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HOUSE OF REPRESENTATIVES

COUNCIL FOR HEALTHY COMMUNITIES
ANALYSIS

BILL #: CS/HB 293

RELATING TO: Health Care Coverage Procedures

SPONSOR(S): Council for Healthy Communities and Representative Benson and others

TIED BILL(S): None

ORIGINATING COMMITTEE(S)/COUNCIL(S)/COMMITTEE(S) OF REFERENCE:

(1) HEALTH PROMOTION YEAS 9 NAYS 2
(2) JUDICIAL OVERSIGHT YEAS 9 NAYS 0
(3) COUNCIL FOR HEALTHY COMMUNITIES YEAS 16 NAYS 0
(4)
(5)

I. SUMMARY:

THIS DOCUMENT IS NOT INTENDED TO BE USED FOR THE PURPOSE OF CONSTRUING STATUTES, OR TO BE CONSTRUED AS AFFECTING, DEFINING, LIMITING, CONTROLLING, SPECIFYING, CLARIFYING, OR MODIFYING ANY LEGISLATION OR STATUTE.

The CS/HB 293 revises various provisions relating to certain health insurers and health maintenance organizations, and health providers, specific to dispute resolution, claim submission, processing, and payment, processing of claims for overpayment, and treatment authorization. Replaces term “managed care organization” with “health plan” for purposes of, and substantially revises the types of entities eligible to utilize, the statewide provider and health plan claim dispute resolution program, providing timeframes for submission of documentation and providing consequences for failure to comply. Provides additional duties and responsibilities for dispute resolution organization and the agency. Substantially revises prompt pay requirements, timeframes, requirements related to appeals, provider billing, retroactive denials, and expands the requirements to include certain health insurers. Prohibits modification of provisions by contract. Establishes permissive error rate, specifies applicability of rate, authorizes fines, provides exception. Defines authorization for health insurers and HMOs including: required elements of response to authorization requests; obligation for payment, with exception; and authorization procedure material change notice requirements. Corrects cross-reference and adds additional cross-references specifying application of additional provisions to certain health insurers. Revises requirements related to direct payment of benefits to specified providers under certain circumstances regardless of contract prohibition. Expands definition of “administrator” to include certain entities contracting with an HMO, and specifies requirements that such entities must meet. Modifies the circumstances under which a provider knows that an HMO is liable.

The CS takes effect on October 1, 2002, and applies to claims for services rendered after that date, except as otherwise provided.

The Agency for Health Care Administration has projected a Year One fiscal impact of $57,727 associated with the expanded workload resulting from the increased access to the dispute resolution program.

SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes []	No [x]	N/A []
2.	Lower Taxes	Yes []	No []	N/A [x]
3.	Individual Freedom	Yes []	No []	N/A [x]
4.	Personal Responsibility	Yes []	No []	N/A [x]
5.	Family Empowerment	Yes []	No []	N/A [x]

For any principle that received a "no" above, please explain:

Less Government: The bill provides that violation of various time frames for payment of claims is a violation of the Florida Insurance Code and that each violation is a separate offense, thus increasing enforcement authority for the Department of Insurance. The Department of Insurance has added responsibilities relating to auditing an HMO's or health insurer's compliance with prompt payment of claims requirements and must determine and utilize a permissive error ratio of 5 percent.

B. PRESENT SITUATION:

PROMPT PAYMENT OF CLAIMS

Other States

With health care providers complaining that laws requiring prompt payment of claims have not resulted in insurers and health maintenance organizations (HMOs) actually paying claims promptly, nine states, Florida among them, in their 2000-2001 legislative sessions revised their laws to tighten deadlines, stiffen fines, or attempt to close other loopholes that providers say allow plans to evade state-mandated time limits. According to a June 4, 2001, *American Medical Association News Report,* even more states are likely to consider further revisions to their prompt pay statutes and regulations in their next regular legislative sessions.

Currently, forty-eight states have put HMOs and/or health insurers on notice to pay clean claims in a timely fashion or face possible penalties and fines. The term "clean claim" generally means a claim that has no defect or impropriety or particular circumstance requiring special treatment. Most states require insurers to pay clean claims within 45 days, however state requirements range from 15 days (Georgia) to 60 days (Michigan). Under Georgia law, insurers are required to pay 18 percent interest on claims not paid within 15 days. Although Georgia's law is considered to be the strictest, Hawaii requires that claims filed electronically be paid within 15 days. The trend in the most recent state "prompt-pay" legislation is to adopt the Medicare standard of 95 percent clean claims paid within 30 days and all claims approved or denied within 30 days.

During their 2001 sessions, five states passed "prompt-pay" laws with specified interest requirements. Typically, these standards are similar, if not identical, to the Medicare 30-day prompt pay requirement.

State	Prompt-Pay Deadline	Interest Rate
Arizona	30 days	Rate equal to state legal rate

Kansas	30 days	1% per month
Kentucky	30 days	12% for up to 60 days and 21% after 90 days
Minnesota	30 days	1.5% per month
New Mexico	45 days	1.5 times state legal rate

Typical of the newly adopted “prompt-pay” laws is the Minnesota law, which requires all health plan companies and third-party administrators to pay or deny clean claims within 30 calendar days of receiving the claims, or face an interest penalty of 1.5 percent per month. The act defines “clean claim” to mean "a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or a particular circumstance requiring special treatment that prevents the timely payment from being made on a claim under this section." This is very similar to the definition for Medicare claims. The Minnesota act applies not only to health plan companies but also to third-party administrators. This act applies to all health care providers except pharmacists. The health plan company or third-party administrator must itemize any interest payment separately from other payments being made for services provided. The health plan company or third-party administrator may, at its discretion, require the health care provider to bill the health plan company or third-party administrator for the interest required under this section before an interest payment is made.

Florida - Health Insurers

Section 627.613, F.S., relating to time of payment of health insurer claims, requires health insurers to pay claims under a health insurance policy within 45 days after receipt of the claim by the health insurer. If a claim or a portion of a claim is contested by the health insurer within the 45 days, then the insured or the insured's assignees must be notified, in writing, that the claim is contested or denied. Upon receipt of the additional information, a health insurer must pay or deny the contested claim or portion of the contested claim within 60 days. All claims must be paid or denied no later than 120 days after receiving the claim. Overdue payment of a claim accrues a simple interest rate penalty at the rate of 10 percent per year. Health insurance policies typically covered by this section include: Medicare supplemental policies, disease specific policies such as cancer policies, and long-term disability policies.

