HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 715 Health Services Claims
SPONSOR(S): Health Care Regulation Policy Committee; Patronis
TIED BILLS: **IDEN./SIM. BILLS:** SB 1232

	REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1)	Health Care Regulation Policy Committee	12 Y, 1 N, As CS	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 hospital 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 provides that all contracts entered into or renewed on or after July 1, 2010 between a health insurer, prepaid limited health service organization, an HMO and a dentist, may not contain any provision that requires the dentist to provide a service at a fee set by an insurer unless the service is covered under an applicable contract. The bill defines a "covered service" as services that are reimbursable under an applicable contract and subject to contractual limitations on benefits, such as deductibles, coinsurance, and copayments.

Moreover, the bill allows health insurers to offer rewards and incentives to benefit plan members who participate in a health insurer's wellness program. The bill provides that rewards or incentives are not insurance benefits. The bill allows health insurers to require benefit plan members to provide documentation that a medical condition makes participation difficult or medically inadvisable.

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]

Provider Contracts

Currently, s. 627.6474, F.S., provides that a health insurer cannot require a contracted health care practitioner[12] to accept the terms of other health care practitioner contracts with the insurer or any other insurer, or HMO, under common management and control with the insurer, including Medicare and Medicaid practitioner contracts, preferred provider[13], exclusive provider organizations[14], or provider contracts[15], except for a practitioner in a group practice[16] who must accept the terms of a contract negotiated for the practitioner by the group, as a condition of continuation or renewal of the contract. Any contract provision that violates this provision is considered void.[17]

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.[18]

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

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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] A health care practitioner is any person licensed under the following provisions: chapter 457 (acupuncturist); chapter 458 (medical doctor); chapter 459 (doctor of osteopathic medicine); chapter 460 (chiropractor); chapter 461 (podiatrist); chapter 462 (naturopaths); chapter 463 (optometrist); chapter 464 (nurses, CNAs); chapter 465 (pharmacist); chapter 466 (dentists, dental hygienists, dental laboratories); chapter 467 (midwifery); part I (speech-language pathologists), part II (nursing home administrator), part III (occupational therapist), part V (respiratory therapist), part X (nutritionist), part XIII (athletic trainer), or part XIV (orthotist, prosthetist, and pedorthist) of chapter 468; chapter 478 (electrologist); chapter 480 (massage therapist); part III (clinical laboratory personnel) or part IV (medical physicist) of chapter 483 chapter 484(opticians and hearing aid technician); chapter 486 (physical therapist); chapter 490 (psychologist and school psychologist); or chapter 491 (clinical social worker, marriage and family therapist, and mental health counselor). *See* s. 465.001(4), F.S.
[13] s. 627.6471, F.S.
[14] s. 627.6472, F.S.
[15] s. 641.315, F.S.
[16] A group practice is a group of two or more health care providers legally organized as a partnership, professional corporation, or similar association such that services are provided through the joint use of shared office space, facilities, equipment, and personnel; services are billed in the name of the group and amounts received are treated as receipts of the group; and overhead expenses and income is distributed by methods determined by the group. *See* s. 456.053(h), F.S.
[17] s. 627.6474, F.S.
[18] s. 627.6141, F.S.

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.[19] 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.[20]

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.

In addition HMOs are required to provide coverage for emergency services and care, and may not:[21]

- Require prior authorization for the receipt of pre-hospital transport or treatment or for emergency services and care.[22]
- Indicate that emergencies are covered only if care is secured within a certain period of time.[23]
- Use terms such as “life threatening” or “bona fide” to qualify the kind of emergency that is covered.[24]
- 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.[25]

EFFECTS OF THE BILL

Wellness Programs

The bill provides in s. 626.9541, F.S., health insurers the authority to offer a voluntary wellness or health improvement program that provides rewards and incentives to benefit plan members in an effort to encourage or reward participation in a health insurer’s wellness program. Additionally, the bill provides authority to health insurers to request health benefit pan members to provide documentation stating that they have a medical condition which makes it unreasonably difficult or medically inadvisable to participate in a wellness program. The bill provides that rewards or incentives are not insurance benefits.

Provider Contracts

The bill adds (via a cross-reference) s. 636.035, F.S., relating to prepaid limited health service organizations to the list of insurers who may not require a health care practitioner to accept the terms of other health care practitioner contracts with an insurer, prepaid limited health service organization, or HMO. The bill provides that all contracts entered into or renewed on or after July 1, 2010 between a health insurer (s. 627.6474, F.S.), prepaid limited health service organization (s. 636.035, F.S.), an HMO (s. 641.315,

[19] s. 641.31569(1), F.S
[20] s. 641.31569(2), F.S.
[21] s. 641.315(1), F.S.
[22] s. 641.315(1)(a), F.S.
[23] s. 641.315(1)(b), F.S.
[24] s. 641.315(1)(c), F.S.
[25] s. 641.315(1)(d), F.S.

F.S.) and a licensed dentist, may not contain any provision that requires a dentist to provide a service at a fee set by an insurer unless the service is covered under an applicable contract. The bill defines a "covered service" as services that are reimbursable under an applicable contract and subject to contractual limitations on benefits, such as deductibles, coinsurance, and copayments.

