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HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH PROMOTION
ANALYSIS

BILL #: HB 293

RELATING TO: Health Insurance

SPONSOR(S): Representative(s) Benson, Negron, and others

TIED BILL(S):

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

(1) HEALTH PROMOTION
(2) JUDICIAL OVERSIGHT
(3) COUNCIL FOR HEALTHY COMMUNITIES
(4)
(5)

I. SUMMARY:

HB 293 revises various provisions relating to health insurers, preferred provider networks (PPN), exclusive provider organizations (EPO), health maintenance organizations (HMO), and health providers, specific to claims processing and payment, as follows:

- Redefines "managed care organization" expanding the types of entities eligible to utilize the statewide provider and managed care organization claim dispute resolution program;
- Includes prepaid health benefits under coordination of benefits provisions and provides for coordination of benefits under health insurance policies regardless of time frames, under specified circumstances, and specifies payment for total covered charges;
- Revises payment of claims for health insurers and HMOs, requiring the Department of Insurance to adopt rules consistent with federal claim-filing standards, providing requirements and procedures for payment of claims, specifying time frames/interest on overpayments/coordination of benefits, and providing for remedies and attorney's fees and costs under specified conditions;
- Entitles insureds and subscribers to prompt insurance payments of claims for covered services, requires payment of claims within specified time frames, and provides penalties;
- Substantially revises health insurer and HMO requirements related to treatment authorization, defining "authorization," requiring such entities that require authorization to provide lists of medical care and health care services that require authorization, prohibits denial of certain claims, and provides procedural requirements for determination of authorization;
- Revises limitations on policies providing differing schedules of payments for preferred provider services and nonpreferred provider services;
- Specifies application of certain additional provisions to group, blanket, and franchise health insurance;
- Provides conforming statutory cross-references throughout; and
- Repeals requirements related to standard health claims forms.

The bill's effective date is July 1, 2002, except where otherwise provided.

II. 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 requires the Department of Insurance to adopt rules consistent with specified federal regulations (some not yet adopted) relating to health claims forms, medical data code sets, and edits. The bill provides that violation of various time frames for payment of claims is a violation of the insurance code and that each violation is a separate offense.

B. PRESENT SITUATION:

PROMPT PAYMENT OF CLAIMS

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 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. Typical, 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.

Health Maintenance Organizations

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 time frame and procedures, time frames 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 receipts for electronically submitted provider claims; prescribed a time frame for an HMO to retroactively deny a claim for services provided to an eligible subscriber, and provided for treatment authorization and payment of claim for emergency services is 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.

Specifically, s. 641.3155, F.S., requires HMOs to pay claims for services provided under contract with the HMO within 35 days after receipt of the claim. For contested claims, the HMO must notify the contract provider, in writing, within 35 days after receipt of the claim, and identify the contested portion of the claim and the specific reason for contesting or denying the claim. In the event the HMO requests additional information, the provider must provide the information within 35 days, and within 45 days after receipt of the information requested, the HMO must pay or deny the contested claim or portion of the contested claim. In any event, 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 penalty at the rate of 10 percent per year.

Health Insurers

Section 627.613, F.S., relating to time of payment of 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.

Statewide Provider and Managed Care Organization Claim Dispute Program

Section 408.7057, F.S., relates to the Statewide Provider and Managed Care Organization Claim Dispute Program (program) administered by the Agency for Health Care Administration (agency). 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. 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 the agency, the mediation statute lacks sanctions for nonresponding plans or providers. In addition, 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.

Additional Current Florida Statutory Provisions

Section 627.613, F.S., relates to time of payment of claims requirements for health insurance policies. Health insurers are required to reimburse all claims or any portion of any claim from an

insured or an insured's assignees, for payment 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, then the insured or the insured's assignees must be notified, in writing, that the claim is contested or denied, within the 45 days after receipt of the claim by the health insurer. A health insurer, upon receipt of the additional information requested from the insured or the insured's assignees shall pay or deny the contested claim or portion of the contested claim, within 60 days. An insurer shall pay or deny any claim no later than 120 days after receiving the claim. In addition, all overdue payments shall bear simple interest at the rate of 10 percent per year.

Section 627.6141, F.S., relating to denial of claims, provides that each claimant, or provider acting for a claimant, who has had a claim denied as "not medically necessary" must be provided an opportunity for an appeal to the insurer's licensed physician who is responsible for the medical necessity reviews under the plan or is a member of the plan's peer review group. Further, the appeal may be by telephone, and the insurer's licensed physician must respond within a reasonable time, not to exceed 15 business days.

