

STORAGE NAME: h0783b.hcs

DATE: April 12, 1999

**HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE SERVICES
ANALYSIS**

BILL #: HB 783

RELATING TO: Provider Contracts

SPONSOR(S): Rep. Murman

COMPANION BILL(S): SB 2554 (s)

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

- (1) HEALTH CARE SERVICES YEAS 15 NAYS 1
 - (2) INSURANCE
 - (3) HEALTH CARE LICENSING & REGULATION
 - (4) HEALTH & HUMAN SERVICES APPROPRIATION
 - (5)
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I. SUMMARY:

HB 783 requires prompt payment to contract health care providers by insurance administrators under specified circumstances, and establishes that an overdue payment of a claim bears simple interest at the rate of 10 percent per year.

In addition, the bill permits subscribers to terminate their HMO contracts with 30 days notice when:

- The HMO terminates the subscriber's primary care physician;
- The HMO terminates a subscriber's specialist physician with whom there is an active relationship; or
- A subscriber's currently employed drug is deleted from the HMO formulary.

The bill also prohibits an HMO from adjusting co-payments for services provided under the group contract between open enrollment periods.

Certain restrictive contractual arrangements between HMOs and medical providers are prohibited as well. A contract between an HMO and health care provider may not contain provisions which prohibit:

- The health care provider from entering into contract with any other HMO; or
- The HMO from entering into contract with any other health care provider.

Finally, the prompt payment provisions in the HMO statutes are applied to fiscal intermediary services organizations.

This legislation is not expected to have a fiscal impact on state or local government.

II. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

Health Maintenance Organizations and Provider Contracts

Part IV, ch. 626, F.S., relating to insurance administrators, provides that "an 'administrator' is any person who directly or indirectly solicits or effects coverage of, collects charges or premiums from, or adjusts or settles claims on residents of this state in connection with authorized commercial self-insurance funds or with insured or self-insured programs which provide life or health insurance coverage or coverage of any other expenses described in s. 624.33(1)." Several exceptions to who can be considered an administrator are listed in this section, some of which include, employers on behalf of their employees, health maintenance organizations, and insurance agents whose activities are limited to the sale of insurance.

Section 627.613, F.S., provides that health insurers must reimburse all claims or any portion of any claim from the insured or insured's assignees, for payment under a group health insurance policy, within 45 days after receipt of the claim by the health insurer. If the claim or a portion of the claim is contested by the health insurer, the insured or the insured's assignees must be notified within 45 days after receipt of the claim by the health insurer, who may request additional information. Upon receipt of the additional information, the insured or the insured's assignees must pay or deny the contested claim or portion of the contested claim within 60 days. An insurer must pay or deny any claim no later than 120 days after receiving the claim, and overdue payments bear simple interest at the rate of 10 percent per year. Section 627.662, F.S., provides that s. 627.613, F.S., applies to group health insurance, blanket health insurance, and franchise health insurance.

In 1998, the Legislature passed language in ch. 98-79, L.O.F, which created prompt payment of claims requirements that are similar to the requirements for health insurers in s. 627.613, F.S. Section 641.3155, F.S., 1998 Supplement, requires HMOs to pay all non-contested claims for services or goods provided under contract, within 35 days from the date the HMO receives the claim. When contesting or denying a claim, HMOs are required to provide notice within 35 days after receipt of the claim and additional information may be requested. Upon receipt of the requested information, the HMO must pay or deny the contested claim with 45 days. Like s. 627.613, F.S., s. 641.3155, F.S., requires HMOs to pay or deny claims no later than 120 days after receiving the claim, and overdue claim payments bear simple interest at the rate of 10 percent per year.

Section 641.31, F.S., sets certain requirements HMOs must meet when contracting with subscribers and provides for certain coverage that must be included in the contract. Subsection (3) of this section allows an HMO to amend any contract with its subscriber or change any rate, subject to the disapproval of the Department of Insurance. Rate changes require the HMO to provide the subscriber with at least 30 days' advance written notice of the change. There is no mention in this section of any action HMO subscribers may take once they have received notice of a contract change by their HMO.

