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: April 14, 1998 Revised: 4/17/98

Subject: Delivery of Health Care Services; Provider-Sponsored Organizations

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

I. Summary:

The Committee Substitute for Committee Substitute for Senate Bill 1432 authorizes the licensure and regulation of provider-sponsored organizations by the Department of Insurance and the Agency for Health Care Administration. Provider-sponsored organizations (PSOs) are authorized to provide health care coverage only to Medicare beneficiaries under the federal Medicare Choice program. The bill creates a new part IV of chapter 641, F.S., and specifies that the provisions of parts I and III of chapter 641, F.S., providing for the regulation of 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 any person who enters into a contract with a licensed insurer, HMO, or PSO (commonly referred to as "downstream risk" providers) to provide health care services to persons insured under the policy issued by the insurer, HMO, or PSO, under certain conditions, and it clarifies that PSOs are not precluded from contracting with more than one company for all necessary administrative and management services. The bill directs the Agency for Health Care Administration (AHCA) to contract for a demonstration pilot project for certain outpatient specialty services.

The bill creates the following sections of the Florida Statutes: 624.1291, 641.801, 641.802, 641.803, 641.804, 641.805, and 641.806; amends the following sections of the Florida Statutes: 409.912, 641.227, and 641.316; and creates one undesignated section of law.

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 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 the state Insurance Code, and the federal Employee Retirement Income Security Act of 1974 (ERISA) would not preempt state regulation. The Employee Retirement Income Security Act of 1974 regulates employee welfare benefit plans that include group health benefit plans established and maintained by an employer for participants and beneficiaries of participants. An ERISA plan can be either an employee welfare benefit plan that fulfills all or part of the benefit obligation through the purchase of insurance or 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 the assumption of such risk 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, contained several suggestions including the following summarized recommendations:

1. 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 PSO should not be directly regulated. However, the Commission recommends that 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 with all statutory, contractual, and reporting arrangements.

3. In all direct contracting arrangements, with the exception of Medicare, when making the determination as to whether PSOs are risk-bearing entities, the combination of elements that determine 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. Legislation passed during the 1997 Legislative Session authorizing the Department of Insurance to promulgate rules to regulate fiscal intermediary service organizations be repealed. Such entities should be regulated the same as PSOs.

5. The Department of Insurance should exercise latitude, judgment, and discretion when it has 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 Financing Administration's (HCFA), of the U.S. Department of Health and Human Services (HHS), authority to contract with a greater variety of managed care and fee-for-service plans under the Medicare program. 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. Medicare Choice provides benefits through coordinated care plans such as a preferred provider organization, a health maintenance organization, or a provider-sponsored organization or through a medical savings account (MSA)/high deductible plan.

Provider-Sponsored Organizations or PSOs

Provider-sponsored organizations are defined as public or private entities established by, or organized by, health care providers or a group of affiliated providers that offer 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. Provider-sponsored organizations can seek waivers of the requirement for state licensure from HHS by filing an application no later than November 1, 2002. The nonrenewable waiver is effective for 3 years and is not effective in another state.

Applications for waivers must be approved by HHS within 60 days. Waiver applications must be approved if: 1) the state fails to process the licensure application within 90 days; 2) the state's non-solvency standards or review process for determination of non-solvency are not generally applicable to other entities substantially in the same business or the state requires 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 imposes solvency standards which are not the same as federal standards or the state's solvency standards or the review process for determination of solvency imposes 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 Department of Health and Human Services is required to provide notice of changes in the methodology and assumptions used in the previous year 45 days before the rate announcement.

Solvency Standards

The Balanced Budget Act 1997 requires the Secretary of HHS to develop interim final regulations establishing solvency standards for PSOs. 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. 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 provider-sponsored organization must provide $750,000 in cash, or a 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) 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) 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

Provider-sponsored organizations 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 provider-sponsored organization 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 Anti-discrimination

Except for medical savings account plans, all Medicare Choice plans are generally required to provide the 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 HHS approval. In general, the Medicare Choice plans must meet standards similar to those under current law related to disclosure, access, quality, grievances, appeals, confidentiality, and 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 Medicare Choice 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: 1) safeguard the privacy of identifiable enrollee information, 2) maintain accurate and timely medical records, and 3) assure timely access of enrollees to their medical records.

