The Florida Senate

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Committee on Banking and Insurance Senator Rudy Garcia, Chairman

DETERMINING THE SUFFICIENCY OF REGULATION OF THIRD PARTY ADMINISTRATORS AND FISCAL INTERMEDIARY SERVICES ORGANIZATIONS

SUMMARY

The current laws regulating health maintenance organizations (HMOs) address problems regarding claims reimbursement to health care providers, such as requiring prompt payment of claims, prohibiting illegal downcoding of claims, and requiring HMO provider contracts to specify rates of reimbursement.

The HMO laws require fiscal intermediary services organizations (FISOs) to be registered with the Office of Insurance Regulation (Office) and to maintain a fidelity bond and surety bond. The law is designed to protect funds received from an HMO and held by entities which have an obligation to distribute those funds to health care providers who contract with the HMO. Florida law also provides for the licensure and regulation of "administrators" by the Office, which typically engage in claims administration or collection of premiums on behalf of an HMO or insurer. The laws regulating administrators are more comprehensive than the statute regulating FISOs.

Concerns have been raised by certain health care provider groups regarding the need for greater oversight and accountability of FISOs. These concerns include late payment or downcoding of claims and a lack of information in the payment statements to determine the reimbursement methodology. Other concerns are the broad category of persons and entities who are exempt from the registration requirements.

After a FISO is registered, there is generally no regulatory activity by the Office other than review of the surety and fidelity bonds. There are no documented investigations or regulatory actions that have been taken against a FISO.

The "prompt payment" statute and persistent efforts by health care provider groups to seek enforcement actions by the Office have resulted in regulatory sanctions against HMOs violating these provisions. Some of these cases involved HMOs that contracted with independent entities which made payments to providers on behalf of the HMO. The Office attempts to hold an HMO responsible for violations of prompt payment requirements regardless of who the HMO may contract with to perform payment services.

Section 641.234(4), F.S., provides that an HMO is responsible for violations of the prompt payment requirements and certain other statutes if the HMO enters a "health care risk contract" to transfer to an "entity" the obligations to pay providers. But, the definition of "entity" is limited to an administrator under s. 626.88, F.S. Also, there are statutory requirements on HMOs regarding payments to providers for which the HMO may not be responsible under such contracts.

Based on the findings of this report, committee staff recommends the following:

Expand the requirements of s. 641.234(4), F.S., to hold a HMO responsible for statutory requirements related to payment to health care providers if the HMO transfers to any entity the obligations to pay providers.

Narrow the exemption from registration as a FISO for a physician group practice to those groups providing fiscal intermediary services to members of that group practice.

Narrow the exemption from registration as a FISO for licensed insurers, HMOs, administrators, hospitals, and prepaid limited health service organizations to those entities themselves, rather than any entity owned operated, or controlled by such licensed entities.

Alternatively, consider repealing the FISO statute and require entities to be licensed as administrators if they

provide fiscal intermediary services to providers under contract with an HMO.

BACKGROUND

The Office of Insurance Regulation regulates health maintenance organization solvency, contracts, rates, and marketing activities under part I of ch. 641, F.S., while the Agency for Health Care Administration (Agency) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a certificate of authority from the Office, an HMO must receive a Health Care Provider Certificate from the Agency. Any entity that is issued a certificate of authority 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.

Fiscal Intermediary Services Organizations

In 1997 the HMO laws were amended to provide for the regulation of fiscal intermediary services organizations (FISOs).[1] At that time, some health care professionals were contracting with unregulated entities to collect payments from HMOs on the providers' behalf and to distribute those funds to the contracting health care providers. There were reported cases of misappropriation of funds by such entities, with no apparent recourse to regulatory agencies.

Essentially, the law is designed to protect funds received from an HMO and held by entities which have an obligation to distribute those funds to medical professionals who contract with the HMO. This is primarily done by requiring those entities to apply for registration with the Office of Insurance Regulation and to post a fidelity bond and a surety bond with the Office.

A "fiscal intermediary services organization" is defined as a person or entity which performs fiduciary or fiscal intermediary services to health care professionals who contract with health maintenance organizations. However, this term excludes FISOs owned, operated, or controlled by a hospital licensed under chapter 395, an insurer licensed under chapter 624, a third party administrator licensed under chapter 626, a prepaid limited health service organization licensed under chapter 636, a health maintenance organization licensed under chapter 641, or physician group practices as defined in s. 455.654(3)(f), F.S.