Florida - Health Maintenance Organizations

In 1999, the Legislature authorized the director of the Agency for Health Care Administration in ch. 99-393, L.O.F., to establish an advisory group on the submission and payment of health claims. The advisory group was composed of eight members, with three members from HMOs licensed in Florida, one representative from a not-for-profit hospital, one representative from a for-profit hospital, one representative who was a licensed physician, one representative from the Office of the Insurance Commissioner, and one representative from the Agency for Health Care Administration. The advisory group was required to study and make recommendations concerning timely and accurate submission and payment of health claims; electronic billing and claims processing; the form and content of claims; and measures to reduce fraud and abuse. The advisory board made its recommendations to the Legislature and Governor on February 1, 2001. The advisory board made the following recommendations for changes of the prompt payment of claims requirements:

- Clarification of the statute on the inclusion of interest with late payments.
- Development of a state-supervised mediation mechanism for both providers and managed care organizations for hearing and resolving claims disputes promises to help resolve serious disputes, including disputes over reimbursement for emergency care, and without

the parties resorting to civil litigation or the termination of their contracts and service relationships.
- Clarification of the balance billing prohibition to make it easier to enforce this consumer protection statute.
- Adoption of the National Uniform Billing Committee definition of institutional clean claim and the endorsement.
- Adoption of the HIPAA Administrative Simplification process to expedite the standardization of claims forms and the automated processing of claims.
- Adoption of electronic claims processing by providers and insurers, as soon as possible.
- Require managed care organizations to pay for pre-authorized services except under very limited circumstances.
- Require a receipt for claims submitted electronically.

In the 2000 legislative session, s. 641.3155, F.S., relating to payment for claims requirements of health maintenance organizations (HMO), was substantially revised as part of ch. 2000-252, L.O.F. That law included the following:

- Deleted provisions relating to provider billings, revised provisions relating to provider contracts, provided for disclosure and notice, and required procedures for requesting and granting authorization for utilization of services.
- Provided for HMO liability for payment for services rendered to subscribers, and prohibited certain provider billing of subscribers.
- Defined the term “clean claim” in the institutional and non-institutional setting, and specified the basis for determining when a claim is to be considered clean or not clean.
- Required the Department of Insurance to adopt rules to establish a claim form and requirement for the form and granted discretionary rulemaking authority for coding standard.
- Provided for payment, denial, and contesting of clean claims or portions of clean claims, and provided for interest accrual, payment of interest, and an uncontestable obligation to pay a claim.
- Required HMOs to make a claim for overpayment; prohibited an HMO from reducing payment for other services and provided exceptions.
- Required providers to pay a claim for overpayment within a specified timeframe and procedures, timeframes for overpayments were specified, and created an uncontestable obligation to ay a claim for overpayment.
- Specified when an electronically transmitted or mailed provider claim is considered received; mandated acknowledgement of receipt for electronically submitted provider claims; prescribed a timeframe for an HMO to retroactively deny a claim for services provided to an eligible subscriber; and provided for treatment authorization and payment of claims for emergency services subject to specified provisions of law.
- Provided that downcoding with intent to deny reimbursement by an HMO is an unfair method of competition and an unfair or deceptive act or practice.
- Authorized the Department of Insurance to issue a cease and desist order for a payment-of-claims violation, and revised provisions relating to treatment-authorization capabilities.
- Established a statewide claim dispute resolution program for providers and managed care organizations for all claims for services rendered after October 1, 2000, submitted by a provider or managed care organization 60 days after a certain date, and provided the Agency for Health Care Administration specific rulemaking authority for the program. [s. 408.7057, F.S.]
- Authorized administrative sanctions against a hospital’s license for improper subscriber billing and violations of requirements relating to claims payments.

- Provided that certain actions by a provider are punishable, and expanded a provision of law relating to fraud against hospitals to include health care providers.

STATEWIDE PROVIDER AND MANAGED CARE ORGANIZATION CLAIM DISPUTE RESOLUTION PROGRAM

In the 2000 legislative session, CS/CS/CS/SB 1508, created s. 408.7057, F.S., relating to the Statewide Provider and Managed Care Organization Claim Dispute Resolution Program. The bill required the Agency for Health Care Administration (agency) to contract with an independent third-party organization to resolve claims payment disputes between managed care organizations and providers, with the organization's final determination adopted by agency order.

The program provides for an independent mediator to hear disputes regarding amounts paid for services. The program requires that physicians have at least $500 in disputed claims to enter the process, hospitals must have $25,000 for inpatient treatment and $10,000 for outpatient services they believe they are owed. In addition, HMOs are also able to initiate the process after meeting the same $500 monetary threshold as physicians. In each case, the loser would pay the cost for the mediation. Submitted claims must be for dates of service after October 1, 2000.

On February 27, 2001, the agency signed a two-year contract with Maximus to resolve claims disputes. Maximus was selected from eight firms through a competitive bid process. The Reston, VA-based firm has contracted since 1986 with the federal government to resolve Medicare beneficiary disputes with their managed care plans. The program became operational on May 1, 2001. On August 18, 2001, the agency received 6 claims (1 was a duplication). According to a recent e-mail from Maximus, the company responsible for the independent mediation, only one health plan has responded to the mediation process. According to provider representatives, providers are hesitant to participate in the program due to its lack of public records exemption for its confidential and proprietary information and the potential costs associated with the review process to the non-prevailing party. The agency issues final orders based on the recommendation by the resolution organization and tracks compliance by the non-prevailing party. All review costs are borne by the parties involved in the dispute and fines can be levied for unpaid review costs.

Authorization for Treatment

Health Insurers

There are no statutory requirements relating to health insurer's authorization for treatment. Some health insurers may require by contract notification or authorization prior to delivery of specified services.

Health Maintenance Organizations

Traditionally, HMOs emphasize preventative medicine and have utilized primary care physicians as "gatekeepers" to obtain referrals to specialists. In addition, such referrals, certain medical or treatment procedures, and hospital admissions typically require authorization prior to service. Section 641.3156, F.S., relating to HMO treatment authorization and payment of claims requires the following:

- An HMO must pay any hospital service or referral service claim for treatment of an eligible subscriber which was authorized by a provider with contract authority to authorize or direct the subscriber's use of the HMO's health care services and which was authorized in

accordance to the HMO's procedures, unless the provider provided misinformation to the HMO with the willful intent to misinform the HMO.
- An HMO may not deny a claim for treatment if the provider followed the HMO's authorization procedures and received authorization for an eligible subscriber for a covered service, unless the provider provided misinformation to the HMO with the willful intent to misinform the HMO.
- Emergency services are not subject to the requirements of this section, but are subject to s. 641.513, F.S.

Additional Current Florida Statutory Provisions

Health Insurers

Section 627.651, F.S., relating to health insurance group contracts and plans of self-insurance requirements, specifically excludes plans established or maintained by an individual employer in accordance with the Employee Retirement Income Security Act of 1974 (ERISA), or to multiple-employer welfare arrangements, defined by s. 624.437(1), F.S., with specified exceptions. Authorized insurers are prohibited from issuing a group health insurance policy or certificate which does not comply with this part.