Medicaid--Cost Effective Purchasing of Health Care Services

Medicaid is a medical assistance program that pays for health care for the poor and disabled. The program is jointly funded by the federal government, the state, and the counties. The federal government has established extensive requirements for the Medicaid Program. The Agency for Health Care Administration is the single state agency responsible for the Florida Medicaid

Program. The statutory provisions for the Medicaid Program appear in ss. 409.901-409.9205, F.S.

Section 409.912, F.S., provides for the cost-effective purchasing of health care services under the Medicaid Program. This section authorizes AHCA to contract with specific provider entities for the delivery of services to Medicaid recipients. These entities include health maintenance organizations, public entities, federally-qualified health centers, provider service networks (on a pilot basis), outpatient mental health service providers (on a pilot basis), insurers, and exclusive provider organizations. Such contracts may be on a prepaid or fixed-sum basis. The agency is prohibited from contracting with entities whose principals have a history of certain criminal wrong doing. Additional provisions of this section address federal Medicaid waivers, utilization review and utilization management, and care coordination. Specific requirements for contracting entities include surplus reserve, insolvency, provider reimbursement, marketing restrictions, agency fines, recipient complaints, toll-free access for consumer issues, quality assurance, care standards, enrollment choice counseling, provider availability, and emergency services and care.

III. Effect of Proposed Changes:

Section 1. Amends s. 409.912, F.S., providing for cost-effective purchasing of health care services under the Medicaid Program, to direct AHCA to issue a request for proposal or intent to negotiate for a 3-year outpatient specialty services pilot project in a rural and urban county in the state on a demonstration basis. Specification of certain requirements for the entity that is ultimately awarded the contract as well as an objective for the project is provided. The Agency for Health Care Administration is required to conduct a quality-assurance review each year of the project and the project contractor is required to submit data to the Agency relating to services provided to Medicaid recipients. The agency must evaluate the project and report its findings to the Governor and the Legislature by January 1, 2001. Language clarifies that this provision is not intended to conflict with existing law providing for competitive bidding for Medicaid home health, clinical laboratory, or x-ray services.

Section 2. Creates s. 624.1291, F.S., to exempt certain health care providers from 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 ch. 641, F.S., providing requirements for HMO and PSO regulation under the provisions of this bill, 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. However, the exemption is conditional and applies only if: 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 otherwise may 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., relating to the regulation of insurance administrators, and any person who is performing fiscal

intermediary services, as defined in s. 641.316, F.S., relating to the regulation of fiscal intermediary services, must meet the requirements of that section.

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

Section 641.801, F.S., provides the title of the act: "Provider-Sponsored-Organization Act".

Section 641.802, F.S., provides a declaration of legislative findings and purpose 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. Additionally, the legislative finding that properly operated plans emphasize cost and quality controls while ensuring the provider has control over medical decisions, along with other stated legislative findings, serves as the basis for the legislative policy declaration in support of PSOs. The Legislature declares that it is state policy to eliminate legal barriers to the organization, promotion, and expansion of PSOs that offer Medicare Choice plans to: 1) encourage development of health care options for Florida's Medicare beneficiaries and 2) recognize that comprehensive PSOs are exempt from state insurance law, except in the manner and to the extent provided under part IV of ch. 641, F.S., as created in this bill.

Section 641.803, F.S., provides definitions of terms used in part IV of chapter 641, F.S., that are unique to PSOs or the Medicare Choice program, 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.
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> "Comprehensive health care services" means services, medical equipment, and supplies required under the Medicare Choice program.
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> "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.

"Medicare Choice" means Medicare+Choice plan established under the federal Balanced Budget Act of 1997, and as provided for under part IV of chapter 641, F.S., the Provider-Sponsored Organization Act.

"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 HHS, 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. *As used in this subsection* the term, "substantial proportion" is defined to mean health care items and services as defined by HHS after having taken into account the need for a PSO 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 HHS, 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.)