Health Insurers

The bill provides in s. that each claimant or hospital acting for a claimant an opportunity to appeal claim or a portion of a denied claim because the hospital failed to obtain the necessary authorization due to an unintentional act or error or omission. If the hospital appeals the denial, the insurer is required to conduct a complete retrospective review of the medical necessity of the service within 30 business days after the appeal was submitted. The bill extends the reasonable time period to respond from 15 days to 30 business days. The bill requires the insurer to reverse the denial and pay the claim if the insurer determined upon review that the service was medically necessary. Additionally, if the insurer determines that the service was not medically necessary, then the insurer is required to submit to the hospital specific written clinical justification for that determination.

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 to cover services that may not be covered or a benefit under a specific health insurance policy.

Health Maintenance Organizations

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

The bill provides that if the hospital 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, then 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, then 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 to 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. 626.9541, F.S., relating to unfair methods of competition and unfair or deceptive acts or practices defined.
Section 2. Amends s. 627.6141, F.S., relating to denial of claims.
Section 3. Amends s. 627.6474, F.S., relating to provider contracts.
Section 4. Amends s. 636.035, F.S., relating to provider arrangements.
Section 5. Amends s. 641.315, F.S., relating to provider contracts.
Section 6. 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.

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:

Patients purchasing network dental insurance may be subject to non-network pricing whenever a service falls outside of the members coverage.

D. FISCAL COMMENTS:

Department of Management Services

According to the Department of Management Services (DMS), the bill may increase costs to the State Group Insurance Program since services denied as "no prior authorization" may be appealed and reversed; whereas currently, the services would simply be denied as "no prior authorization." To the extent the bill limits the effectiveness of prior authorization programs, there could be an additional negative fiscal impact to the PPO plan and state contracted HMO plans.[26]

State employees purchasing network dental insurance may be subject to non-network pricing whenever a service falls outside of the members coverage.[27]

According to initial cost estimates received by DMS from the two HMO plan vendors within the State Group Insurance program, this legislation could result in an additional program cost increase of $3.15 to $4 per member per month.[28]

Florida Healthy Kids Corporation

Currently, the Florida Healthy Kids Corporation contracts with four statewide prepaid dental plans[29] to provide a comprehensive dental benefit to its enrollees. All subsidized enrollees in the Healthy Kids program receive dental benefits as part of their benefit package and our non-subsidized enrollees pay an additional $12 per member per month for the benefit. Non-subsidized enrollees may opt out of the benefit and reduce their rates by the $12 per member per month amount. In March 2010, there were 209,094 children enrolled in Florida Healthy Kids.[30]

The current dental benefit package includes all dental services covered under Medicaid for children under an annual benefit cap of $1,000. All four dental plans offer enrollees a discount on non-covered services of

[26] Department of Management Services, Agency Analysis of Committee Substitute for House Bill 291 (April 15, 2010).
[27] *Id.*
[28] *Id.*
[29] The four dental plans are: Atlantic Dental, Inc.\DentaQuest, CompBenefits\Humana, United Healthcare Dental and MCNA Dental Plan.
[30] Email correspondence with the Florida Healthy Kids Corporation on file with Health Care Regulation Policy Committee staff (April 1, 2010).

either 25 percent or 30 percent, depending on the plan. Non-covered services could include services that would be covered under the contract but the enrollee has met their annual cap for the benefit year or for cosmetic services (i.e. orthodontics). Due to changes in federal law, the annual benefit cap is expected to be removed effective July 1, 2010.[31]

Committee substitute for HB 715 adversely impacts the ability of the four dental plans to offer a discount on non-covered services as part of the benefit package to enrollees. Florida Healthy Kids Corporation has stated that if this provision is passed into law, families would be notified that the discount would no longer be available for non-covered services and clarifies that the discount was just an added "extra" that our dental plans offered families and not a mandatory part of the benefit package.[32]

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.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill amended ss. 627.6141 and 641.3156, F.S., narrowing existing law to apply only to hospitals. Under these two provisions other providers were provided statutory access to an internal appeals process, which is no longer available, since the bill amended them out of the provision.

The bill provides when a hospital 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.[33]

IV. AMENDMENTS/COUNCIL OR COMMITTEE SUBSTITUTE CHANGES

On March 31, 2010, the Health Care Regulation Policy Committee adopted three amendments and reported the bill favorably as a committee substitute. The amendments:

- Narrow the scope of the bill to apply only to hospitals, instead of all providers (effectively eliminates the appeal process for other provider types).

- Amend the provisions of HB 291 onto the bill, but narrows the scope to relate specifically to dentists. Prohibits health insurers from including any provision in a contract with a dentist setting the fee for services by the dentist unless the services are "covered services" under the contract with the insured.

[31] *Id.*
[32] *Id.*
[33] Office of Insurance Regulation 2009 Bill Analysis of House Bill 243 (March 12, 2009).

- Allow health insurers to offer rewards and incentives to benefit plan members who participate in the insurer's wellness program; allow health insurers to require benefit plan members to provide documentation that a medical condition makes participation difficult or medically inadvisable; and provide that rewards or incentives are not insurance benefits.

This analysis is drafted to the committee substitute.