HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 659 Health Plans
SPONSOR(S): Abbott
TIED BILLS: **IDEN./SIM. BILLS:** SB 584

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Select Committee on Health Innovation		Lloyd	Calamas
2) Insurance & Banking Subcommittee			
3) Health Care Appropriations Subcommittee			
4) Health & Human Services Committee			

SUMMARY ANALYSIS

The Agency for Health Care Administration (AHCA) contracts with a third party resolution organization for the review of the claim disputes between health care providers, health insurers and health maintenance organizations. Claims are reviewed by the organization and then submitted to the AHCA with a payment recommendation based on desk reviews by the third party resolution organization and, if requested, a review of evidence and additional documentation in a hearing. Acting as an alternative dispute resolution process for eligible heath care providers and insurers, the AHCA issues any final order after receipt of the recommendation and the non-prevailing party or parties has 35 days to pay. Non-prevailing parties are also responsible for review costs incurred by the review organization and their share of any costs from a hearing.

HB 659 prohibits a health plan from declining to participate in Program when the health plan had a disputed claim under review. However, providers, both group and individual health insurers, and health plans still retain the ability to file a dispute in state or federal court, but once a suit has been filed, the claim can no longer be considered by the Statewide Provider and Health Plan Claim Dispute Program (Program). Additionally, if a provider or a plan fails to respond to a request for supporting documentation within 15 days after receipt of a request from the Program, the AHCA will issue a default against the provider and notify the AHCA of the default.

The bill creates requirements for a standardized identification card for insureds that clearly identifies whether or not the plan is subject to state regulation and which provides the insured with quick access information to the consumer services website of the Department of Financial Services' Division of Consumer Services website.

The bill has an indeterminate fiscal impact on state, local, governments and the private sector.

The bill provides for an effective date of January 1, 2025.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Statewide Provider and Health Plan Claim Dispute Resolution Program

The Statewide Provider and Health Plan Claim Dispute Resolution Program (Program) assists contracted and non-contracted providers and managed care organizations with the resolution of claim disputes.[1] The Agency for Health Care Administration (AHCA) contracts with a third party resolution organization (MAXIMUS) for the timely review, consideration, and recommendation for these filed claim disputes. The Program serves as a modified alternative dispute resolution process for health plans and providers who have payment disputes. Typically, these payment disputes are between larger facilities and smaller providers who do not have an existing contractual relationship. The program was designed to resolve only disputes between providers, health maintenance organizations (HMOs), prepaid health clinics, exclusive provider organizations, prepaid health plans, medical expense insurance policies, preferred provider organizations, and Statewide Medicaid Managed Care Plans.[2] The existing contract language has been repeated in the 2023-2024 re-procurement of the SMMC contracts.

Certain types of claims are excluded from consideration such as those related to interest payments, or claims that do not meet a minimum aggregate threshold as established by agency rule.[3] A physician or health care facility filing an appeal must aggregate claims for one or more patients from the same insurer, which is also referred to as batching of claims.

Claims are also excluded if:

- Related to an internal Medicare managed care organization;
- Part of a reconsideration of a claim appeal through the Medicare appeals process;
- Related to a health plan not regulated in Florida;
- Is the basis for an action pending in state or federal court;
- Part of a Medicaid Fair Hearing Process pursued under 42 C.F.R. ss. 431.220 et seq.; or,
- Is the subject to a binding-claim-dispute-resolution process provided by contract entered into prior to October 1, 2000, between the provider and managed care organization.[4]

[1] S. 408.7057. F.S.

[2] *Supra,* note 7.

[3] *See* 59A-12.030, Statewide Provider and Health Plan Claim Dispute Resolution Program. The jurisdictional threshold amounts are the minimum, aggregate amount that a claim or claims must total for consideration by the Program. For health plan contracted hospitals, the threshold is $25,000 and for non-contracted hospitals, the threshold is $10,000.

[4] S. 408.7057(2)(b)1.-7, F.S.

MAXIMUS operated a toll-free hotline to provide information and dispute application forms to interested parties while the contractor. The contract was a "no cost" contract to the state in that MAXIMUS was paid by the users of the Program. Costs for the Program were to be set by the AHCA through the rulemaking process. The final rule established that the non-prevailing party would pay the review costs. If both parties prevailed in parts of the action, then the costs of the review fee are required to be apportioned based on the final judgement.[5]

When a claim is received, it is investigated either through a desk review of the documentation submitted by the parties or sometimes through the involvement of other experts. Either party may call an evidentiary hearing to review the evidence and call witnesses.[6] Each party pays for the costs of their own witnesses, but the parties share the cost of the hearing equally.[7]
The AHCA's responsibility is to issue a final order adopting the recommendation of the resolution entity. The failure of the non-prevailing party to pay the ordered review cost within 35 days of the agency's order subjects the nonpaying party to a penalty of not more than $500 per day until the penalty is paid.[8]

