SB 46-E — Health Care/Health Flex Plans

by Senators Saunders, Pruitt, and Lee

Health Flex Plans

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 (AHCA) and the Department of Insurance (DOI) may approve health flex plans in the three areas of the state having the highest number of uninsured persons and in Indian River County. As determined by the Florida Health Insurance Study, the three areas of the state having the highest number of uninsured persons are District 1 (Bay, Escambia, Gadsden, Leon, Okaloosa, and Santa Rosa Counties), District 16 (Broward County), and District 17 (Dade County).

The health flex plans would be exempt from the requirements of the Florida Insurance Code. 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 approved plans will not be subject to the licensing requirements of the Insurance Code or ch. 641, F.S., relating to health maintenance organizations (HMOs), unless expressly made applicable. The bill provides that for the purposes of prohibiting unfair trade practices, plans are considered insurance subject to the applicable provisions of part IX of ch. 626 (Unfair Trade Practices), F.S., except as otherwise provided in the bill.

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. DOI 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; that provide benefits that are unreasonable in relation to the premium charged; or that cannot demonstrate that the health flex plan is financially sound.

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.

AHCA and DOI must evaluate the pilot program and 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. The portion of the bill governing health-flex plans expires on July 1, 2004.

Alzheimer's Disease Research

The bill establishes the Florida Alzheimer's Center and Research Institute at the University of South Florida. The center and institute will be governed and operated by a not-for-profit corporation, 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.

The members of the board of directors will be 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. The university and public representatives will be appointed initially by the Governor, the President of the Senate, and the Speaker of the House of Representatives to serve 3-year terms. Thereafter, when a 3-year term of a university or public representative expires, the vacancy will be filled by a majority vote of the directors.

The chief executive officer of the institute may establish programs that fulfill the mission of the institute in research, education, treatment, prevention, and early detection of Alzheimer's disease, but must have 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 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 council of scientific advisors will review programs and recommend research priorities and initiatives to maximize the state's investment in the institute. The State Board of Education will appoint five of the members of the council of scientific advisors and the board of directors will appoint the others. Members of the council will serve 2-year terms.

Prompt Payment of Health Insurance Claims

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 separate prompt pay time frames for claims to be submitted to a "primary" and "secondary" health insurer or HMO. It allows a permissible error ratio of 5 percent of an insurer's or HMO's claims' payments violations under which no fines could be assessed by DOI for the noted violations during an audit period and specifies how the error ratio is determined. If the ratio exceeds 5 percent, a fine may be assessed by DOI, however, the department could still levy a fine, notwithstanding the error ratio, under the prompt pay provisions pertaining to the "uncontestable obligation" to pay a claim. Also, the bill provides time frames for pharmacy claims.

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 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 provides 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, 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. A "health care risk contract" means a contract in which an entity receives compensation in exchange for providing to the HMO a provider network or other services, 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, nor does it 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.

Ophthalmology Services/HMOs

The bill deletes the requirement that the HMO (in addition to the primary care physician) must 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.

Patient Self-Referral

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. This exclusion does not apply to a home health agency licensed under ch. 400, F.S.

Small Group Insurance

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.

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 DOI 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.

If approved by the Governor, these provisions take effect October 1, 2002, except that sections 1, 2, 16, and 17 of the bill take effect July 1, 2002.
Vote: Senate 39-0; House 80-28