HMOs failed to make timely payments to health care providers and they were fined a total of $550,000. Under the 15 consent orders which were issued by the department, the HMOs have agreed to implement measures to ensure the timely payment of claims no later than June 1, 2002. In all the cases, the HMOs agreed to the department's orders and paid the fines.

In general, department officials did state that the number of prompt pay complaints against both insurers and HMOs have declined in 2001 from previous years. For example, for 2001, the number of complaints received by the department against health insurers totaled 2,755 as compared to 3,124 for 2000, and for HMOs, the number of complaints received totaled 3,653 for 2001 as compared to 4,746 for 2000.

According to information provided by the largest insurer in the state, Blue Cross and Blue Shield of Florida, which has a total statewide enrollment of 3.4 million Floridians (i.e., this includes all their plans, HMO, PPO and indemnity), the company paid 96.4 percent of its 2001 claims within 30 days, and nearly 90 percent within 20 days for its HMO (Health Options). Its insurance and PPO (PPC) claims payment performance for 2001 was the following: 99.4 percent of claims were paid within 30 days and 97.3 percent were paid within 20 days. According to company representatives, for its insurance and PPO claims, on an annualized basis for 2001, it paid $2.475 billion in claims within 30 days, with less than $70 million paid thereafter even though the statutory threshold is 45 days.

Florida Statewide Provider and Managed Care Organization Claim Dispute Resolution Program

The Statewide Provider and Managed Care Organization Claim Dispute Resolution Program (Dispute Program), administered by AHCA, was established 2 years ago (s. 408.7057, F.S.; ch. 2000-252, L.O.F.). According to the parties involved in proposing the legislation, the Dispute Program was to serve as an alternative to providers suing HMOs. Under the law, AHCA has contracted with Maximus, an independent dispute resolution organization, which conducts "paper reviews" of disputes between HMOs and providers with regard to amounts paid for

[5] S. 624.3161, F.S.
[6] S. 641.27, F.S.
[7] S. 624.310, F.S.
[8] S. 641.281, F.S.
[9] S. 641.3903, F.S., for HMOs and Part IX of ch. 626, F.S., for insurers.

services. Maximus, in turn, recommends to AHCA an appropriate resolution of the claims dispute and the agency has 30 days to review it before taking final agency action.

The Dispute Program requires that physicians have at least $500 (in aggregate) in disputed claims to enter the dispute process, while hospitals must have $25,000 (in aggregate) for inpatient treatment and $10,000 (in aggregate) for outpatient services they believe they are owed. In addition, HMOs are able to initiate the dispute process after meeting the same $500 monetary threshold as physicians. In each case, the loser pays the cost for the dispute review. The Dispute Program became operational on May 1, 2001, and as of January 25, 2002, Maximus had received eight claims (one was a duplication). Three of the claims have been submitted to AHCA for final order, two are outstanding and two have been dismissed.

Representatives with provider groups assert that the Dispute Program has not been utilized because it has not been publicized by AHCA (for example, it is not on their web site), therefore not enough providers know about the program. Agency representatives respond that they have spoken about the program to various groups, but that there were no funds appropriated to publicize the program and therefore they have left it up to the various stakeholders in the process (i.e., providers groups and HMOs) to tell their constituents. The agency also comments that the Dispute Program statute lacks sanctions for nonresponding plans or providers. In addition, some HMOs assert that they are hesitant to participate in the Dispute Program because the law does not contain a public records exemption for confidential and proprietary information (i.e., health plan reimbursement agreements with providers). Further, some providers feel that the costs associated with the review process to the non-prevailing party are too high. But according to AHCA records, the costs as to the current claims submitted to the Dispute Program are very low and range from $175 to $187.

Health Insurance Fraud

According to estimates by the National Health Care Anti-Fraud Association, the losses due to fraud add $100 billion to the annual cost of health care in this country. The Florida Division of Insurance Fraud within the Department of Insurance and the Coalition Against Insurance Fraud estimate that insurance fraud in Florida costs $6.5 billion annually and every insurance consumer family in the state annually pays over $1,414 in additional premiums as a result of such fraud with health care fraud constituting a significant percentage of that amount. Further, according to a recent report by the Office of Program Policy Analysis and Government Accountability (OPPAGA), Florida's losses due to Medicaid fraud and abuse range from $2.1 billion to $4.3 billion, or between 5 percent and 10 percent of total Medicaid health services expenditures.[10]

The risks posed by health care fraud and abuse to insurers and managed care plans are enormous: financial loss, consumer dissatisfaction, provider desertion, malpractice lawsuits by patients, shareholder lawsuits, sanctions and criminal investigations, a damaged reputation and loss of customers. For most employers, fraud increases the cost of providing benefits to their employees and, therefore, their overall cost of doing business. That translates into higher premiums and out-of-pocket expenses.

[10] Report No. 01-39, Sept. 2001. This estimate is over a six-year period (FY 1995-96 to 2000-01).

According to the report issued to the Legislature on the submission and payment of health claims, the vast majority of providers, insurers and managed care plans maintain high ethical standards and do not knowingly abuse or defraud our complex health care finance system; however, a few unscrupulous individuals do extract or withhold billions of dollars fraudulently.[11] Division of Insurance Fraud officials state that the common types of health care fraud involve billing for a treatment or procedure never rendered (i.e., X-rays, laboratory tests, or drugs never dispensed) or double billing wherein a provider obtains payment from two sources. In the area of automated processing of claims, there have been charges of abusive practices against both providers and insurers. For instance, certain providers may fraudulently "upcode" various medical procedures so that a minor service can be upcoded as a more labor intensive or expensive service. "Kickbacks" are also common in healthcare fraud cases. Another scheme involves misrepresenting the diagnosis and symptoms on patient records and then submitting invoices to insurers to receive a higher rate of reimbursement. An example of this would be a patient who visited the doctor for a common cold treatment, but the health insurer was billed for a condition diagnosed as pneumonia, with associated pneumonia testing.

Additional Health Care Payment Provisions under Current Florida Law

Section 627.6141, F.S., relating to denial of claims, provides that each claimant, or provider acting for a claimant, who has had a claim denied as "not medically necessary" must be provided an opportunity for an appeal to the insurer's licensed physician who is responsible for the medical necessity reviews under the plan or is a member of the plan's peer review group. Further, the appeal may be by telephone, and the insurer's licensed physician must respond within a reasonable time, not to exceed 15 business days.

