By the Committee on Banking and Insurance; and Senators Laurent and Saunders

311-1935A-00

A bill to be entitled

An act relating to health maintenance organizations; creating s. 408.7057, F.S.; providing for a statewide provider and managed care organization claim dispute mediation program; providing an exemption from open meetings requirements; amending s. 641.315, F.S.; requiring payment for specified services; providing for disclosure and notice; amending s. 641.3155, F.S.; defining the term "clean claim"; revising the procedures for payment of claims submitted by providers; amending s. 641.495, F.S.; providing for 24-hour, on-line or telephone service; amending s. 641.3903, F.S.; revising the criteria for what constitutes false statements and entries and unfair claim settlement practices; amending s. 641.3909, F.S.; providing for additional fines; amending s. 641.31, F.S.; conforming a statutory cross-reference; providing for rulemaking authority; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 408.7057, Florida Statutes, is created to read:

<u>408.7057 Statewide provider and managed care organization claim dispute mediation program.--</u>

<u>(1) As used in this section, the term:</u>

(a) "Managed care entity" means a health maintenance organization or a prepaid health clinic certified under chapter 641, a prepaid health plan authorized under s. 409.912, or an exclusive provider organization certified under s. 627.6472.

(b) "Panel" means a statewide provider and managed care claim dispute panel selected as provided in subsection (7).

(c) "Agency" means the Agency for Health Care Administration.

(2) The agency shall adopt and implement a program to provide assistance to contracting and noncontracting providers for those claim disputes that are not resolved by the managed care entity to the satisfaction of the provider, and to provide assistance to managed care entities that seek to recover an alleged overpayment to a provider. The program shall consist of one or more panels that meet as often as necessary to timely review, consider, and hear grievances and recommend to the agency or the department any actions that should be taken concerning individual cases heard by the panel. The panel shall hear every claim dispute filed by providers and every overpayment claim filed by managed care entities, unless the disputed claim:

(a) In the aggregate, is for an amount of $5,000 or less for institutional claims or, in the aggregate, $500 or less for physician claims;

(b) Is part of an internal grievance in a Medicare managed care entity or a reconsideration appeal through the Medicare appeals process;

(c) Is related to a health plan not regulated by the state such as an administrative services organization,

third-party administrator, or federal employee health benefit program;

(d) Is part of a Medicaid fair hearing pursued under 42 C.F.R. ss. 431.220 et seq.;

(e) Is the basis for an action pending in state or federal court;

(f) Was filed before the provider or the managed care entity made a good-faith effort to resolve the dispute;

Failure of the provider, the provider's representative, or the managed care entity or its representative filing the claim dispute resolution to attend the hearing is considered a withdrawal of the request.

(3) The agency shall review all requests for claims dispute resolution within 30 days after receipt and make a determination whether the claims dispute shall be heard. Once the agency notifies the panel, the provider, and the managed care entity that a claims dispute resolution will be heard by the panel, the panel shall hear the claims dispute either in the network area or by teleconference no later than 60 days after the date the claims dispute was filed, unless waived by all the parties. The agency shall notify the parties, in writing, by facsimile transmission, or by phone, of the time and place of the hearing. The panel may take testimony under oath, request certified copies of documents, and take similar actions to collect information and documentation that will assist the panel in making findings of fact and a recommendation. The panel shall issue a written recommendation, supported by findings of fact, to the provider and the managed care entity no later than 30 days after hearing the claims dispute. If at the hearing the panel

requests additional documentation or additional records, the time for issuing a recommendation is tolled until the information or documentation requested has been provided to the panel. The proceedings of the panel are not subject to chapter 120.

(4) If, upon receiving a proper patient authorization along with a properly filed claims dispute, the agency requests medical records from a health care provider or managed care entity, the health care provider or managed care entity that has custody of the records has 10 working days to provide the records to the agency. Failure to provide requested medical records may result in the imposition of a fine of up to $500.