Section 627.647, F.S., relating to standard health claim form requirements for indemnity plans, requires all hospitals, physicians, dentists, and pharmacists to use a standard health claim form as prescribed by the Department of Insurance. This section specifies that the form must be one that allows for the use of generally accepted coding systems by providers and must provide for disclosure by the claimant of the name, policy number, and address of every insurance policy which may cover the claimant with respect the to submitted claim. Required information on diagnosis, dental procedures, medical procedures, services, date of service, supplies, and fees may also be met by an attachment. This requirement does not apply to Medicaid claims nor to claims submitted by electronic or electromechanical means. These requirements do not apply to coordination of benefits against an indemnity-type policy, an excess insurance policy as defined in s. 627.635, F.S., a policy with coverage limited to specified illnesses or accidents, or a Medicare supplement policy . [Note: Rule 4-161.004-007, F.A.C., requires the use of specified: health insurance claim form; dental claim forms; pharmacy claim forms; and hospital claim forms. In addition, Rule 4-161.008, F.A.C., clarifies that additional information not contained on the forms may be requested by the insurer.]

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. 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 30 days of receipt of the claim;
- If additional information is needed, the HMO shall request the additional information in writing within 30 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.

COORDINATION OF BENEFITS

"Coordination of Benefits" (COB) is a method of determining payment of claims when the insured or a dependent may have more than one source of coverage. In general, insurers apply COB procedures when an insured or a dependent of the insured receives services that may be covered under more than one plan. COB procedures determine which plan is primary, meaning which plan pays the benefits first, and which plan pays benefits secondarily, after the primary plan has made its determination and payment.

In general, the primary plan pays benefits or amounts without regard to the secondary plan. The secondary plan then pays for any covered services which have not been paid by the primary plan, taking into consideration all applicable coverage provisions and limitations. For example: You have a mole removed and the treating physician renders that service for $100; the primary plan pays $60; the secondary plan will coordinate with the other carrier and pay the remaining $40. This scenario assumes that applicable coverage provisions and limitations of both the primary and secondary coverage would allow full payment of the service. Claims filed should be filed with the primary plan first. After the provider has received payment from the primary plan, the claim should be filed with the secondary plan.

While Florida statutes require certain types of insurance contracts to contain coordination of benefits provisions, the actual process of coordination is not defined. Coordination of benefits in group health insurance plans is primarily governed by s. 627.4235, F.S., relating to insurance rates and contracts. Section 641.31(7), F.S., relating to health maintenance contracts, provides that an HMO is subject to the coordination of benefits requirements of s. 627.4235, F. S. Under these two statutes, specified types of plans must contain a provision for coordination of its benefits with any similar benefits provided by other specified plans as against the same loss. In addition, the specified plans may contain a provision to reduce or refuse to pay benefits otherwise payable on account of the existence of a similar plan if, as a condition of coordinating benefits, the insurers together pay 100 percent of the total reasonable covered expenses actually incurred.

Chapter 2000-252, L.O.F., amended s. 641.3155, F.S., relating to the payment of claims. While this bill did not directly address the coordination of benefits issue, the bill did define what constitutes a "clean claim" and provides time limitations for additional information requests and payment.

In addition to the above listed statutes, the Department of Insurance has promulgated several rules relating to standards for prompt, fair, and equitable settlements and coordination of benefits, and relating to requiring specified contracts, HMO certificates, and member handbooks to contain a description of COB provisions. Chapter 4-166.026(2), F.A.C., provides standards for prompt, fair, and equitable settlement applicable to all insurers and applies to, among other policy provisions, coordination of benefits. Chapter 4-191.039(10), F.A.C., requires each HMO certificate and member handbook to contain a description of the coordination of benefits provisions. Chapter 4-203.026(1)(q), F.A.C., requires prepaid limited health service organizations' contracts to include provisions relating to coordination of benefits.

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 bill provides the following:

- Expands the existing Statewide Provider and Managed Care Organization Claims Dispute Resolution to include claims of preferred provider organizations;

- Makes substantial changes to payment of claims, authorization, and coordination of benefits for health insurers and HMOs;
- Creates automatic approval for certain violation of time frames, and civil liability for certain violations of time frames,
- Makes substantial changes in retroactive reviews of claims by health insurers and HMOs;
- Substantially changes existing statutory requirements relating to: authorization, payment of claims, look-back reviews, overpayment claims, and requirements for HMOs; and requires health insurers to also conform to the revised standards;
- Requires both HMOs and health insurers that require authorization to provide insureds, subscribers, and certain providers with lists of services and procedures and prohibits the denial of payment for any service or procedure not contained on the list; and
- Substantially expands health insurer obligations for emergency services and care.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends paragraph (a) of subsection (1) and paragraph (c) of subsection (2) of s. 407.7057, F.S., relating to the statewide provider and managed care organization claim dispute resolution program, to:

- Expand the definition of "managed care organization" to include preferred provider organizations; and
- Expand the requirement of exhaustion of internal dispute-resolution process prerequisite to also provide that if such process is not completed within 60 calendar days after filing of the claim dispute with the managed care organization the provider may file a claim dispute with the dispute-resolution organization.