Section 627.647, F.S., relating to standard health claim form requirements for indemnity plans, requires all hospitals, physicians, dentists, and pharmacists to use a standard health claim form as prescribed by the Department of Insurance. This section specifies that the form must be one that allows for the use of generally accepted coding systems by providers and must provide for disclosure by the claimant of the name, policy number, and address of every insurance policy which may cover the claimant with respect the to submitted claim. Required information on diagnosis, dental procedures, medical procedures, services, date of service, supplies, and fees may also be met by an attachment. This requirement does not apply to Medicaid claims or to claims submitted by electronic or electromechanical means. These requirements do not apply to coordination of benefits against an indemnity-type policy, an excess insurance policy as defined in s. 627.635, F.S., a policy with coverage limited to specified illnesses or accidents, or a Medicare supplement policy. (Note: Rule 4-161.004-007, F.A.C., requires the use of specified health insurance claim forms; dental claim forms; pharmacy claim forms; and hospital claim forms. In addition, Rule 4-161.008, F.A.C., clarifies that additional information not contained on the forms may be requested by the insurer.)

Section 641.3155, F.S, regulates payment of claims for HMOs and relates to HMO provider contracts and payment of claims. Specifically authorized are temporary timeframes for payment of noncontested claims, contesting of claims, prompt payment of claims, and payment

[11] February 2000 Report by the Florida Advisory Group on the Submission and Payment of Health Claims. The Report noted that in the area of automated processing of claims, there have been charges of abusive practices against both providers and insurers. Automated "upcoding or downcoding of claims is an area of particular concern."

reconciliation until adoption of a rule by the department. Rule 4-191.066, F.A.C., provides specific timeframes for the payment of "clean claims" and refers to "clean claims" as "valid undisputed claims." Specific authority for this rule is derived from s. 641.36, F.S., relating to the adoption of rules, s. 641.31(12), F.S., relating to health maintenance contracts, and s. 641.3903(5)(c)3., 5., and 6., F.S., relating to unfair methods of competition and unfair or deceptive acts or practices.

Federal Activities Relating to Managed Care Payment of Claims

The Centers for Medicare & Medicaid Services (CMS), formerly known as the Health Care Financing Administration, as part of its administration of the Medicare program, currently requires organizations, including health care providers and institutions, to:

- Pay 95 percent of the "clean claims" within 30 days of receipt if they are submitted by, or on behalf of, an enrollee of Medicare for services that are not furnished under a written agreement between the organization and the provider;
- Pay interest on clean claims that are not paid within 30 days; and
- All other claims must be approved or denied within 60 calendar days from the date of the request.

A "clean claim" is defined to mean a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim (Social Security Act, § 1816(c)(2)(B) and 1842(c)(2)(B)).

Claim Filing Requirements under the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996

In 1996, Congress passed the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), commonly known as HIPAA, which required the Health Care Financing Administration (HCFA) to identify and implement standard electronic formats for health insurance transactions, including claims, eligibility and payments. Rule-making was begun to implement a nationwide standard format so as to provide for common claims forms, procedure codes and data sets. The implementation of the rule, known as the Administrative Simplification (AS) rule, was recently delayed for a year by Congress due in part to the enormity of its impact.

The requirements outlined by the AS rule are far-reaching, and all health care organizations that maintain or transmit electronic health information must comply. This includes: payers (health plans, health insurers, and health care clearinghouses) and health care providers, from large integrated delivery networks to individual physician offices. When the rule is implemented, all health care providers will be required to submit specified transactions in specified formats with standardized transaction codes, and all insurance carriers will be required to accept these forms and codes by specified compliance dates.

Currently, there is no federal common standard for the transfer of information between health care providers and payers. As a result, providers have been required by payers to meet many different requirements. For some providers who submit claims to multiple payers, determining which data to submit and on which form has been a difficult and expensive process whether done

manually or electronically. HIPAA will ultimately simplify this process by requiring payers to accept specific transaction standards for Electronic Data Interchange (EDI), depending on provider type and service type. Providers are given the option of whether to submit the transactions electronically or "on paper," however, if they elect to submit them electronically, they must use the standards agreed upon under the law. Payers are required to accept these transmissions in the standard format in which they are sent and must not delay a transaction or adversely affect a provider who wants to submit the transactions electronically.

Health Flex Plans

The Florida Health Insurance Study (FHIS)

In 1998, the Legislature created the Florida Health Insurance Study (FHIS)[12] to be conducted by the University of Florida for AHCA. This multi-year project was intended to provide a detailed understanding of the exceedingly complex issues of uninsurance and health insurance coverage. The primary focus was a large-scale telephone survey of Floridians under the age of 65. The research team surveyed over 14,000 households representing more than 37,000 individuals.

According to the FHIS report released in March 2000, while the Florida population has increased steadily through the 1990s, the number of uninsured Floridians has fallen from 2.6 million or 18.5 percent of the population (RAND 1993) to 2.1 million or 16.8 percent of the population (FHIS 1999).[13] The uninsured are heavily concentrated in certain regions of the state, where they are putting significant stress on "safety net" health care providers.

The FHIS report indicated that the uninsured are best defined by four characteristics: *income, employment status, ethnicity, and region of the state*. When considering Florida's uninsured rate (under age 65), no single factor plays a greater role than income. Nearly half of the uninsured earn less than 150 percent of the federal poverty level ($25,575 annual income for a family of four). About 58 percent of the uninsured earn less than 200 percent of the federal poverty level ($35,300 annual income for a family of four).

The 34 percent rate of uninsurance for the population earning less than 150 percent of the federal poverty level is more than twice the statewide average, and nearly four times the 8.6 percent rate of uninsurance for those earning more than 250 percent of the poverty level ($42,625 annual income for a family of four). By far the most commonly cited answer to the question, "What is the main reason that you do not have health insurance?" was "Too expensive/can't afford it/premiums too high." This answer was cited by 74 percent of the respondents.

Regarding employment status, the FHIS report found that 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) say they do not have health insurance because their employer does not offer it, or they are not eligible, or they cannot afford it. Employers with one to nine employees have the highest rate of uninsureds (24.6 percent), compared to companies with 100 or more employees (4.78 percent).

[12] http://www.fdhc.state.fl.us/Publications/FHIS/index.html

[13] Note that the 2000 Census estimated the total number of uninsured Floridians to be 19 percent of the population (U.S. Department of Labor).

As far as ethnicity is concerned, the report stated that 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).