Requirements for contracts between HMOs and providers are established in s. 641.315, F.S. According to this section all contracts between HMOs and providers must be in writing and must contain a provision that the subscriber shall not be liable to the provider for any services covered by the subscriber's contract with the HMO. Section 641.315, F.S., also sets out requirements for cancellation of the contract by both the provider and the HMO that must be included in the contract. Subsection (8) of this section provides that a contract between a health maintenance organization and a provider may not contain any provision restricting the provider's ability to communicate information to the provider's patient regarding medical care or treatment options. Currently, there is no statutory provision relating to contract language that prohibits the contracting HMO and the health care provider from contracting with any other HMO or health care provider.

Section 641.316, F.S., provides requirements for the use of fiscal intermediary services by contracting health care professionals and health maintenance organizations. According to this section, fiscal intermediary services organization 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 managements, compensation and reimbursement disbursement services, or other related fiduciary services pursuant to health care professional contracts with health maintenance organizations. Section 641.316, F.S., states that a fiscal intermediary services

organization is a person or entity which performs 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 ch. 395, an insurer licensed under ch. 624, a third-party administrator licensed under ch. 626, a prepaid limited health service organization licensed under ch. 626, a prepaid limited health service organization licensed under ch. 636, a health maintenance organization licensed under this chapter, or physician group practices as defined in s. 455.654(3)(f).

State Group Health Insurance Plan

The state health insurance program is operated under section 125 of the Internal Revenue Code and other state and federal regulations. Enrollees in the program may only make a change in coverage during a plan year if they experience a qualifying status change event and report that change to their employer within 31 days of the event. In addition, the event must result in a gain or loss of coverage. Qualifying status change events, as defined in current IRS regulations, include: change in marital status, change in number of dependents, reduction or increase in the number of hours of employment and change of residence or work site. A hospital or physician ceasing to be available through a health care plan's network is not a qualifying status change.

The state must comply with these federal regulations to preserve the tax-exempt status of the state employees' group health plans. Failure to comply could result in financial penalties to the state, as well as income tax implications for all plan enrollees.

B. EFFECT OF PROPOSED CHANGES:

An administrator of an insurance provider will be required to reimburse all claims or portion of any claim made by a contract provider for services or goods provided under the contract with the administrator which the administrator does not deny within 35 days after receipt of the claim. If the administrator denies or contests the claim, or any portion of such claim, he or she will be required to notify the contract provider within 35 days after receipt of the claim. The administrator will be required to identify why the claim was denied or contested and may request additional information. If additional information is requested, the provider will be required to provide the information within 35 days after receipt of the request. The administrator will be required to pay or deny the claim or portions of the claim within 45 days after receipt of the additional information. An overdue payment of a claim will bear simple interest at the rate of 10 percent per year, and administrators will be required to pay or deny any claim no later than 120 days after receiving the claim.

After receiving a written notice from the health maintenance organization of a material change in member benefits, subscribers to a health maintenance organization will be permitted to terminate their contracts 30 days after providing advance written notice to the health maintenance organization. Health maintenance organizations will be prohibited from deleting, amending, limiting, or increasing the copayment for services the subscriber is entitled to under the group contract between open enrollment periods. Health maintenance organizations will be permitted to amend the contract with its group subscribers, subject to the provisions of 641.31(3), F.S., upon written notice at least 30 days before the next enrollment period. Such amendments will become effective immediately upon the expiration of the enrollment period.

Qualifying status change events, as defined in current IRS regulations, include: change in marital status, change in number of dependents, reduction or increase in the number of hours of employment and change of residence or work site. A hospital or physician ceasing to be available through a health care plan's network is not a qualifying status change.

In allowing enrollees of the state employees' group health plan to terminate their contracts without experiencing a qualifying status change event, state will not be complying with these federal regulations and the state employees' group health plans may lose tax-exempt status. This loss of tax-exempt status could result in financial penalties to the state, as well as income tax implications for all plan enrollees.

It will be prohibited for contracts between health maintenance organizations and a provider of health care services to contain any provision which prohibits or restricts health care providers from entering into contract with any other health maintenance organization or health maintenance organizations from entering into contract with any other health care provider.

The provisions in s. 641.3155, F.S., will apply to fiscal intermediary services organizations as defined by s. 641.316, F.S.

