HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 715 Health Services Claims
SPONSOR(S): Patronis
TIED BILLS: **IDEN./SIM. BILLS:** SB 1232

	REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1)	Health Care Regulation Policy Committee		Holt	Calamas
2)	Insurance, Business & Financial Affairs Policy Committee			
3)	Government Operations Appropriations Committee			
4)	General Government Policy Council			
5)				

SUMMARY ANALYSIS

The bill provides a provider or claimant an opportunity to appeal a claim submitted to a health insurer or health maintenance organization (HMO) if the claim or a portion of the claim was denied because the provider or claimant failed to obtain the necessary authorization due to unintentional act or error or omission.

The bill requires the health insurer or HMO to conduct a retrospective review of the medical necessity of the service within 30 days after the provider or claimant submits an appeal. If the service is determined to be medically necessary, the health insurer or HMO is required to reverse the denial and pay the claim. If the service is determined not to be medically necessary, the health insurer or HMO must provide a written clinical justification of the denial.

The bill will have an indeterminate negative fiscal impact to the State Group Insurance Program, within the Department of Management Services (See Fiscal Comments).

The bill takes effect July 1, 2010.

HOUSE PRINCIPLES

Members are encouraged to evaluate proposed legislation in light of the following guiding principles of the House of Representatives

- Balance the state budget.
- Create a legal and regulatory environment that fosters economic growth and job creation.
- Lower the tax burden on families and businesses.
- Reverse or restrain the growth of government.
- Promote public safety.
- Promote educational accountability, excellence, and choice.
- Foster respect for the family and for innocent human life.
- Protect Florida's natural beauty.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Regulation of Health Insurers and HMOs

The Office of Insurance Regulation regulates health insurance contracts and rates under Part VI of Chapter 627, F.S., and Health Maintenance Organization (HMO) contracts and rates under Part I of Chapter 641, F.S., while the Agency for Health Care Administration regulates the quality of care provided by HMOs under Part III of Chapter 641, F.S.

Employee Retirement Income Security Act of 1974

The Employee Retirement Income Security Act of 1974 (ERISA)[1] is a federal law that sets minimum standards for retirement and health benefit plans in private industry. ERISA places the regulation of employee benefit plans (including health plans) primarily under federal jurisdiction.[2] ERISA does not require any employer to establish a plan. ERISA only requires that those who establish plans must meet certain minimum standards.[3] ERISA contains an express preemption provision that provides, "[ERISA] supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan…."[4] This portion of ERISA was designed to ensure that plans would be subject to the same benefit laws across all states.[5] However, the wording "relates to" is not precise, and as a result, the courts continue to define this term, case by case.[6]

Another provision, s. 514(b)(2)(A), referred to as the "savings" clause, retains state authority over the business of insurance.[7] The business of insurance typically refers to the regulation of plan solvency,

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[1] Public Law 93-406.
[2] Congressional Research Service, Report for Congress, ERISA Regulation of Health Plans: Fact Sheet (RS20315), March 6, 2003.
[3] Department of Labor, Employee Benefits Security Administration, Compliance Assistance, available at: http://www.dol.gov/ebsa/compliance_assistance.html (last viewed March 25, 2010).
[4] 29 U.S.C. s. 1144(a).
[5] Congressional Research Service, Report for Congress, ERISA Regulation of Health Plans: Fact Sheet (RS20315), March 6, 2003.
[6] *See, e.g., Shaw v. Delta Air Lines*, 463 U.S. 85 (1983) (finding that a state law "relates to" an employee benefit plan "if it has a connection with or reference to such plan," while recognizing that some state actions may be too remote or tenuous to warrant a finding that the law relates to an employee benefits plan); *see, e.g., Arkansas Blue Cross and Blue Shield v. St. Mary's Hospital, Inc.,* 947 F.2d 1341 (8th Cir. 1991).
[7] Congressional Research Service, Report for Congress, ERISA Regulation of Health Plans: Fact Sheet (RS20315), March 6, 2003.

marketing, information disclosure, consumer grievances and may also include mandating benefits, taxing insurance premiums, and mandating participation in state risk pools and uncompensated care plans.[8]

Lastly, s. 514(b)(2)(B), referred to as the "deemer" clause, does not allow states to deem an employee benefit plan to be in the business of insurance.[9] The effect of this clause is that self-insured plans are not subject to state rules governing the business of insurance.[10]

According to the Department of Financial Services, ERISA poses the most significant obstacle to state regulators' efforts to expand or enforce provisions governing consumer rights related to health insurance contracts.[11]

Health Insurers

Section 627.6141, F.S., requires each claimant, or provider acting for a claimant, who has had a claim denied as not medically necessary to 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. Currently, an appeal may be by telephone, and the insurer's licensed physician must respond within a reasonable time, not to exceed 15 business days.[12]

Currently s. 627.6686(6), F.S., provides that an insurer may not deny or refuse to issue coverage for medically necessary services, refuse to contract with, or refuse to renew or reissue or otherwise terminate or restrict coverage for an individual because the individual is diagnosed as having a developmental disability.