Section 627.662, F.S., relates to health insurance and other applicable provisions. These provisions apply to group health insurance, blanket health insurance, and franchise health insurance. The applicable provisions are as follows:

- Provisions relating to the use of dividends, refunds, rate reductions, commissions, and services fees (s. 627.569, F.S.);
- Identification numbers and statement of deductible provisions (s. 627.602(1)(f) and (2), F.S.);
- Excess insurance (s. 627.635, F.S.);
- Direct payment for hospital or medical services (s. 627.638, F.S.);
- Filing and classification of rates (s. 627.640, F.S.);
- Denial of claims (s. 627.645(1), F.S.);
- Time of payment of claims (s. 627.613, F.S.);
- Preferred provider organizations (s. 627.6471, F.S.);
- Exclusive provider organizations (s. 627.6472, F.S.);
- Combined preferred provider and exclusive provider policies (s. 627.6473, F.S.); and
- Provider contracts (s. 627.6474, F.S.).

Section 627.638(2), F.S., relating to direct payment for hospital and medical services, requires that whenever a health insurance claim form specifically authorizes payment of benefits directly to a recognized hospital or physician, the insurer must make the payment to the designated provider unless such payment is prohibited in the insurance contract.

Insurance Field Representatives and Operations

Subsection 626.88 (1), F.S., includes a definition for "administrator," providing that an 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 coverage of any other expenses described in s. 624.33(1), F.S.," relating to jurisdiction regarding health or life coverage, and providing for specified exceptions.

Health Maintenance Organizations

Section 641.30(1), F.S., relating to HMO contract construction and relationship to other laws, requires every HMO to accept the standard health claim form prescribed in s. 627.647, F.S., relating to the standard health claim form.

Section 641.3154(4), F.S., relates to HMO liability and prohibitions of provider billing, specifying that a provider under contract with an HMO is prohibited from collecting or attempting to collect money from, maintaining an action against, or reporting to a credit agency a subscriber of an HMO for payment of services for which the HMO is liable, if the provider, in good faith knows or should know that the HMO is liable. Specifies that this prohibition applies during any on-going claim for payment of services, legal proceedings, or dispute resolution process to determine whether the HMO is liable, if the provider is informed that such proceedings are taking place. In addition, specifies when it is presumed that a provider does know and should not know that an HMO is liable.

Section 641.3155, F.S, regulates payment of claims for HMOs and relates to HMO provider contracts and payment of claims. Specifically authorized are temporary timeframes for payment of noncontested claims, contesting of claims, prompt payment of claims, and payment reconciliation until adoption of a rule by the Department of Insurance. Rule 4-191.066, F.A.C., provides specific timeframes for the payment of "clean claims" and refers to "clean claims" as "valid undisputed claims." Specific authority for this rule comes from s. 641.36, F.S., relating to the adoption of rules, s. 641.31(12), F.S., relating to health maintenance contracts, and s. 641.3903(5)(c)3., 5., and 6., F.S., relating to unfair methods of competition and unfair or deceptive acts or practices. The current rule requires the following:

- HMOs pay all valid undisputed claims within 35 days of receipt of the claim;
- If additional information is needed, the HMO shall request the additional information in writing within 35 days of receipt of the claim and shall maintain that request in the claim file; and
- If additional information is requested, the HMO shall affirm and pay any valid claim within 30 days of receipt of the additional information.

FEDERAL ACTIVITIES RELATING TO MANAGED CARE

Federal Bipartisan Patient Protection Act – S. 1052 and H.R. 2563

As part of the overall federal reform package addressing "Patient's Rights", both S. 1052 and H.R. 2563 contain identical "prompt payment" requirements for plans and issuers offering group health insurance with respect to covered benefits. Specifically, both bills utilize the Medicare prompt payment requirement and preempt state prompt payment laws inconsistent with this standard.

The Centers for Medicare & Medicaid Services (CMS), formerly known as the Health Care Financing Administration, as part of its administration of the Medicare program, currently requires organizations, including health care providers and institutions, to:

- Pay 95 percent of the "clean claims" within 30 days of receipt if they are submitted by, or on behalf of, an enrollee of Medicare for services that are not furnished under a written agreement between the organization and the provider; and
- Pay interest on clean claims that are not paid within 30 days; and
- All other claims must be approved or denied within 60 calendar days from the date of the request.

A "clean claim" is defined to mean a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim (Social Security Act, §§ 1816(c)(2)(B) and 1842(c)(2)(B)).

Health Insurance Portability and Accountability Act (HIPAA) of 1996

In 1996, Congress passed the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), commonly known as HIPAA. The statutory deadline for Congress to enact legislation to implement HIPAA was August 21, 1999. However, absent such legislation, DHHS has developed its recently adopted rule. The Administrative Simplification rule was published August 17, 2000. The rule goes into effect on October 16, 2002. Some small organizations have until October 16, 2002, to comply. All others, including all health care providers, must comply with these standards by October 16, 2003. While HIPAA does not contain specific "prompt pay" standards, the standardization of the various transactions from forms to coding is expected to help reduce the volume of claims held up in processing due to plan-specific variations in required data, formatting, coding, or documentation requirements variations that inevitably cause systems problems for providers, plans, and insurers.

The requirements outlined by the law and the regulations promulgated by DHHS for HIPAA are far-reaching, and all health care organizations that maintain or transmit electronic health information must comply. This includes: payors (health plans, health insurers, and health care clearinghouses) and health care providers, from large integrated delivery networks to individual physician offices. All health care providers are required to submit specified transactions in specified formats with standardized transaction codes and all insurance carriers will be required to accept these forms and codes by specified compliance dates.

Currently, there is no federal common standard for the transfer of information between health care providers and payers. As a result, providers have been required by payers to meet many different requirements. For some providers who submit claims to multiple payers, determining which data to submit and on which form has been a difficult and expensive process whether done manually or electronically. HIPAA will ultimately simplify this process by requiring payers to accept specific transaction standards for Electronic Data Interchange (EDI), depending on provider type and service type. [Note: These standards were not imposed by the law, but instead were developed by federal regulation, a process which included significant private sector input.] Providers are given the option of whether to submit the transactions electronically or "on paper," however, if they elect to submit them electronically, they must use the standards agreed upon through the law. Payers are required to accept these transmissions in the standard format in which they are sent and must not delay a transaction or adversely affect a provider who wants to submit the transactions electronically.

The recently adopted HIPAA rules restate definitions contained in previously adopted HIPAA rules. Specifically, the rule establishes transaction standards using the ANSI X12 standard. Transactions covered by this standard include:

- Health care claims or equivalent encounter information;
- Health care payment and remittance advice;
- Coordination of benefits;
- Health care claim status;
- Enrollment and disenrollment in a health plan;
- Eligibility for a health plan;
- Health plan premium payments;

- Referral certification and authorization;
- First report of injury;
- Health claims attachments; and
- Other transactions that the Secretary may prescribe by regulation.