The rates of uninsurance vary widely from region to region across the state. The three areas with the highest *number* of uninsured residents are District 1 with 128,000 uninsured (Bay, Escambia, Gadsden, Leon, Okaloosa and Santa Rosa), District 16 with 178,000 uninsured (Broward) and District 17 with 450,000 uninsured (Dade). The three areas with the highest *percentage rate* of uninsured residents are District 13 with 25.5 percent (De Soto, Glades, Hardee, Hendry, Highlands, Monroe and Okeechobee), District 17 at 24.6 percent (Dade), and District 14 at 19.8 percent (Charlotte, Collier, and Lee). In Dade County, nearly 43 percent of those earning less than 150 percent of the federal poverty level are uninsured.

According to a Kaiser Family Foundation study published in September 2000, many workers and retirees dependent on employer-sponsored health insurance are likely to face significant premium increases in the near future. The anticipated premium hikes come in addition to an average increase of 8.3 percent in 2000, and both are driven largely by higher costs for care, including prescription drug costs. The Kaiser report, based on a survey of 3,402 employers nationwide, predicted that premiums will continue to go up and that "employers may respond to the rising cost of health insurance [by passing] some portion of the increased cost on to employees." In interviews, managers of companies, large and small, as well as health insurance analysts, indicated that many workers can expect to pay even bigger percentages in the future, especially in a weak economy.

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 (s. 624.404, F.S.). 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.

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. Under s. 624.407, F.S., for a health insurer, the minimum surplus is the greater of $2.5 million or 6 percent of total liabilities requirement.

The maximum amount of insurance that an insurer may write is controlled by its surplus as to policyholders. Section 624.4095, F.S., sets maximum ratios of premiums written to surplus as to

policyholders. The basic ratio is 10 to 1 for gross written premiums and 4 to 1 for net written premiums ("gross premiums written" includes premiums that are reinsured, "net" does not). These ratios are modified for certain kinds of insurance. For health insurance, premiums may not be more than 3.2 times surplus.

Health Maintenance Organizations

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 who 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 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, F.S., 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.

Mandatory Health Insurance Benefit Requirements

State laws frequently require private health insurance policies and health maintenance organization contracts to include specific coverages for particular treatments, conditions, persons, or providers. These are referred to as "mandated (health) benefits."

Recognizing that "most mandated benefits contribute to the increasing cost of health insurance premiums," while acknowledging the social and health benefits of many of the mandates, the Legislature in 1987 called for a "systematic review of current and proposed" mandated benefits. At that point, the Legislature had approved 16 mandated benefits. In the 13 years since, the Legislature has approved an additional 35 mandated benefits. With 51 mandated health benefits, Florida now has one of the nation's most extensive sets of coverage requirements. A procedural requirement established for reviewing mandated benefits--that proponents submit an impact analysis for any proposed mandate benefit prior to consideration--is found in s. 624.215, F.S. (Source: House Committee on Insurance, Interim Project, "Managing Mandated Health Benefits: Policy Options for Consideration," January 28, 2000.)

Although there has never been a study on the cumulative cost of mandated benefits in Florida, a 1998 Blue Cross/Blue Shield report studied the cumulative cost of mandated benefits in various states including Maryland (only Maryland had more mandates than Florida — 47 at the time of the study). According to the report, Maryland mandates are estimated to add 15.4 percent to the

average monthly premium for a group policy. In Maine, 19 of its 31 mandates were found to increase premium costs on groups of 21 or more by just over 7 percent.

The Employee Health Care Access Act (Small Employer Policies)

In 1992, the Legislature enacted the Employee Health Care Access Act in s. 627.6699, F.S., which requires insurers in the small group market to guarantee the issuance of coverage to any small employer with 1 to 50 employees, including sole proprietors and self-employed individuals, regardless of their health condition.

According to the Department of Insurance, as of December 31, 2001, there were 28 carriers offering small employer health benefit plans. This number reflects a continuing reduction in recent years in the number of carriers offering small employer benefit plans in Florida. In 1997, there were 116 carriers, and in 1998, there were 90 carriers, offering small employer benefit plans in Florida.

"One-Life Groups"

Legislation in 2000 provided that employers with fewer than 2 employees, typically referred to as "one-life groups," are now limited to a one-month open enrollment period in August of each year, rather than the year-round guarantee-issue requirement that previously applied, and that continues to apply to employers with 2-50 employees.[14] Carriers have consistently reported that their claims experience for one-life groups is much worse than for larger size employers. The department notes, as an example, that some carriers report a loss ratio of about 135 percent for one-life groups, meaning that for every one dollar of premium, the insurer pays $1.35 in benefits.

Using Health-Related Factors in Setting Premiums

The 2000 law also changed the requirements for "modified community rating," which previously prohibited insurers from considering health status or claims experience in establishing premiums and allowed only age, gender, geographic location, tobacco usage, and family size to be used as rating factors. As amended in 2000, the law now allows small group carriers to adjust a small employer's rate by plus or minus 15 percent, based on health status, claims experience, or duration of coverage. The renewal premium can be adjusted up to 10 percent annually (up to the total 15 percent limit) of the carrier's approved rate, based on these factors.

Standard, Basic, and Limited Benefit Plans

Small group carriers are required to offer the standard health benefit plan and the basic health benefit plan to each small employer applying for coverage. The act lists certain benefits that must be included in each of these policies. The act also authorizes the appointment of a health benefit plan committee to recommend to the department additional provisions for the plans which the department approved and were incorporated into the standard and basic policies.

A *limited benefit* policy or contract may be offered by a small employer carrier, which is a policy or contract providing coverage for named insureds for a specific named disease, accident, or

[14] Ch. 2000-256 and 2000-296, L.O.F.

limited market such as the small group market. Small employer carriers offering coverage under limited benefit policies or contracts must make certain disclosures to small employer groups including, explaining the mandated benefits and providers not covered under the policy or contract; explaining the managed care and cost control features of the policy or contract; and explaining the primary and preventative care features of the policy or contract.

The current law provides that the standard, basic, and limited benefit plans are exempt from any law requiring coverage for a specific health care service or benefit, or any law requiring reimbursement, utilization, or consideration of a specific category of licensed health care practitioner, unless that law is made expressly applicable to such policies or contracts.