Health Maintenance Organizations

Section 641.3156, F.S., requires a HMO to pay any hospital service or referral service claim for treatment for an eligible subscriber if the services or referral was authorized by an approved HMO provider who is tasked to direct the patient's utilization of health care services. An HMO does not have to pay for any hospital services or referral services for treatment if the approved HMO provider provided information to the HMO with the willful intention to misinform.[13] In addition, a claim for treatment may not be denied if a provider follows the HMOs authorization procedures and receives authorization for a covered service for an eligible subscriber, unless the provider provided information to the HMO with the willful intention to misinform the HMO.[14]

Currently, an HMO is required to provide coverage for medically necessary services under the following circumstances:

- Section 641.315(9), F.S., provides that a contract between a HMO and a contracted primary care or admitting physician may not contain any provision that prohibits such physician from providing inpatient services in a contracted hospital to a subscriber if such services are determined by the organization to be medically necessary and covered services under the organization's contract with the contract holder.

- Section 641.31089(6), F.S. provides that a HMO may not deny or refuse to issue coverage for medically necessary services, refuse to contract with, or refuse to renew or reissue or otherwise terminate or restrict coverage for an individual solely because the individual is diagnosed as having a developmental disability.

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[8] *Id.*
[9] *Id.*
[10] *Id.*
[11] Department of Financial Services, Bill Analysis and Fiscal Impact Statement of House Bill 243 (January 20, 2009).
[12] s. 627.6141, F.S.
[13] s. 641.31569(1), F.S
[14] s. 641.31569(2), F.S.

In addition HMOs are required to provide coverage for emergency services and care, and may not:[15]

- Require prior authorization for the receipt of pre-hospital transport or treatment or for emergency services and care.[16]
- Indicate that emergencies are covered only if care is secured within a certain period of time.[17]
- Use terms such as "life threatening" or "bona fide" to qualify the kind of emergency that is covered.[18]
- Deny payment based on the subscriber's failure to notify the health maintenance organization in advance of seeking treatment or within a certain period of time after the care is given.[19]

EFFECTS OF THE BILL

Health Insurers

The bill provides that an opportunity to appeal applies if the claim or a portion of the claim is denied because the provider or claimant failed to obtain the necessary authorization due to unintentional act or error or omission.

The bill extends the reasonable time period to respond from 15 days to 30 days. The bill deletes provisions that allow appeals to be submitted by telephone and removes the ability of medical necessity reviews to be conducted by a member of the plan's peer review group. Removing the ability of medical necessity reviews to be conducted by a member of the plan's peer review group may impact the business model of some organizations.

The bill requires health insurers to cover services that are medically necessary, this provision may have an unintended consequence of requiring plans cover services that may not be covered or a benefit under a specific health insurance policy.

Health Maintenance Organizations

The bill provides a provider or claimant an opportunity to appeal a claim submitted an HMO if the claim or a portion of the claim is denied because the provider or claimant failed to obtain the necessary authorization due to unintentional act or error or omission.

The bill provides that if the provider or claimant appeals the denial, an HMO is required to conduct and complete a retrospective review of the medical necessity of the service within 30 days after submitting the appeal. The bill provides that if service was determined to be medically necessary, than the health insurance is required to reverse the denial and pay the claim. Moreover, the bill provides that if the service was determined not to be medically necessary, than the health insurer or HMO must provide a written clinical justification of the denial.

The bill requires HMOs to cover services that are medically necessary, this provision may have an unintended consequence of requiring plans cover services that may not be covered or a benefit under a specific health insurance policy.

The bill takes effect July 1, 2010.

B. SECTION DIRECTORY:

Section 1. Amends s. 627.6141, F.S., relating to denial of claims.
Section 2. Amends s. 641.3156, F.S., relating to treatment authorization and payment of claims.
Section 3. Provides that the bill takes effect July 1, 2010.

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[15] s. 641.315(1), F.S.
[16] s. 641.315(1)(a), F.S.
[17] s. 641.315(1)(b), F.S.
[18] s. 641.315(1)(c), F.S.
[19] s. 641.315(1)(d), F.S.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

D. FISCAL COMMENTS:

According to the Department of Management Services, the bill would have a negative fiscal impact on the State Group Insurance Program.[20] The provisions could negate the pre-admission certification provisions contained within the PPO Plan resulting in the payment of hospital admissions that would have otherwise been denied or subject to a penalty.[21]

In addition, the provisions of the bill may reduce the ability of the health plans in the State Group Insurance Program to implement cost control measures (i.e. referrals and prior authorization).[22] To the extent that the bill limits the effectiveness of prior authorization programs, there could be an indeterminate negative fiscal impact to the contracted State PPO Plan and State HMO Plans. Two State HMO Plan vendors estimated that this legislation could result in a program cost increase of $3.15 to $4 per member per month.[23]

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The Office of Insurance Regulation has sufficient rule making authority to implement the provisions of the bill.

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[20] Department of Management Services 2009 Analysis of House Bill 243 (March 25, 2009).
[21] *Id.*
[22] Department of Management Services 2010 Analysis of House Bill 715 (March 26, 2010).
[23] *Id.*

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill provides when a provider appeals a denial, a health insurer or HMO is required to complete and submit a retrospective review of the medical necessity of a service within 30 business days. The bill does not mention what happens if additional information is required after the appeal is submitted.

According to the Office of Insurance Regulation, the bill requires the health insurer or HMO to provide clinical justification for determining a specific medical service or treatment is not "medically necessary." This would require the health insurer or HMO to periodically re-examine its policies and procedures to determine "medical necessity" as medical services and treatments evolve.[24]

IV. AMENDMENTS/COUNCIL OR COMMITTEE SUBSTITUTE CHANGES

[24] Office of Insurance Regulation 2009 Bill Analysis of House Bill 243 (March 12, 2009).