Florida's Managed Care Regulations

A Summary of Provisions Most Relevant to Providers

November 2006

An Association of Hospitals & Health Systems

Contents

Staff Contacts:

Kim Streit, VP/Health Care Research & Information, kims@fha.org, (407) 841-6230

Kathy Reep, VP/Financial Services, kathyr@fha.org, (407) 841-6230

The Florida Hospital Association, as a resource for providers and the managed care enrollees they serve, has created this summary of Florida managed care regulations, with a special emphasis on the provisions most relevant to providers. This brochure outlines the statutory requirements associated with the payment of claims for patients covered by health plans licensed in Florida. "Health Plan," for purposes of this document, includes those organizations licensed as health maintenance organizations (HMO) under Ch. 641, F.S. and under Ch. 627, F.S. Those provisions only applying to HMOs or non-HMO plans are so noted by the statute citation following the requirement. Any person who provides billing and collection services to health insurers and health maintenance organizations on behalf of healthcare providers is required to comply with the provisions under 627.6131, 641.3155, and 641.51(4). Note that there were no changes from the 2006 Legislative session.

Definitions

- "Office" means Office of Insurance Regulation.
- "Emergency medical condition" means:
  - A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (1) Serious jeopardy to the health of a patient, including a pregnant woman or a fetus. (2) Serious impairment to bodily functions. (3) Serious dysfunction of any bodily organ or part.
  - With respect to a pregnant woman: (1) That there is inadequate time to affect safe transfer to another hospital prior to delivery; (2) That a transfer may pose a threat to the health and safety of the patient or fetus; or (3) That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes. 641.19(6)
  - "Emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital. 641.19(7)
- A claim for a non-institutional provider refers to a paper or electronic billing instrument submitted to the health plan's designated location that consists of the HCFA 1500 data set, or its successor, that has all mandatory entries as required for the provider. 627.6131(2), 641.3155(1)
- For institutional providers, "claim" refers to a paper or electronic billing instrument submitted to the health plan's designated location that consists of the UB-92 data set or its successor with entries stated as mandatory by the National Uniform Billing Committee. 627.6131(2), 641.3155(1)

Contract Issues

- The office may require an HMO to submit any contract for administrative services, contract with a provider other than an individual physician, contract for management services, and contract with an affiliated entity to the office. 641.234(1)
- After review of a contract, the office may order the HMO to cancel the contract in accordance with the terms of the contract and applicable law if it determines: (a) That the fees to be paid by the HMO under the contract are so unreasonably high as compared with similar contracts entered into by the HMO or as compared with similar contracts entered into by other HMOs in similar circumstances that the contract is detrimental to the subscribers, stockholders, investors, or creditors of the HMO; or (b) That the contract is with an entity that is not licensed under state statutes, if such license is required, or is not in good standing with the applicable regulatory agency. 641.234(2)

- Each HMO shall file, upon the request of the office, financial statements for all contract providers of comprehensive healthcare services who have assumed, through capitation or other means, more than 10 percent of the healthcare risks of the HMO. However, this provision shall not apply to any individual physician. 641.2342

- If an HMO, through a healthcare risk contract, 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 organization, the HMO shall remain responsible for any violations of ss. 641.3155, 641.3156, and 641.51(4). The provisions of ss. 624.418-624.4211 and 641.52 shall apply to any such violations. 641.234(4)(a)

- Each contract between an HMO and a provider of healthcare services must be in writing and must contain a provision that the subscriber is not liable to the provider for any services for which the HMO is liable as specified in s. 641.3154. (641.315(1))

- All provider contracts must provide that the HMO will provide 60 days advance written notice to the provider and the office before canceling, without cause, the contract with the provider, except in a case in which a patient's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action by the Board of Medicine or other governmental agency. 641.315(2)(b)

- A contract between a health plan and a provider of healthcare services must not contain any provision restricting the provider's ability to communicate information to the provider's patient regarding medical care or treatment options for the patient when the provider deems knowledge of such information by the patient to be in the best interest of the health of the patient. 641.315(5)