Standard code sets have been defined as including:

- International Classification of Diseases, 9th Edition, Clinical Modification, (ICD-9-CM), Volume 1 and 2 (including the official ICD-9-CM guidelines for Coding and Reporting;
- International Classification of Diseases, 9th Edition, Clinical Modification, Volume 3 Procedures (including the Official ICD-9-CM Guidelines for Coding and Reporting);
- National Drug Codes (NDC);
- Code on Dental Procedures and Nomenclature;
- The combination of Health Care Financing Administration Common Procedure Coding System (HCPCS) and the Current Procedural Terminology, Fourth Edition, (CPT-4); and
- The Health Care Financing Administration Common Procedure Coding System (HCPCS).

Section 1178 of the Social Security Act provides that standards for the transactions will supercede any State law that is contrary to them, but allows for an exception process. The final Privacy Standard Rule was issued April 14, 2001. Most health plans and health care providers that are covered by the new rule must comply with the new requirements by April 2003. In addition to the exceptions for conflicting State laws, an exception may be allowed for the testing of proposed modifications to the standards. An entity wishing to test a different standard may apply for an exception to test the new standard. Instructions for applications are published in the final rule.

Legislation has been in introduced in both the House and Senate to delay implementation of the HIPAA administrative simplification requirements by two years. S. 836 sponsored by Senator Larry Craig (R-Idaho) and H.R. 1975 sponsored by Representative John Shadegg (R-Ariz.) are similar pieces of legislation that would exempt the privacy standard from any changes in implementation requirements and deal only with regulations pertaining to administrative simplification. The legislation would not affect implementation of the medical record privacy regulations that are scheduled to go into effect in 2003.

C. EFFECT OF PROPOSED CHANGES:

The CS revises various provisions relating to certain health insurers, preferred provider organizations (PPOs), exclusive provider organizations (EPOs), health maintenance organizations (HMOs), and health providers, specific to dispute resolution, claim processing, claims for overpayment, overpayment, and treatment authorization. Revises requirement related to direct payment of benefits to specified provider under certain circumstances, regardless of contract prohibition. Expands the definition of "administrator" to include certain entities contracting with an HMO, and specifies requirements that such entities must meet.

The CS takes effect on October 1, 2002, and applies to claims for services rendered after such date, except as otherwise provided.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 408.7057, F.S., relating to the statewide provider and managed care organization claim dispute resolution program.

Subsection (1), defining the terms used in the section, is amended, as follows:

Adds paragraph (a), to define "agency" to mean the Agency for Health Care Administration.

Amends paragraph (b), to define the term "health plan" rather than "managed care organization," and expand the definition to include major medical expense health insurance policy (s. 627.643(2)(3), F.S.), offered by a group or individual health insurer licensed pursuant to chapter 624, F.S., including preferred provider organizations (s. 627.6471, F.S.).

Amends subsection (2), to update references replacing "Agency for Health Care Administration" with "agency" and "managed care organizations" with "health plans."

Adds paragraph (e), to require those seeking dispute resolution to submit supporting documentation within specified timeframes. Authorizes the resolution organization to extend time frames. Provides that failure to submit supporting documents within the timeframe results in the dismissal of the claim of the submitter.

Adds paragraph (f), to require the resolution organization to require the respondent to submit all documentation in support of its position within 15 days after receiving a request from the dispute resolution organization for supporting documentation. Authorizes the resolution organization to extend the time, if appropriate. Provides that failure to submit the requested documentation within the timeframe will result in a default against the health plan or provider. Provides that, in the event of default, the resolution organization must issue its written recommendation to the agency that a default be entered against the defaulting entity. The written recommendation must include a recommendation to the agency that the defaulting entity pay the entity submitting the claim the full amount of the claim dispute, plus all accrued interest, and must be considered a nonprevailing party for the purposes of this section.

Adds paragraph (g), to require a resolution organization that has reason to believe that a pattern exists on the part of a particular health plan or provider to evaluate the cases to determine whether there is evidence of a pattern of violations, and report its findings and evidence to the appropriate licensure or certification entity.

Amends subsection (3), to update terminology and to specify that the agency's rules establishing the process to be used by the resolution organization must specify that the written recommendation must be submitted to the agency within 60 days after the requested information is received by the resolution organization, and prohibits the extension of the timeframes from exceeding 90 days following the receipt of the initial claim dispute.

Adds subsection (5), to require the agency to notify within 7 days the appropriate licensure or certification entity whenever there is a violation of the final order issued by the agency pursuant to this section.

Section 2. Amends subsection (1) of s. 626.88, F.S., relating to definitions of "administrator" and "insurer". Expands the definition of "administrator" to include any entities that provide provider billing and collection services to health insurers and health maintenance organizations on behalf of health care providers and requires such entities to comply with insurer and HMO prompt payment requirements, and adverse determination requirements.

Section 3. Creates s. 627.6131, F.S., relating to payment of claims by health insurers, as follows:

Subsection (1) requires health insurance policy contracts to contain specific language relating to payment notice requirements.

Subsection (2) provides a definition of "claim" for institutional and noninstitutional providers, delivered to the insurer's designated location, as follows:

- Noninstutional providers: A paper or electronic billing instrument consisting of the HCFA 1500 data set, or its successor, with all mandatory entries for a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461 or other appropriate billing instrument with all mandatory entries for any other noninstitutional provider.
- Institutional providers: A paper or electronic billing instrument consisting of the UB-92 data set or its successor that all mandatory entries.

Subsection (3) specifies for all claims, electronic or nonelectronic, the following:

- Specifies when claims for payment are considered received.
- Specifies that claims for payments must be mailed or electronically transferred to the insurer within 9 months after completion of the service by the provider.
- Prohibits submission of duplicate claims unless it is determined that the original claim was not received or is lost.

Subsection (4) specifies requirements for electronically submitted health insurer claims, as follows:

Paragraph (a) requires that within 24 hours of the beginning of the next business day after the receipt of the claim electronic acknowledgement of the receipt of the claim be provided to the electronic source submitting the claim.

Paragraph (b) requires that within 20 days of the receipt of the claim, the insurer must pay the claim or notify the provider or designee if the claim is denied or contested. Notice of the insurer's action on the claim and payment of the claim is considered to be made on the date notice or payment was mailed or electronically transferred.

Subparagraph (c)1. requires that notification of a contested claim must be accompanied by an itemized list of additional information or documents reasonably necessary for the insurer to process the claim.

Subparagraph (c)2. requires that a provider must submit the requested additional information or documentation within 35 days of receipt of the notification. Failure to provide the requested information or documentation within the 35 days may result in denial of the claim.

Subparagraph (c)3. prohibits an insurer from making more than one request for documents under this paragraph in connection with a claim, unless the provider fails to submit all of the requested documents to process the claim. An additional request for more documents can be made if the documents submitted raise new additional issues which were not included in the original itemization. In such cases, the insurer may allow the provider one additional opportunity to submit additional documents needed to process the claim. Under no circumstances may an insurer request duplicate documents.

