SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: Health Care Committee

BILL: SB 1800

SPONSOR: Banking and Insurance Committee

SUBJECT: Health Maintenance Organizations

DATE: April 24, 2005 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Deffenbaugh	Deffenbaugh	BI	**Favorable**
2.	Harkey	Wilson	HE	**Favorable**
3.				
4.				
5.				
6.				

I. Summary:

Senate Bill 1800 is based on the recommendations of the 2005 Banking and Insurance Committee staff interim project, *Determining the Sufficiency of Regulation of Third-Party Administrators and Fiscal Intermediary Services Organizations* (2005-109).

The laws regulating health maintenance organizations (HMOs) provide for the regulation of fiscal intermediary services organizations (FISOs). The law is designed to protect funds received from an HMO and held by entities, which have an obligation to distribute those funds to health care providers who contract with the HMO. This is primarily done by requiring those entities to apply for registration and to post a fidelity bond and a surety bond with the Office of Insurance Regulation. The bill revises the definition of those who must be registered as a FISO by deleting the exemption for entities that are *owned, operated, or controlled* by certain licensed entities. As revised, only the licensed entities themselves would be exempt, including hospitals, authorized insurers, third party administrators, prepaid limited health service organizations, and HMOs. Also, the current exemption for physician group practices would be limited to group practices providing services under the scope of licenses of the members of that group practice.

Currently, HMOs remain responsible for compliance with statutory requirements related to prompt payment, treatment authorization, and adverse determinations, if the HMO transfers its payment obligations under a health care risk contract to a licensed administrator. The bill would broaden this responsibility to include an HMO transferring its payment obligations to any entity, not just licensed administrators, but would maintain exceptions for contracts with providers, group practices, and hospitals. The bill also deletes the condition that the payment obligations must be transferred under a *health care risk contract*, so that the HMO would

remain responsible, regardless of the type of contract, if the HMO transfers its obligations to pay any provider for claims arising from services provided to any subscriber of the HMO.

This bill amends ss. 641.316 and 641.234, F.S.

II. Present Situation:

Regulation of Health Maintenance Organizations

The Office of Insurance Regulation (OIR) regulates health maintenance organization solvency, contracts, rates, and marketing activities under part I of chapter 641, F.S., while the Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of chapter 641, F.S. Before receiving a certificate of authority from OIR, an HMO must receive a Health Care Provider Certificate from AHCA. Any entity that is issued a certificate of authority and that is otherwise in compliance with the licensure provisions under part I may enter into contracts in Florida to provide an agreed-upon set of comprehensive health care services to subscribers.

Fiscal Intermediary Services Organizations (FISOs)

Legislation in 1997 amended the HMO laws to provide for the regulation of FISOs.[1] At that time, some health care professionals were contracting with unregulated entities to collect payments from HMOs on the providers' behalf and to distribute those funds to the contracting health care providers. There were reported cases of misappropriation of funds by such entities, with no apparent recourse to regulatory agencies. Essentially, the law is designed to protect funds received from an HMO and held by entities, which have an obligation to distribute those funds to medical professionals who contract with the HMO. This is primarily done by requiring those entities to apply for registration and to post a fidelity bond and a surety bond with OIR.

A *fiscal intermediary services organization* is defined as:

> *a person or entity which performs fiduciary or fiscal intermediary services to health care professionals who contract with health maintenance organizations, **other than** a fiscal intermediary services organization owned, operated, or controlled by a hospital licensed under chapter 395, an insurer licensed under chapter 624, a third party administrator licensed under chapter 626, a prepaid limited health service organization licensed under chapter 636, a health maintenance organization licensed under chapter 641, or physician group practices as defined in s. 456.053(3)(h).*[2]

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[1] ch. 97-159, L.O.F.; s. 641.316, F.S.