Section 2. Amends s. 627.4235, F.S., relating to coordination of benefits, as follows:

Subsections (1) through (6) are renumbered as subsections (2) through (7).

A new subsection (1) is added to clarify the meanings of "coordination of benefits" and "coordinating benefits," specific to claim order and payment of *covered charges*.

Existing subsections (1) and (2) are renumbered as subsections (2) and (3) and are amended to also apply to a prepaid health plan licensed pursuant to chapter 641, F.S.

Renumbered subsection (3) is also amended to include prepaid health plans licensed pursuant to chapter 641, F.S. *Requires*, rather than *permits*, a hospital, medical, or surgical expense policy, health care service plan, prepaid health plan licensed pursuant to chapter 641, or self-insurance plan that provides protection or insurance against hospital, medical, or surgical expenses issued in this state or issued for delivery in the state, to contain a provision whereby the insurer may reduce or refuse to pay benefits otherwise payable due to the existence of a similar benefits provided, as specified. The bill also deletes the requirement that health insurers together must pay 100 percent of the *total reasonable expenses* and replaces it with the requirement that health insurers must pay 100 percent of the *total covered charges*.

Renumbered subsection (4) updates a reference to renumbered subsection (3).

Subsection (8) is added, providing the provider 60 calendar days to submit correct billing information to a primary health insurer when the insured has failed to provide the provider the correct name and address of the primary health insurer and the claim has been submitted to a secondary insurer or prepaid health plan.

Section 3. Effective October 16, 2002, substantially rewords s. 627.613, F.S., related to time of payment of claims, as follows:

Paragraph (1)(a) defines "clean claim" for *noninstitutional providers* to mean a paper or electronic billing instrument consisting of the HCFA 1500 data set with all mandatory entries completed for a physician licensed under ch. 458 or ch. 459 or other appropriate form for any other noninstitutional provider, or its successor. [Note: This would apply to all noninstitutional providers not just to physicians licensed under chapter 458 or chapter 459.] Defines "clean claim" for *institutional providers* to mean a paper or electronic billing instrument that consists of the UB-92 data set or its successors that has all mandatory entries completed.

Paragraph (1)(b) grants rulemaking authority to the Department of Insurance to establish claim forms consistent with code sets required or adopted by the Secretary of the United States Department of Health and Human Services. Specifies, but does not limit required code sets. Also, specifies the use of the National Correct Coding Initiative edits used by Medicare. [Note: These latter edits are not included in the listing of standard code sets as specified by the Secretary of the United States Department of Health and Human Services for HIPAA regulations.]

Paragraph (1)(c) restricts providers and payors to the use of standard code sets defined for their area of operation by the Secretary of the United States Department of Health and Human Services for filing and adjudication of electronic claims. Requires the version of the set used to be the version that is valid at the time the health care is furnished which is defined as the date of discharge for inpatient services and date of service for health care provided in an outpatient or ambulatory setting.

Paragraph (2)(a) provides time frames for payment of claims or portion of claims made by providers for goods or services, including 15 calendar days after receipt of an electronic claim; and 35 calendar days after a nonelectronic claim. Provides that an investigation and determination of eligibility for payment, excluding coordination of other payments, does not extend the time periods specified. [Current law specifies payment 45 days after receipt of claim.]

Paragraph (2)(b) provides timeframes for notifying providers of the insurers' denying or contesting a claim or portion of a claim again using the 15 and 35 day parameters. Requires the notice to:

- Identify the contested portion of the claim;
- Specify the reason for contesting or denying the claim; and,
- If contested, give the provider a written itemization of any additional information or additional documents needed to process the claim or any portion of the claim not being paid.

Prohibits health insurers from making more than one request in connection with a claim, unless a provider fails to submit all of the requested information to process the claim. In that event, the health insurer may allow the provider one additional opportunity to submit the additional information needed to process the claim.