The chart below shows the volume of claims received by the Program and the status of claims at the end of each reporting year. The total number of claims filed with the system has dramatically increased in the past two years.[9]

Statewide Provider Health Plan Claim Dispute Program - Trends					
Year	Claims Received	Claims Reviewed	Claims Withdrawn	Claims Ineligible/ Dismissed	Highest Claim (aggregated)
2019	74	45	7	19	$675,209
2020	68	41	13	19	$669,012
2021	111	73	13	19	$2,320,399
2022	563	443	7	19	$1,001,694,838

Currently, the Program does not have a vendor to process claims. The contract with previous third party administrator ended June 30, 2023 and the AHCA has started a new procurement for a replacement vendor. No new claims are being accepted until a new vendor is in place.

Federal External Review Process

As part of the federal Patient Protection and Affordable Care Act (PPACA), patients were to be provided both an internal and external appeals process for review of unpaid claims.[10] For states which did not have an external review process that met those standards or if the individual was in a certain type of plan such as a self-insured plan, then the federal external review process would apply. Similarly, for claims disputes between providers and facilities, for disputes between providers and facilities.[11]

Standard Health Plan Identification Cards

The *No Surprises Act* addressed many health care transparency and consumer empowerment provisions which ensure that the patient receives accurate and up to date information from his or her

[5] Rule 59A-12.030(4)(a), F.A.C.
[6] 59A-12.030, F.A.C.(7).
[7] Id.
[8] S. 408.7057(5), F.S.
[9] Agency for Health Care Administration, *Statewide Health Provider and HealthPlan Claim Dispute Resolution Program,* available at https://ahca.myflorida.com/health-care-policy-and-oversight/bureau-of-health-facility-regulation/certificate-of-need-and-commercial-managed-care-unit/commercial-managed-care/statewide-provider-and-health-plan-claim-dispute-resolution-program (last reviewed January 10, 2024). Chart created from data retrieved from individual Annual Reports from 2019 through 2022.
[10] Public Law 111-148 (March 10, 2010) and Public Law 111-152 (March 30, 2010).
[11] Sec. 340B of the Public Health Service Act (42 U.S.C. 256b) (PHSA), as amended.

insurer on a consistent basis allowing the patient to make better informed health care choices. One provision included in the *No Surprises Act* addresses the standard content to be included on every group or individual health plan identification card whether the card is a physical card or digital.

Current law addresses information on both health plan and prescription benefits cards. For prescription drug cards, a list of requirements includes the name of the claims processor, the processor's address and the help desk phone number; the insured's prescription group number, identification number and name; and any other information helpful to the timely processing of a claim. Information can be embedded on the card or through a magnetic stripe.[12] The HMOs must provide information in a readily identifiable manner or have the information be embedded on the card such that it can be easily accessed through a magnetic reader or smart card also . The information may also be provided through other electronic technology.[13]

Beginning January 1, 2022, the law required health plans and insurers to include the following minimum information on the insured's card:

- Any deductible applicable to coverage.
- Any out of pocket maximum applicable to the coverage.
- A telephone number and website address that individuals can use to find consumer assistance information and facilities and providers under contract with the plan.[14]

Effect of Proposed Changes

Statewide Provider and Health Plan Claim Dispute Resolution Program Authority

HB 659 modifies the Statewide Provider and Health Plan Claim Dispute Resolution Program (Program) to require eligible health insurers and health plans with claims that meet the designated thresholds to participate in the program. Currently, the only plans required to participate in the Program are those contracted plans in the SMMC program. Participants retain the option of seeking recourse for claims disputes through litigation in state or federal court rather than through this alternative dispute resolution process. The proposed changes provide the AHCA with the necessary authority to assess sanctions on non-responsive participants and to implement final orders once issued..

HB 659 establishes a specific time standard for payment of any orders at 35 days after the order is entered and provides a daily fine for each day such payment is not made. Existing statutes does not include such a standard and the AHCA does not currently have the authority to enforce the orders issued from the current process. If the Program today issues an order for payment to a party, the AHCA is not able to set a timeline or deadline for payment and cannot anticipate when a payment may or may not be received or for what amount.

Standard Health Plan Identification Cards

The requirements to incorporate certain standardized components to any hard copy or digital health insurance benefits card became effective under the *No Surprises Act* in 2022. HB 693 enhances those provisions for any plan subject to state regulation and provides other requirements for non-state regulated plans.

For the card, the bill requires:

- The letters "FL" on the back, left-hand side of the card; and
- A quick response code (QR) on the card which directs the insured or subscriber to a consumer services website of the Division of Consumer Services of the Department of Financial Services.

