INFORMATIONAL MEMORANDUM
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ISSUED
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Florida Office of Insurance Regulation
David Altmaier, Commissioner

NOTIFICATION TO ALL INSURERS AND HEALTH MAINTENANCE ORGANIZATIONS ENGAGING A THIRD PARTY TO PROVIDE SERVICES

The purpose of this informational memorandum is to notify all insurers and health maintenance organizations (HMO)s, if the insurer or HMO engages a third party to provide services, of certain provisions of the Insurance Code.

Pursuant to Section 626.8817, Florida Statutes, it is the sole responsibility of the insurer or HMO to provide for competent administration of its programs. If the insurer or HMO engages the services of an administrator, the insurer or HMO is responsible for determining benefits, premium increases, underwriting criteria, and claims payment procedures, and is also responsible for conducting a semi-annual review of the administrator's operations when the administrator administers benefits for more than one hundred (100) certificateholders.

Pursuant to Section 626.883(1), Florida Statutes, an insured's payment of premiums or charges for insurance to the administrator shall be deemed to have been received by the insurer. Payments forwarded by the insurer to the administrator, for purposes of a return of premiums or payment of claims, are not deemed to have been paid to the insured or claimant until such payments are received by the insured or claimant.

Pursuant to Section 641.35(3)(a), Florida Statutes, if an HMO, through a health risk contract, transfers to any entity the obligation to pay providers for subscriber claims, the liability for any such payment remains with the HMO until the payment is received by the provider and should be reflected in loss reserves.

Pursuant to Section 641.234(4), Florida Statutes, if an HMO, through a health risk contract, transfers to any entity the obligations to pay a provider for any claims on behalf of a subscriber, the HMO shall remain responsible for any violations of Sections 641.3155 (prompt payment), 641.3156 (treatment authorization), and 641.51(4) (balance billing), Florida Statutes.

If you have any questions regarding the contents of this Memorandum, please contact Eric Johnson, Florida Office of Insurance Regulation at Eric.Johnson@floir.com or (850) 413-5059.

626.8817 Responsibilities of insurance company with respect to administration of coverage insured.—

(1) If an insurer uses the services of an administrator, the insurer is responsible for determining the benefits, premium rates, underwriting criteria, and claims payment procedures applicable to the coverage and for securing reinsurance, if any. The rules pertaining to these matters shall be provided, in writing, by the insurer or its designee to the administrator. The responsibilities of the administrator as to any of these matters shall be set forth in a written agreement binding upon the administrator and the insurer.
(2) It is the sole responsibility of the insurer to provide for competent administration of its programs.
(3) If an administrator administers benefits for more than 100 certificateholders on behalf of an insurer, the insurer shall, at least semiannually, conduct a review of the operations of the administrator. At least one such review must be an onsite audit of the operations of the administrator. The insurer may contract with a qualified third party to conduct such review.
(4) For purposes of this section, the term "insurer" means a licensed insurance company, health maintenance organization, prepaid limited health service organization, or prepaid health clinic.

626.883 Administrator as intermediary; collections held in fiduciary capacity; establishment of account; disbursement; payments on behalf of insurer.—

(1) If an insurer utilizes the services of an administrator under the terms of a written agreement, the payment to the administrator of any premiums or charges for insurance by or on behalf of the insured shall be deemed to have been received by the insurer, and return premiums or claim payments forwarded by the insurer to the administrator shall not be deemed to have been paid to the insured or claimant until such payments are received by the insured or claimant. Nothing in this part limits any right of the insurer against the administrator resulting from the failure of the administrator to make payments to the insurer, insureds, or claimants.

641.35 Assets, liabilities, and investments.—

(3) LIABILITIES.—In any determination of the financial condition of a health maintenance organization, liabilities to be charged against its assets shall include:
(a) The amount, estimated consistently with the provisions of this part, necessary to pay all of its unpaid losses and claims incurred for or on behalf of a subscriber, on or prior to the end of the reporting period, whether reported or unreported, including contract and premium deficiency reserves. If a health maintenance organization, through a health care risk contract, transfers to any entity the obligation to pay any provider for any claim arising from services provided to or for the benefit of any subscriber, the liabilities of the health maintenance organization under this section shall include the amount of those losses and claims to the extent that the provider has not received payment. No liability need be established if the entity has provided to the health maintenance organization a financial instrument acceptable to the office securing the obligations under the contract or if the health maintenance organization has in place an escrow or withhold agreement approved by the office which assures full payment of those claims. Financial instruments may include irrevocable, clean, and evergreen letters of credit. As used in this paragraph, the term "entity" does not include this state, the United States, or an agency thereof or an insurer or health maintenance organization authorized in this state.

641.234 Administrative, provider, and management contracts.—

(4)(a) If a health maintenance organization, through a health care 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 health maintenance organization 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.

(b) As used in this subsection:

1. The term "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.

2. The term "entity" means a person licensed as an administrator under s. 626.88 and does not include any provider or group practice, as defined in s. 456.053, 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.