For health insurance policies, the law does not specify maximum deductibles, maximum co-payments, or minimum annual or lifetime benefits. Therefore, health insurance policies sold to small or large employers may impose limits for such benefits (unless a specific mandatory benefit states that a deductible may not apply). For example, according to the department, health insurance policy forms have been approved that limit annual benefits to $5,000 and $10,000. Preferred provider contracts are subject to the statutory limitation on the maximum difference between the deductibles and coinsurance amounts for services by preferred providers compared to non-preferred providers.[15]

However, for HMO contracts, the laws and rules restrict an HMO's authority to limit deductibles and co-payments. The law states that HMO contracts must provide "comprehensive" health care services.[16] The department rules more specifically limit the maximum co-payments that an HMO may impose to $15 per visit and also limit the annual maximum out-of-pocket costs for an HMO subscriber to $1500 for single coverage and $3000 for family coverage.[17] However, the rules do not specify a minimum annual or lifetime maximum benefit that an HMO contract must contain. According to representatives for the department, no HMO has yet made a filing to force the department to make a determination as to whether a proposed annual or lifetime maximum would be too low to be considered "comprehensive."

The standard benefit plan currently has a lifetime benefit limit of $1 million and deductibles in the range of $250 - $1,000 for an individual and $750 - $3,000 for a family. The maximum out-of-pocket expense limit for the standard benefit plan is $2,000 for an individual and $4,000 for a family. The basic benefit plan currently has a lifetime benefit limit of $500,000 and a $500 annual deductible for individuals and $1,000 annual deductible for a family. The maximum out-of-pocket expense limit is $4,800 for an individual and $9,600 for a family.

Alzheimer's Disease

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.

[15] ss. 627.6471 and 627.662(8), F.S.
[16] s. 641.19 (12), F.S.
[17] Department of Insurance Rule 4-191.035, F.A.C.

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 only help control symptoms and/or slow the progression of the disease. Approximately 100,000 victims die and 360,000 new cases of Alzheimer's disease are diagnosed each year in the United States. It is estimated that by 2050, 14 million Americans will have this disease. In every nation where life expectancy has increased, so has the incidence of Alzheimer's disease. It is estimated that by 2020, 30 million people will be affected by this disorder worldwide and by 2050 the number could increase to 45 million.

The National Institute on Aging currently funds 29 Alzheimer's Disease Centers (ADC's) at major medical institutions across the nation. In addition, there are three Affiliate Centers. Researchers at these centers are working to translate research advances into improved care and diagnosis for Alzheimer's disease patients while, at the same time, focusing on the program's long-term goal--finding a way to cure and possibly prevent Alzheimer's disease. Florida is host to only one of the affiliate centers (the Mayo Clinic in Jacksonville).

Alzheimer's disease 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 (USF) hired the head 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 disease, and that develop symptoms quickly, has accelerated research into a vaccine.

Florida's Alzheimer's Disease Initiative

Section 430.502, F.S., establishes memory disorder clinics at 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 Elderly 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 to 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 disease brain bank at Mt. Sinai hospital which collects the brains of 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 of Elderly Affairs 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.

Approval of University Instructional Centers

Under s. 240.209(2)(n), F.S., the Board of Regents must submit to the State Board of Education, for approval, all new instructional centers approved by the board. During this period of transition in education governance, the policies and procedures for approving, classifying, operating, reviewing, and disbanding institutes and centers at state universities are set forth on Chancellor's Memorandum CM-C-07.00-01-99. Under s. 1001.74(27), F.S., of the revised School Code being considered in SB 20-E during the current Special Session of the Legislature, each university board of trustees is required to submit to the State board of Education, for approval, all new campuses and instructional centers.

End Stage Renal Disease/Kidney Dialysis

Kidney dialysis is an artificial means of filtering waste products from the blood when the kidneys have failed to do so. In kidney disease, often referred to as End Stage Renal Disease (ESRD), dialysis is a life-saving treatment. Patients most commonly receive dialysis three times per week in sessions that last several hours. Dialysis is not a cure for ESRD, but rather is a way of keeping a patient alive until he or she can receive a kidney transplant. Laboratory testing of the patient's blood is an essential component of dialysis services, providing a physician information about the patient's renal condition.

There are primarily four major companies providing ESRD services in Florida: DaVita, Inc., also known as Total Renal Laboratories, with a laboratory located in Deland; ESRD Laboratories, with a laboratory located in Broward County; Fresenius, a German company with U.S. headquarters in Lexington, Massachusetts; and Gambro Healthcare, Inc., a Swedish company with laboratory headquarters located in Broward County.

In 1972, Congress established the Medicare End Stage Renal Disease Program to provide for the medical needs of individuals with ESRD. Most individuals who require dialysis or kidney transplantation to sustain life receive services, including laboratory services, that are paid for by Medicare. Approximately 75-80 percent of ESRD patients in Florida are covered by Medicare which pays a composite rate for dialysis and routine laboratory tests. If additional tests are medically necessary, with proper documentation, they may be paid by Medicare as well. In Florida approximately 500 ESRD patients who do not qualify for Medicare, for lack of work history or other reasons, receive services through Medicaid. ESRD services--both dialysis and routine laboratory services--are paid by an all-inclusive fee under Medicaid. Additional laboratory services would only be covered if provided by an independent laboratory.

Prohibitions on Patient Self-Referral

Section 456.053, F.S., is the "Patient Self-Referral Act of 1992" (Patient Self-Referral Act or Act). The 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 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. Allopathic, osteopathic, chiropractic, and podiatric physicians, optometrists and dentists are health care providers under the Act.

The Patient Self-Referral 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.

The current exemption for group practices requires direct supervision by the referring health care provider or group practice. This exemption would not apply to services delivered in the patients home by an employee who was not directly supervised by a physician or dentist.

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.

Studies of Laboratory Services for Dialysis Patients

In 2001, AHCA published a report on Laboratory Services for Dialysis Patients in Florida in response to a request by the 1999 Legislature. The Legislature asked AHCA to analyze six areas: past and present utilization rates of clinical lab services for dialysis patients; financial arrangements among dialysis centers and among centers and medical directors; business relationships and affiliations with clinical labs; the extent of self-referral of dialysis patients to clinical labs; quality and responsiveness of clinical lab services for dialysis patients; and the average annual revenue for dialysis patients for clinical lab services in the past 10 years.

The agency encountered a lack of consistent data that made it impossible to answer several of the questions. The report stated that Florida's dialysis industry is dominated by three large national health care corporations. Only four centers reported that they were owned by their medical director. The report did not contain information on utilization rates. The report stated, "The issue of lab test utilization could not be ascertained as neither Fresenius nor Gambro, the two major players in the Florida dialysis market, chose to respond to the request for information citing proprietary issues. Without the cooperation of the mentioned companies, the agency would be required to commit investigative resources that the Legislature did not provide in order to secure reliable data." The agency recommended that the Legislature provide funding for a study by one of the state universities or a private consultant.