[2] s. 641.316(2)(b), F.S. Section 456.053(3)(f), F.S., provides, *"Group practice" means a group of two or more health care providers legally organized as a partnership, professional corporation, or similar association:*

1. In which each health care provider who is a member of the group provides substantially the full range of services which the health care provider routinely provides, including medical care, consultation, diagnosis, or treatment, through the joint use of shared office space, facilities, equipment, and personnel;

2. For which substantially all of the services of the health care providers who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group; and

The term *fiduciary* or *fiscal intermediary services* means:

> *reimbursements received or collected on behalf of health care professionals for services rendered, patient and provider accounting, financial reporting and auditing, receipts and collections management, compensation and reimbursement disbursement services, or other related fiduciary services pursuant to health care professional contracts with health maintenance organizations...*[3]

The above definition of a FISO exempts physician group practices, but it is not clear that this exemption is limited to providing fiscal intermediary services only to members of that group practice, though that may be the intent. This appears to be a broader exemption than a similar exemption for physician group practices from licensure as an administrator in s. 626.88(1)(o), F.S. (See, Administrators, below.) That statute limits the exemption for physician group practices to providing services under the scope of the license of the members of the group practice. The definition of a FISO also exempts organizations *owned, operated, or controlled by* various licensed entities, such as hospitals, insurers, third-party administrators, HMOs, etc. In contrast, the exemption from licensure as an administrator includes licensed insurers, HMOs, and certain other entities, but does not exempt subsidiaries or other independent organizations that are owned, operated, or controlled by such licensed entities.

The express legislative intent of the statute is to ensure the financial soundness of FISOs. A FISO which is operated for the purpose of acquiring and administering provider contracts with managed care plans must secure and maintain a fidelity bond and a surety bond. As currently required, a fidelity bond must be maintained in the minimum amount of 10 percent of the funds handled by the FISO during the prior year or $1 million, whichever is less, but not less than $50,000. This bond protects the FISO from loss due to dishonesty of its employees. A surety bond must also be maintained in the minimum amount of 5 percent of the funds handled by the FISO during the prior year or $250,000, whichever is less, but not less than $10,000. The surety bond protects against misappropriation of funds within the FISO's control or custody.

A FISO registering with OIR must meet certain application requirements of chapter 641, F.S. that apply to HMOs.[4] These require that a FISO provide OIR with a list of the names, addresses and official capacities of the persons who are responsible for the operations of the company, including officers, directors, and owners of more than 5 percent of the common stock of the company. The listed persons must fully disclose all contracts or arrangements between them and the company, including any conflicts of interest, and must submit autobiographical statements, fingerprints, and an independently performed background report. In general, receiving authority to operate as a FISO is conditioned on OIR being satisfied that the ownership, control and management of the entity is competent and trustworthy, and possesses managerial experience that would make the proposed operation beneficial to its constituents.

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3. In which the overhead expenses of and the income from the practice are distributed in accordance with methods previously determined by members of the group.

[3] s. 641.316(2)(a), F.S.

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

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

Regulation of ("Third Party") Administrators

A person who acts as an *administrator*, more commonly referred to as a third party administrator or TPA, must be licensed by OIR. As defined:

> *[A]n administrator is any person who directly or indirectly solicits or effects coverage of, collects charges or premiums from, or adjusts or settles claims on residents of this state in connection with authorized commercial self-insurance funds or with insured or self-insured programs which provide life or health insurance coverage...or any person who, through a health care risk contract as defined in s. 641.234 with an insurer or health maintenance organization, provides billing and collection services to health insurers and health maintenance organizations on behalf of health care providers,...*[5]

The two definitions for a FISO and an administrator overlap to some extent, by encompassing persons or entities that provide billing and collection services to HMOs on behalf of health care providers. However, the definition for an administrator includes authority to engage in claims adjudication or collection of premiums for a health insurer or HMO, which activities are not authorized by the FISO statute. Administrators that are licensed by OIR are exempt from the requirement of being registered as a FISO.

The requirements for administrators under ss. 626.88-626.894, F.S., are more extensive than the regulation of FISOs. For example, an administrator must make its books and records available to OIR for examination, audit, and inspection and must maintain its business records for five years.[6] Administrators are also required to file annual financial statements with OIR.[7] However, the fidelity bond requirement may be less for an administrator as compared to a FISO, depending on the amount of funds handled, and a separate surety bond is not required for an administrator as it is for a FISO.[8]

Administrators must have a written agreement with an insurer containing specified provisions. The insurance company, and not the administrator, must be responsible for determining the benefits, rates underwriting criteria, and claims payment procedures.[9] A

[5] s. 626.88(1), F.S.
[6] s. 626.884, F.S.
[7] s. 626.89, F.S.
[8] Section 626.8809, F.S., requires an administrator to maintain a fidelity bond of at least 10 percent of the amount of funds handled or managed annually, but not greater than $500,000, unless OIR, after notice and opportunity for hearing, requires an amount in excess of $500,000 but not more than 10 percent of the amount of the funds handled or managed annually.
[9] ss. 626.8817 and 626.882, F.S.

payment to the administrator of any premiums on behalf of the insured are deemed to have been received by the insurer and all premiums collected by an administrator on behalf of an insurer must be held by the administrator in a fiduciary capacity. If an administrator is collecting premiums for more than one insurer, the administrator must keep records clearly recording each insurer's accounts.

