HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1111 Fiscal Intermediary Services Organizations
SPONSOR(S): Healthcare Council; Kendrick and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 666

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Health Innovation	7 Y, 0 N	Ciccone	Calamas
2) Healthcare Council	16 Y, 0 N, As CS	Ciccone	Gormley
3)			
4)			
5)			

SUMMARY ANALYSIS

CS/HB 1111 revises the definition of fiscal intermediary services organizations (FISOs) by the Office of Insurance Regulation. State regulation of FISOs is designed to protect funds received from a Health Maintenance Organization (HMO) and held by these fiscal intermediary entities, which are obligated to distribute those funds to health care providers who contract with an HMO.

The bill revises the definition of FISOs 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. The bill also provides that the current exemption for physician group practices would be limited to group practices providing services under the scope of licenses of the group practice membership. The bill specifies that FISOs that are owned, operated, or controlled by a third party administrator holding a certificate of authority, are exempt from surety bond requirements. The bill adds registration exemption for not-for-profit clinics that provide health care services by employed physicians providing health care services affiliated with licensed hospitals.

The bill exempts FISOs from surety bond exemption for FISOs that are owned, operated or controlled by certified third party administrators.

The bill requires FISOs to comply with certain statutory requirement regarding claims payments and adverse determination of claims. The bill directs OIR to periodically examine FISOs operations and to take remedial action when necessary.

The fiscal impact of the bill appears to be insignificant, which may be absorbed within existing resources.

The bill provides an effective date of October 1, 2007.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government - The bill directs the Office of Insurance Regulation to conduct periodic examinations of fiscal intermediary services organizations and to take remedial action when necessary.

B. EFFECT OF PROPOSED CHANGES:

House Bill 1111 amends s. 641.316, F.S., revising the definition of entities that must register 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.

The bill also revises the current exemption for physician group practices by limiting the exemption to group practices providing services under the scope of licenses of the group membership.

The bill specifies that FISOs that are owned, operated, or controlled by a third party administrator holding a certificate of authority, are exempt from surety bond requirements. The bill adds registration exemption for not-for-profit clinics that provide health care services by employed physicians providing health care services affiliated with licensed hospitals.

The bill requires FISOs to be subject to s. 641.27, F.S., which would require OIR to conduct periodic examinations of the operations of the FISO and to take remedial action when necessary.

The bill further requires FISOs to comply with the following statutory requirements (which apply to HMOs):

- Section 641.3155, F.S., which contains 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 bill requires FISOs to comply with s. 641.21(1)(j), F.S., which requires entities to provide additional reasonable data, financial statements, and other information as requested by the OIR.

Present Situation:

Regulation of Health Maintenance Organizations

The Office of Insurance Regulation 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. Any entity that is issued a certificate of authority and 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)

The 1997 Legislature amended the HMO laws to provide for the regulation of FISOs under s. 641.316, F.S.[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

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

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.

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]

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 FISO definition exempts physician group practices; however, 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, Regulations of Administrators, to follow.) 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 that 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 the OIR must meet certain application requirements of chapter 641, F.S., that applies to HMOs. These require that a FISO provide the 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 the OIR being satisfied that the ownership, control and management of the entity is competent and trustworthy, and possesses

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

managerial experience that would make the proposed operation beneficial to its constituents.

There are currently 16 active FISOs registered with the OIR. Interviews with representatives of the 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 the OIR. Section 626.88, F.S., defines an administrator as:

> . . . 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. . .[4]

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 the OIR are exempt from the requirement of being a registered 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 the OIR for examination, audit, and inspection and must maintain its business records and file annual financial statements with the OIR. 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.

Administrators must have a written agreement with an insurer containing specified provisions. The insurance company, rather than the administrator, must be responsible for determining the benefits, rates underwriting criteria, and claims payment procedures.[5] A payment to the administrator of any premiums on behalf of the insured are deemed to have been received by the insurer and all premiums collected by an administrator on behalf of an insurer must be held by the administrator in a fiduciary capacity. If an administrator is collecting premiums for more than one insurer, the administrator must keep records clearly recording each insurer's accounts.