(5) After hearing a claims dispute, the panel shall make a recommendation to the agency which may include specific actions the managed care entity must take to comply with state laws or rules regulating managed care entities and which may include requiring the managed care entity to pay the unpaid portion of any claim not paid by the managed care entity or the provider's billed charges. In the case of a claims dispute filed by a managed care entity seeking to recover an alleged overpayment, the panel's recommendation to the agency may include requiring the provider to refund any of the previous overpayment.

(6) No later than 30 days after the issuance of the panel's recommendation, the agency may adopt the panel's recommendation or findings of fact in a final order as provided in chapter 120, which it shall issue to the managed care entity and the provider. The final order may require payment of the unpaid portion of any claim not paid by the entity or the provider's billed charges, which shall bear a

simple interest rate of 10 percent from the 36th day after the date the managed care entity received the claim. In the case of a claims dispute filed by the managed care entity seeking to recover an overpayment, the final order may require payment of any of the amount overpaid. The agency or the department may modify all or part of the panel's recommendation as provided in s. 120.57.

(7) The panel shall be composed of eight members, consisting of two medical directors of health maintenance organizations that hold current certificates of authority to operate in the state; a physician licensed pursuant to chapters 458 or 459; a physician licensed under chapter 460; a physician licensed under chapter 461; a member representing a hospital; a member employed by the agency; and a member employed by the department. The Governor or his designee shall appoint the six members of the panel not employed by the agency or the department. The remaining two members of the panel shall be chosen with the mutual agreement of the agency and the department. All members of the panel shall be proficient in coding methodology.

(8) Meetings of the panel are open to the public unless the provider or managed care entity who requested the claims dispute resolution or the agency determines that information of a sensitive personal nature which discloses a subscriber's medical treatment or history; information which constitutes a trade secret as defined by s. 812.081; or information relating to internal risk management programs as defined in s. 641.55(5)(c), (6), and (8) may be revealed at the panel meeting, in which case that portion of the meeting during which such sensitive personal information, trade secret information, or internal risk management program information

is discussed is exempt from the provisions of s. 286.011 and s. 24(b), Art. I of the State Constitution. All closed meetings shall be recorded by a certified court reporter.

Section 2. Section 641.315, Florida Statutes, is amended to read:

641.315 Provider contracts.--

(1) Whenever a contract exists between a health maintenance organization and a provider and the organization fails to meet its obligations to pay fees for services already rendered to a subscriber, the health maintenance organization shall be liable for such fee or fees rather than the subscriber; and the contract shall so state.

(2) Upon receipt of authorization as required in s. 641.495(4), covered medical services ordered by a provider and entered on the patient's medical record or covered medical services ordered by the organization's employee or by an entity contracting with or acting on behalf of the organization for an eligible subscriber are considered to be binding upon the health maintenance organization and payment may not be denied by the organization.

(3) Whenever a contract exists between a health maintenance organization and a provider, the organization shall disclose to the provider:

(a) The mailing address or electronic address where claims should be sent for processing;

(b) The telephone number a provider may call to have questions and concerns regarding claims addressed; and

(c) The address of any separate claims processing centers for specific types of services.

An organization shall provide in no less than 30 calendar days, prior written notice of any changes in the information required in this subsection to its contracted providers.

(4)~~(2)~~ No subscriber of an HMO shall be liable to any provider of health care services for any services covered by the HMO.

(5)~~(3)~~ No provider of services or any representative of such provider shall collect or attempt to collect from an HMO subscriber any money for services covered by an HMO and no provider or representative of such provider may maintain any action at law against a subscriber of an HMO to collect money owed to such provider by an HMO.

(6)~~(4)~~ Every contract between an HMO and a provider of health care services shall be in writing and shall contain a provision that the subscriber shall not be liable to the provider for any services covered by the subscriber's contract with the HMO.

(7)~~(5)~~ The provisions of this section shall not be construed to apply to the amount of any deductible or copayment which is not covered by the contract of the HMO.