Paragraph (d) requires, for the purposes of this section, that electronic means of transmission of claims, notices, documents, forms, and payment must be used to the greatest extent possible by the health insurer and the provider.

Paragraph (e) requires a claim to be paid or denied within 90 days of the receipt of the claim. Provides that failure to pay or deny a claim within 120 days after the receipt of the claim creates an uncontestable obligation to pay the claim.

Subsection (5) specifies requirements for nonelectronically submitted health insurer claims, as follows:

Paragraph (a) beginning November 1, 2003, requires the provision of acknowledgement of the receipt of the claim to the provider within 15 days of receipt of the claim or provide a provider within 15 days of receipt with electronic access to the status of a submitted claim. [Note: The November 1, 2003, effective date only applies to this paragraph.]

Paragraph (b) requires that within 40 days of receipt of the claim, the insurer must pay the claim or notify the provider or the provider's designee that the claim is denied or contested. Notification of a claim or payment of a claim is considered to have been made on the date the notice or payment was mailed or electronically transferred.

Subparagraph (c)1. requires notification of the insurer's determination of a contested claim to be accompanied by an itemized list of additional information or documents reasonably necessary for the insurer to process the claim.

Subparagraph 2. requires a provider to submit the requested additional documentation or information within 35 days of receipt of the notification. Failure to submit by mail or electronically the requested additional information or documentation within the 35 days may result in the denial of the claim.

Subparagraph 3. prohibits an insurer from making more than one request for documents in connection with a claim except when a provider fails to submit all the requested documents or if the documents submitted raise new additional issues not included in the original written request, however, the insurer may provide the provider one additional opportunity to submit the additional documents needed to process the claim. Prohibits the insurer from requesting duplicate documents.

Paragraph (d) requires for the purposes of this subsection, electronic means of transmission of claims, notices, documents, forms, and payment be used to the greatest extent possible by the health insurer and provider.

Paragraph (e) requires a claim to be paid or denied within 90 days of the receipt of the claim. Provides that failure to pay or deny a claim within 120 days after the receipt of the claim creates an uncontestable obligation to pay the claim.

Subsection (6) provides that payment of a claim is considered made on the date the payment was mailed or electronically transferred. Provides than an overdue payment bears simple interest at a rate of 12 percent per year. Interest on an overdue payment for a claim or for any portion of claim begins to accrue when the claim should have been paid, denied, or contested. Requires the interest to be paid with the payment of the claim.

Subsection (7) requires an insurer to make a claim for overpayment if it determines that an overpayment has occurred. Requires an insurer to give the provider a written or electronic statement specifying the basis for the retroactive denial or payment. Requires the insurer to identify the claim or claims, or overpayment claim portion of the claim.

Paragraph (a) requires that in the case where an overpayment determination is the result of a retroactive review or audit of coverage decisions or payment levels not related to fraud, the health insurer must do the following:

- Submit the claim for overpayment to the provider within 30 months after the insurer's payment of the claim. The provider must pay, deny, or contest the claim for overpayment within 40 days of the receipt of the claim. Requires all contested claims for overpayment to be paid or denied within 120 days of the receipt of the claim. Failure to pay or deny the claim for overpayment within 140 days of receipt creates an uncontestable obligation to pay the overpayment claim.
- Providers that deny or contest a claim for overpayment or any portion of the claim for overpayment must notify the insurer, in writing, within 35 days after the provider received the claim. The provider's notice that the overpayment claim is being denied or contested must include a request for additional information. The provider's notice must identify the contested portion of the overpayment claim and the specific reason for contesting or denying the overpayment claim. If contested, the notice must include a request for additional information. If the insurer submits the additional information, the insurer must provide the information within 35 days after the receipt of the request and must mail or electronically transfer the information to the provider within that time. The provider must pay or deny the overpayment claim within n45 days after receipt of the information. Notice is considered made on the date the notice is mailed or electronically transferred by the provider.
- Failure to respond to a provider's contestment of the overpayment claim or request for additional information within the 35 days after receipt of the claim may result in the denial of the claim by the provider.
- An insurer is prohibited from reducing payment to a provider for other services unless the provider has agreed to the reduction in writing or has failed to respond to the insurer's overpayment claim, as required by this paragraph.
- Payment of an overpayment claim is considered made on the date the payment was mailed or electronically transferred. An overdue overpayment claim bears simple interest of 12 percent per year. Interest begins to accrue when the claim should have been paid, denied, or contested.

Paragraph (b) prohibits claims for overpayment beyond 30 months after the insurer's payment of a claim unless the provider has been convicted of fraud pursuant to s. 817.234, F.S., relating to false and fraudulent insurance claims.

Subsection (8) requires, for all contracts entered into or renewed on or after October 1, 2002, an insurer's internal dispute resolution process related to a denied claim not under active review by a mediator, arbitrator, or third-party dispute entity to be finalized within 60 days of the receipt of the provider's request for review or appeal.

Subsection (9) prohibits providers or provider's designee from billing an insured or attempting to collect money, maintain a cause of action, or report to a credit reporting agency when the health insurer contests or denies a provider's claim or portion of a claim and specifies the time of the prohibition not to exceed 60 days.

Subsection (10) prohibits the provisions of this section from being waived, voided, or nullified by contract.

Subsection (11) prohibits retroactive denial of a claim due to insured ineligibility more than 1 year after the date of the payment of the claim.

Subsection (12) requires the health insurer to pay a contracted primary care or admitting physician, pursuant to the contract, for providing inpatient services in a contracted hospital to the insured if the services are determined by the insurer to be medically necessary and covered.

Subsection (13) requires an insurer, upon written notification by an insured, to investigate any claim of improper billing by a provider. Requires the insurer to determine if the insured was properly billed. If the insured was improperly billed, the insurer must notify the insured and the provider and must reduce the amount of the payment the provider by the amount which was improperly billed. If a reduction is made due to the insured's notification, the insurer must pay the insured 20 percent of the amount of the reduction up to $500.

Subsection (14) specifies a permissive error ratio of 5 percent for the purposes of determining claims payment violations. Specifies method of calculation of error ratio, with fines for violations and such violations create an uncontestable obligation to pay a claim. Prohibits the department from assessing a fine for a violation which the department determines was due to circumstances beyond the insurer's control.

Subsection (15) limits the applicability of this section to major medical expense health insurance policies, as defined by statute, or individual health insurers licensed pursuant to statute, including specified preferred provider policies, exclusive provider organizations and group or individual dental insurance contracts.

Section 4. Creates s. 627.6135, F.S., relating to treatment authorization, as follows:

Subsection (1) specifies what an "authorization" is and specifies that each authorization request from a provider must be assigned a unique identification number by the health insurer.

Subsection (2) requires submitted authorization to be acknowledged and responded to based on a determination within a reasonable time appropriate to medical circumstances. Specifies that urgent care requests must take into account medical exigencies.

Subsection (3) requires each authorization to be assigned an identification number and must include: the date of the request; timeframe of the authorization; length of stay, if applicable; identification number of the authorization; place of service; and type of service.