The administrator law requires that a person who provides billing and collection services to HMOs on behalf of health care providers must comply with s. 641.3155, F.S., the prompt payment statute, and s. 641.51(4), F.S., which requires that only a Florida-licensed allopathic physician or osteopathic physician may render an adverse determination regarding a service provided by a physician and specifies procedures that must be followed.[6]

Payment Documentation by FISOs and Administrators

In 1999, the Legislature amended the FISO and administrator laws to require that payment by a fiscal intermediary to a health care provider include specified information.[7] This was in response

[4] Section 626.88(1), F.S.
[5] Section 626.8817 and 626.882, F.S.
[6] Section 626.88, F.S.
[7] Ch. 99-273, L.O.F.; ss.626.883(6) and 641.316(2)(a), F.S.

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.

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.[8] Commonly referred to as the prompt payment law, 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.

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.[9] However, 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, 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 law also provides the following definitions, which 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.
- 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.

The enactment of the prompt payment requirements and persistent efforts by health care provider groups to document complaints and seek enforcement actions by the OIR have resulted in market conduct examinations and regulatory sanctions against HMOs violating these provisions. An interim project by the Senate Banking and Insurance Committee in 2005 (cited below) reviewed

[8] Section 641.3155, F.S.
[9] Ch. 2002-389, L.O.F.; s. 641.234,F.S.

22 market conduct examinations by the OIR 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 included situations where HMOs contracted with entities referred to as "management service organizations" and "independent practice associations" which made payments to providers on behalf of the HMO and which did not appear to have been licensed administrators. Interviews with the OIR personnel indicated that the OIR attempted to hold an HMO responsible for violations of prompt payment requirements regardless of whom the HMO may have contracted with to perform payment services. In the market conduct examinations of this type reviewed, a Consent Order was issued by the OIR with the agreement of the HMO, where the HMO consented to pay a fine and to take corrective actions, but did not agree with the findings of the Consent Order.

Banking and Insurance Committee Interim Project (2005-109)
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 an HMO 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.
- 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.[10]

C. SECTION DIRECTORY:

Section 1. Amends s. 641.316, F.S.; relating to fiscal intermediary services.

Section 2. Provides an effective date of October 1, 2007.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

There is currently no registration fee charged for FISO registration.

2. Expenditures:

See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

[10] Senate Staff Analysis, March 2007, on file with the Committee.

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Increased FISO regulation would increase fiscal protection for medical providers and health maintenance organizations transacting services with a fiscal intermediary services organization.

An indeterminate number of entities that are no longer exempt from registration with the OIR as a fiscal intermediary services organization would be subject to expenses associated with registering with the OIR, including, but not limited to a surety bond and a fidelity bond, and fingerprint processing fees. In addition, the FISO would be responsible to pay the costs associated with a market conduct examination conducted by the OIR. Pursuant to s. 641.27, F.S., such expenses may not exceed a maximum of $50,000 for any 1-year period.

D. FISCAL COMMENTS:

Application of s. 641.27, F.S., relating to examinations, will require the OIR to conduct onsite examinations at least once every 5 years. There are currently 16 FISOs registered with the OIR. The number of entities that would be required to register with the OIR and be subject to examination by the OIR is indeterminate at this time.

To absorb the expanded regulatory responsibilities required, the OIR requests authorization for two positions and an appropriation of $126,723 to implement this proposal. These positions include one Financial Examiner to conduct examinations and one Management Review Specialist for the purposes of examination oversight, review of work papers, and preparation of compliance reports related to the application of prompt pay, treatment authorization requirements, and second opinion notification requirements specified by this legislation. Because the number of entities that would be required to register with the OIR and subjected to examination by the OIR is indeterminate at this time, however, there is insufficient information to determine whether the additional staff is warranted\.

1. COMMENTS

B. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenues.

2. Other:

None.

C. RULE-MAKING AUTHORITY:

None.

D. DRAFTING ISSUES OR OTHER COMMENTS:

None.

E. STATEMENT OF THE SPONSOR

No statement provided.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

On **April 10, 2007**, the Healthcare Council adopted 2 amendments to the bill that was reported favorable by the Health Innovation Committee on **March 21, 2007**.

These amendments:

- Adds registration exemption for not-for-profit corporations that provide health care services by employed physicians providing health care services affiliated with licensed hospitals.
- Adds surety bond exemption for fiscal intermediary services organizations owned, operated or controlled by third-party administrators.

The bill was reported favorable as a Council Substitute. The analysis reflects the Council Substitute.