The University of South Florida's (USF) College of Public Health produced the 2001 Florida Dialysis Study which addressed the issues of laboratory test utilization; financial arrangements among dialysis centers, their medical directors, and any business relationships and affiliations with clinical laboratories; any self-referral of dialysis patients to clinical laboratories; and the quality and responsiveness of clinical lab services for dialysis patients. The researcher at USF obtained information and documents that were previously considered proprietary, and the report contains much useful information about the dialysis industry. However, regarding the question of utilization costs, the report states, "Fresenius and Davita have provided summary data, though the two data sets are not compatible. Gambro did not provide data, despite initial assurances that it would." In a conclusion similar to that of the AHCA study, the USF study found that the Legislature's concerns could not be addressed due to the lack of subpoena power on the part of those conducting the study and an absence of standardized reporting requirements for dialysis organizations.

In 2001, the Committee on Health Regulation of the Florida House of Representatives conducted an interim project on ESRD care. Committee staff reviewed the two previous legislatively mandated studies and examined the need for the exemptions granted to clinical laboratories and nephrologists under the Patient Self-Referral Act. The interim project aimed to determine whether Florida is at financial risk due to fraud or abuse in the Medicaid system. The study also addressed the question of whether the three major companies providing services in Florida control the market, thereby eliminating competition and increasing the cost for services. The report concluded that the Medicaid and Medicare programs are regulated by the state and federal governments with remedies to investigate, fine, and prosecute providers for abuses. Regarding the Patient Self-Referral Act, the report recommended no legislative action, stating that removing the exemption for laboratory services related to dialysis would not increase competition or provide opportunities for competition.

III. Effect of Proposed Changes:

Section 1. Creates an unnumbered section of law that authorizes the issuance of health flex plans.

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

- Affordability and availability of health care coverage for low-income Florida residents unable to obtain such coverage;
- Encouraging entities that provide health insurance to develop alternative approaches to traditional health insurance;
- Providing basic and preventative health care services; and
- Coordinating with existing local service programs.

Subsection (2) provides definitions for the terms: "agency," "department," "enrollee," "health care coverage," "health flex plan," and "health flex plan entity." The definition of a "health flex plan entity" which may be approved to issue health flex plans, includes a health insurer, HMO, health care provider-sponsored organization, local government, health care district, or other public or private community-based organization that develops and implements a plan and is responsible for administering the plan and paying all claims.

Subsection (3) creates the pilot program in which AHCA and the Department of Insurance (department) are directed to each approve or disapprove health flex plans that provide health care coverage for eligible participants residing in the three areas of the state having the highest number of uninsured persons, as determined by the Florida Health Insurance Study (FHIS). The three areas in the FHIS are District 1 (Bay, Escambia, Gadsden, Leon, Okaloosa, and Santa Rosa Counties), District 16 (Broward County), and District 17 (Dade County). In addition, Indian River County would be included. The health flex plans are authorized to:

- limit or exclude mandated benefits;
- cap the total amount of claims paid per year per enrollee,
- limit the number of enrollees, or
- take any combination of the above actions.

The bill specifies that AHCA must develop guidelines for reviewing health flex plan applications and must disapprove or withdraw approval of plans that do not meet minimum standards for quality of care and access to care. The Department of Insurance must also develop guidelines for reviewing health flex plan applications and must 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, contain 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 health flex plan is financially sound and that the applicant has the ability to underwrite or finance the benefits provided.

Both ACHA and the department are given authority to adopt rules as needed to implement 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 (HMOs), unless expressly made applicable. The subsection 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 (Unfair Trade Practices), 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. Individual employer 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 ($35,300 annual income for a family of four);
- 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, such as Kidcare, and have not been covered at any time during the past 6 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 must maintain enrollment data and reasonable records of its loss, expense, and claims experience and must 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 must be reported to AHCA biannually so that the agency can monitor access to care.

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

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

Subsection (9) provides that AHCA and the department must evaluate the pilot program and its effect on the entities that seek approval as health flex plans, as well as the number of enrollees, and the scope of the coverage offered. AHCA and the department must assess the plans and their potential applicability in other settings and by January 1, 2004, jointly submit a report to the Governor, President of the Senate and Speaker of the House of Representatives.

Subsection (10) specifies that this section expires on July 1, 2004.

Section 2. 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, pursuant to an agreement with the State Board of Education. The corporation is to act as an instrumentality of the state. The not-for-profit corporation and any not-for-profit subsidiaries created by the corporation are authorized to receive, hold, invest, and administer property and any moneys received from private, state, 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 affairs of the corporation are to be managed by a board of directors who will serve without compensation. The President of the University of South Florida and the chair of the State Board of Education, or their designees, together with 5 representatives of the state universities and no more than 14 or fewer than 9 representatives of the public who are not medical doctors or state employees are to be directors of the not-for-profit corporation. Each director would have only one vote, serve a term of 3 years, and could be reelected to the board. The initial board of directors would be composed of:

- The President of the University of South Florida, or her designee;
- The chair of the State Board of Education, or his designee;
- Five university representatives, one appointed by the Governor, two by the President of the Senate, and two by the Speaker of the House of Representatives; and
- Nine public representatives, three appointed by the Governor, three by the President of the Senate, and three by the Speaker of the House of Representatives.

The bill requires the State Board of Education to enter into an agreement with the not-for-profit corporation that provides for:

- Use of facilities on the campus of the University of South Florida to be known as the Florida Alzheimer's Center and Research Institute;
- Approval by the State Board of Education of articles of incorporation of the corporation and subsidiaries;
- Use of hospital facilities and personnel for teaching and research programs;
- An annual postaudit of the not-for-profit corporation's financial accounts and an audit report to be submitted to the Auditor General and the State Board of Education for review;
- Submission by the not-for-profit corporation and its subsidiaries or auditors of any other data relative to the operation of the not-for-profit corporation or a subsidiary as required by the State Board of Education, the Auditor General, and the Office of Program Policy Analysis and Government Accountability; and

- Provision by the not-for-profit corporation and its subsidiaries of equal employment opportunities for all persons regardless of race, color, religion, sex, age, or national origin.

The State Board of Education is authorized to secure liability insurance for the not-for-profit corporation and its subsidiaries. The bill provides for the State Board of Education to assume governance and operation of the facilities in the event that the agreement between the State Board of Education and the not-for-profit corporation is terminated.