C. APPLICATION OF PRINCIPLES:

1. Less Government:

a. Does the bill create, increase or reduce, either directly or indirectly:

(1) any authority to make rules or adjudicate disputes?

No.

(2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

No.

(3) any entitlement to a government service or benefit?

No.

b. If an agency or program is eliminated or reduced:

(1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

N/A

(2) what is the cost of such responsibility at the new level/agency?

N/A

(3) how is the new agency accountable to the people governed?

N/A

2. Lower Taxes:

a. Does the bill increase anyone's taxes?

No.

b. Does the bill require or authorize an increase in any fees?

No.

c. Does the bill reduce total taxes, both rates and revenues?

No.

d. Does the bill reduce total fees, both rates and revenues?

No.

e. Does the bill authorize any fee or tax increase by any local government?

No.

3. Personal Responsibility:

- a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

No.

- b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

No.

4. Individual Freedom:

- a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs?

Yes. Subscribers are given statutory authority to terminate their contracts with health maintenance organizations under certain conditions. Allowable contract options will be increased for both health maintenance organizations and subscribers.

- b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

No.

5. Family Empowerment:

- a. If the bill purports to provide services to families or children:

- (1) Who evaluates the family's needs?

No.

- (2) Who makes the decisions?

No.

- (3) Are private alternatives permitted?

No.

- (4) Are families required to participate in a program?

No.

- (5) Are families penalized for not participating in a program?

No.

- b. Does the bill directly affect the legal rights and obligations between family members?

No.

- c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

(1) parents and guardians?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. STATUTE(S) AFFECTED:

Sections 626.8812, 641.31, 641.315, 641.3155, F.S.

E. SECTION-BY-SECTION ANALYSIS:

Section 1. Creates s. 626.8812, F.S., relating to providing contract payment claims. The following subsections of this section are created:

Subsection (1)(a) provides that an administrator shall pay any claim or any portion of a claim made by a contract provider for services or goods provided under a contract with the administrator which the administrator does not contest or deny within 35 days after receipt of the claim by the administrator which is mailed or electronically transferred by the provider.

Subsection (1)(b) requires an administrator that denies or contests a provider's claim, or any portion of such claim, to notify the contract provider, in writing, that the claim is denied or contested within 35 days after receipt of the claim. Such notice must identify the contested portion of the claim and the specific reason for contesting or denying the claim, and may include a request for additional information, which must be provided by the administrator by mail or electronic transfer within 35 days after the request. The administrator must pay or deny the claim or portion of the claim within 45 days after receipt of the additional information.

Subsection (2) provides that payment of a claim is considered made on the date the payment was received or electronically transferred or otherwise delivered. An overdue payment of a claim bears simple interest at the rate of 10 percent per year.

Subsection (3) requires an administrator to pay or deny any claim no later than 120 days after receiving the claim.

Section 2. Amends s. 641.31, F.S., relating to health maintenance contracts, to allow subscribers to terminate their health maintenance organization contracts 30 days after providing advance written notice to the health maintenance organization after receiving a written notice from the health maintenance organization of a material change in members' benefits. The material change may include, but is not limited to:

- Termination by the health maintenance organization of the provider contract of the subscriber's primary care physician;
- Termination of the provider contract of any specialist physician with whom the subscriber has an active physician-patient relationship; or
- The deletion from the approved formulary of any prescription drug currently prescribed to the subscriber.

The health maintenance organization may not delete, amend, limit, or increase the copayment for any of the services the subscriber is entitled to through contract between open enrollment periods. The health maintenance organization may amend the contract with its group subscribers, subject to the provisions of subsection (3) of this section, upon written notice to the subscriber at least 30 days before the next open enrollment. Such amendments will become effective immediately upon the expiration of the open enrollment period.

Section 3. Amends s. 641.315, F.S., relating to health maintenance organization and provider contracts, to provide that a contract renewed or entered into after July 1, 1999, between a health maintenance organization and a provider of health care services shall not contain any provision which prohibits or restricts:

- The health care provider from entering into contract with any other health maintenance organization; or
- The health maintenance organization from entering into contract with any other health care provider.