Section 641.804, F.S., relating to the applicability of other laws, states that, except as provided in this part, PSOs are governed by part IV of ch. 641, F.S., and are exempt from all other provisions of the Florida Insurance Code.

Section 641.805, F.S., restricting PSOs relating to insurance business, 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.

Section 641.806, F.S., providing for the applicability of parts I and III of ch. 641, F.S., relating to the regulation of health maintenance organizations, provides that parts I and III of ch. 641, F.S., apply to PSOs to the same extent such sections apply to HMOs, except: 1) the definitions used in part IV control, to the extent that a conflict exists with the definitions used in s. 641.19, F.S.;

2) the certificate of authority and all other forms issued or prescribed by the Department of Insurance pursuant to this part must refer to a "provider-sponsored organization" instead of a "health maintenance organization;" 3) provisions of parts I and III of ch. 641, F.S., do not apply to the extent that there is any conflict with ss. 1855 and 1856 of the Balanced Budget Act of 1997 and rules adopted by the Secretary of HHS, 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) provisions of parts I and III of ch. 641, F.S., do not apply to the extent of any waiver granted by the Secretary of HHS under s. 1856(a)(s) of the Balanced Budget Act of 1997; 5) provisions of parts I and III of ch. 641, F.S., do not apply to the extent that they are unrelated to, or inconsistent with, the limited authority of PSOs to offer only Medicare Choice plans; 6) s. 641.228, F.S., relating to the Florida HMO Consumer Assistance Plan does not apply; and 7) clarifies that provider-sponsored organizations are not precluded from contracting with more than one company for all necessary administrative and management services.

Section 4. Amends s. 641.227, F.S., relating to the Rehabilitation Administrative Expense Fund, to require a PSO, as HMOs are currently required, to deposit with the Department of Insurance $10,000 in cash for use in the Rehabilitation Administrative Expense Fund to be used for payment of the administrative expenses of the department during any rehabilitation of an HMO or PSO, when rehabilitation is ordered by a court of competent jurisdiction. 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., providing for regulation of fiscal intermediary services, to add PSOs to the list of health care providers and health care entities whose wholly owned, operated, or controlled fiscal intermediary services organization is exempt from regulation under this provision of law. 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 are exempt from the statute's requirements.

Section 6. Creates an undesignated section of law that exempts PSOs from s. 455.654, F.S., providing for the regulation of patient self-referrals by certain health care providers, 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 an appropriation of $188,659 from the Health Care Trust Fund and authorizes four positions to implement the provisions of this bill.
Section 8. Provides that the act shall take effect October 1, 1998.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, subsections 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

Provider-sponsored organizations applying for a *certificate of authority* through the Department of Insurance must submit a $1,000 application fee. Once issued a certificate of authority, PSOs must then pay a $150 annual fee. However, as a prerequisite to applying for a certificate of authority issued by the Department of Insurance, a PSO is 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 otherwise may be subject to regulation. Such regulation pertains to solvency-related requirements applicable to insurers that is designed to protect policyholders from financial loss in the event that the insurer 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 section VII. Related Issues, of this analysis.

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	4	4
Salaries	$138,103	$169,822
Expenses	29,942	39,923
Total Recurring	**$168,045**	**$209,745**

The demonstration project that AHCA is directed to issue a request for proposals or an intent to negotiate relating to outpatient specialty services for the Medicaid Program is an opportunity for the State to explore whether such health care delivery would offer more cost-effective alternatives for the purchase of the specified services. $188,659 from the Health Care Trust Fund and 4 positions are appropriated in this bill to AHCA.

VI. Technical Deficiencies:

None.

VII. Related Issues:

A Medicaid demonstration project, enacted under s. 10 of ch. 97-260, L.O.F., authorizes the Agency for Health Care Administration to establish up to four provider service networks (PSNs) to test the feasibility of Medicaid direct contracting with providers. While similar to the federal

PSOs in terms of the type of services offered, the PSNs will be under contract with the state and paid a percentage of the traditional Medicaid fee-for-service rate and not paid on a capitated basis as risk-bearing entities like the PSOs.

VIII. Amendments:

None.

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