STORAGE NAME: h3895s1.hhs
DATE: April 6, 1998

HOUSE OF REPRESENTATIVES
AS REVISED BY THE COMMITTEE ON
HEALTH AND HUMAN SERVICES APPROPRIATIONS
BILL RESEARCH & ECONOMIC IMPACT STATEMENT

BILL #: CS/HB 3895

RELATING TO: Delivery of Health Care Services

SPONSOR(S): The Committee on Health Care Services and Rep. Saunders

COMPANION BILL(S): SB 1432 Compare

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:

(1) HEALTH CARE SERVICES YEAS 7 NAYS 3
(2) HEALTH AND HUMAN SERVICES APPROPRIATIONS
(3)
(4)

I. SUMMARY:

This bill creates a new part IV of chapter 641, F.S., to regulate provider service organizations (PSOs) by the Department of Insurance (department). Statutory regulatory requirements for PSOs will be virtually identical to HMO statutory requirements contained in part I of chapter 641, F.S., except that PSOs will only be authorized to serve Medicare beneficiaries. In addition, the bill subjects PSOs to the regulatory requirements of part III of chapter 641, F.S., which provides for regulatory standards related to quality of care. Part III is regulated by the Agency for Health Care Administration (AHCA or agency). As created in this act, a PSO will only be authorized to serve Medicare beneficiaries through a contract with the federal Health Care Financing Administration. In serving Medicare beneficiaries, a PSO is exempt from the provisions of s. 455.654, F.S., the "Patient Self Referral Act of 1992".

In addition, this bill creates two new sections in ch. 624, F.S., to clearly state when a party, including a network of health care providers, who has entered into contract with an HMO or PSO, or with a self-funded employee benefit plan under ERISA, is subject to state regulation by the department. According to these sections, regulation by the department is not authorized if: 1) the employer, insurer, HMO, or PSO retains the ultimate obligation to provide health benefits to covered employees or the financial risk relating thereto; and 2) the party or network of providers does not receive any premium payment or per-capita fee from the covered employees other than fees for services not covered under the plan, such as deductible amounts, co-payments, or charges in excess of plan limits which are otherwise permitted to be collected.

Also created within this bill is the "Panel for the Study of Regulation of Health Care Services", a 12 member panel composed of a House and Senate member, the Secretary of the Department of Health and the Director of the Agency for Health Care Administration, and representatives of hospitals, physicians, and outpatient facilities. The panel is to submit its recommendations for streamlining health regulation to the Legislature and the governor by March 1, 1999.

The department estimates enactment of this legislation will result in a cost of $78,100 in FY 1998-1999 and $100,679 in FY 1999-2000. The Agency for Health Care Administration estimates the cost of implementing this bill to be $188,658 in FY 1998-99 and $209,745 in

1999-2000. According to the agency, its first year costs will have to be General Revenue funded. DOI costs and second year agency costs are from trust funds. There is currently no appropriation provided in the bill.

II. SUBSTANTIVE RESEARCH:

A. 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. The commission was to 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 Financing Administration's (HCFA's), of the Department of Health and Human Services (HHS), 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. Medicare+Choice provides benefits through coordinated care plans, such as a preferred provider organizations, HMOs or PSOs 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 three 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. 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 towards the minimum net worth requirement.

Ongoing net worth requirements, as of the first day of operations, for PSOs are 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, 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 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 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.

B. EFFECT OF PROPOSED CHANGES:

Medicare beneficiaries will be given an additional choice of managed care providers in Florida, the PSO. Regulatory authority of the department with regard to networks of providers under contract with self-insured employers will be expressly stated in Florida law. Such provider networks will **not** be subject to regulation by the department, if the employer maintains the ultimate financial responsibility for providing health care to his employees, and if the provider network collects no premiums from the employees.

Based on the recommendations of the "Panel for the Study of Regulation of Health Care Services", certain health care regulations may be eliminated or reduced.