The term "fiscal intermediary services" includes reimbursements received or collected on behalf of health care professionals for services rendered or other related fiduciary services pursuant to health care professional contracts with health maintenance organizations.

The expressed legislative intent is to ensure the financial soundness of FISOs. A FISO which is operated for the purpose of acquiring and administering provider contracts with managed care plans must secure and maintain a fidelity bond and a surety bond. The initial 1997 act required a $10 million fidelity bond, but the amount was significantly lowered the following year, when it was recognized that the collateralization requirements for obtaining such a bond would have precluded anyone but a large company from forming a FISO.[2] As currently required, the fidelity bond must be in the minimum amount of 10 percent of the funds handled by the FISO during the prior year or $1 million, whichever is less, but not less than $50,000. This bond protects the FISO from loss due to dishonesty of its employees. A surety bond must also be maintained in the minimum amount of 5 percent of the funds handled by the FISO during the prior year or $250,000, whichever is less, but not less than $10,000. The surety bond protects against misappropriation of funds within the FISO's control or custody.

A FISO registering with the Office of Insurance Regulation ("Office") must meet certain application requirements of Chapter 641 that apply to HMOs.[3] The applicable provisions require that a FISO provide the Office with a list of the names, addresses and official capacities of the persons who are responsible for the operations of the company, including officers, directors, and owners of more than 5% of the common stock of the company. The listed persons must also fully disclose all contracts or arrangements between them and the company, including any conflicts of interest. Further, such persons must submit autobiographical statements, fingerprints, and an independently performed background report. In general, receiving authority to operate as a FISO is conditioned on the Office being satisfied that the ownership, control and management of the entity is competent and trustworthy, and possesses managerial

[1] ch. 97-159, L.O.F.

[2] ch. 98-159, L.O.F.

[3] ss. 641.21(1)(c) and 641.22(6), F.S.

experience that would make the proposed operation beneficial to its constituents. There are a number of specifically enumerated reasons (relating to experience, competence, etc.) for which the Office may deny or suspend the authority of a FISO.

Third Party Administrators (TPAs)

An "administrator," more commonly referred to as a third party administrator or TPA, must be licensed by the Office of Insurance Regulation and typically engages in claims adjudication or collection of premiums for a health insurer or HMO, which are activities not addressed by the FISO statute.[4] Administrators that are licensed by the Office of Insurance Regulation are specifically exempt from the requirements of being registered as a FISO.

The regulatory requirements for administrators under ss. 626.88-626.894, F.S., are more extensive than the regulation of FISOs. For example, an administrator must make its books and records available to the Office for examination, audit, and inspection and must maintain its business records for five years.[5] Administrators are also required to file annual financial statements with the Office.[6] However, the fidelity bond requirement may be less for an administrator as compared to a FISO, depending on the amount of funds handled, and a separate surety bond is not required for an administrator as it is for a FISO.[7]

Administrators must have a written agreement with an insurer containing specified provisions. The insurance company, and not the administrator, must be responsible for determining the benefits, rates underwriting criteria, and claims payment procedures.[8] A payment to the administrator of any premiums on behalf of the insured are deemed to have been received by the insurer and all premiums collected by an administrator on behalf of an insurer must be held by the administrator in a fiduciary capacity. If an administrator is collecting premiums for more than one insurer, the administrator must keep records clearly recording each insurer's accounts.

The administrator law requires that a person who provides billing and collection services to HMOs on behalf of health care providers must comply with s. 641.3155, F.S., the prompt payment statute, and s. 641.51(4), F.S., which requires that only a Florida licensed physician or osteopath may render an adverse determination regarding a service provided by a physician and specifies procedures that must be followed.[9]

Payment Documentation by FISOs and TPAs

In 1999, the FISO statute was amended to require that payment by a FISO to a health care provider include specified information.[10] This was in response to complaints by health care providers that claims payments by FISOs did not delineate sufficient information for the providers to reconcile their records as to which claims were being paid. The law now requires that for a "capitated" health provider, the statement must include the number of patients covered by the contract, the rate per patient, total amount of payment, and the identification of the plan on which behalf the payment is made. For a "noncapitated" provider, the statement must include an explanation of services being reimbursed, including the patient name, date of service, procedure code, amount of reimbursement, and plan identification. The law does not define "capitated" or "noncapitated" but is understood to distinguish those contracts that provide for a specified payment rate per patient for all services or specified types of services, and those contracts that, instead, provide payment on a fee for service basis.