- A contract between a health plan and a provider of healthcare services may not contain any provision that in any way prohibits or restricts the healthcare provider from entering into a commercial contract with any other HMO or which restricts the health plan from entering into a commercial contract with any other healthcare provider. 641.315(6)

- A health insurer must not require a contracted healthcare practitioner to accept the terms of other healthcare practitioner contracts with the insurer or any other insured, or health plan, under common management and control with the insurer, except for a practitioner in a group practice who must accept the terms of a contract negotiated for the practitioner by the group, as a condition of continuation or renewal of the contract.

- Effective January 1, 2005, a health plan is required to disclose to the provider the complete schedule of reimbursements for all services that the HMO and provider have contracted, as well as any changes in or deviations from the contracted schedule of reimbursements. The HMO can satisfy this requirement by providing either an electronic or written copy of the reimbursement schedule and any applicable changes or deviations. The schedule of reimbursements is subject to the nondisclosure provisions of the contract and the provider must maintain the confidentiality of the schedule. 641.315(4)(d)

Authorizations

- The HMO must provide treatment authorization 24 hours a day, seven days a week. Requests for treatment authorization may not be pended unless the requesting provider contractually agrees to take a pending or tracking number. 641.495(4)

- The HMO must establish written procedures for a contract provider to request and for the organization to grant authorization for utilization of healthcare services. The health plan must give written notice to the contract provider prior to any change in these procedures. 641.315(8)

- An HMO must pay any hospital service or referral service claim for treatment for an eligible subscriber which was authorized by a provider empowered to contract with the organization to authorize or direct the patient's utilization of healthcare services and which was also authorized in accordance with the organization's current and communicated procedures, unless the provider submitted information to the HMO with the willful intention to misinform the organization. 641.3156

Claims Submission and Payment Issues

- All claims for payment or overpayment, whether submitted electronically or nonelectronic, are considered received on the date the claim is received by the organization at its designated claims-receipt location or the date a claim for overpayment is received by the provider at its designated location. 627.6131(3), 641.3155(2)

- All claims for payment or overpayment, whether submitted electronically or nonelectronic, must be mailed or electronically transferred to the primary organization within six months after (1) discharge for inpatient services or the date of service for outpatient services; and (2) the provider has been furnished with the correct name and address of the patient's health plan. All claims for payment must be mailed or electronically transferred to the secondary organization within 90 days after final determination by the primary organization. A provider's claim is considered submitted on the date it is electronically transferred or mailed. 627.6131(3), 641.3155(2)

- Duplicate claims must not be submitted unless it is determined that the original claim was not received or was otherwise lost. 627.6131(3)(c), 641.3155(2)(c)

- For all <u>electronically</u> submitted claims, a health plan is to provide electronic acknowledgement of the receipt of the claim to the electronic source submitting the claim within 24 hours (*15 days for nonelectronic)* after the beginning of the next business day after receipt of the claim. The health plan must pay the claim or notify the provider or its designee if a claim is denied or contested within 20 days (*40 days for nonelectronic)* after receipt of the claim. Notice of the organization's action on the claim and payment of the claim is considered to be made on the date the notice or payment was mailed or electronically transferred. 627.6131(4)(5), 641.3155(3)(4)

- <u>Electronically</u> submitted claims must be paid or denied within 90 days (*120 days for nonelectronic)* after receipt of the claim. Failure to pay or deny a claim within 120 days (*140 days nonelectronic)* after receipt creates an uncontestable obligation to pay the claim. 627.6131(4), 627.6131(4)(c)2(e), (5)(c) 2(e), 641.3155(3)(e), (4)(e)

- Notification of the health plan's determination of a contested claim must be accompanied by an itemized list of additional information or documents that the insurer can reasonably determine are necessary to process the claim. A provider must submit the additional information or documentation, as specified in the itemized list, within 35 days after receipt of the notification. Additional information is considered submitted on the date it is electronically transferred or mailed. The health plan may not request duplicate documents. 627.6131(5)(c), 641.3155(4)(c)