(8)~~(6)~~(a) For all provider contracts executed after October 1, 1991, and within 180 days after October 1, 1991, for contracts in existence as of October 1, 1991:

1. The contracts must provide that the provider shall provide 60 days' advance written notice to the health maintenance organization and the department before canceling the contract with the health maintenance organization for any reason; and

2. The contract must also provide that nonpayment for goods or services rendered by the provider to the health

maintenance organization shall not be a valid reason for avoiding the 60-day advance notice of cancellation.

(b) For all provider contracts executed after October 1, 1996, and within 180 days after October 1, 1996, for contracts in existence as of October 1, 1996, the contracts must provide that the health maintenance organization will provide 60 days' advance written notice to the provider and the department before canceling, without cause, the contract with the provider, except in a case in which a patient's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action by the Board of Medicine or other governmental agency.

(9)~~(7)~~ Upon receipt by the health maintenance organization of a 60-day cancellation notice, the health maintenance organization may, if requested by the provider, terminate the contract in less than 60 days if the health maintenance organization is not financially impaired or insolvent.

(10)~~(8)~~ A contract between a health maintenance organization and a provider of health care services shall not contain any provision restricting the provider's ability to communicate information to the provider's patient regarding medical care or treatment options for the patient when the provider deems knowledge of such information by the patient to be in the best interest of the health of the patient.

(11)~~(9)~~ A contract between a health maintenance organization and a provider of health care services may not contain any provision that in any way prohibits or restricts:

(a) The health care provider from entering into a commercial contract with any other health maintenance organization; or

(b) The health maintenance organization from entering into a commercial contract with any other health care provider.

(12)~~(10)~~ A health maintenance organization or health care provider may not terminate a contract with a health care provider or health maintenance organization unless the party terminating the contract provides the terminated party with a written reason for the contract termination, which may include termination for business reasons of the terminating party. The reason provided in the notice required in this section or any other information relating to the reason for termination does not create any new administrative or civil action and may not be used as substantive evidence in any such action, but may be used for impeachment purposes. As used in this subsection, the term "health care provider" means a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461, or a dentist licensed under chapter 466.

Section 3. Section 641.3155, Florida Statutes, is amended to read:

641.3155 ~~Provider contracts;~~Payment of claims submitted by providers.--

(1)(a) As used in this section, the term "clean claim" means a completed claim, as determined under department rules adopted pursuant to ch. 120, submitted by institutional providers on a UB-92 claim form or by other providers on a HCFA 1500 claim form for medical care or health care services under a health care plan. The department shall use the most recently adopted format adopted by the National Uniform Billing Committee for institutional providers and by the National Uniform Claims Committee for all other providers.

(b) A health maintenance organization shall notify the provider within 14 days after receipt of a claim whether the submitted claim is deficient in any way, whether the patient receiving the service is an eligible subscriber, or if the service is not authorized, if applicable. The failure of a health maintenance organization to provide the provider with such notice constitutes a complete waiver of the health maintenance organization's right to deny any part of the claim. The notification by the organization that the submitted claim is deficient shall toll the 35-day period provided by paragraph (2)(a) until the provider submits the necessary information to the organization to properly complete the claim.

(2)~~(1)~~(a) A health maintenance organization shall pay any clean claim or any portion of a clean claim made either by a contract provider for services or goods provided under a contract with the health maintenance organization or by a noncontracted provider which the organization does not contest or deny within 35 days after receipt of the clean claim by the health maintenance organization which is mailed or electronically transferred by the provider.

(b) A health maintenance organization that denies or contests a provider's clean claim or any portion of a clean claim shall notify the ~~contract~~ provider, in writing, within 35 days after receipt of the claim by the health maintenance organization that the claim is contested or denied. The notice that the claim is denied or contested must identify the contested portion of the claim and the specific reason for contesting or denying the claim, and may include a request for additional information. If the health maintenance organization requests additional information, the provider shall, within 35

days after receipt of such request, mail or electronically transfer the information to the health maintenance organization. The provider may charge the organization the reasonable costs of copying and providing the additional information, including reasonable staff time, as provided in s. 395.3925 and s. 455.667.The health maintenance organization shall pay or deny the claim or portion of the claim within 45 days after receipt of the information.