C. APPLICATION OF PRINCIPLES:

1. Less Government:

a. Does the bill create, increase or reduce, either directly or indirectly:

(1) any authority to make rules or adjudicate disputes?

Yes, the bill gives the department and the agency regulatory and rule making authority over PSOs.

(2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

Entities wishing to be regulated as a PSO will be required to meet the regulatory standards in the bill.

(3) any entitlement to a government service or benefit?

No.

b. If an agency or program is eliminated or reduced:

(1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

N/A

(2) what is the cost of such responsibility at the new level/agency?

N/A

(3) how is the new agency accountable to the people governed?

N/A

2. Lower Taxes:

a. Does the bill increase anyone's taxes?

No.

b. Does the bill require or authorize an increase in any fees?

No.

c. Does the bill reduce total taxes, both rates and revenues?

No.

d. Does the bill reduce total fees, both rates and revenues?

No.

e. Does the bill authorize any fee or tax increase by any local government?

No.

3. Personal Responsibility:

a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

No.

b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

Yes, PSOs will pay for the cost of regulation through fees.

4. Individual Freedom:

a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs?

The bill does permit another option for Medicare beneficiaries in the selection of a managed care plan.

b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

No.

5. Family Empowerment:

a. If the bill purports to provide services to families or children:

(1) Who evaluates the family's needs?

N/A

(2) Who makes the decisions?

N/A

(3) Are private alternatives permitted?

N/A

(4) Are families required to participate in a program?

N/A

(5) Are families penalized for not participating in a program?

N/A

b. Does the bill directly affect the legal rights and obligations between family members?

No.

c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

(1) parents and guardians?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. STATUTE(S) AFFECTED:

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

E. SECTION-BY-SECTION RESEARCH:

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, F.S., 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, to the extent permitted by federal law, 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 the 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. Creates a new 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., as follows:

Section 641.801, F.S., designates this part as the “Provider-Sponsored Organization Act.”

Section 641.802, F.S., 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.

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 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 providers share 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 the 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.

Section 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.

Section 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.

Section 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 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 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. Creates the "Panel for the Study of Regulation of Health Care Services", a 12 member panel composed of a House and Senate member, the Secretary of the Department of Health and the Director of the Agency for Health Care Administration, and representatives of hospitals, physicians, and outpatient facilities. The panel is to submit its recommendations for streamlining health regulation to the Legislature and the governor by March 1, 1999.

Section 8. Provides that the act shall take effect October 1 of the year in which it is enacted, except as otherwise provided herein.

III. FISCAL RESEARCH & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

AHCA Expenditures	1998-99	1999-2000
Non-Recurring Expenses -- Furniture & Equipment for FTEs		
Professional Staff 3 @ $2,132	$6,396	$0
Support Staff 1 @ $1,469	$1,469	$0
Total Non-Recurring Expenses for 4 FTEs	$7,865	$0
Non-Recurring Capital Outlay		
Professional Staff 3 @$3,167	$ 9,501	$0
Support Staff	$ 3,247	$0
Total Non-Recurring OCO for 4 FTEs	$12,748	$0
Total Non-Recurring Costs	$20,613	$0

2. Recurring Effects:

	1999-00	2000-01
Department of Insurance		
FTEs	2	2
Salaries and benefits	$67,738	$90,317
Expenses	$10,362	$10,362
Other capital outlay	0	0
Total	$78,100	$100,679
AHCA		
FTE salaries and benefits	4 FTEs	4 FTEs
1 Administrative Secretary	$ 19,508	$ 26,010
1Health Facilities Consultant Supervisor	$ 42,946	$ 42,946
2 Health Facilities Consultants	$ 75,649	$100,866
Total Salary and Benefits	$138,013	$169,822
Recurring Expenses - Office Expenses for FTEs		
Professional staff-3@$11,057	$24,878	$33,171
Support Staff 1@6,752	$ 5,064	$ 6,752
Total Recurring Expenses for FTEs	$29,942	$39,923
Total Recurring Expenses	$168,045	$209,745

3. Long Run Effects Other Than Normal Growth:

   None.