These same requirements are also placed in the laws regulating third-party administrators, but its terms refer to payments by a "fiscal intermediary" rather than an

[4] As provided in s. 626.88(1), F.S., "…*[A]n "administrator" is any person who directly or indirectly solicits or effects coverage of, collects charges or premiums from, or adjusts or settles claims on residents of this state in connection with authorized commercial self-insurance funds or with insured or self-insured programs which provide life or health insurance coverage . . . or any person who, through a health care risk contract as defined in s. 641.234 with an insurer or health maintenance organization, provides billing and collection services to health insurers and health maintenance organizations on behalf of health care providers, . . ."*

[5] s. 626.884, F.S.

[6] s. 626.89, F.S.

[7] Section 626.8809, F.S., requires an administrator to maintain a fidelity bond of at least 10 percent of the amount of funds handled or managed annually, but not greater than $500,000, unless the Office, after notice and opportunity for hearing and after consideration of the record, requires an amount in excess of $500,000 but not more than 10 percent of the amount of the funds handled or managed annually.

[8] ss. 626.8817 and 626.882, F.S.

[9] s. 626.88. F.S.

[10] ch. 99-251, L.O.F.; ss. 626.883 and 641.316, F.S.

"administrator," so its applicability to an administrator may be unclear.[11]

Health Care Risk Contracts

HMOs may shift risk to the providers or provider groups with which they contract. This is typically done through a capitation contract that will pay a provider a specified fee per subscriber for all services or specified types of services provided by the health care provider. The primary goal of the state is to assure financial solvency, so that health plans have the resources needed to pay claims and meet their contractual obligations. This presents the issue of how the state should regulate "down stream" risk, where the HMO passes risk on to providers or other entities through capitation or similar payment arrangements.

Legislation intended to strengthen HMO solvency was enacted in 2002.[12] The law defines a "health care risk contract" by an HMO as one in which an individual or entity receives consideration or other compensation in an amount greater than 1 percent of the HMOs annual gross written premium in exchange for providing to the HMO a provider network or other services, which may include administrative services.[13] For purposes of determining its financial condition, if an HMO, through a health care risk contract, transfers to any entity the obligation to pay any provider for any claim, the HMO must include as a liability on its financial statements liabilities associated with such payment obligations for which the provider has not received payment, unless the payment obligations are secured by a financial instrument acceptable to the department which assures full payment of those claims.[14] The actuarial certification filed annually with the Office must certify that the HMO has adequately provided for such obligations.[15]

"Prompt Payment" Requirements

HMOs are currently required to reimburse claims by providers within 35 days of receipt, subject to a 10 percent interest penalty for late payment.[16] This was first enacted in 1998, commonly referred to as the "prompt payment" law.[17] This law was substantially revised in 2000 based on recommendations of an advisory group appointed by the Agency for Health Care Administration. The advisory group was appointed in response to concerns from health care providers regarding delays in payment, underpayment, and obtaining treatment authorizations.[18] The changes in 2000 included a definition of a "clean claim," more specific time frames and interest penalties, and required procedures for HMOs to file claims against providers for overpayments.

The 2000 act also prohibited HMOs from "systematic downcoding with the intent to deny reimbursement otherwise due."[19] "Downcoding" is not defined, but is understood to mean an HMO substituting a procedure code that is a lower level of service with a lower reimbursement rate than the procedure billed by the provider. If performed with such frequency as to indicate a general business practice, such systematic downcoding is an unfair claims settlement practice subject to regulatory penalties by the Office of Insurance Regulation.

Disclosure or Reimbursement Rates; "All Product" Restrictions

In 2004, legislation was enacted that requires an HMO to disclose in its health care provider contracts the complete schedule of reimbursement for all the services for which the HMO and provider have contracted and any changes in or deviations from the schedule.[20] The contract may require that the physician maintain the confidentiality of the schedule. The physician's net reimbursement may vary after consideration of other factors, such as bundling codes and member cost-sharing, as long as these factors are disclosed in the provider contract. The reimbursement schedule may be stated as a percentage of the Medicare fee schedule for specific relative-value services, or as a listing of the reimbursement to be paid by Current Procedural Terminology codes for physicians that pertain to each physician's practice. However, the law further allows the reimbursement to be stated in any other method agreed upon by the parties.