The board must appoint a chief executive officer of the institute to serve at the pleasure of the board. The bill provides the chief executive officer with the authority to establish programs that fulfill the mission of the institute in research, education, treatment, prevention, and early detection of Alzheimer's disease, but requires approval by the State board of Education before any academic program is established that confers academic credit or awards degrees. The chief executive officer has control over the budget and funds appropriated or donated to the institute, as well as income from practice activities. However, professional income generated by faculty from practice activities at the institute would be shared between the institute and the university as determined by the executive director and the appropriate university dean or vice president. The chief executive officer is authorized to appoint representatives of the institute to carry out research, patient care, and educational activities, and he or she may set compensation, benefits and terms of service for the representatives. Representatives of the institute are eligible to hold concurrent appointments at affiliated academic institutions, and university faculty are authorized to hold concurrent appointments at the institute. The chief executive officer has control over the use and assignment of equipment and space within the institute's facilities and may create the administrative structure necessary to carry out the mission of the institute. The chief executive officer has a reporting relationship to the Commissioner of Education and is required to provide a copy of the institute's annual report to the Governor and Cabinet, the President of the Senate, the Speaker of the House of Representatives, and the chair of the State Board of Education.

The board of directors must establish a council of scientific advisors to review programs and recommend research priorities and initiatives to maximize the state's investment in the institute. The State Board of Education would appoint five of the members of the council of scientific advisors and the board of directors would appoint the others. Members of the council will serve 2-year terms.

The not-for-profit corporation and its subsidiaries are declared not to be agencies within the meaning of s. 20.03 (11), F.S. The corporation and its subsidiaries would not be subject to the provisions of ch. 120, F.S., for rulemaking or for remedies. Whether the not-for-profit corporation and its subsidiaries would be granted sovereign immunity protection and whether they would be subject to public records and public meetings requirements is not clear.

Section 3. Amends s. 408.7057, F.S., relating to the Statewide Provider and Managed Care Organization Claim Dispute Resolution Program (Program), to redesignate the Program title to reflect "health plan" rather than "managed care organization" and to expand the Program to include major medical expense health insurance policies offered by a group or individual health insurer, including a preferred provider organization. This section establishes timeframes for the submission of supporting documentation and sanctions for failing to timely submit supporting

documentation, limits review time by the Program to 90 days, requires AHCA to prepare a report to the Legislature and Governor by February 1 of each year, and mandates that AHCA determine if there is a "pattern of noncompliance" by health plans or providers as to claims payments and to report such findings to licensure or certification entities. The Agency for Health Care Administration must also notify, within 7 days, the appropriate licensure or certification entity whenever there is a violation of a final order issued by the agency under the Program.

Section 4. Amends s. 626.88, F.S., relating to definitions for insurance administrators, by adding to the definition of an "administrator," a person who, through a health care risk contract as defined under s. 641.234, F.S., with an insurer or HMO, provides billing and collection services to health insurers and HMOs on behalf of health care providers and mandates that such a person comply with the prompt pay provisions of the bill, and with the adverse determinations provisions of the HMO law under s. 641.51(4), F.S. It exempts from the definition of an "administrator," any provider or group practice as defined under the patient self-referral law (s. 465.053, F.S.), who provides services under the scope of the license of the provider or the member of the group practice. It further exempts from the term "administrator," 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.

Section 5. Creates a new section of law designated as s. 627.6131, F.S., relating to the prompt payment of health care claims by insurance companies. This section provides for the following:

- Requires health insurance policy contracts to contain specific language relating to payment notice requirements.
- Provides that a "claim" for "noninstitutional" providers means a paper or electronic billing instrument submitted to the insurer's designated location consisting of the HCFA 1500 data set, or its successor, that has all mandatory entries for a physician licensed under specified sections of law or a psychologist licensed under ch. 490, F.S. For "institutional" providers, a "claim" is a paper or electronic billing instrument submitted to the insurer's designated location consisting of the UB-92 data set, or its successor, with entries stated as mandatory by the National Uniform Billing Committee.
- Specifies that all claims for payment or overpayment, whether electronic or nonelectronic, are received on the date the claim is received by the insurer at its location, or the date the claim for overpayment is received by the provider at its location. The claim must be mailed or electronically transferred to the "primary" insurer within *6 months* after discharge for inpatient services or after the date of service for outpatient services and the provider is furnished with the correct name and address of the patient's health insurer. The claim must be mailed or electronically transferred to the "secondary" insurer within *90 days* after determination by the "primary" insurer. Submission of a provider's claim is considered made on the date it is electronically transferred or mailed. Further, a claim for payment must not duplicate a claim previously submitted.
- Delineates between electronic and nonelectronic submissions of claims as follows:
    a) For "*electronic claims*," an insurer must provide electronic acknowledgment within *24 hours* after receipt and must pay, deny, or contest a claim within *20 days* after receipt. An insurer that contests a claim must notify the provider and submit an itemized list of additional information it requests of the provider who in turn must respond with the requested information within *35 days* after receipt of the insurer's notice. An insurer may not request duplicate documents. Further, an

insurer must finally pay or deny a claim within *90 days* after receipt of the claim and failure to pay or deny a claim within *120 days* after receipt creates an "uncontestable obligation" to pay the claim by the insurer.

b) For "*nonelectronic claims*," effective November 1, 2003, an insurer must provide acknowledgment within *15 days* after receipt or provide a provider within *15 days* after receipt with electronic access to the status of the claim, and must pay, deny, or contest a claim within *40 days* after receipt. An insurer that contests a claim must notify the provider and submit an itemized list of additional information it requests of the provider who in turn must respond with the requested information within *35 days* after receipt of the insurer's notice. An insurer may not request duplicate documents. Further, an insurer must finally pay or deny a claim within *120 days* after receipt of the claim and failure to pay or deny a claim within *140 days* after receipt creates an "uncontestable obligation" to pay the claim by the insurer.