Paragraph (2)(c) requires a health insurer that requests additional information or additional documentation from a person other than the provider who submitted the claim must provide a copy of the request to the provider who submitted the claim. Prohibits a health insurer from withholding payment pending receipt of information requested from a person other than the provider. Prohibits a health insurer from denying or withholding payment on a claim because the insured has not paid a required deductible or co-payment.

Subsection (3) specifies that payment is considered received on the date payment is received, electronically transferred, or otherwise delivered. Provides that health insurers that do not pay a claim within the time frame of subsection (4) must pay the provider's *billed charges* submitted on the claim.

Subsection (4) requires all claims, regardless of requests for additional information, additional documentation, or other investigations, must be paid or denied no later than 50 calendar days after receiving the claim electronically or 70 calendar days if claim is received nonelectronically. Creates an *uncontestable obligation* on the health insurer to pay the claim to the provider. Provides for tolling of the time based on the number of days taken by the provider who submitted the claim to submit the additional information requested by the health insurer.

Subsection (5) prohibits health insurers from reducing payments for other provider services based on a retroactive review of coverage decisions. Specifies that *look-back* or *audit* review periods may not exceed 1 year of the date of discharge or to 1 year from the date the health service was provided.

Subsection (6) provides that a provider's claim for payment is considered received if the claim has been electronically submitted, when the receipt is verified electronically. Provides that a provider's claim for payment is considered received if the claim has been mailed to the address disclosed by the health insurer, on the date indicated on the return receipt or, if delivered, on the date the delivery receipt is signed by the health insurer. Prohibits insurers from requiring providers to resubmit a claim for payment if the claim has been received by the health insurer. Requires a provider to wait 35 days following a receipt of a claim before submitting a duplicate claim.

Subsection (7) requires health insurers to provide a provider or a provider's designee who bills electronically, an electronic acknowledgement of the receipt of the claim within 24 hours of receipt.

Subsection (8) prohibits health insurers from retroactively denying a claim because of subscriber ineligibility.

Paragraph (9)(a) provides that, regardless of other remedies or relief which a provider is entitled to, any provider who is aggrieved by a violation of this section by a health insurer may bring an action to enjoin a person who has violated, or is violating, this section. Provides that the provider may recover any *amounts due* the provider by the health insurer, including *accrued interest*, plus *attorney's fees* and *costs* as specified.

Paragraph (9)(b) provides that for *any action* arising from the health insurer's violation of this section, the provider, after judgment in trial court and exhaustion of all appeals, will be awarded *reasonable attorney's fees* and *costs* from the health insurer.

Subsection (10) provides that the provisions of this section apply to contracts entered pursuant to contracts for reduced rates of payment, preferred provider networks (PPN) (s. 627.6471, F.S.) and exclusive provider organizations (EPO) (s. 627.6472, F.S.).

Subsection (11) prohibits the provisions of this section from being waived, voided, or nullified by contract.

Section 4. Adds subsection (3) to s. 627.614, F.S., relating to payment of claims, requiring payment of the electronic claim of an insured or on the behalf of the insured within 15 days or 30 days if nonelectronic. Also requires the health insurer to advise the insured of what additional

information is required within the same time periods. After receiving the additional information, the health insurer must pay electronic claims within 10 days.

If the health insurer fails to pay within the time period, the health insurer must pay the insured *twice the amount of the claim*. Failure to pay claims and penalties, within time frames specified, is a violation of the Insurance Code, and each occurrence is considered a separate violation.

Section 5. Creates s. 627.6142, F.S., relating to treatment authorization and payment of claims, as follows:

Subsection (1) defines "authorization."

Subsection (2) requires health insurers that require authorization to provide PPN and EPO contracted providers a list of the medical care and health care services that require authorization and the authorization procedures used by the health insurer at the time the contract becomes effective. Health insurers that require authorization are also required to provide such list and procedures to all other providers, within 10 working days after a request is made. Health insurers that require authorization are prohibited from modifying the list or procedures unless written notice is provided, at least 30 days in advance, to all affected insureds, to all contracted providers, and to all other providers that had previously requested the list and procedures.

Subsection (3) specifies that any claim for treatment that is not specifically listed as requiring authorization, is ordered by a physician, and entered on the medical record may not be denied by the health insurer.

Paragraph (4)(a) prohibits denial of a claim for treatment not requiring authorization, which was ordered by a provider. Provides an exception for information submitted by a provider with the *willful intent to misinform* a health insurer.

Paragraph (4)(b) requires a health insurer to issue a determination indicating if the authorization is granted or denied. The determination must be issued no later than *8 hours* after the request is made. Failure of a health insurer to respond to a written request for authorization within the allotted time frame results in automatic authorization of the request and payment shall not be denied. If authorization is denied, the health insurer must notify the insured at the same time notification is sent to the provider.