In 2001, a law was enacted to prohibit a health insurer or an HMO from requiring a health care provider, who

[11] Section 641.316(2)(a), F.S.
[12] ch. 2002-247, L.O.F.
[13] s. 641.19(21), F.S.
[14] s. 641.35(3)(a), F.S. For this purpose an "entity" does not include the state of Florida, the United States, or agencies thereof, or an insurer or HMO authorized in Florida.
[15] s. 641.26(1)(f), F.S.
[16] s. 641.3155, F.S.
[17] ch. 98-79, L.O.F.
[18] ch. 2000-252, L.O.F.
[19] s. 641.3903(5), F.S.
[20] ch. 2004-321, L.O.F.; ss. 641.315 and 641.19(16), F.S.

is currently under contract with the insurer or HMO, to accept the terms of other health care provider contracts as a condition of continuing or renewing the initial contract.[21] While the law effectively prohibits *renewals* of provider contracts being conditioned on provider participation in other plans or requiring future participation by the provider in other plans, it does allow insurers and HMOs to "bundle" all their plans in a health care provider contract for those providers who are not currently under contract.

Ultimate Responsibility for HMOs to Comply with Prompt Payment and Other Requirements

A law enacted in 2002 holds HMOs ultimately responsible for compliance with certain statutory requirements related to prompt payment, treatment authorization, and adverse determinations, if the HMO transfers its payment obligations to certain entities.[22] This law 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, that the HMO remains responsible for any violations of three specified statutes. The cited statutes are:

- s. 641.3155, F.S., which are the prompt payment requirements;
- s. 641.3156, F.S., which requires HMOs to pay claims for treatment if a provider follows the treatment authorization procedures and receives authorization; and
- s. 641.51(4), F.S., which requires that only a Florida licensed physician or osteopath may render an adverse determination regarding a service provided by a physician and specifies procedures that must be followed.

This section is limited to "health care risk" contracts with an "entity," as these terms are defined in s. 641.234(4), F.S. "Health care risk contact" is defined to mean "a contract under which an entity receives compensation in exchange for providing to the health maintenance organization a provider network or other services which may include administrative services." The term "entity" is defined to mean "a person licensed as an administrator under s. 626.88 F.S., and does not include any provider or group practice under s. 456.053, F.S., providing services under the scope of the license of the provider or the members of the group practice." The definition also excludes 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.

METHODOLOGY

Staff has reviewed the current statutory requirements for fiscal intermediary services organizations and administrators, requirements for HMOs related to prompt payment and other provider contract issues, and the legislative history of these provisions. Staff has interviewed various stakeholders, including representatives of health care provider associations and the Office of Insurance Regulation, reviewed relevant market conduct examinations by the Office, and researched model regulations of the National Association of Insurance Commissioners.

FINDINGS

There are currently 15 active fiscal intermediary services organizations registered with the Office of Insurance Regulation. Interviews with representatives of the Office indicate that after a FISO is registered, there is generally no regulatory activity other than periodic review of the surety bond and fidelity bonds to determine if the amounts are adequate relative to the amount of funds handled annually by the FISO, as required by statute. There are no documented investigations or regulatory actions that have been taken against a FISO.

The FISO law appears to have overly broad exemptions from registration requirements. For example, there is an exemption for a physician group practice, but it is not clear that this exemption is limited to providing fiscal intermediary services only to members of that group practice, though that is presumably the intent. This appears to be a broader exemption than similar exemptions for physician group practices from licensure as an administrator in s. 626.88(1)(o), F.S., and from the definition of an "entity" that enters a health care risk contract with an HMO in s. 641.234(4), F.S., for purposes of holding an HMO responsible for prompt payment and other requirements. Both of these statutes limit the exemption for physician group practices to providing services under the scope of the license of the members of the group practice.