The administrator law requires that a person who provides billing and collection services to HMOs on behalf of health care providers must comply with s. 641.3155, F.S., the prompt payment statute, and s. 641.51(4), F.S., which requires that only a Florida licensed allopathic physician or osteopathic physician may render an adverse determination regarding a service provided by a physician and specifies procedures that must be followed.[10]

Payment Documentation by FISOs and Administrators

Legislation in 1999 amended both the FISO and administrator laws to require that payment by a fiscal intermediary to a health care provider include specified information.[11] This was in response to complaints by health care providers that claims payments by FISOs did not delineate sufficient information for the providers to reconcile their records as to which claims were being paid. The law now requires that for a *capitated* health care provider, the statement must include the number of patients covered by the contract, the rate per patient, total amount of payment, and the identification of the plan on which behalf the payment is made. For a *noncapitated* health care provider, the statement must include an explanation of services being reimbursed, including the patient name, date of service, procedure code, amount of reimbursement, and plan identification. The law does not define *capitated* or *noncapitated*, but is understood to distinguish those contracts that provide for a specified payment rate per patient for all services or specified types of services, and those contracts that, instead, provide payment on a fee-for-service basis.

Prompt Payment Requirements

The law requires HMOs to reimburse claims by providers within 35 days of receipt, subject to a 10 percent interest penalty for late payment. Commonly referred to as the *prompt payment law*, enacted in 1998 and revised in 2000, the law also includes a definition of a *clean claim*, other specific time frames for actions relative to claims payments, and required procedures for HMOs filing claims against providers for overpayments. The law also prohibits HMOs from *systematic downcoding with the intent to deny reimbursement otherwise due*. The law does not define *downcoding*, but the term is generally understood to mean an HMO substituting a procedure code that is a lower level of service with a lower reimbursement rate than the procedure billed by the provider. If performed with such frequency as to indicate a general business practice, such systematic downcoding is an unfair claims settlement practice subject to regulatory penalties by OIR.

[10] s. 626.88, F.S.
[11] ch. 99-275, L.O.F.; ss. 626.883(6) and 641.316(2)(a), F.S.

HMO Responsibility for Violations of Prompt Pay Law (etc.) if Payment Obligations are Transferred

A law enacted in 2002 holds HMOs ultimately responsible for compliance with certain statutory requirements related to prompt payment, treatment authorization, and adverse determinations, if the HMO transfers its payment obligations to a licensed administrator.[12] But the law apparently does not hold an HMO responsible for compliance with such requirements if it transfers its payment obligations to an entity other than a licensed administrator.

Specifically, this law provides that if an HMO, through a *health care risk contract*, transfers to any *entity* the obligations to pay a provider for any claim arising from services provided to a subscriber, that the HMO remains responsible for any violations of three specified statutes:

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

The following definitions apply to administrative, provider, and management contracts:

- *Health care risk contract* means:*...a contract under which an entity receives compensation in exchange for providing to the health maintenance organization a provider network or other services which may include administrative services.*[13]

- *Entity* means:*...a person licensed as an administrator under s. 626.88, F.S., and does not include any provider or group practice under s. 456.053, F.S., providing services under the scope of the license of the provider or the members of the group practice. The term does not include a hospital providing billing, claims, and collection services solely on its own and its physicians' behalf and providing services under the scope of its license.*[14]

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

Some of these examinations include situations where HMOs contracted with entities referred to as "management service organizations" and "independent practice associations" which made

[12] ch. 2002-389, L.O.F.; s. 641.234(4), F.S.
[13] s. 641.234(4)(b)1.
[14] s. 641.234(4)(b)2., F.S.

payments to providers on behalf of the HMO and which do not appear to have been licensed administrators. Interviews with OIR personnel indicate that OIR attempts to hold an HMO responsible for violations of prompt payment requirements regardless of whom the HMO may contract with to perform payment services. In the market conduct examinations of this type reviewed, a Consent Order was issued by the Office with the agreement of the HMO, where the HMO consents to pay a fine and to take corrective actions, but does not agree with the findings of the Consent Order.