Subsection (5) provides that for inpatient admissions requiring authorization, the insurer must review and issue a written or electronic authorization for the total estimated length of the stay for the admission based on the recommendation of the patient's physician. Health insurers must issue the authorization or denial within *1 hour* after the request is made by the provider. A health insurer who fails to respond to such a request within *1 hour* is considered to have authorized the requested medical service or health care and denial of payment is prohibited.

Subsection (6) excludes the provision of emergency services and care from the provisions of this section, and specifies that such services are subject to s. 641.513, F.S., relating to requirements for providing emergency services and care by managed care entities.

Subsection (7) prohibits the provisions of this section from being waived, voided, or nullified by contract.

Subsection (8) applies the provisions of this section to ss. 627.6471 (contracts for reduced rates of payments, preferred provider networks), and 627.6472 (exclusive provider organizations), F.S.

Section 6. Amends paragraph (h) of subsection (4) of s. 627.6471, F.S., relating to contracts for reduced rates, as follows:

- Requires health insurers provide each preferred provider a list of all payors with whom the health insurer has entered into agreements to use the services of the preferred provider and specifies that no additional payors are permitted to be added to the agreement unless approved in writing by the preferred provider.
- Prohibits health insurers and the health insurers' claims administrators from disclosing contract rate information without the written approval of the preferred provider.
- Deletes the requirement that if any service or treatment is not within the scope of services provided by the network of preferred providers but is within the scope of services or treatment covered by the policy, the service or treatment must be reimbursed at a rate not less than 10 percentage points lower than the percentage rate paid to preferred providers.
- Deletes the requirement for the reimbursement rate to be applied to be the usual and customary charges in the area.

Section 7. Amends s. 627.662, F.S., relating to other provisions applicable, adding statutory references to newly created sections and renumbering subsequent subsections.

Section 8. Adds paragraph (m) to subsection (1) of s. 641.185, F.S., relating to health maintenance organization subscriber protections, as follows:

- States that HMO subscribers are entitled to prompt payment from an HMO whenever the subscriber pays an out-of-network provider for a covered service and then submits a claim to the HMO.
- Requires that electronic claims submitted by the subscriber or on behalf of the subscriber by the out-of-network provider must be paid to the subscriber within 15 days or the HMO must advise the subscriber of any additional information needed to adjudicate the claim and requires the HMO to pay the claim within 10 days after receiving the requested information.
- Requires that nonelectronic claims to be paid to the subscriber within 30 days, or the HMO must advise the subscriber of any additional information needed to adjudicate the claim. Requires the HMO to pay the claim within 10 days after receiving the information.
- Requires the HMO to pay the subscriber *twice the amount of the claim* if the HMO fails to pay the claims within the prescribed time period.
- Provides that failure to pay claims and applicable penalties within the time frames of this paragraph is a violation of the Insurance Code, and each occurrence is considered a separate violation.

Section 9. Effective October 16, 2002, subsection (1) of s. 641.30, F.S., relating to construction of HMO contracts and relationship to other laws, is amended to make claims form requirements consistent with other requirements in this bill.

Section 10. Effective October 16, 2001, s. 641.3155, F.S, relating to payment of claims, is amended, as follows:

Paragraph (1)(a), is amended, as follows:

- Deletes the term "clean";
- Defines the term "claim";
- Deletes the language clarifying what a "clean claim" is; and

- Deletes the Department of Insurance's rulemaking authority to define "clean claim" for noninstitutional providers.

Existing paragraph (1)(b), relating to the definition of "clean claim" for institutional providers, is deleted.

Existing paragraph (1)(c) is redesignated as (b) and amended, as follows:

- Deletes outdated reference to the federal Health Care Financing Administration and updates the reference to the Secretary of the United States Department of Health and Human Services;
- Requires the Department of Insurance to adopt rules to require code sets consistent with those adopted by the Secretary of the United States Department of Health and Human Services;
- Requires that the specified code sets apply to electronic claims;
- Defines "code sets"; and
- Deletes obsolete reference to Medicare coding standards adopted by federal Health Care Financing Administration. Also specifies the use of the National Correct Coding Initiative edits used by Medicare. [Note: These edits are not included in the listing of standard code sets as specified by the Secretary of the United States Department of health and Human Services for HIPAA regulations.]