As described in Background, above, the laws regulating administrators are much more comprehensive than the single statute regulating FISOs. For example, an administrator must make its

[21] ch. 2001-107, L.O.F.; s. 641.315(10), F.S.
[22] ch. 2002-389, L.O.F.; s. 641.234(4), F.S.

books and records available to the Office for examination, audit, and inspection and must file annual financial statements with the Office. A review of the model laws for third party administrators published by the National Association of Insurance Commissioners does not reveal any significant differences from the Florida law.[23]

The enactment of the "prompt payment" requirements and persistent efforts by health care provider groups to document complaints and seek enforcement actions by the Office of Insurance Regulation have resulted in market conduct examinations and regulatory sanctions against HMOs violating these provisions. The Office website lists 22 market conduct examinations of HMOs that found violations of the prompt payment statute which resulted in consent orders and corrective action by the targeted HMO, including payment of required interest to providers and, in 14 of theses cases, fines against the HMO ranging from $10,000 to $85,500.[24]

Some of these examinations include situations where HMOs contracted with entities referred to as "management service organizations" and "independent practice associations" which made payments to providers on behalf of the HMO and which do not appear to have been licensed administrators. Interviews with Office personnel indicate that the Office attempts to hold an HMO responsible for violations of prompt payment requirements regardless of who the HMO may contract with to perform payment services. In the market conduct examinations of this type reviewed, a Consent Order was issued by the Office with the agreement of the HMO, where the HMO consents to pay a fine and to take corrective actions, but does not agree with the findings of the Consent Order.

Since 2002, as described in Background above, s. 641.234(4), F.S., has provided that an HMO is responsible for violations of the prompt payment requirements and certain other statutes if the HMO enters a "health care risk contract" to transfer to an "entity" the obligations to pay providers. But, the definition of "entity" is limited to an administrator under s. 626.88, F.S. This may not include a fiscal intermediary services organization under s. 641.316, F.S., or possibly other unregulated entities providing management services for HMOs that include payments to providers. There also may be confusion with the term "health care risk contract" as defined in s. 641.234(4), F.S., due to a different, more limited, definition of the same term in the general definitions section, s. 641.19(21), F.S. But, it should be clear that the specific definition in s. 641.234(4), F.S., applies to that subsection.

There is also a requirement in the law regulating administrators, s. 626.88, F.S., that any "person" providing billing and collection services to HMOs on behalf of health care providers must comply with the prompt payment statute and the statute regarding adverse determinations. While the term "person" appears to give this provision an expansive meaning, its placement in the part of the Insurance Code that is limited to regulation of administrators may limit its application to administrators.

Although the Office attempts to hold HMOs responsible for prompt payment violations regardless of the type of entity with which the HMO contracts to pay providers, and has issued Consent Orders to this effect, the HMO's legal liability may not be clear. Also, there are other statutory requirements on HMOs regarding payments to providers, such as the requirement to specify the schedule of reimbursement in provider contracts, for which the HMO may not be responsible, if a payment methodology is changed by an intermediary under contract with the HMO.

The concerns expressed by certain health care provider groups, regarding fiscal intermediary services organizations, include late payment or downcoding of claims submitted by providers and a lack of information in the payment statements to determine the rate of compensation or the reimbursement methodology. Although general discussions have been held by representatives of these providers with representatives of the Office of Insurance Regulation, there have not been specific documented complaints submitted to the Office. Providing specific complaints would be necessary for the Office to investigate and determine if any regulatory action is necessary. As noted, it may be more appropriate to focus on the obligations of the HMO, rather than the FISO, particularly with regard to complaints regarding late payment of claims, for which the HMO may be ultimately responsible.

[23] Third Party Administrator Statute (090), National Association of Insurance Commissioners Model Regulation Service (2004)

[24] http://www.fldfs.com/companies/mc/is_mc_exams.htm

RECOMMENDATIONS

Based on the findings of this report, committee staff recommends the following:

Expand the requirements of s. 641.234(4), F.S., to hold a health maintenance organization responsible for statutory requirements related to payment to health care providers if the HMO transfers to any entity the obligations to pay providers. The current law may limit this liability to HMO contracts with licensed administrators and limit this responsibility to violations of only certain statutes.

Narrow the exemption from registration as a FISO for a physician group practice in s. 641.316, F.S., to physician group practices providing fiscal intermediary services to members of the group practice.

Narrow the exemption from registration as a FISO for licensed insurers, HMOs, administrators, hospitals, and prepaid limited health service organizations to those entities themselves, rather than any entity owned operated, or controlled by such licensed entities.

Alternatively, consider repealing the FISO statute and require entities to be licensed as third party administrators if they provide fiscal intermediary services to providers under contract with HMO.