- Payment of a claim is considered made on the date the payment was mailed or electronically transferred. <u>An overdue payment of a claim bears simple interest of 12 percent per year</u>. Interest on an overdue payment for a claim or for any portion of a claim begins to accrue when the claim should have been paid, denied, or contested. The interest is payable with the payment of the claim. 627.6131(7), 641.3155(6)

- A permissible error ratio of five percent is established for health plan's claims payment violations of paragraphs (3)(a), (b), (c), and (e) and (4)(a), (b), (c), and (e). If the error ratio of a particular insurer does not exceed the permissible error ratio of five percent for an audit period, no fine shall be assessed for the noted claims violations for the audit period. The error ratio shall be determined by dividing the number of claims with violations found on a statistically valid sample of claims for the audit period by the total number of claims in the sample. If the error ratio exceeds the permissible error ratio of five percent, a fine may be assessed according to s. 624.4211 for those claims payment violations which exceed the error ratio. Notwithstanding the provisions of this section, the office may fine an HMO for claims payment violations of paragraphs (3)(e) and (4)(e) which create an uncontestable obligation to pay the claim. The office shall not fine organizations for violations which the office determines were due to circumstances beyond the organization's control. 627.6131(14), 641.3155(12)

- Whenever, in any health insurance claim form, an insured specifically authorized payment of benefits directly to any recognized hospital, physician, or dentist, the insurer must make payment to the designated provider, unless otherwise provided in the insurance contract. Note that the insurance contract may not prohibit, and claim forms must provide an option for, the payment of benefits directly to a licensed hospital, physician, or dentist. This provision is effective for all policies or contracts issued or renewed on or after July 1, 2005. 627.638(2) *This applies to emergency services only.*

Time of Payment of Claims - 627.613

- Health insurers shall 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, the insured or the insured's assignees shall be notified, in writing, that the claim is contested or denied, within 45 days after receipt of the claim by the health insurer. The notice that a claim is contested shall identify the contested portion of the claim and the reasons for contesting the claim.

- 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.

- Payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery.

- All overdue payments shall bear simple interest at the rate of 10 percent per year.

- Upon written notification by an insured, an insurer shall investigate any claim of improper billing by a physician, hospital, or other healthcare provider. The insurer shall determine if the insured was properly billed for only those procedures and services that the insured actually received. If the insurer determines that the insured has been improperly billed, the insurer shall notify the insured and the provider of its findings and shall reduce the amount of payment to the provider by the amount determined to be improperly billed. If a reduction is made due to such notification by the insured, the insurer shall pay to the insured 20 percent of the amount of the reduction up to $500.

Overpayments

- If a health plan determines that it has made an overpayment to a provider for services rendered to an enrollee, the health plan must make a claim for the overpayment to the provider's designated location. The health plan must provide a written or electronic statement specifying the basis for the retroactive denial or payment adjustment and must identify the claim or claims, or portion thereof, for which a claim for overpayment is submitted. 627.6131(6), 641.3155(5)

- If an overpayment determination is the result of a retroactive review or audit of coverage decisions or payment levels – unrelated to fraud – the following procedures apply:

  - All claims for overpayment must be submitted to a provider within 30 months after the health plan's payment of the claim. A provider must pay, deny, or contest the health plan's claim for overpayment within 40 days after receipt of the claim. All contested claims for overpayment must be paid or denied within 120 days after receipt of the claim. Failure to pay or deny the claimed overpayment within 140 days after receipt creates an uncontestable obligation to pay the claim.

  - A provider that denies or contests a health plan nonelectronic's claim for overpayment or any portion of a claim must notify the organization, in writing, within 35 days after the provider receives the claim that the claim for overpayment is contested or denied. The notice must identify the contested portion of the claim and the specific reason for contesting or denying the claim and, if contested, a request for additional information. If the organization submits additional information, the organization must, within 35 days after receipt of the request, mail or electronically transfer the information to the provider. The provider must pay or deny the claim for overpayment within 45 days of the receipt of the information. The notice is considered made on the date the notice is mailed or electronically transferred by the provider.

- The health plan may not reduce payment to the provider for other services unless the provider agrees to the reduction in writing or fails to respond to the health plan's overpayment claim as required.

- Payment of an overpayment claim is considered made on the date the payment was mailed or electronically transferred. An overdue payment of a claim bears simple interest at the rate of 12 percent per year. Interest on an overdue payment for a claim for an overpayment begins to accrue when the claim should have been paid, denied, or contested.

- A claim for overpayment will not be permitted beyond 30 months after the health plan's payment of the claim, except that claims for overpayment may be sought beyond that time from providers convicted of fraud.

Balance Billing

- If an HMO is liable for services rendered to a subscriber by a provider, regardless of whether a contract exists between the organization and the provider, the organization is liable for payment of fees to the provider and the subscriber is not liable for payment of fees to the provider. 641.3154(1)

- For purposes of this section, an HMO is liable for services rendered to an eligible subscriber by a provider if the provider follows the HMO's authorization procedures and receives authorization for a covered service for an eligible subscriber, unless the provider provided information to the HMO with the willful intention to misinform the HMO. 641.3154(2)

- The liability of an organization for payment of fees for services is not affected by any contract the organization has with a third party for the functions of authorizing, processing, or paying claims. 641.3154(3)

- A provider or any representative of a provider, regardless of whether the provider is under contract with the HMO, may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency a subscriber of an organization for payment of services for which the organization is liable, if the provider in good faith knows or should know that the organization is liable. This prohibition applies during the pendency of any claim for payment made by the provider to the organization for payment of the services and any legal proceedings or dispute resolution process to determine whether the organization is liable for the services if the provider is informed that such proceedings are taking place. It is presumed that a provider does not know and should not know that an organization is liable unless: (a) the provider is informed by the organization that it accepts liability; (b) a court of competent jurisdiction determines that the organization is liable; (c) the office or agency makes a final determination that the organization is required to pay for such services subsequent to a recommendation made by the Subscriber Assistance Panel pursuant to s. 408.7056; or (d) the agency issues a final order that the organization is required to pay for such services subsequent to a recommendation made by a resolution organization pursuant to s. 408.7057. 641.3154(4), 627.6131(9)(10), 641.3155(8)(9)

Denials

- A health plan may not retroactively deny a claim because of subscriber ineligibility more than one year after the date of payment of the claim. 627.6131(11), 641.3155(10)

- 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. The appeal may be by telephone, and the insurer's licensed physician must respond within a reasonable time, not to exceed 15 business days. 627.6141

Emergency Room Access Issues

Unless otherwise noted, the provisions in this section are applicable to HMOs only (641.513)

- Health plans shall provide, on their Internet Web sites, information regarding appropriate utilization of emergency care services, which shall include, but not be limited to, a list of alternative urgent care contracted providers, the

types of services offered by these providers, and what to do in the event of a true emergency. 641.31097(2), 627.6405(2)

- As a disincentive for subscribers to inappropriately use emergency department services for non-emergency care, health plans may require higher copayments for urgent care or primary care provided in an emergency department and higher copayments for use of out-of-network emergency departments. Higher copayments may not be charged for the utilization of the emergency department for emergency care. For the purposes of this section, the term "emergency care" has the same meaning as provided in s. 395.002 and shall include services provided to rule out an emergency medical condition. 641.31097(4), 627.6405(4)

- An HMO may not (a) require prior authorization for pre-hospital transport or treatment or for emergency services and care; (b) indicate that emergencies are covered only if care is secured within a specific period of time; (c) use terms such as "life threatening" or "bona fide" to qualify the kind of emergency that is covered; or (d) deny payment based on the subscriber's failure to notify the HMO in advance of seeking treatment or within a certain period of time after the care is given.

- When a subscriber presents to a hospital seeking emergency care, the determination as to whether an emergency medical condition exists must be made, for the purposes of treatment, by a physician of the hospital or, to the extent permitted by applicable law, by other appropriate licensed professionals under the supervision of the hospital physician. The physician or the appropriate personnel must indicate in the patient's chart the results of the screening, examination, and evaluation.

- The HMO is required to compensate the provider for the screening, examination, and evaluation that is necessary for the healthcare provider to determine whether the patient's condition is an emergency medical condition. If a determination is made that an emergency medical condition does not exist, payment for services rendered subsequent to that determination is governed by the contract under which the subscriber is covered.

- If a determination has been made that an emergency medical condition exists and the subscriber has notified the hospital, or the hospital has knowledge that the patient is a subscriber of the HMO, the hospital must make a reasonable attempt to notify the subscriber's primary care physician, if known, or the HMO, if the HMO had previously requested in writing that the notification be made directly to them.

- If the primary care physician is not known, or has not been contacted, the hospital must (a) notify the HMO as soon as possible prior to discharge of the subscriber from the emergency care area; and (b) notify the HMO within 24 hours or on the next business day after admission of the subscriber as an inpatient to the hospital.

- If notification is not accomplished, the hospital must document its attempts to notify the HMO of the circumstances that precluded attempts to notify the HMO. An HMO may not deny payment for emergency services and care based on a hospital's failure to comply with the notification requirements.

- Reimbursement for emergency services by a provider who does not have a contract with the HMO will be the lesser of (a) the provider's charges; (b) the usual and customary provider charges for similar services in the community where the services were provided; or (c) the charge mutually agreed to by the HMO and the provider within 60 days of the submission of the claim. Reimbursement for services provided to subscribers who are Medicaid recipients by a non-contracted provider are the lesser of the above or the Medicaid rate. *Any healthcare provider that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in a Medicare Advantage plan must accept, as payment in full, the lesser of the amounts they could collect if the beneficiary were enrolled in original Medicare or the amount of the claim.*

Utilization Management

- The HMO must make available to subscribers, upon request, a detailed description of the process used to determine whether healthcare services are "medically necessary." 641.54(4)

- The organization must ensure that only a physician holding an active unencumbered license issued under chapter 458 or chapter 459, or an allopathic or osteopathic physician with an active, unencumbered license in another state with similar licensing requirements, may render an adverse determination regarding a service provided by a

physician licensed in this state. The organization must submit to the treating provider and the subscriber written notification regarding the organization's adverse determination within 2 working days after the subscriber or provider is notified of the adverse determination. The written notification must include the utilization review criteria or benefits provisions used in the adverse determination, identify the physician who rendered the adverse determination, and be signed by an authorized representative of the organization or the physician who rendered the adverse determination. The organization must include with the notification of an adverse determination, information regarding the appeal process for adverse determinations. 641.51(4)

Appeals

- Each claimant, or provider acting on his behalf, who has a claim denied as not medically necessary must be provided an opportunity to 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. The appeal may be by phone, and the insurer's licensed physician must respond within a reasonable time, not to exceed 15 days. 627.6141

- Every organization must have a grievance procedure available to its subscribers for the purpose of addressing complaints and grievances. An organization must maintain records of all grievances and report annually to the agency the total number of grievances handled, a categorization of the cases underlying the grievances, and the final disposition of the grievances. 641.511(1)

- Agency for Healthcare Administration (AHCA) is required to adopt and implement a program to provide assistance to subscribers, including those whose grievances are not resolved by the managed care entity to the satisfaction of the subscriber. The program is to consist of one or more panels that meet as often as necessary to timely review, consider, and hear grievances and recommend to the agency or the department any actions that should be taken concerning individual cases heard by the panel. The panel will not hear appeals by in-plan suppliers and providers unless related to quality of care provided by the plan, nor will it hear appeals by nonparticipating providers, unless related to the quality of care provided to a subscriber by the managed care entity and the provider is involved in the care provided to the subscriber. 408.7056 revised

Dispute Resolution

- The Agency is to contract with a dispute resolution organization to timely review and consider claims disputes submitted by providers and health plans and recommend an appropriate resolution.

- A health plan's internal dispute resolution process related to a denied claim not under active review by a mediator, arbitrator, or third-party dispute entity must be finalized within 60 days after the receipt of the provider's request for review or appeal. 627.6131(8), 641.3155(7)(a)

- AHCA is to establish a program to provide assistance to contracted and non-contracted providers and health plans for resolution of claim disputes that are not resolved by the provider and the health plan. 408.7057(2)(a)

- The resolution organization is to review claim disputes filed by contracted and non-contracted providers and health plans unless the disputed claim (1) is related to interest payment; (2) does not meet the jurisdictional amounts or the methods of aggregation established by agency rule; (3) is part of an internal grievance in a Medicare managed care organization or a reconsideration appeal through the Medicare appeals process; (4) is related to a health plan that is not regulated by the state; (5) is part of a Medicaid fair hearing; (6) is the basis for an action pending in state or federal court; or (7) is subject to a binding claims dispute resolution process provided by contract entered into before July 1, 2000, between the provider and the health plan. 408.7057(2)(b)

- A contracted or non-contracted provider or health plan may not file a claim dispute with the resolution organization more than 12 months after a final determination has been made on a claim by a health plan or provider. 408.7057(2)(d)

Additional details on the dispute resolution program can be found in 408.7057(2)(e-g)(3-6).

Terminated Contracts

- Providers must give 60 days advance written notice to the health plan and the Office of Insurance Regulation before canceling a health plan contract for any reason. 641.315(2)(a) Letters should be sent to:

  Market Investigation
  Fax: (850) 922-5686
  Office of Insurance Regulation
  200 East Gaines Street
  Tallahassee, FL 32399

- Providers whose contracts have been terminated without cause by a health plan must be given 60 days written notice of the termination except in those cases in which a patient's health is in imminent danger or a physician's ability to practice medicine is effectively impaired by an action of the Board of Medicine or other governmental agency. 641.315(2)(b)

- The contracts must require the provider to give 60 days advance written notice to the HMO and the office before canceling the contract with the HMO for any reason; and the contract must also provide that nonpayment for goods or services rendered by the provider to the HMO is not a valid reason for avoiding the 60-day advance notice of cancellation. 641.315(2)(a)

- Upon receipt by the HMO of a 60-day cancellation notice, the HMO may, if requested by the provider, terminate the contract in less than 60 days if the HMO is not financially impaired or insolvent. 641.315(3)

- An HMO or healthcare provider may not terminate a contract with a healthcare provider or HMO unless the party terminating the contract provides the terminated party with a written reason for the contract termination, which may include termination for business reasons of the terminating party. The reason provided in the notice required in this section or any other information relating to the reason for termination does not create any new administrative or civil action and may not be used as substantive evidence in any such action, but may be used for impeachment purposes. As used in this subsection, the term "healthcare provider" means a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461, or a dentist licensed under chapter 466. 641.315(7).

- When a contract between an organization and a treating provider is terminated for any reason other than for cause, each party shall allow subscribers for whom treatment was active to continue coverage and care when medically necessary, through completion of treatment of a condition for which the subscriber was receiving care at the time of the termination, until the subscriber selects another treating provider, or during the next open enrollment period offered by the organization, whichever is longer, but not longer than six months after termination of the contract. Each party to the terminated contract shall allow a subscriber who has initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care and coverage until completion of postpartum care. This does not prevent a provider from refusing to continue to provide care to a subscriber who is abusive, noncompliant, or in arrears in payments for services provided. For care continued under this subsection, the organization and the provider shall continue to be bound by the terms of the terminated contract. Changes made within 30 days before termination of a contract are effective only if agreed to by both parties. 641.315(8)