Subsection (4) prohibits the denial of a claim for treatment if the provider follows the authorization process and receives authorization for a covered service of an eligible insured, unless the provider provided information with the intention to misinform the insurer.

Subsection (5) requires a health insurer making material changes to authorization procedures or requirements to notify all contracted providers at least 30 days prior to the implementation of the change and all noncontracted providers upon request, and provides that a health insurer that makes such procedures accessible to providers and insureds electronically at least 30 days prior to the implementation of the material change shall be deemed to be in compliance with this requirement.

Section 5. Amends s. 627.651(4), F.S., relating to group contracts, to correct a cross-reference.

Section 6. Amends and renumbers s. 627.662, F.S., relating to other provisions applicable to group health insurance, blanket health insurance, and franchise health insurance, to make

applicable to such coverage the payment of claims and authorization requirements specified in the bill.

Section 7. Amends subsection (2) of s. 627.638, F.S., relating to direct payment for hospital and medical services, to specify that notwithstanding any contrary provisions contained in the insurance contract, payments must be made directly to the hospital, physician, or other licensed provider for services for the treatment of mental health or substance abuse, including drug and alcohol treatment if,

- The benefit is covered under the terms of the policy;
- The claim is limited to treatment of mental health or substance abuse, including drug and alcohol abuse; and
- The insured authorized the insurer, in writing, as part of the claim to make a direct payment to the recognized hospital, physician, or other licensed provider.

Section 8. Amends subsection (1) of s. 641.30, F.S., relating to HMO contract construction and relationship to other laws, to delete obsolete language and provide a cross-reference relating to HMO claim forms pursuant to s. 641.3155, F.S.

Section 9. Adds paragraph (d) of subsection (4) of s. 641.3154, F.S., relating to HMO liability and timeframes of the prohibition from collecting money from a subscriber, maintaining a cause of action against a subscriber, or reporting to a credit agency of a subscriber, adding to the existing presumptions of a provider to know that an HMO is liable when the agency issues a final order of the claim dispute resolution organization requiring the HMO to pay for services pursuant to s. 408.7057, F.S.

Section 10. Substantially rewrites s. 641.3155, F.S., relating to HMO payment of claims, as follows:

Subsection (1) provides definition of “claim” for institutional and noninstitutional providers, delivered to the HMO’s designated location, as follows:

- Noninstutional providers: A paper or electronic billing instrument consisting of the HCFA 1500 data set, or its successor, with all mandatory entries for a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461 or other appropriate billing instrument with all mandatory entries for any other noninstitutional provider.
- Institutional providers: A paper or electronic billing instrument consisting of the UB-92 data set or its successor that all mandatory entries.

Subsection (2) specifies for all claims, electronic or nonelectronic, the following:

- Specifies when claims for payment are considered received.
- Specifies that claims for payments must be mailed or electronically transferred to the HMO within 9 months after completion of the service by the provider.
- Prohibits submission of duplicate claims unless it is determined that the original claim was not received or is lost.

Subsection (3) specifies requirements for electronically submitted HMO claims, as follows:

Paragraph (a) requires that within 24 hours of the beginning of the next business day after the receipt of the claim electronic acknowledgement of the receipt of the claim be provided to the electronic source submitting the claim.

Paragraph (b) requires that within 20 days of the receipt of the claim, the HMO must pay the claim or notify the provider or designee if the claim is denied or contested. Notice of the HMO's action on the claim and payment of the claim is considered to be made on the date notice or payment was mailed or electronically transferred.

Subparagraph (c)1. requires that notification of a contested claim must be accompanied by an itemized list of additional information or documents reasonably necessary for the HMO to process the claim.

Subparagraph (c)2. requires that a provider must submit the requested additional information or documentation within 35 days of receipt of the notification. Failure to provide the requested information or documentation within the 35 days may result in denial of the claim.

Subparagraph (c)3. prohibits an HMO from making more than one request for documents under this paragraph in connection with a claim, unless the provider fails to submit all of the requested documents to process the claim. An additional request for more documents can be made if the documents submitted raise new additional issues which were not included in the original itemization. In such cases, the HMO may allow the provider one additional opportunity to submit additional documents needed to process the claim. Under no circumstances may an HMO request duplicate documents.

Paragraph (d) requires, for the purposes of this section, that electronic means of transmission of claims, notices, documents, forms, and payment must be used to the greatest extent possible by the HMO and the provider.

Paragraph (e) requires a claim to be paid or denied within 90 days of the receipt of the claim. Provides that failure to pay or deny a claim within 120 days after the receipt of the claim creates an uncontestable obligation to pay the claim.

Subsection (4) specifies requirements for nonelectronically submitted HMO claims, as follows:

Paragraph (a), beginning November 1, 2003, requires the provision of acknowledgement of the receipt of the claim to the provider within 15 days of receipt of the claim or provide a provider within 15 days of receipt with electronic access to the status of a submitted claim. [Note: The November 1, 2003, effective date only applies to this paragraph.]

Paragraph (b) requires that within 40 days of receipt of the claim, the HMO must pay the claim or notify the provider or the provider's designee that the claim is denied or contested. Notification of a claim or payment of a claim is considered to have been made on the date the notice or payment was mailed or electronically transferred.

Subparagraph (c)1. requires notification of the HMO's determination of a contested claim to be accompanied by an itemized list of additional information or documents reasonably necessary for the HMO to process the claim.

Subparagraph 2. requires a provider to submit the requested additional documentation or information within 35 days of receipt of the notification. Failure to submit by mail or electronically the requested additional information or documentation within the 35 days may result in the denial of the claim.

Subparagraph 3. prohibits an HMO from making more than one request for documents in connection with a claim except when a provider fails to submit all the requested documents or if the documents submitted raise new additional issues not included in the original written request, however, the HMO may provide the provider one additional opportunity to submit the additional documents needed to process the claim. Prohibits the HMO from requesting duplicate documents.

Paragraph (d) requires for the purposes of this subsection, that electronic means of transmission of claims, notices, documents, forms, and payment be used to the greatest extent possible by the HMO and provider.

Paragraph (e) requires all claims to be paid or denied within 120 days after receipt of the claim. Creates an uncontestable obligation to pay the claim if the claim is not paid or denied within 140 days after the receipt of the claim.

Subsection (5) provides that payment of a claim is considered made on the date the payment was mailed or electronically transferred. Provides than an overdue payment bears simple interest at a rate of 12 percent per year. Interest on an overdue payment for a claim or for any portion of claim begins to accrue when the claim should have been paid, denied, or contested. Requires the interest to be paid with the payment of the claim.

Subsection (6) requires an HMO to make a claim for overpayment if it determines that an overpayment has occurred. Requires an HMO to give the provider a written or electronic statement specifying the basis for the retroactive denial or payment. Requires the HMO to identify the claim or claims, or overpayment claim portion of the claim.