Committee Staff Interim Project

The Present Situation, above, summarizes the background and findings in the 2005 Senate Banking and Insurance Committee staff interim project, *Determining the Sufficiency of Regulation of Third-Party Administrators and Fiscal Intermediary Services Organizations* (2005-109). The interim project made the following recommendations:

- Expand the requirements of s. 641.234(4), F.S., to hold a health maintenance organization responsible for statutory requirements related to payment to health care providers if the HMO transfers to any entity the obligations to pay providers. The current law may limit this liability to HMO contracts with licensed administrators and limit this responsibility to violations of only certain statutes.
- Narrow the exemption from registration as a FISO for a physician group practice in s. 641.316, F.S., to physician group practices providing fiscal intermediary services to members of the group practice.
- Narrow the exemption from registration as a FISO for licensed insurers, HMOs, administrators, hospitals, and prepaid limited health service organizations to those entities themselves, rather than any entity owned operated, or controlled by such licensed entities.
- Alternatively, consider repealing the FISO statute and require entities to be licensed as third party administrators if they provide fiscal intermediary services to providers under contract with HMO.

III. Effect of Proposed Changes:

Definition of Fiscal Intermediary Services Organizations

Section 1. Amends s. 641.316, F.S., to revise the definition of a *fiscal intermediary services organization* by narrowing certain exemptions from the current definition. By doing so, certain entities that are currently exempt would be required to be licensed as a FISO. Specifically, the bill deletes the exemption for entities that are *owned, operated, or controlled by* certain licensed entities, so that only the licensed entity itself would be exempt. These licensed entities include hospitals licensed under ch. 395, F.S., insurers licensed under ch. 624, F.S., third party administrators licensed under ch. 626, F.S., prepaid limited health service organizations licensed under ch. 636, F.S., and health maintenance organizations licensed under ch. 641, F.S. Also, the current exemption for entities owned, operated, or controlled by physician group practices is revised to be limited to physician group practices, as defined in s. 456.053(3)(h), F.S., providing services under the scope of licenses of the members of the group practice. In other words, a physician group practice providing fiscal intermediary services to members outside of that group practice would not be exempt from licensure as a FISO.

HMO Responsibility for Violations of Prompt Pay Law (etc.) if Payment Obligations are Transferred

Section 2. Amends s. 641.234, F.S., to broaden the responsibility for an HMO to remain responsible for violations related to prompt payment, treatment authorization, and adverse determinations, if the HMO transfers its payment obligations to another entity. The bill would broaden this responsibility to include an HMO transferring its payment obligations to any entity, not just to a licensed administrator under s. 626.88, F.S. This would include transfer of payment obligations to a FISO or possibly to an unregulated entity that may not meet the definition of an administrator or FISO. However, the bill would maintain the current provisions that an HMO is not responsible for violations related to prompt payment (etc.) if payment obligations are transferred to any provider or group practice, as defined in s. 456.053, F.S., providing services under the scope of the license of the provider or the members of the group practice, or to a hospital providing billing, claims, and collection services solely on its own and its physicians' behalf and providing services under the scope of its license.

The bill also deletes the reference to an HMO transferring its payment obligations *through a health care risk contract* as a condition for the HMO to remain responsible for violations related to prompt payment (etc.). Therefore, regardless of the type of contract, if the HMO transfers to any entity the obligations to pay any provider for any claims arising from services provided to or for the benefit of any subscriber of the HMO, the HMO would remain responsible for the specified violations.

Section 3. Provides that this act take effect October 1, 2005.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Health maintenance organizations would have broader liability for interest payments, fines, and other sanctions for violations of laws related to prompt payment, treatment authorizations, and adverse determinations, if the HMO transfers its payment obligations to another entity, potentially impacting premiums for HMO coverage. Health care providers may benefit by greater compliance with such laws or by regulatory sanctions for non-compliance under such arrangements.

Entities which are no longer exempt from registration with OIR as a fiscal intermediary services organization would be subject to the expense of obtaining a surety bond maintained in the minimum amount of 5 percent of the funds handled by the FISO during the prior year or $250,000, whichever is less, but not less than $10,000, and a fidelity bond in the minimum amount of 10 percent of the funds handled by the FISO during the prior year or $1 million, whichever is less, but not less than $50,000.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Summary of Amendments:

None.