On the website, requirements for posting information will depend on the type of plan and may include:

[12] Ch. 627.4302, F.S.
[13] Ch. 641.31(42), F.S. Similar provisions for identification cards issued under individual coverage can be found at 627.642, F.S., and at 627.657, F.S. for group health insurance policies.
[14] 42 U.S.C. 300gg-111(e).

- Name of regulatory entity with relevant contact information, including a telephone number or website hyperlink; and
- A notice that if the letters "FL" are not included, that the plan may not be regulated by the State of Florida and direct the consumer to the Division of Consumer Services website.

These changes are effective with any identification cards issues or reissued on or after January 1, 2025.

The bill provides an effective date of January 1, 2025.

B. SECTION DIRECTORY:

Section 1: Amends s. 408.7057, F.S.; prohibits health plans from declining to participate in filed claims and provides defaults against health plans for failure to respond; requires the Agency for Health Care Administration to provide health plans with notices of failure to pay providers the amounts provided in claim dispute orders within a specified period of time; requires health plans to pay providers the amounts provided in the claims dispute process under certain circumstances; and provides penalties for failure to pay such amounts.

Section 2: Amends s. 627.4302, F.S.; requires certain health insurance plans and health maintenance organization benefit identification cards to include specific information in a certain manner and provides the Agency for Health Care Administration with rulemaking authority.

Section 3: Amends s. 627.642, F.S., requires certain health maintenance organization benefit identification card to include specific information in a certain manner and provides the AHCA with rulemaking authority.

Section 4: Amends s. 627.657, F.S.; requires certain health insurers to include specific information in a certain manner on its identification cards and provides the AHCA with rulemaking authority.

Section 5: Amends s. 641.31, F.S.; requires certain health insurers to include specific information in a certain manner on its identification cards and provides the AHCA with rulemaking authority.

Section 6: Authorizes the AHCA to conduct rulemaking to implement the provisions of the bill.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

HB 659 authorizes the AHCA to assess a penalty on non-prevailing providers who fail to pay the required amount within 35 days of a final order. The amount of the penalty must be established by rule and may not exceed $500 per day. Currently, the statute does not permit the AHCA to assess a fee or penalty on parties who fail to pay an order.

Any fees collected would be additional revenue to the AHCA. The amount can be no more than $500 and AHCA indicates that the current rule for the Program would be revised and updated to allow for this assessment and collection.

The total amount that could be collected is indeterminate given a number of unknown variables, including the penalty amount or methods to be set out in the AHCA rule, the amount collection rate, and also unknown is how much participation behavior or negotiation behavior may change under a revised participation model.

2. Expenditures:

The AHCA is required to contract with a third party vendor to handle the Program. Previous contracts with the prior vendor were "no cost" contracts where the vendor was paid from the fees

collected from the voluntary participants in the process. However, the vendor's contract ended June 30, 2023 and no new disputes are being considered until a new contract is awarded.[15]

The state has required all contracted SMMC plans to participate in the Program and has prohibited opt outs by those plans. An alternative dispute process on disputed claims may result in lower than expected claims costs for the SMMC plans which can result in lower than expected trend rates with medical costs from out of network providers over time.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

More extensive use of the Program by providers and insurers to resolve disputes could result in lower costs to all parties leading in the long term to lower premiums. Insurers and health plans as well as providers spread risk and costs among all paying customers. When there are more claims that are paid rather than unpaid, then the plans and providers have less financial responsibility or risk to spread to other customers.

2. Expenditures:

If local governments are self-funded, those local governments may incur costs related to the new identification cards that must be produced to the federal specifications. Additionally, self-funded plans are subject still to the federal external review process and not the state process. If local government were to file a claims dispute as a payor, the federal review process does have fees associated with such filings; however, the amounts are currently under review.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

A health plan that does not comply with a final order would face the suspension or loss of its Health Care Provider Certificate, according to the AHCA, as it is considered a sanction. Such non-compliance with an order has the practical effect of prohibiting the entity from conducting business as a managed care entity. The disruption in health care to its members and to that company's operations would likely be significant.

D. FISCAL COMMENTS:

The cost of the new vendor contract to oversee the state's provider dispute process is unknown. Until the vendor is selected and a schedule of fees or other costs are released, it is difficult to determine the total fiscal impact of revised participation provisions in the state process.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable.

2. Other:

The federal process has been challenged in different jurisdictions from the amount of the filing fees to how claims are batched together and reviewed. The federal portal has opened and closed several times during these different legal challenges and federal CMS has recently re-opened the portal and began processing claim requests.

[15] MyFloridaCFO, *Consumer Services – Medical Providers,* available at https://myfloridacfo.com/division/consumers/medicalprovider/ (last viewed January 9, 2024).

B. RULE-MAKING AUTHORITY:

C. DRAFTING ISSUES OR OTHER COMMENTS:

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES