SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based only on the provisions contained in the legislation as of the latest date listed below.)

Date: March 23, 1998 Revised: ________ ________ ________ ________

Subject: Delivery of Health Care Services

	Analyst	Staff Director	Reference	Action
1.	Johnson	Deffenbaugh	BI	Favorable/CS
2.			HC	
3.			WM	
4.				
5.				

I. Summary:

The bill authorizes the licensure and regulation of provider service organizations by the Department of Insurance and Agency for Health Care Administration. Provider-service organizations (PSOs) are authorized to provide health care coverage only to Medicare beneficiaries under the Medicare Choice plan. The bill creates a new part IV of chapter 641 and specifies that the provisions of parts I and III (the current laws that apply to health maintenance organizations) also apply to PSOs, subject to certain exceptions. Exceptions include, among others, any provision that conflicts with the federal Balanced Budget Act of 1997 and rules adopted pursuant to that act, and provisions that are unrelated to the limited authority of PSOs to offer only Medicare Choice Plans.

The bill also provides exemptions from the Insurance Code for two classifications of persons: (1) any person who enters into a contract with a licensed insurer, HMO, or PSO to provide health care services to persons insured under the policy issued by the insurer, HMO, or PSO, under certain conditions (commonly referred to as "downstream risk" providers); and (2) an insurer, HMO, PSO, hospital, or licensed health care provider who contracts with an employer that has established a self-funded employee-benefit plan under the Employee Retirement Income Security Act (ERISA), under certain circumstances.

The committee substitute made the following changes to the original bill: 1) Revised the exemption from the Insurance Code for persons providing health care services under a contract with an insurer, HMO, or PSO ("downstream risk" providers); 2) Revised the exemption from the Insurance Code for certain persons who contract with an employer that has established a self-funded plan under ERISA; 3) Creates a new part IV of chapter 641, F.S., for the regulation and licensure of provider-sponsored organizations; and 4) Replacing the bill's specific requirements

for PSOs with general applicability of parts I and III of chapter 641, F.S., subject to specified exceptions.

The bill creates the following sections of the Florida Statutes: 624.1291, 624.1292, 641.801, 624.802, 641.803, 641.804, 641.805, 641.806 and amends the following sections of the Florida Statutes: 641.227 and 641.316.

II. Present Situation:

The Florida Commission on Integrated Health Care Delivery Systems
In recent years, health care providers, insurers, and managed care organizations have become increasingly innovative in the financial arrangements used to provide the delivery of health care services. In response, during the 1997 legislative session, a 13-member panel, The Florida Commission on Integrated Health Care Delivery Systems, was established and directed to evaluate the business arrangements between health care providers, insurers, health maintenance organizations, and other health care purchasers or potential purchasers for the provision of health care goods and services and recommend regulatory requirements, including whether and to what extent various arrangements should be regulated and what quality of care standards should be met.

The Commission noted that the Department of Insurance currently regulates, as risk bearing entities, HMOs, prepaid limited health clinics, and prepaid limited health service organizations; therefore, the commission focused on provider sponsored organizations (PSOs), a term that is defined by the federal Balanced Budget Act of 1997, described below. If the Commission determined that a PSO's contracting arrangement put it in the "business of insurance," then, the PSO, as an insuring entity, could be regulated by the state under its insurance power, and the law would be saved from preemption under ERISA (the federal Employee Retirement Income Security Act of 1974). ERISA regulates employee welfare benefit plans that include group health benefit plans established and maintained by an employer for the participants and beneficiaries. An ERISA plan includes both an employee welfare benefit plan that fulfills all or part of the benefit obligation through the purchase of insurance and one that fulfills its obligations by self-funding each service directly out of plan assets without purchasing insurance.

The Commission concluded that the assumption of "insurance risk" by a PSO creates the "direct contracting" arrangement, that subjects the PSO to regulation just as it would any other health insurer. The Commission also noted that any arrangement between a purchaser and a provider or a PSO, that is based on fee-for-service or discounted fee-for-service reimbursement, is not a "direct contracting" arrangement for purposes of the Commission's report. The Commission's final report, dated January 1, 1998, included the following recommendations:

1. The Commission finds that in all "direct contracting" arrangements, when a PSO is a "risk-bearing entity" in the "business of insurance," it is an insurer, and when it is the "primary risk-taker," such PSO shall be regulated under the Insurance Code.

2. In all direct contracting arrangements, when the PSO is a downstream risk-taker, the Commission's recommendation is not to regulate PSOs directly. However, the Commission recommends enforceable cut through requirements be established where the duty is placed on the primary risk-taker as the regulated entity to assure full compliance by the downstream risk-taker for all statutory, contractual and reporting arrangements.
3. In all direct contracting situations, with the exception of Medicare, when making the determination as to whether PSOs are risk-bearing entities, the Commission recommends that the elements of what constitutes the business of insurance, insurance risk, and the transfer and assumption of insurance risk be determined under traditional insurance law and regulation.
4. In recognition of the federal role in determining Medicare PSO solvency standards, as well as the related timing concerns, the Commission included within its recommendation (1) above, all such PSOs, including Medicare PSOs.
5. The Commission recommends that legislation passed during the 1997 Legislative session authorizing the Department of Insurance to promulgate rules to regulate Fiscal Intermediary Service Organizations be repealed. These entities should be regulated in the same regulatory scheme as PSOs.
6. The Commission defines PSOs, as defined in the federal Medicare Choice program. (See below.)
7. The Commission recommends that the Department of Insurance exercise latitude, judgment, and discretion when they have the opportunity to review payment arrangements between purchasers and providers in determining whether a particular payment method is, in fact, the business of insurance.

Federal Medicare Choice Program
The federal Balanced Budget Act of 1997 (Public Law 105-33) extends the Health Care Finance Administration's (HCFA's), of the Department of Health and Human Services, authority to contract with a greater variety of managed care and fee-for-service plans. As a result, most Medicare enrollees now have an option of receiving benefits through the traditional fee-for-service program or through the new Medicare Choice Program. The Medicare Choice provides benefits through coordinated care plans, such as preferred provider organizations, health maintenance organizations or provider service organizations or through a medical savings account (MSA)/high deductible plan.

Provider-Sponsored Organizations or PSOs
PSOs are defined as public or private entities established by or organized by health care providers or a group of affiliated providers that provide a substantial proportion of health care services and items directly through providers or affiliated groups of providers. Affiliated providers share, directly or indirectly, substantial financial risk and have at least a majority financial interest in the PSO.

Licensure of PSOs
A Medicare+Choice plan must be organized and licensed under state law as a risk bearing entity to offer health insurance or health benefits coverage. PSOs can seek waivers of the requirement

for state licensure from the U.S. Department of Health and Human Services (HHS) by filing an application no later than November 1, 2002. The nonrenewable waiver is effective for 3 years and is not applicable in another state.

Applications for waivers must be approved by HHS within 60 days. Waiver applications must be approved if: 1) the state failed to process the licensure application within 90 days; 2) the state's non-solvency standards or review process were not generally applicable to other entities in substantially the same business or the state required the PSOs as a condition of licensure to offer any product or plan other than a Medicare Choice plan; or 3) for applications filed after the publication of federal solvency standards for PSOs, the state imposed solvency standards which were not the same as federal standards or the state's solvency standards or review process imposed requirements that were not generally applicable to other entities in substantially the same business.

Rates for plans are set by HHS and will be announced March 1 of the year before the year to which they apply. The HHS will provide notice of changes in the methodology and assumptions used in the previous year 45 days before the rate announcement.

Solvency Standards
The federal act required the Secretary of HHS to develop interim final regulations establishing solvency standards for PSOs to meet. On March 5, 1998, an interim final rule was released providing initial and ongoing requirements for net worth, the financial plan content and coverage requirements, and insolvency deposit requirements for uncovered expenditures.

At the time of application, a PSO must have a minimum net worth of $1.5 million. However, HCFA may lower the net worth requirement to less than $1 million, based on a business/financial plan demonstrating that the PSO has or has available to it an administrative infrastructure that will reduce the PSO's start-up costs. If at least $1 million of the initial minimum net worth requirement is met by cash or cash equivalents, then HCFA will admit the generally accepted accounting principles (GAAP) value of intangible assets up to 20 percent of the minimum net worth amount required.

At the time of application, the PSO, which has been waived, must submit a financial plan, satisfactory to HCFA, covering the first 12 months of operation which includes: 1) detailed marketing plan; 2) statements of revenue and expenses on an accrual basis; 3) a cash flow statement; 4) balance sheets; 5) the assumptions in support of the financial plan; and 6) if applicable, availability of financial resources to meet projected losses.

If the plan projects losses, the financial plan must cover the period through 12 months beyond projected break-even. In the financial plan, the PSO must demonstrate that it has the resources available to meet the projected losses for the entire period to break-even. Except for the use of guarantees, the resources must be assets on the balance sheet of the PSO in a form that is either cash or will be converted to cash in a timely manner. The PSO must provide $750,000 in cash or cash equivalent toward the minimum net worth requirement.

Ongoing net worth requirements, as of the first day of operations, for PSOs is equal to the greater of: 1) $1 million; 2) or 2 percent of annual premium revenues, as reported on the most recent annual financial statement filed with HCFA on the first $150 million of premium and 1 percent of annual premium on the premium in excess of $150 million; 3) or an amount equal to the sum of 3 months uncovered health expenditures, as reported on the most recent financial statements filed with HCFA; or 4) an amount equal to the sum of 8 percent of annual health care expenditures paid on a non-capitated basis to non-affiliated providers; and 4 percent of annual health care expenditures paid on a capitated basis to non-affiliated providers plus annual health care expenditures paid on a non-capitated basis to affiliated providers.

Application of Federal and State Regulations
PSOs that obtain a federal waiver are required to comply with all state consumer protection and quality standards as long as those standards are consistent with standards for Medicare Choice plans and are generally applicable to other Medicare Choice organizations. A PSO that is not licensed by a state and that has obtained a federal waiver would be required to meet federal solvency standards.

Federal non-solvency standards preempt any state law or regulation with respect to Medicare Choice plans that are inconsistent with federal standards. Specifically, state standards with regard to benefit requirements, and requirements relating to inclusion or treatment of providers and coverage determinations (including appeals and grievance procedures) are preempted.

Benefits, Disclosures, and Antidiscrimination
Except for Medical Savings Account plans, all Medicare Choice plans are generally required to provide current Medicare benefit package (excluding hospice services). Medicare Choice benefits provided through coordinated care plans may offer mandatory supplemental benefits, subject to the Secretary of the U.S. Department of Health and Human Services approval. In general, the Medicare+Choice plans must meet standards similar to those under current law related to disclosure, access, quality, grievances, and appeals, confidentiality, and information of advance directives. The plans are prohibited from health screening enrollees or discriminating with respect to participation, payment, or indemnification against any provider acting within the scope of the provider's license or certification.

The plans are also required to provide at the time of enrollment and at least annually, in a clear, accurate, and standardized form specific information to each enrollee, such as the plan's service area, benefits, number and mix of providers, out-of-area coverage, emergency coverage, supplemental benefits, prior authorization rules, appeals and grievances procedures, and quality assurance program. An emergency medical condition is defined using a prudent, layperson's standard. The plans must establish procedures to safeguard the privacy of identifiable enrollee information to maintain accurate and timely medical records, and to assure timely access of enrollees to their medical records.

III. Effect of Proposed Changes:

Section 1. Creates s. 624.1291, F.S., to exempt certain health care providers from the provisions of the Insurance Code. Specifically, any person who enters into a contract or agreement with an authorized insurer, or with an HMO or PSO that has obtained a certificate of authority pursuant to chapter 641 to provide health care services to persons insured under a health insurance policy, HMO contract, or PSO contract is not deemed to be an insurer and not subject to the Insurance Code, regardless of the risk assumed, provided that: 1) the authorized insurer, HMO, or PSO remains contractually liable to the insured to the full extent provided in the policy or contract with the insured; and 2) the person does not receive any premium payment or per-capita fee from the insured other than fees for services not covered under the contract or policy, such as deductibles, co-payments, or charges in excess of policy or contract limits which are otherwise allowed to be collected; and 3) any person who is an administrator as defined in s. 626.88, F.S. (i.e., third-party administrators), must meet the requirements of part VII of ch. 626, F.S., and any person who is performing fiscal intermediary services as defined in s. 641.316, F.S., must meet the requirements of that section.

Section 2. Creates s. 624.1292, F.S., relating to exemption of contracts with self-funded ERISA plans from the Insurance Code, to provide that an insurer, HMO, PSO, hospital, licensed health care provider, or any group or combination of such persons or entities, is not deemed to be an insurer and is exempt from the Insurance Code with respect to contracts or agreements with an employer that has established a self-funded employee-benefit plan under ERISA, under which: 1) the employer retains ultimate obligation to provide health benefits to covered employees or the related financial risk; and 2) the insurer, HMO, PSO, hospital, or licensed health care provider does not receive any premium payment or per-capita fee from the covered employees other than fees for services not covered by the plan, such as deductible amounts, co-payments, or charges in excess of plan limits that are otherwise allowed to be collected.

Section 3. A new part IV of ch. 641, F.S., is created consisting of ss. 641.801, 641.802, 641.803, 641.804, 641.805, and 641.806, F.S., designated as the "Provider-Sponsored Organization Act."

The bill provides legislative findings that a major restructuring of health care has taken place and alternative methods for the delivery of health care services are needed to promote competition and increase patients' choices and that the U.S. Congress has enacted legislation that allows provider-sponsored organizations to provide coordinated-care plans to Medicare enrollees through the Medicare Choice program. The federal act requires any organization that offers a Medicare Choice Plan to be organized under state law as an entity eligible to offer health-benefit coverage in the state in which it offers Medicare Choice plans.

The section provides definitions of terms used in part IV of chapter 641, F.S., that are unique to PSOs or the Medicare Choice plan, as follows:

"Affiliation" means a relationship between providers in which, through contract, ownership, or otherwise: 1) One provider controls, is controlled by, or is under common control of the other; 2) Both providers are part of a controlled group of corporations under s. 1653 of the Internal Revenue Code of 1986; 3) Each provider is a participant in a lawful combination under which provider shares substantial financial risk in connection with the organization's operations; or 4) Both providers are part of an affiliated service group under s. 414 of the Internal Revenue Code of 1986.

"Comprehensive health care services" means services, medical equipment, and supplies required under Medicare Choice program.

"Copayment" means a specific dollar amount that the subscriber must pay upon receipt of covered health care services as required or authorized under the Medicare Choice program.

"Provider-sponsored contract" means any contract entered into by a provider-sponsored organization that serves Medicare Choice beneficiaries.

"Provider-sponsored organization (PSO)" means any organization authorized under this part which 1) is established, organized, and operated by a health care provider or group of affiliated health care providers; 2) provides a substantial proportion of the care items and services specified in the Medicare Choice contract, as defined by the Secretary of the United States Department of Health and Human Services, directly through the provider or affiliated group of providers; and 3) shares, with respect to its affiliated providers, substantial financial risk in the provision of such items and services and has at least a majority financial interest in the entity.

"Substantial proportion" of health care items and services shall be defined by the U.S. Department of Health and Human Services after having taken into account the need for such an organization to assume responsibility for providing significantly more than the majority of the items and services under the Medicare Choice contract through its own affiliated providers and the remainder of the items and services with which the organization has an agreement to provide such items and services. Consideration will also be given to the need for the organization to provide a limited proportion of the items and services under contract through entities that are neither affiliated with nor have an agreement with the organization.

"Subscriber," is defined to mean a Medicare Choice enrollee who is eligible for coverage as a Medicare beneficiary.

"Surplus" means total assets in excess of total liabilities as determined by the federal rules on solvency standards established by the U.S. Department of Health and Human Services, pursuant to s. 1856(a) of the federal Balanced Budget Act of 1997, for PSOs that offer Medicare Choice plans. (See II. Present Situation for a further discussion of these rules.)

New s. 641.804, F.S., provides that, except as provided in this part, PSOs, are governed by this part and are exempt from all other provisions of the Insurance Code.

New s. 641.805, F.S., provides that the Insurance Code and part IV of ch. 641, F.S., do not authorize any PSO to transact any insurance business other than to offer Medicare Choice plans pursuant to s. 1855 of the federal Balanced Budget Act of 1997.

New s. 641.806, F.S., provides that parts I and III of ch. 641, F.S., will apply to PSOs to the same extent such sections apply to HMOs, except: 1) the definitions used in this part (part IV) will control to the extent of any conflict the definitions used in s. 641.19, F.S.; 2) the certificate of authority and all other forms issued or prescribed by the department pursuant to this part must refer to a "provider service organization" instead of a "health maintenance organization"; 3) such provisions will not apply to the extent of any conflict with ss. 1855 and 1856 of the Balanced Budget Act of 1997 and rules adopted by the Secretary of Health and Human Services, including, but not limited to requirements related to surplus, net worth, assets, liabilities, investments, PSO contracts, payment of benefits, and procedures for grievances and appeals; 4) such provisions will not apply to the extent of any waiver granted by the Secretary of Health and Human Services; 5) such provisions will not apply to the extent that they are unrelated to, or inconsistent with, the limited authority of PSOs to offer only Medicare Choice plans; and 6) s. 641.228, F.S., related to the Florida HMO Consumer Assistance Plan does not apply.

Section 4. Amends s. 641.227, F.S., to require a PSO, as HMOs are currently required, to deposit with the department $10,000 in cash for use in the Rehabilitation Administrative Expense Fund, as established in s. 641.227, F.S., to be used for payment of the administrative expenses of the department during any rehabilitation of a HMO or PSO, when rehabilitation is ordered by a court. Upon successful rehabilitation of a PSO, the PSO is required to reimburse the fund for the expenses incurred by the department during the court-ordered rehabilitation period or liquidation.

Section 5. Amends s. 641.316, F.S., regarding fiscal intermediary services organizations. Currently, a $10 million fidelity bond is required for persons or entities engaged in the business of providing fiduciary or fiscal intermediary services to any contracted health care provider or provider panel. Organizations owned, operated, or controlled by a hospital, authorized insurer, licensed third-party administrator, prepaid limited health organization, HMO, or physician group practice is exempt from the statute's requirements. The bill provides the same exemption for PSOs.

Section 6. Creates a new (unnumbered) section that exempts PSOs from s. 455.654, F.S., for the provision of health care services to enrollees of a Medicare Choice plan. The cited section prohibits certain financial arrangements between referring health care providers and providers of health care services.

Section 7. Provides that the act shall take effect October 1, 1998.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

PSOs applying for a certificate of authority through the Department of Insurance would be subject to the $1,000 filing fee. PSOs issued a certificate of authority would be subject to a $150 annual fee. As a precedent for applying for a certificate of authority, the PSO would be required to submit a $1,000 application fee to the Agency for Health Care Administration and meet certain requirements in order to obtain a health care provider certificate.

B. Private Sector Impact:

The bill provides persons eligible for Medicare an opportunity to enroll with a PSO for the delivery of their health care services.

The exemptions from the Insurance Code may result in exempting certain insurance arrangements from regulation that would otherwise be subject to regulation under the Insurance Code. Such regulation includes solvency-related requirements for a person engaged in the business of providing insurance, which protect policyholders from financial loss in the event that the person or entity is unable to fulfill the requirements of the insurance contract.

C. Government Sector Impact:

The Department of Insurance is requesting one examiner and one analyst at this time to implement the provisions of the bill. However, the extent of the regulatory role is not yet determined. (See VI. Related Issues.)

Estimated Resources Required by Department of Insurance:	1999-00	2000-01	2001-02
FTEs	2	2	2
Salaries and Benefits	$67,738	$90,317	$90,317
Expense	$10,362	$10,362	$10,362
Other Capital Outlay	0	0	0
Total Fiscal Impact on Insurance Commissioner's Regulatory Trust	**$78,100**	**$100,679**	**$100,679**

The Agency for Health Care Administration indicated that the bill would have an impact on the agency by increasing workload due to regulating a new type of entity. At this time there are no estimates of how many potential PSOs may be subject to state regulation. However, the agency provided the following estimated fiscal impact:

	FY 1998-99	FY 1999-00
Nonrecurring:		
Expenses	$7,865	0
Other Capital Outlay	12,748	0
Total Nonrecurring	**$20,613**	**0**
Recurring		
FTEs	$138,103	$169,822
Expenses	29,942	39,923
Total Recurring	**$168,045**	**$209,745**

VI. Technical Deficiencies:

None.

VII. Related Issues:

A Medicaid project, enacted by the Legislature in 1997, authorizes the Agency for Health Care Administration to establish up to four provider service networks (PSNs) to test the feasibility of direct contracting with providers. The PSNs, while very similar to the federal PSOs in the type of services offered, will be under contract with the state and paid a percentage of the traditional Medicaid fee-for-service rate not paid on a capitated basis as a risk-bearing entity.

VIII. Amendments:

None.

This Senate staff analysis does not reflect the intent or official position of the bill's sponsor or the Florida Senate.