Paragraph (a) requires that in the case where an overpayment determination is the result of a retroactive review or audit of coverage decisions or payment levels not related to fraud, the HMO must do the following:

- Submit the claim for overpayment to the provider within 30 months after the HMO's payment of the claim. The provider must pay, deny, or contest the claim for overpayment within 40 days of the receipt of the claim. Requires all contested claims for overpayment to be paid or denied within 120 days of the receipt of the claim. Failure to pay or deny the claim for overpayment within 140 days of receipt creates an uncontestable obligation to pay the overpayment claim.
- Providers that deny or contest a claim for overpayment or any portion of the claim for overpayment must notify the HMO, in writing, within 35 days after the provider received the claim. The provider's notice that the overpayment claim is being denied or contested must include a request for additional information. The provider's notice must identify the contested portion of the overpayment claim and the specific reason for contesting or denying the overpayment claim. If contested, the notice must include a request for additional information. If the HMO submits the additional information, the HMO must provide the information within 35 days after the receipt of the request and must mail or electronically transfer the information to the provider within that time. The provider must pay or deny the overpayment claim within 45 days after receipt of the information. Notice is considered made on the date the notice is mailed or electronically transferred by the provider.
- Failure to respond to a provider's contestment of the overpayment claim or request for additional information within the 35 days after receipt of the claim may result in the denial of the claim by the provider.
- An HMO is prohibited from reducing payment to a provider for other services unless the provider has agreed to the reduction in writing or has failed to respond to the HMO's overpayment claim, as required by this paragraph.

- Provides that a payment for an overpayment claim is considered made on the date the payment was mailed or electronically transferred. Provides that an overdue payment for a claim for overpayment bears a simple interest rate of 12 percent per year. Provides that interest begins to accrue on an overdue payment for claim on the date when the claim should have been paid, denied, or contested.

Paragraph (b) prohibits claims for overpayment beyond 30 months after the HMO's payment of a claim unless the provider has been convicted of fraud pursuant to s. 817.234, F.S., relating to false and fraudulent insurance claims.

Paragraph (7)(a) requires, for all contracts entered into or renewed on or after October 1, 2002, an HMO's internal dispute resolution process related to a denied claim not under active review by a mediator, arbitrator, or third-party dispute entity to be finalized within 60 days of the receipt of the provider's request for review or appeal.

Paragraph (b) requires all HMO claims begun after October 1, 2000, which are not under active review by a mediator, arbitrator, or third-party dispute entity, to have a final decision on the clam by the HMO by January 2, 2003, for the purposes of the statewide provider and managed care organization claim dispute resolution program pursuant to s. 408.7057, F.S.

Subsection (8) prohibits providers or provider's designee from billing a subscriber or attempting to collect money, maintain a cause of action, or report to a credit reporting agency when the HMO contests or denies a provider's claim or portion of a claim and specifies the time of the prohibition not to exceed 60 days.

Subsection (9) prohibits the provisions of this section from being waived, voided, or nullified by contract.

Subsection (10) prohibits retroactive denial of a claim due to subscriber ineligibility more than 1 year after the date of the payment of the claim.

Subsection (11) requires the HMO to pay a contracted primary care or admitting physician, pursuant to the contract, for providing inpatient services in a contracted hospital to the subscriber if the services are determined by the HMO to be medically necessary and covered.

Subsection (12) requires an HMO, upon written notification by an HMO, to investigate any claim of improper billing by a provider. Requires the HMO to determine if the subscriber was properly billed. If the HMO was improperly billed, the HMO must notify the subscriber and the provider and must reduce the amount of the payment to the provider by the amount which was improperly billed. If a reduction is made due the subscriber's notification, the HMO must pay the subscriber 20 percent of the amount of the reduction up to $500.

Subsection (13) specifies a permissive error ratio of 5 percent for the purposes of determining claims payment violations. Specifies method of calculation of error ratio, with fines for violations and such violations create an uncontestable obligation to pay a claim. Prohibits the department from assessing a fine for a violation which the department determines was due to circumstances beyond the HMO's control.

Section 11. Amends s. 641.3156, F.S., relating to treatment authorization and payment of claims, as follows:

Amends subsection (1) to specify, for the purposes of this section, an "authorization" is "any requirement of a provider to obtain prior approval or to provide documentation relating to the necessity of a covered medical treatment or service as a condition for reimbursement for treatment or service prior to the treatment or service." Specifies that each authorization request from a provider must be assigned an identification number by the HMO. Deletes existing language requiring an HMO to pay any hospital service or referral service claim for treatment of an eligible subscriber if it was authorized by a provider empowered by contract with the HMO to authorize or direct the patient's use of health care services which was in accordance with the HMO's current and communicated procedures, except if the provider provided information with the willful intent to misinform the HMO.

Adds new subsection (3), to require submitted authorization to be acknowledged and responded to based on a determination within a reasonable time appropriate to medical circumstances. Specifies that urgent care requests must take into account medical exigencies.

Adds subsection (4), to require each authorization to be assigned an identification number and to include: the date of the request; timeframe of the authorization; length of stay, if applicable; identification number of the authorization; place of service; and type of service.

Adds subsection (5), to prohibit the denial of a claim for treatment if the provider followed the authorization process and receives authorization for a covered service of an eligible subscriber, unless the provider provided information with the intention to misinform the insurer. Requires a health maintenance organization making material changes to authorization procedures or requirements to notify all contracted providers at least 30 days prior to the implementation of the change and all noncontracted providers upon request, and provides that a health maintenance organization that makes such procedures accessible to providers and subscribers electronically at least 30 days prior to the implementation of the material change shall be deemed to be in compliance with this requirement.

Renumbers subsection (3) as subsection (6), relating to emergency services.

Section 12. Specifies that this act takes effect October 1, 2002, and applies to all claims for services rendered after that date, except as otherwise provided.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The Department of Insurance will incur costs relating to monitoring activities.

The CS may result in increased costs in providing health benefits coverage to employees.

According to the Agency for Health Care Administration, the CS has a direct fiscal impact on the agency because it permits all health insurers licensed under Chapter 627, F.S., to access the Statewide Provider and Health Plan Claim Dispute Resolution Program. Currently, only managed care organizations licensed under Chapter 641, F.S., can access the program. The agency is responsible for issuing final orders for all claim disputes submitted to the Statewide

Provider and Health Plan Claim Dispute Resolution Program. While the current caseload has been very low and far below the expectations of the agency, the inclusion of additional health insurance providers under this program, may increase the caseload. For this reason, the agency projects the following added staff support costs.