Section 4. Amends s. 641.3155, F.S., to provide that the section applies to fiscal intermediary services organizations as defined in s. 641.316, F.S.

Section 5. Provides for an effective date of July 1, 1999.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

See fiscal comments.

2. Recurring Effects:

See fiscal comments.

3. Long Run Effects Other Than Normal Growth:

See fiscal comments.

4. Total Revenues and Expenditures:

See fiscal comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

None.

2. Recurring Effects:

None.

3. Long Run Effects Other Than Normal Growth:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

It is anticipated that there would be a fiscal impact on health insurance companies and HMOs.

2. Direct Private Sector Benefits:

None.

3. Effects on Competition, Private Enterprise and Employment Markets:

None.

D. FISCAL COMMENTS:

According to the Division of State Group Insurance, allowing enrollees in the state health insurance plan to drop or change coverage because their doctors are no longer affiliated with the managed care plan is not permissible by federal law as related to pre-tax plans. The inclusion of a subscriber's primary physician or specialist termination from an HMO's network as a qualifying change of status event would make the State Employees Group Health Insurance Program non-compliant with section 125 of the Internal Revenue Code. The program, therefore, would lose its pre-tax status. Without the pre-tax status, the state would lose over \$11 million in the State Employees' Group Insurance Trust Fund. In addition, program participating state employees would lose about \$31 million in tax withholding (estimated by the Comptroller's Office, Bureau of State Payroll), and the Division would incur costs that are not currently budgeted by undergoing additional administrative procedures for handling additional enrollment and disenrollment.

The Division is also concerned that the bill would require additional member notification of benefits to all State Group Health Insurance enrollees. The Division estimates that such notification would cost \$48,500, based on current insurance enrollment of 161,512 subscribers and a production and bulk rate mailing cost of \$0.30 per piece of mail. If the bill were to provide for an effective date of January 1, 2000, rather than July 1, 1999, then notification could occur during the regular open enrollment period and no additional expenditures would be required by the Division.

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 an action 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 aggregate.

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

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

V. COMMENTS:

Under s. 627.613, F.S., health insurers must already meet the prompt claim payment requirements similar to the requirements set out in this bill for insurance administrators. Nothing in s. 627.613, F.S., states that health insurers who use administrators to settle claims are exempt from these prompt claim payment requirements. There may be some question as to why legislation requiring prompt payment of claims by administrators is necessary when the insurance company for which an administrator is administering claims must already meet such requirements.

The term "contract provider" is not defined. Its use in section 1 of the bill relating to terms of obligation to pay claims to "contract providers" is unclear in that third party administrators do not necessarily operate on such a basis.

The term "active physician-patient relationship" used in section 2 is not defined. If a clear meaning of this term were provided the opportunity for dispute might be reduced and administrative effectiveness increased.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On April 12, 1999, the Committee on Health Care Services passed a strike everything amendment sponsored by Representative Murman. This amendment does the following:

- Prohibits certain restrictive contractual arrangements between HMOs and health care providers. A contract between an HMO and health care provider may not contain provisions which prohibit or restrict: the health care provider from entering into a contract with any other HMO to provide services for the HMO's commercial subscriber; or the HMO from entering into a contract with any other health care provider to provide services for the HMO's commercial subscribers.
- Requires all health care provider fiscal intermediaries and all HMO fiscal intermediaries to include a detailed explanation of benefits for payments to a health care provider.
- Provides that a health maintenance organization may increase the copayment for any benefit, or delete, amend, or limit any of the benefits to which a subscriber is entitled under the group contract only, upon written notice to the contract holder at least 45 days in advance of the time of coverage renewal. The health maintenance organization may amend the contract with the contract holder with such amendment to be effective immediately at the time of coverage renewal. The written notice to the contract holder shall specifically identify any deletions, amendments, or limitations to any of the benefits provided in the group contract during the current contract period that will be included in the group contract upon renewal.
- Provides that all health maintenance contracts that provide coverage for massage shall also cover the services of persons licensed to practice massage pursuant to chapter 480, F.S., if the massage is prescribed by a physician licensed under chapter 458, 459, 460 or 461, F.S., as medically necessary and the prescription specified the number of treatments.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:

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