Paragraph (1)(c) is added, as follows:

- Requires all providers and payors to use the standard code sets defined for their area of operation by the Secretary of the United States Department of Health and Human Services for the filing and adjudication of electronic claims; and
- Requires that the version of the code set used be the version that is valid at the time the health care is furnished, defined as the date of discharge for inpatient services and date of service for health care provided in an outpatient or ambulatory setting.

Paragraph (2)(a) is amended, as follows:

- Deletes obsolete terms and changes time frames for payment of claims for consistency;
- Requires HMOs to pay any claim or portion of a claim, submitted by a provider, within 15 calendar days after receipt of an electronic claim by the HMO provider [current law specifies 35 days];
- Requires HMOs to pay any claim or portion of a claim, submitted by a provider, within 35 days after the receipt of a nonelectronic claim by the HMO provider; and
- Provides that the investigation and determination of eligibility for payment, including any coordination of other payments, does not extend these time periods.

Paragraph (2)(b) is amended, as follows:

- Specifies time frames are *calendar* days;
- Requires an HMO that denies or contests a claim or portion of a nonelectronic claim to notify the provider within 35 calendar days after the HMO receives the claim;
- Requires an HMO that denies or contests a claim or portion of an electronic claim to notify the provider within 15 calendar days after the HMO receives the claim;
- Requires an HMO contesting a claim or portion of a claim, in addition to current requirements (identify the contested portion and the specific reason for contesting) to give

the provider a written itemization of any additional information or additional documents needed to process the claim or any portion of the claim that is not being paid;
- Deletes provider requirement to provide additional information or additional documents within 35 days;
- Reduces the current 45 day after receipt to pay or deny to 35 calendar days;
- Prohibits the HMO from making more than one request under this paragraph in connection with a claim, unless the provider fails to submit all of the requested information, in which case the HMO may allow the provider one additional opportunity to submit the additional information. [Note: Regardless, the HMO must pay or deny the claim within 35 calendar days.]

Paragraph (2)(c) is added, to require the HMO to notify the provider if the HMO requests additional information or additional documents from a person other than the provider who submitted the claim and provide the provider a copy of the request. Prohibits an HMO from withholding payment pending receipt of any information or documents requested pursuant to this paragraph. If, upon receiving information or documents requested, the HMO determines the existence of an error of payment, the HMO may recover the payment subject to subsection (5).

Paragraph (2)(d) is added to prohibit an HMO from denying or withholding payment on a claim because the insured has not paid a requested deductible or co-payment.

Subsection (3) is amended, as follows:

- Requires *insurers* who do not pay claims within the time frames provided to pay the provider submitting the claim the *full amount of the billed charges* submitted on the claim or *twice the provider's contracted rate*, whichever is less; and
- Deletes existing language requiring overdue payment of claims to bear a simple interest at a rate of 10 percent for any clean claim or uncontested portion of a clean claim to accrue on the 36th day; and
- Deletes the requirement that interest is to be paid with the payment of the claim.

Subsection (4) is amended, as follows:

- Reduces the number of days an HMO has to pay or deny any claim from 120 days to 50 calendar days for electronic claims and 70 calendar days for nonelectronic claims;
- Provides that failure to pay or deny a claim within the time periods creates an *uncontestable obligation* for the HMO to pay the claim to the provider; and
- Requires tolling of the running of time specified for requesting of additional information or documents pursuant to (2)(b).

Paragraph (5)(a) provides that with regards to retroactive review of coverage decisions or payment levels, if the HMO determines an overpayment has been made to a provider, the HMO must make a claim for the overpayment and the provider must agree to the reduction, in writing, after receipt of the HMO's claim for overpayment.

Paragraph (5)(b) is amended to reduce the number of days a provider has to pay a claim for overpayment which is not contested or denied from 35 days to 15 calendar days after the receipt of a claim which is electronically transferred to the provider; or within 35 calendar days after the receipt of a nonelectronic claim is submitted to the provider.

Paragraph (5)(c) specifies that the provider has 35 calendar days to deny or contest all or part of the HMO's nonelectronic claim or 15 calendar days to deny or contest all or part of the HMO's

electronic claim. Reduces the number of days within which the HMO must submit additional information from 35 days to 21 calendar days for both electronic and nonelectronic claims. Reduces the number of days a provider has to pay or deny a claim for overpayment from 45 days to 30 calendar days after receipt of the information.

Paragraph (5)(d) increases the simple interest rate for an overdue payment of a claim from 10 percent a year to 18 percent a year.

Paragraph (5)(e) reduces the number of days that a provider is required to pay or deny an electronic claim from 120 days to 71 calendar days after receipt. Requires the provider to pay or deny any nonelectronic claim within 91 calendar days.

Subsection (6) limits the time for a look-back to 1 year for retroactive reductions of payments or demands for refund of previous overpayments. Expands time frame to include audit reviews. Deletes authority to define the look-back period in contract.

Paragraph (7)(a) provides that a provider's claim for payment is considered to be received when the receipt is verified electronically or on the date indicated on the return receipt for nonelectronic claims or on the date the delivery receipt is signed by the HMO if the claim is hand delivered. Prohibits an HMO from requiring a provider from resubmitting a claim for payment if the claim has been received by the HMO. Specifies that a provider must wait 45 calendar days following receipt of a claim before submitting a duplicate claim.

Paragraph (7)(b) prohibits a provider from requiring an HMO to resubmit a claim for payment if the claim for overpayment has been received by the provider. Specifies that an HMO must wait 45 calendar days following a provider's receipt of a claim for overpayment before g a duplicate claim.

Paragraph (7)(c) deletes authorization for an HMO and provider to agree to other methods for transmission and receipt of claims.

Subsection (8) requires an HMO to provide a provider, or provider's designee who bills electronically, electronic acknowledgement of the receipt of a claim within 24 hours after receipt. Deletes the current 72 hour requirement for acknowledgment of the receipt of a claim.

Subsection (9) specifies that an HMO may not retroactively deny a claim because of subscriber ineligibility. Deletes authorization for such denials to 1 year after the date of payment of the clean claim.

Paragraph (11)(a) is added to require each policy issued by an HMO to contain a provision for coordinating benefits under the policy with any similar benefits provided by any other HMO, group hospital, medical or surgical expense policy; any group health care services plan; any auto medical policy; any governmental medical policy; or any group-type self-insurance plan that provides protection or insurance against hospital, medical or surgical expenses for the same loss.

Paragraph (11)(b) is added to require HMO policies to contain a provision permitting the HMO to reduce or refuse to pay benefits otherwise payable under the policy solely due to the existence of similar benefits provided under insurance policies issued by the same or another HMO, insurer, health care services plan, or self-insurance plan if the similar benefits provide protection or insurance against hospital, medical or surgical expenses, if, as a condition of coordinating benefits with another insurer, 100 percent of the *total covered changes* described in the policies and presented for payment are paid. [Note: this appears to be a typographical error.]

Paragraph (11)(c) is added to permit the provider 60 calendar days from the date the provider obtains correct billing information to submit a claim, regardless of any time periods for submission of claims established by contract, if the subscriber fails to provide correct specified information. Provides that, for the purposes of this section, "insurer" includes preferred provider networks and exclusive provider networks.

Paragraph (12)(a) is added to provide that regardless of other remedies or relief a provider is entitled to, any provider aggrieved by the violation of this section may bring an action to enjoin a person who has violated or is violating this section. Authorizes providers who suffer such loss to recover any amounts due the provider by the HMO, including: *accrued interest*, *attorney's fees*, and *costs*.

Paragraph (12)(b) is added to require that in an action arising out of the violation of this section by an HMO, if the HMO if found to have violated this section, the provider, after judgment and exhausting all appeals, is required to be awarded *attorney's fees* and *costs* from the HMO.

Subsection (13) is added to prohibit the waiver, voidance, or nullification by contract of the provisions of this section.

Section 11. Substantially rewrites and renumbers s. 641.3156, F.S., relating to treatment authorization, as follows:

Subsection (1) is rewritten to define "authorization" for the purposes of this section to include, but is not limited to direct or indirect use of preauthorization, precertification, notification, or any other similar terminology.

Subsection (2) is added to require the following from HMOs that require authorization for medical care and health services:

- Provide each contracted provider, at the time of the contract, a signed list of medical and health care services that require authorization and the authorization procedures used by the HMO.
- Provide to each noncontracted provider, within 10 working days after a request is made, a list of medical and health care services that require authorization and the authorization procedures used by the HMO.
- Notify all subscribers, contracted providers, and noncontracted providers who had previously requested a list, in writing and at least 30 days in advance, of any changes or modification to the list.

Subsection (3) is added to prohibit the denial of any claim for treatment that does not require authorization for a covered service which is ordered by a contracted physician.

Deletes existing language relating to requirement of payment by HMOs for certain services which were authorized in accordance with the HMO's current and communicated procedures, unless the provider provided information to the HMO with the willful intent to misinform the HMO.

Paragraph (4)(a) renumbers subsection (2).

Paragraph (4)(b) is added, as follows:

- Requires an HMO to issue a determination indicating whether the service or services are authorized on receipt of a request from a provider for authorization.