Fiscal Impact on the Agency for Health Care Administration		
Expenditures – Non-Recurring	**Amount Year 1 (FY 02-03)**	**Amount Year 2 (FY 03-04)**
Expense	$ 2,59	$0
OCO	$ 1,389	$0
Total Non-Recurring Expenditures	**$ 4,048**	**$0**

Expenditures – Recurring **1 Senior Attorney (PG 230)** **(Lapsed for 10/01/02 effective date)**		
Salaries	$45,386	$60,515
Expense (Agency standard package)	$ 8,293	$11,057
Total Recurring Expenditures	**$53,679**	**$71,572**

Subtotal Non-Recurring Expenditures	$ 4,048	$0
Subtotal Recurring Expenditures	$53,679	$71,572
Total Expenditures	**S57,727**	**$71,572**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

This bill may result in increased costs in providing health benefits coverage to employees.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Providers of health care services should receive more timely reimbursement and potentially greater reimbursement under the provisions of this bill.

The provisions of the CS may result in increased costs to health insurers and HMOs as a result of the following:

- Reduction of time frames for processing of claims;
- Increase in penalties for health insurers and HMOs for failure to pay claims within newly abbreviated time frames.

D. FISCAL COMMENTS:

According to the Agency for Health Care Administration, the CS has a fiscal impact on health insurers and HMOs by shortening payment timeframes, shortening treatment authorization periods, and implementing stricter penalties for any violation of the prompt pay provisions.

The CS appears to have a direct fiscal impact on the Department of Insurance. Under the provisions of this bill, the department is required to expand its monitoring activities and implement new rules. In addition, the CS provides for a permissive error rate of 5 percent which can only be determined by department monitoring of insurers and HMOs, thereby requiring additional enforcement activities by the department.

III. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take actions requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that municipalities or counties have to raise revenues in the expenditure of funds.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of state tax shared with counties or municipalities.

IV. COMMENTS:

A. CONSTITUTIONAL ISSUES:

None.

B. RULE-MAKING AUTHORITY:

None.

C. OTHER COMMENTS:

None.

V. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On December 18, 2001, the **Committee on Health Promotion** considered a “strike-everything” amendment and adopted three amendments to the “strike-everything” amendment. However, the meeting time expired before the amended “strike-everything” amendment could be voted on. On January 8, 2002, the House Committee on Health Promotion adopted 20 additional amendments to the “strike-everything” amendment and adopted the “strike-everything” amendment, as amended. The “strike-everything” amendment substantially revised the provisions of the bill.

The following provisions contained in the bill as filed were not contained in the “strike-everything” amendment:

- Prepaid health benefits under coordination of benefits provisions and coordination of benefits under health insurance policies regardless of timeframes, under specified circumstances, and specification of payment for total covered charges;
- Rulemaking authority for the Department of Insurance to adopt rules consistent with federal claim-filing standards;

- Authorization for a provider to submit a claim to the dispute resolution panel prior to completing internal review processes of the HMO or insurer;
- Requirements for insurers and HMOs to comply with federal transaction standards under HIPAA, by October 16, 2002 – reflecting Congressional delay; and
- Insurer payment of claims applicability references to preferred provider organizations and exclusive provider organizations, which duplicated other provisions.

The original bill contained provisions that were equally applied to health insurers and HMOs. Through the amendatory process, some apparent inconsistencies were created in applicability. Examples are as follows:

- Applicability of time of payment of claim provisions to individual health insurers (section 2 of the amendment, page 3, line 4 thru page 7, line 16) versus the applicability of treatment authorization and payment of claim provisions to group health insurers (section 3 of the amendment, page 7, line 17 thru page 10, line 5), and especially the applicability of these provisions to PPOs and EPOs (see especially page 10, lines 4-5).
- Prohibiting duplicate informational requests on claims, but authorizing additional requests for new or additional issues based on submitted additional information (for insurers, page 3, line 28 thru page 4, line 6; for HMOs, page 15, lines 10-20).
- Making insurers and HMOs liable for reimbursement if the insurer (page 7, lines 5-8) or HMO (page 18, lines 22-26) verified eligibility status to provider, with no opportunity for the HMO to subsequently revoke eligibility status authorization, even prior to the rendering of the care or services; however, only requires employers with contracts with HMOs to notify the HMO of changes in eligibility status within 30 days (page 18, lines 26-30).
- Providing an incentive that imposes revised claims processing and payment standards for claims submitted to insurers electronically effective October 1, 2003 (page 7, lines 14-16), but not applying these same standards to claims submitted to HMOs.
- Essentially duplicative language relating to prompt payments by an HMO to a subscriber, resulting from the adoption of similar language in two similar amendments inserting that language into two places in the amendment (page 12, line 7 thru page 13, line 2; and page 19, lines 11-26).
- Inconsistent interest rate charges as late payment penalties (18% on page 19, line 22; 12% elsewhere).

On February 12, 2002, the **Committee on Judicial Oversight** adopted a substitute amendment to the amendment adopted by the Committee on Health Promotion. The substitute amendment substantially revised the provisions of the bill.

Two amendments to the amendment were adopted. These amendments to the amendment provided for a civil cause of action against health insurers (in s. 627.613, F.S.) and HMOs (in s. 641.3155, F.S.) for failure to promptly pay clean claims. An aggrieved provider may bring an action to recover moneys owed plus attorney's fees and court costs. If an insurer or HMO is found to have violated the prompt pay requirements, the insurer or HMO is required to pay attorney's fees and costs, provided that attorney's fees cannot exceed the greater of either the amount in controversy or $2,500. If the insurer or HMO is found not to have violated the requirements, it can recover attorney's fees on any claim or defense that the provider knew or should have known was not supported by material facts necessary to establish the claim or defense.

After the amendment was adopted, the bill, as amended, was temporarily deferred.

On February 21, 2002, the Committee on Judicial Oversight adopted another substitute amendment with two amendments to the substitute. The amendment is substantially similar to the amendment adopted

on February 12, 2002, but changed the civil cause of action provisions. Under the substitute amendment as amended, an aggrieved provider may bring an action against a health insurer or an HMO to recover monies owed and attorney's fees. The prevailing party in the action is entitled to attorney's fees not to exceed $5,000 or two times the amount in controversy, whichever is greater. In addition, if the prevailing party can demonstrate (1) that the acts giving rise to a violation occur with such frequency as to indicate a general business practice and (2) the losing party failed to act in good faith, then the prevailing party is entitled to two times the amount due plus attorney's fees.

The bill, as amended, was reported favorably.

On February 26, 2002, the **Council for Healthy Communities** adopted a council substitute which again substantially revised the provisions of the bill, and which did not include the civil cause of action provisions.

VI. SIGNATURES:

COMMITTEE ON HEALTH PROMOTION:

Prepared by:	Staff Director:
Tonya Sue Chavis, J.D.	Phil E. Williams

AS REVISED BY THE COMMITTEE ON JUDICIAL OVERSIGHT:

Prepared by:	Staff Director:
L. Michael Billmeier, Jr., J.D.	Nathan L. Bond, J.D.

AS FURTHER REVISED BY THE COUNCIL FOR HEALTHY COMMUNITIES:

Prepared by:	Council Director:
Tonya Sue Chavis, J.D.	David De La Paz