- Both the organization and the provider are bound by the terms of the terminated contract during this period of continued care. 641.51(8)

Member Rights

- Every HMO contract or member handbook must clearly state all of the services to which the subscriber is entitled and must include a clear and understandable statement of any limitations on the services or kinds of services to be provided. 641.31(4)

- The organization must ensure that the healthcare services provided to subscribers are rendered under reasonable standards of quality of care consistent with the prevailing standards of medical practice in the community. 641.51(1)

- Every HMO must make available to its subscribers the estimated copay, coinsurance percentage, or deductible, whichever is applicable, for any covered services; the status of the subscriber's maximum annual out-of-pocket payments for a covered individual or family; and the status of the subscriber's maximum lifetime benefit. 641.54(6)

Mandated Coverage (HMOs) - 641.31

- Birthing centers and nurse midwives
- Bone marrow transplants
- Child health supervision services
- Children: Adoption, foster care and custody
- Children: Handicapped
- Children: Newborn coverage
- Cleft lip/palate for children
- Coverage due to breast cancer
- Dental procedures for children: general
- Dermatologists (Direct access)
- Diabetes treatment
- Emergency care (HMO)
- Mammograms
- Massage therapists
- Mastectomy: Length of stay and outpatient coverage
- Mastectomy: Surgical procedures and devices
- Maternity care: Length of stay and post-delivery care
- Mental and nervous disorders
- Newborn coverage for injury or sickness, including medically diagnosed congenital defects, birth abnormalities or prematurity and transportation costs for newborns up to 18 months after the birth of the child.
- Newborn hearing screenings
- Nurse anesthetists
- Ophthalmologists
- Optometrists (HMO)
- Osteopathic hospitals
- Osteoporosis diagnosis and treatment
- Podiatrists (HMO)
- Primary care physicians
- Substance abuse
- TMJ

Discount Medical Plans - 636.202-636.244

- "Discount medical plan" means a business arrangement or contract in which a person, in exchange for fees, dues, charges, or other consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. The term "discount medical plan" does not include any product regulated under chapter 627, chapter 641, or part I of this chapter. 636.202(1)

- All providers offering medical services to members under a discount medical plan must provide such services pursuant to a written agreement. The agreement may be entered into directly by the provider or by a provider network to which the provider belongs. 636.214(1)

- A provider agreement between a discount medical plan organization and a provider must provide the following: (a) A list of the services and products to be provided at a discount; (b) The amount or amounts of the discounts or, alternatively, a fee schedule which reflects the provider's discounted rates; (c) That the provider will not charge members more than the discounted rates. 636.214(2)

- A provider agreement between a discount medical plan organization and a provider network shall require that the provider network have written agreements with its providers which: (a) Contain the terms described in subsection (2); (b) Authorize the provider network to contract with the discount medical plan organization on behalf of the provider; (c) Require the network to maintain an up-to-date list of its contracted providers and to

provide that list on a monthly basis to the discount medical plan organization; (4) The discount medical plan organization shall maintain a copy of each active provider agreement into which it has entered. 636.214(3)

- Each discount medical plan organization must maintain an up-to-date list of the names and addresses of the providers with which it has contracted, on an Internet Web site page, the address of which shall be prominently displayed on all its advertisements, marketing materials, brochures, and discount cards. This section applies to those providers with whom the discount medical plan organization has contracted directly, as well as those who are members of a provider network with which the discount medical plan organization has contracted. 636.226

Corporate Office:
306 East College Avenue
Tallahassee, FL 32301
Phone: 850/222-9800
Fax: 850/561-6230

Regional Office - Orlando
307 Park Lake Circle
Orlando, FL 32803
Phone: 407/841-6230
Fax: 407/422-5948

Washington, D.C. Office
444 N. Capitol Street, NW, Suite 532
Washington, DC 20001
Phone: 202/434-4848
Fax: 202/434-4846

www.fha.org **www.flacareers.com**