- Requires the determination to be transmitted to the provider making the request within *8 hours* after the request is made.
- Requires the HMO to notify both the subscriber and the provider at the same time if the HMO denies the request for authorization.
- Provides that an HMO that fails to respond to a request for authorization from a provider pursuant to this paragraph is considered to have authorized the requested medical care or health care service and is prohibited from denying payment.

Subsection (5) is added, as follows:

- Requires HMOs that require authorization as a condition of payment for proposed medical care or health care service or services involved in an inpatient admission to issue a written or electronic authorization for the total estimated length of stay for the admission.
- Requires HMOs that require authorization for proposed medical care or health care service or services for a subscriber who is an inpatient at the health care facility at the time the services are proposed, to issue a determination indicating whether the proposed services are authorized no later than *1 hour* after the request by the provider.
- Provides that the failure of an HMO to respond to a request for authorization within *1 hour* is considered to have authorized the requested medical care or health care service and such payment may not be denied.

Subsection (6) amends and renumbers subsection (3) to expand the exemption of emergency services from the provisions of this section to include any inpatient admission required in order to stabilize the patient pursuant to federal and state law.

Subsection (7) is added to prohibit the waiver, voidance, or nullification of the provisions of this section by contract.

Section 12. Amends subsection (4) of s. 627.651, F.S., relating to the requirements that group contracts and plans of self-insurance must meet, to conform a statutory cross-reference.

Section 13. Provides that effective October 16, 2002, s. 627.647, F.S., relating to standard health claim form, is repealed.

Section 14. Specifies that, except as otherwise provided, this act takes effect October 1, 2002.

III. 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 rules development and monitoring activities.

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

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 this bill may result in increased costs to health insurers and HMOs as a result of the following:

- Deletion of requirements that providers submit accurate claims with supporting documentation before triggering payment timeframes;
- Deletion of health insurers' and HMOs' use of confidential edits to detect fraud and abuse;
- Reduction of time frames for processing of claims and specifying that days are "calendar" days;
- Elimination of health insurers' and HMOs' abilities to conduct confidential inquiries relating to suspected fraudulent claims;
- Increase in penalties for health insurers and HMOs for failure to pay claims within newly abbreviated time frames;
- Elimination of health insurers' and HMOs' abilities to conduct audits and look-backs prior to 1 year of the date of service, regardless of the date of submission or payment of the claim;
- Elimination of the insurers' and HMOs' ability to require adequate information regarding insured's or subscriber's eligibility due to abbreviated authorization time frames.
- Requirement that total covered charges be reimbursed under coordination of benefits; and
- Creation of a civil liability for any person who violates provisions relating to claims payment, subject to attorney's fees and costs, regardless of the De minimus nature of the violation.

D. FISCAL COMMENTS:

According to the Agency for Health Care Administration, the proposed bill has a fiscal impact on health insurers and HMOs by shortening payment time frames, shortening treatment authorization periods, and implementing stricter penalties for any violation of the prompt pay provisions. According to the agency, the proposed bill has no direct fiscal impact on the agency.

The proposed bill 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 proposed bill classifies certain violations of time frames by health insurers and HMOs as violations of the Insurance Code, thereby requiring additional enforcement activities by the department. Such enforcement activities by the department typically consist of suspension or revocation of a health insurer's or HMO's certificate of authority or imposition of administrative fines in lieu of such suspension or revocation.

IV. 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.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

N/A

B. RULE-MAKING AUTHORITY:

The Department of Insurance is specifically directed to adopt rules consistent with standards authorized by the Secretary of the United States Department of Health and Human Services. Such standards are not in effect at this time and there are two bills in Congress to delay the implementation of these referenced HIPAA standards.

C. OTHER COMMENTS:

See private sector fiscal impact on III.C. above.

This bill makes no provisions for insurers' or providers' failure to meet established timeframes due to natural or man-made disasters.

Section 8 of the bill, in amending s. 641.185, F.S., relating to HMO subscriber protections, creates language inconsistent with current provisions of that section. The current subscriber protections outlined are identified via cross-references to statutes which provide the specific protections referenced. An alternative would be to separately create provisions relating to HMO prompt payments to subscribers, and cross-references to this provision as part of s. 641.185, F.S.

There is a need for a technical amendment on page 24, line 18, to replace the word "insurer" with the phrase "health maintenance organization."

There is a need for a technical amendment on page 29, line 14, to replace the word "changes" with "charges."

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

N/A

VII. SIGNATURES:

COMMITTEE ON HEALTH PROMOTION:

Prepared by:	Staff Director:
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