4. Total Revenues and Expenditures:

AHCA Expenditures	1998-99	1999-2000
Total Salary and Benefits	$138,103	$169,822
Total Expenses	$ 37,807	$ 39,923
Total Operating Capital Outlay	$ 12,748	$ 0
Total Expenditures	$188,659	$209,745

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

   None.

2. Recurring Effects:

   None.

3. Long Run Effects Other Than Normal Growth:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

   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.

2. Direct Private Sector Benefits:

   Medicare beneficiaries will have access to an additional choice of managed care provider, the PSO.

3. Effects on Competition, Private Enterprise and Employment Markets:

   Medicare HMOs will face competition from Medicare PSOs.

D. FISCAL COMMENTS:

None.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that municipalities or counties have to raise revenues.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

The issue of whether to subject to insurance regulation a network of health care providers under contract with an ERISA qualified self-insured employer is controversial. The Florida Commission on Integrated Health Delivery Systems recommended "...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." However, a minority report issued by that same commission dissented on this issue as it relates to ERISA self insurance plans, and suggested "This recommendation would have the effect of imposing regulations on PSOs that are not imposed on HMOs, thus creating an uneven regulatory environment."

The Department of Insurance, the HMO industry, Agency for Health Care Administration, and the Academy of Florida Trial Lawyers expressed concern about the exemption from regulation contained in section 2 of the bill. According to the department, the exemption may be quite large since virtually any employer can file documents with the federal Department of Labor and qualify as an ERISA plan, even small employers. The agency expressed concern that there will be no mechanism to resolve consumer complaints for persons receiving health care through these unregulated entities.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

A "strike everything" amendment was adopted during the March 24, 1998 meeting of the Health Care Services Committee. This amendment accomplishes the same goal as the original bill, to provide a regulatory structure for PSOs, but through a much simpler means. The amendment contains the same legislative intent language and the same changes to part III of ch. 641, F.S. However, instead of republishing most of the provisions of part I of ch. 641, F.S., and changing the term "health maintenance organization" to "provider sponsored organization", (as the original bill does) the amendment simply states that the provisions of part I and III of ch. 641, F.S., apply to PSOs to the same extent such sections apply to HMOs. Exceptions are made for provisions in part I and III which are not applicable to PSOs serving Medicare beneficiaries to the extent of any conflict with federal law.

In addition, the amendment creates two new sections in ch. 624, F.S., to clearly state when a party, including a network of health care providers, who has entered into contract with an HMO or PSO, or with a self-funded employee benefit plan under ERISA, is subject to state regulation by the department. According to these sections, regulation by the department is not authorized if: 1) the employer, insurer, HMO, or PSO retains the ultimate obligation to provide health benefits to covered employees or the financial risk relating thereto; and 2) the party or network of providers does not receive any premium payment or per-capita fee from the covered employees other than fees for services not covered under the plan, such as deductible amounts, co-payments, or charges in excess of plan limits which are otherwise permitted to be collected.

Three amendments were adopted to the amendment. The first amendment relates to the exemption from insurance regulation for certain entities to require plan administrators to be in compliance with regulatory requirements of part VII of ch. 626, F.S., and any person who is performing fiscal intermediary services must be in compliance with s. 641.316, F.S. The second creates the "Panel for the Study of Regulation of Health Care Services" composed of a House and Senate Member, three hospital and three physician representatives, the Secretary of the DOH and the Director of the agency, and two representatives of outpatient services. The panel is to submit a report to the Governor and Legislature on reforms to health regulation by March 1, 1999. The third amendment to the amendment clarifies that the exemptions from regulation for HMOs, insurers, PSO's and health care providers must not conflict with federal law.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by: Michael P. Hansen

Legislative Research Director: Michael P. Hansen

AS REVISED BY THE COMMITTEE ON HEALTH AND HUMAN SERVICES APPROPRIATIONS:

Prepared by:	Legislative Research Director:
Eliza Hawkins	Lynn S. Dixon