- Provides procedures for "overpayment" claims by insurers which specifies that all such claims must be submitted to providers within *30 months* after the insurer's payment of the claim and all contested claims for overpayment must be paid or denied within *120 days* after receipt. Failure to pay or deny an overpayment within *140 days* creates an "uncontestable obligation" to pay the claim. A provider must notify the insurer if the overpayment is denied or contested within *35 days* and the insurer has *35 days* to submit requested information to the provider who shall have *45 days* to pay or deny the claim for overpayment. Insurers are prohibited from reducing payment to providers for other services unless the provider agrees to the reduction in writing or fails to respond. All overdue payments of a claim bear simple interest at 12 percent per year. Further, a claim for overpayment is not permitted beyond *30 months* after the health insurer's payment of a claim, except that claims for overpayment may be sought beyond that time from providers convicted of fraud.
- Specifies that for contracts entered into or renewed on or after October 1, 2002, a health insurer's internal dispute resolution process must be finalized within *60 days* after receipt of the provider's request for review or appeal.
- Prohibits providers from collecting payment from insureds for covered services, but does not prohibit collection of co-payments, coinsurance, or deductible amounts due the provider. Prohibits health insurers from retroactively denying claims because of insured ineligibility more than 1 year after the date of payment of the claim.
- Requires health insurers to pay a contracted primary care or admitting physician, pursuant to the physician's contract, for providing inpatient services in a contracted hospital to an insured if such services are determined by the insurer to be medically necessary and covered services under the contract.
- Provides for insurers to investigate any claim for improper billing by a physician, hospital, or provider, upon written notification by the insured. If the insurer determines that the insured has been improperly billed, the insurer must notify the insured and the provider and must reduce the amount of payment to the provider by the amount improperly billed. If the reduction is made due to such notification by the insured, the insurer shall pay to the insured 20 percent of the amount of the reduction up to $500.
- Allows a permissible error ratio of 5 percent for insurer's claims' payments violations under which no fines would be assessed by the Department of Insurance for the noted violations during an audit period. This section specifies how the error ratio is determined

and provides that if the ratio exceeds 5 percent, a fine may be assessed under s. 624.4211, F.S. However, the department could still levy a fine, notwithstanding the error ratio, under the prompt pay sections relating to the "uncontestable obligation" to pay a claim.

- Applies the prompt pay provisions only to a major medical expense health insurance policy offered by a group or an individual health insurer, including a preferred provider and an exclusive provider organization, or a group or individual insurance contract that only provides direct payments to dentists for enumerated dental services.
- Provides an exception for electronic and nonelectronic "pharmacy" claims to provide that when an electronic pharmacy claim is submitted to a pharmacy benefits manager acting on behalf of an insurer, the manager must, within *30 days* of receipt, pay the claim or notify the provider it is denied or contested; effective November 1, 2003, when a nonelectronic pharmacy claim is submitted to such a benefits manager acting on behalf of an insurer, the manager must acknowledge the receipt of the claim within *30 days* after its receipt to the provider or give a provider within *30 days* after receipt electronic access to the status of a submitted claim.

Section 6. Amends s. 627.651, F.S., relating to group contracts and plans of self-insurance, to correct a cross-reference that requires multiple-employer welfare arrangements to comply with the denial of claims provisions under s. 627.645(1), F.S.

Section 7. Amends s. 627.662, F.S., relating to group, blanket, and franchise health insurance policies, to require such policies to comply with the prompt pay provisions under either s. 612.613 or s. 627.6131, F.S., whichever is applicable. The effect of this provision would require such policies to comply with the prompt pay provisions of s. 627.6131, F.S., if such policies are major medical expense health insurance policies or to comply with s. 627.613, F.S., for other health insurance policies such as limited benefit type policies.

Section 8. Amends s. 641.185, F.S., relating to HMO subscriber protections, to provide that HMO subscribers "should" receive prompt payment from their HMO pursuant to s. 641.3155, F.S. (Note, however, that Section 12 of the bill clearly applies the prompt payment provisions to claims submitted by an HMO subscriber under an HMO subscriber contract for payment, in s. 641.3155(13), as amended.)

Section 9. Amends s. 641.234, F.S., relating to administrative, provider and management contracts, to provide that if an HMO, through a health care risk contract, transfers to any entity the obligations to pay a provider for any claim arising from services provided to a subscriber, that the HMO remains responsible for any violations of the claims' payment, treatment authorization, and adverse determination provisions of law and for specified violations under the insurance code. The section defines a "health care risk contract" to mean a contract in which an entity receives compensation in exchange for providing to the HMO a provider network or other services, which may include administrative services. The term "entity" is defined to mean a person licensed as an administrator, but it does not include any provider or group practice under the patient-self referral law, that provides services under the scope of the license of the provider or members of the group practice. The term "entity" also does not include 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 s. 641.30, F.S., relating to HMOs, to require every HMO to accept the specified claim forms prescribed under the prompt pay provisions under s. 641.3155, F.S.

Section 11. Amends s. 641.3154, F.S., applying to provider billing. Current law prohibits a provider from collecting money from a subscriber of an HMO for payment of services for which the HMO is liable, if the provider in good faith knows or should know that the HMO is liable. The law creates a presumption that the provider does not know and should not know that the HMO is liable for payment unless there is specified information (which is listed in the law) to the contrary. This section adds a provision which states that the presumption that the provider does not know and should not know that the HMO is liable should apply unless AHCA issues a final order stating that the HMO is required to pay for services subsequent to a recommendation made by the Dispute Resolution Program under s. 408.7057, F.S.

Section 12. Amends s. 641.3155, F.S., relating to prompt payment of claims for HMOs. The provisions of this section are virtually the same as the prompt payment requirements outlined above under Section 5 which apply to health insurers. The only exceptions are the following:

a) under the HMO prompt pay provisions under subsection (7)(b), all claims to an HMO begun after October 1, 2000 (the effective date of the HMO prompt pay law enacted in 2000, ch. 2000-252, L.O.F.), which are not under active review by a mediator or third-party dispute entity, must result in a final decision on the claim by the HMO by January 2, 2003, for the purposes of the Statewide Provider and Managed Care Organization Claim Dispute Resolution Program. This provision is not in Section 5 because it is not applicable to health insurers.
b) the HMO prompt pay provisions do not contain the health insurer improper billing provisions which are under Section 5 under subsection (13).
c) under subsection (13), the HMO prompt pay provisions apply to claims submitted by an HMO subscriber under an HMO subscriber contract for payment. Section 5 does not contain a similar provision.

Section 13. Amends s. 641.51, F.S., to delete the provision which authorizes the HMO, in addition to the primary care physician, to determine whether a subscriber requires an examination by a licensed ophthalmologist for medically necessary, contractually covered services. The effect of this provision would be to allow only the contracted primary care physician to make a determination that referral to an ophthalmologist is medically necessary.

Section 14. Amends s. 456.053(3)(o), F.S., to remove 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 contained in the "Patient Self-Referral Act of 1992." Thus, a health care provider would be prohibited from referring patients for diagnostic laboratory services related to renal dialysis to a clinical laboratory in which the referring provider had a financial interest.

The bill adds language to s. 456.053(3)(o), F.S., that will not allow a referral exclusion for nephrologists ordering laboratory services related to renal dialysis.

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, except for services rendered by a home health agency licensed under chapter 400, F.S. For the purposes of this exemption, a patient's private residence could be a private home, independent living center, or assisted living facility, but not a skilled nursing facility.

Section 15. Amends s. 627.6699, F.S., relating to the Employee Health Care Access Act (small employer policies). The bill makes the following changes:

Rates for One-Life Groups - The bill allows, for rating purposes, the experience of small employer groups of less than two employees (i.e., one employee, sole proprietors, and self-employed individuals) to be separated from the rating experience of small employer groups of 2 to 50 employees. Thus, the rates for one-life groups would be solely based on the claims experience of the one-life group rating pool. However, the rate charged to one-life groups would be subject to a rate cap of 150 percent above the small employer carrier's approved rate for groups of 2-50 employees. The rate cap would be 125 percent for policies in effect on July 1, 2002, for the first annual renewal, and 150 percent for subsequent annual renewals. The carrier would be permitted to charge any excess losses of the one-life group pool to the experience pool of the 2-50 employees.

Deductibles, Co-Payments, and Maximum Benefits - The bill provides that any law restricting or limiting deductibles, co-insurance, co-payments, or annual or lifetime maximum benefits would not apply to any health plan policy offered to a small employer, including the standard or basic health benefit plan, unless such law is made expressly applicable to such policy or contract. This would primarily affect HMO contracts, for which current Department rules limit co-payments and out-of-pocket expenses. For health insurance policies, the current law does not generally limit deductibles, co-payments, or lifetime or annual benefits.

Section 16. Provides that if any law amended by this bill was also amended by a law enacted in the 2002 Regular Session of the Legislature, the laws will be construed as if they were enacted at the same session of the Legislature and full effect will be given to each if that is possible.

Section 17. Provides an effective date of October 1, 2002, except that this section and sections 1, 2, and 16 of the bill will take effect July 1, 2002.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Art. VII, s. 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

It is not clear whether the records of the not-for profit corporation governing the Florida Alzheimer's Center and Research Institute would be public records under the requirements of Art. I, s. 24(a) of the Florida Constitution. In order to provide a public records exemption for proprietary confidential business information, trade secrets,

contracts for managed care arrangements, or the identity of donors who wished to remain anonymous, a separate public records bill would be required.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Art. III, s. 19(f) of the Florida Constitution.

D. Other Constitutional Issues:

Under Sections 5 and 12 of the bill, the reference to a claim for both noninstitutional and institutional providers, as to a paper or an electronic billing instrument that consists of respectively, the HCFA 1500 data set, "or its successor," and the UB-92 data set "or its successor," may raise the issue of unlawful delegation of legislative authority by referring to data sets which are not yet in existence.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Uninsured persons at or below 200 percent of the federal poverty level who live in one of the "three areas" of the state with the highest number of uninsured persons and in Indian River County would be eligible to purchase a health flex plan. It is anticipated that such coverage would be less expensive (and would provide lower benefits) than health insurance or HMO coverage currently available.

Health flex plan entities that are approved by the Agency for Health Care Administration to sell health flex plans are potentially subject to the profits or losses of underwriting such products. The financial ability of the entity to underwrite the plan would be subject to approval of the agency and Department of Insurance, for which the bill provides no specific requirements.

To the extent that local community providers, hospitals, and local government programs provide uncompensated care to low-income persons, such providers may see a decrease in demand for uncompensated care as a result of this pilot project. These same local providers may seek to become health flex plan provider entities.

Health plans could be sanctioned or penalized for not promptly responding to the various timeframes provided for under the provisions for the Statewide Dispute Resolution Program and for engaging in a pattern of not complying with the prompt pay provisions of the bill.

Providers of health care services should receive more timely reimbursement for claims submitted to HMOs and health insurers and potentially achieve greater reimbursement under the prompt pay provisions of this bill.

The following prompt pay provisions of the bill may result in increased costs to health insurers and HMOs, and ultimately policyholders due to:

- Deleting the requirements that providers submit accurate "clean" claims with supporting documentation before triggering payment timeframes;
- Eliminating health insurers' and HMOs' abilities to conduct audits and look-back reviews as to claims for overpayments beyond 30 months after the payment of a claim (although this exception does not involve instances where providers are convicted of fraud);
- Increasing from 10 to 12 percent the interest on overdue claims; and
- Prohibiting insurers' and HMOs' ability to retroactively deny a claim due to subscriber ineligibility beyond 1 year.

Health care costs could also increase for HMOs due to the bill's provision which will only allow a contracted primary care physician to determine whether a subscriber requires an examination by a licensed ophthalmologist for medically necessary, contractually covered services.

Health maintenance organizations which enter into health care risk contracts and thus transfer to another entity the obligation to pay provider claims would be responsible for any violations of the prompt pay provisions of the bill as well as the treatment authorization and adverse determination provisions under current law.

To the extent that health care providers currently refer patients for clinical laboratory services at facilities in which the referring provider has a financial interest, 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.

The allowance for small group carriers to establish a separate rating pool of one-life groups could increase rates by as much as 50 percent for some one-life groups, according to the department, but this would be offset by rate decreases for groups of 2-50 employees.

C. Government Sector Impact:

According to both the Agency for Health Care Administration and the Department of Insurance, implementation of the health flex plans can be accomplished with existing staff and resources within their respective agencies.

The bill appears to have a direct fiscal impact on the Department of Insurance because the department would have to expand its monitoring activities to ensure that health insurers and HMOs are in compliance with the various prompt pay provisions.

According to AHCA, the bill has a direct fiscal impact on the agency because it expands the type of health plans which have access to the Statewide Provider and Managed Care Claim Dispute Resolution Program (Dispute Program). The agency is responsible for issuing final orders for all claim disputes submitted to the Dispute Program and while the Program's current caseload is very low, the inclusion of major medical expense health insurance policies offered by a group or an individual health insurer will likely increase the caseload.

There could be indeterminate cost increases to local government health plans arising from claims handling and/or claims settlement expenses.

Medicare is the most prevalent source of funding for laboratory services related to dialysis services. The payment amounts are established by the federal government. If the bill were to have an impact on state expenditures, the amount, and whether it would be a positive or negative impact, is indeterminate.

The Florida Alzheimer's Center and Research Institute will require funding for the facility and for operations. A cost has not been determined.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.