(3) In order for a health maintenance organization to contest a portion of a clean claim, the health maintenance organization must pay the provider the uncontested portion of the claim. The failure to pay the uncontested portion of a claim constitutes a complete waiver of the health maintenance organization's right to deny any part of the claim.

(4)~~(2)~~ Payment of a claim is considered made on the date the payment was received or electronically transferred or otherwise delivered. An overdue payment, either after 35 days for clean, uncontested claims, or after 120 days for all other claims, reverts to the provider's billed charges. The failure of the health maintenance organization to pay the claim in a timely manner constitutes a waiver of the discount agreed to by the provider and the organization.~~of a claim bears simple interest at the rate of 10 percent per year.~~

(5)~~(3)~~ A health maintenance organization shall pay or deny any claim no later than 120 days after receiving the original claim.

(6) A claim shall be considered received by the health maintenance organization, if the claim has been electronically transmitted to the organization, when receipt is verified electronically or, if the claim is mailed to the address disclosed by the organization pursuant to s. 641.315(3), on

the date indicated on the return receipt. Providers must wait 45 days from receipt of a claim before submitting a duplicate claim.

~~(4) Any retroactive reductions of payments or demands for refund of previous overpayments which are due to retroactive review-of-coverage decisions or payment levels must be reconciled to specific claims unless the parties agree to other reconciliation methods and terms. Any retroactive demands by providers for payment due to underpayments or nonpayments for covered services must be reconciled to specific claims unless the parties agree to other reconciliation methods and terms. The look-back period may be specified by the terms of the contract.~~

Section 4. Subsection (4) of section 641.495, Florida Statutes, is amended to read:

641.495 Requirements for issuance and maintenance of certificate.--

(4) The organization shall ensure that the health care services it provides to subscribers, including physician services as required by s. 641.19(13)(d) and (e), are accessible to the subscribers, with reasonable promptness, with respect to geographic location, hours of operation, provision of after-hours service, and staffing patterns within generally accepted industry norms for meeting the projected subscriber needs. The health maintenance organization shall maintain on-line or telephone services 24 hours, 7-days-per week for purposes of confirming subscriber eligibility and authorization of services. Requests for treatment authorization may not be pended. Each organization shall make available communication to a live person for authorization and information on the coverage status of a person. If prior

authorization is required by the contract between the organization and the provider, each organization shall confirm, by facsimile or electronic transmission, subscriber eligibility and authorization of services within 60 minutes of the initiation of the request.

Section 5. Subsections (4) and (5) of section 641.3903, Florida Statutes, are amended to read:

641.3903 Unfair methods of competition and unfair or deceptive acts or practices defined.--The following are defined as unfair methods of competition and unfair or deceptive acts or practices:

(4) FALSE STATEMENTS AND ENTRIES.--

(a) Knowingly:

1. Filing with any supervisory or other public official,

2. Making, publishing, disseminating, or circulating,

3. Delivering to any person,

4. Placing before the public, or

5. Causing, directly or indirectly, to be made, published, disseminated, circulated, or delivered to any person, or place before the public,

any material false statement.

(b) Knowingly making any false entry of a material fact in any book, report, or statement of any person.

(c) Denying a provider's claim for which an authorization had been obtained pursuant to s. 641.315(2).

(5) UNFAIR CLAIM SETTLEMENT PRACTICES.--

(a) Attempting to settle claims on the basis of an application or any other material document which was altered

without notice to, or knowledge or consent of, the subscriber or group of subscribers to a health maintenance organization;

(b) Making a material misrepresentation to the subscriber or provider for the purpose and with the intent of effecting settlement of claims, loss, or damage under a health maintenance contract on less favorable terms than those provided in, and contemplated by, the contract; or

(c) Committing or performing against a provider or subscriber with such frequency as to indicate a general business practice any of the following:

1. Failing to adopt and implement claims standards defined in this chapter, including s. 641.3155, for the proper processing, payment, and investigation of claims;

2. Misrepresenting pertinent facts or contract provisions relating to coverage at issue;

3. Failing to acknowledge and act promptly upon any communications from a subscriber or provider with respect to claims;

4. Denying of subscriber's or provider's claims or portions of claims without conducting reasonable investigations based upon available information;

5. Failing to affirm or deny coverage of claims upon written request of the subscriber or provider within a reasonable time not to exceed 30 days after a claim or proof-of-loss statements have been completed and documents pertinent to the claim have been requested in a timely manner and received by the health maintenance organization;

6. Failing to promptly provide a reasonable explanation in writing to the subscriber of the basis in the health maintenance contract in relation to the facts or applicable law for denial of a claim or for the offer of a

compromise settlement or failing to promptly provide a reasonable explanation in writing to the provider of the basis in the health maintenance contract in relation to the facts or applicable law or, in the case of a contracted provider, the basis in the provision of the provider's contract for denial of a claim or partial payment of a claim;

7. Downcoding of a provider's claim without seeking additional information or documentation;

8. Takebacks of alleged overpayments through reductions or holdbacks of current payments;

9.~~7.~~ Failing to provide, upon written request of a subscriber, itemized statements verifying that services and supplies were furnished, where such statement is necessary for the submission of other insurance claims covered by individual specified disease or limited benefit policies, provided that the organization may receive from the subscriber a reasonable administrative charge for the cost of preparing such statement; or

10.~~8.~~ Failing to provide any subscriber with services, care, or treatment contracted for pursuant to any health maintenance contract without a reasonable basis to believe that a legitimate defense exists for not providing such services, care, or treatment. To the extent that a national disaster, war, riot, civil insurrection, epidemic, or any other emergency or similar event not within the control of the health maintenance organization results in the inability of the facilities, personnel, or financial resources of the health maintenance organization to provide or arrange for provision of a health service in accordance with requirements of this part, the health maintenance organization is required only to make a good faith effort to provide or arrange for

provision of the service, taking into account the impact of the event. For the purposes of this paragraph, an event is not within the control of the health maintenance organization if the health maintenance organization cannot exercise influence or dominion over its occurrence.

Section 6. Section 641.3909, Florida Statutes, is amended to read:

641.3909 Cease and desist and penalty orders.--After the hearing provided in s. 641.3907, the department shall enter a final order in accordance with s. 120.569. If it is determined that the person, entity, or health maintenance organization charged has engaged in an unfair or deceptive act or practice or the unlawful operation of a health maintenance organization without a subsisting certificate of authority, the department shall also issue an order requiring the violator to cease and desist from engaging in such method of competition, act, or practice or unlawful operation of a health maintenance organization. Further, if the act or practice constitutes a violation of s. 641.3155, s. 641.3901, or s. 641.3903, the department may, at its discretion, order any one or more of the following:

(1) Suspension or revocation of the health maintenance organization's certificate of authority if it knew, or reasonably should have known, it was in violation of this part.

(2) If it is determined that the person or entity charged has engaged in the business of operating a health maintenance organization without a certificate of authority, an administrative penalty not to exceed $1,000 for each health maintenance contract offered or effectuated.

(3) Notwithstanding s. 641.25, with respect to any nonwillful violation, a fine of between $750 and $1,000 per violation; with respect to any knowing and willful violation, a fine of between $2,500 and $10,000 per violation. For purposes of this subsection, each claim not paid in accordance with s. 641.3155 constitutes a separate violation.

Section 7. Paragraph (d) of subsection 38 of section 641.31, Florida Statutes, is amended to read:

641.31 Health maintenance contracts.--

(38)

(d) Notwithstanding the limitations of deductibles and copayment provisions in this part, a point-of-service rider may require the subscriber to pay a reasonable copayment for each visit for services provided by a noncontracted provider chosen at the time of the service. The copayment by the subscriber may either be a specific dollar amount or a percentage of the reimbursable provider charges covered by the contract and must be paid by the subscriber to the noncontracted provider upon receipt of covered services. The point-of-service rider may require that a reasonable annual deductible for the expenses associated with the point-of-service rider be met and may include a lifetime maximum benefit amount. The rider must include the language required by s. 627.6044 and must comply with copayment limits described in s. 627.6471. Section 641.315(4) and (5) ~~641.315(2) and (3)~~does not apply to a point-of-service rider authorized under this subsection.

Section 8. The Agency for Health Care Administration shall adopt rules to administer this act.

Section 9. This act shall take effect July 1, 2000, and shall apply to all claims submitted by a provider to a health maintenance entity after that date.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR
Senate Bills 706 and 2234

Provides that an HMO is bound by and required to, make payment for an eligible subscriber upon receipt of authorization as required by s. 641.495(4), (which requires HMO authorization and confirmation of eligibility within 60 minutes of the request), for covered medical services ordered by a provider and entered on the patient's medical record or covered medical services ordered by the HMO's employee or by an entity contracting with or acting on behalf of the HMO.

Requires an HMO to notify the provider within 14 days after receipt of a claim whether it is deficient in any way, whether the patient receiving the service is an eligible subscriber, or if the service is not authorized. Failure to do so constitutes a complete waiver of the HMO's right to deny any part of the claim.

Requests for treatment authorization may not be held pending. Requires the HMO to confirm, by facsimile or electronically, subscriber eligibility and authorization within 60 minutes of the request.

Requires an HMO to disclose to contract providers the mailing or electronic address where claims should be sent for processing; the telephone number a provider may call for questions; and the address of any separate claims processing centers for specific types of services. The HMO must provide written notice to contract providers at least 30 days prior to any change in this information.

Applies the prompt payment statute, s. 641.3155, F.S., to claims by non-contract providers.

Applies the requirements of the prompt payment statute (s. 641.3155) to a "clean claim," defined as determined under Department of Insurance rules, submitted by institutional providers on specified claim forms.

Provides that a claim shall be considered received by the HMO, if the claim has been electronically transmitted, when receipt is verified electronically; or if the claim is mailed to the address disclosed by the HMO, on the date indicated on the return receipt. Providers must wait 45 days before resubmitting a duplicate claim.

Authorizes the Department of Insurance to assess a penalty of between $750 and $1,000 for each non-willful violation, and between $2,500 and $10,000 for each knowing and willful violation of ss. 641.3901, 641.3903 (all current and new unfair trade practices), or 641.3155 (prompt payment). Each claim not paid in accordance with s. 641.3155 shall constitute a separate violation.

Prohibits retroactive reduction of previous overpayments through reduction of current payments, which would be an unfair trade practice subject to department sanctions; and repeals current s. 641.3155(4) which requires such reductions

to be reconciled to specific claims.

Creates a new Statewide Provider and Managed Care Organization Claim Dispute Mediation Program, established by the Agency for Health Care Administration to assist contracting and non-contracting providers and managed care entities to assist providers whose claims are not resolved to their satisfaction and managed care entities that seek to recover an overpayment.

Provisions related to the new claims dispute mediation program contain exemptions from public meetings and public records laws and constitutional requirements.

The committee substitute deletes provisions in SB 2234 that: added definitions for covered services, noncovered services, and subscriber expenses; required an HMO to notify the provider that a claim had been received within 2 days or 10 days for claims submitted electronically or by mail, respectively; required HMOs to acknowledge receiving requested additional information for a provider within 5 days after its receipt; authorized the Department of Insurance to impose an administrative penalty against an HMO of up to $50,000 for certain violations; and required that HMOs ensure that only a licensed Florida physician may render an adverse determination