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HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE SERVICES
BILL RESEARCH & ECONOMIC IMPACT STATEMENT

BILL #: HB 3895

RELATING TO: Provider Sponsor Organizations

SPONSOR(S): Rep. Saunders

COMPANION BILL(S): SB 1432 Compare

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

(1) HEALTH CARE SERVICES
(2) HEALTH AND HUMAN SERVICES APPROPRIATIONS
(3)
(4)
(5)

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.

This bill exempts from regulation under chapters 627 or 641, F.S., a PSO, a hospital, a physician, a group of physicians, or other health care providers, or a combination of physicians and other health care providers, when contracting with a self-insured employer, a health maintenance organization (HMO), a PSO, or a health insurer. The bill specifies that in such circumstances, risk is not transferred to the provider but remains with the self-insured employer, HMO, PSO, or health insurer.

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.

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.

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 a new part IV of chapter 641, F.S., consisting of ss. 641.801 through 641.895, F.S. In addition, the bill amends ss. 641.227, 641.316, 641.47, 641.48, 641.49, 641.495, 641.51, 641.512, 641.513, 641.515, 641.54, 641.59, and 641.60., F.S.

E. SECTION-BY-SECTION RESEARCH:

Section 1. Provides legislative findings and intent that a major restructuring of health care is occurring and there is an emphasis on cost-conscious services delivered through managed care programs. The Legislature recognizes the establishment of the Medicare+Choice program and declares it is the policy of the state to eliminate legal barriers for PSOs offering Medicare+Choice plans, to not extend insurance regulation to health care providers when contracting with self-insured employers under the Employee Retirement Income Retirement Act (ERISA), or with HMOs, insurance companies, or PSOs.

Section 2. Creates part IV of chapter 641, F.S., consisting of the following sections:

Section 641.801, F.S.**,** designates this part as the "Provider Sponsored Organization Act."

Section 641.803, F.S., provides legislative findings as follows. 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. HMOs are developing rapidly and provide cost effective, quality care. It is the policy of the state to eliminate legal barriers which hinder expansion of these plans and at the same time to protect consumers by providing appropriate regulation.

Section 641.805, F.S., creates definitions for the part, using many of the definitions used in the current part I of chapter 641, F.S. and provides conforming definitions for these terms.

Section 641.807, F.S., provides that, except as provided in this part, PSOs, like HMOs, shall be governed by this part and part III of chapter 641, F.S., and are exempt from all other provisions of the Insurance Code.

Section 641.809, F.S.**,** requires any entity that has not yet obtained a certificate of authority to operate a PSO, like a HMO, in Florida must be incorporated or be a division of a corporation formed under chapter 607 or 617, F.S., or a public entity that is organized as a political subdivision. If the PSO is a division of a corporation, the financial requirements of this part apply to the entire corporation.

Section 641.811, F.S., provides that the Insurance Code and part IV of chapter 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. In determining the type of activities by a PSO which require licensure by the department, certain transactions are exempted from regulation:

A PSO, a hospital, a physician licensed under chapters 458 or 459, F.S., a single specialty or mult- specialty group of physicians, other licensed providers, or any combination thereof, contracting with an HMO or PSO, or contracting with an insurer are exempt from the requirements of chapters 627 and 641, F.S. The provider group is not subject to regulation by the department in such an arrangement because the contractual obligation is deemed to only exist between the provider group and the self-insured employer, the licensed HMO, the PSO, or the insurer and the entity continues to bear

full and direct responsibility to the employee with no transfer of risk. In the event the provider group fails to provide the contractual services, the employer, HMO, PSO, or insurer still retains the risk to either provide or pay for health care services.

If a health care provider is the ultimate risk-bearer, that is directly obligated to individuals to provide, arrange, or pay for health care services, the department has regulatory jurisdiction of the health care provider. (These regulatory exemptions are not found in chapters 627 or 641, F.S.)

Section 641.813, F.S., requires an entity to obtain a certificate of authority from the department prior to operating a PSO. A PSO, as well as an HMO must submit: 1) articles of incorporation, 2) bylaws, rules, and regulations, or similar document, if any, regulating the conduct of the affairs of the applicant; 3) listing of the names, addresses, and official capacities of the persons responsible for conducting the affairs of the PSO, including officers, directors, and owners in excess of 5 percent of the common stock of the corporation, and documentation relating to the extent and nature of any contract or arrangement between the person and the PSO, including any possible conflict of interest; 4) biographical statement on forms prescribed by the department and an independent investigation report and fingerprints obtained pursuant to chapter 624, F.S., of each person responsible for the affairs of the PSO; 5) a statement generally describing the PSO, its operation, and its grievance procedures; 6) a statement describing with reasonable certainty the areas to be served by the PSO; 7) An audited financial statement prepared in accordance with statutory accounting principles, except that surplus notes that are acceptable to the department and meet the requirements of this part are to be included in the calculation of surplus; and 8) any additional data, financial statements, or other pertinent information required by the department, including a comprehensive feasibility study, conducted by a certified actuary in conjunction with a certified public accountant. The department is not authorized to issue a certificate to any applicant that does not possess a valid health care provider certificate issued by the agency.

Section 641.815, F.S., provides conditions precedent to issuance or maintenance of certificate of authority and effect of bankruptcy proceedings. As a condition precedent to the issuance or maintenance of a certificate, the PSO must file or have on file with the department an acknowledgment that a delinquency proceeding pursuant to part I of chapter 631 or supervision by the department pursuant to ss. 624.80 - .87 constitutes the exclusive method for the liquidation, rehabilitation, reorganization, or conservation of a PSO, and a waiver of any right to file or to be subject to a bankruptcy proceeding. (Same as an HMO.)

Section 641.817, F.S., requires the department to issue the certificate of authority within 90 days of receipt to any entity filing a completed application in conformity with s. 641.813, F.S., upon payment of the prescribed fees and upon the department determining: 1) the entity has obtained a health care provider certificate from the agency; 2) the PSO is actuarially sound; 3) the entity has met the applicable requirements of s. 641.821 , F.S.; 4) the procedures for offering comprehensive health care services and offering and terminating contracts to subscribers will not unfairly discriminate on the basis of age, sex, race, health, or economic status; 5) the entity furnishes evidence of adequate insurance coverage or adequate plan for self-insurance to respond to claims for injuries arising out of the furnishing of comprehensive health care services; 6) the ownership, control, and management of the entity is competent and

possesses managerial experience sufficient to make the proposed operation of the PSO beneficial to the subscribers.

The department may not grant or continue authority to transact the business of the PSO if the department has good reason to believe that the ownership, control, or management of the organization includes any person who is: 1) incompetent or untrustworthy; 2) lacking in expertise as to make the PSO operation hazardous to potential and existing subscribers; 3) affiliated with any person whose business operations are or have been marked by business practices or conduct that is detrimental to the public, investors, or creditors; 4) engaged or has been engaged in business practices or conduct that is detrimental to the public, investors, or creditors; 5) in a position to exercise or has the ability to exercise effective control of or influence the business of the PSO and has been found guilty of, or has pled guilty or no contest to, any felony or crime punishable by imprisonment of one year or more under the laws of the United States or any state thereof, or other country, which felony or crime involves moral turpitude, without regard to whether judgment or conviction has been entered by the court having jurisdiction in such case.

The entity is required to obtain a blanket fidelity bond in the amount of $100,000, which will reimburse the entity in the event that anyone handling the funds of the entity either misappropriates or absconds with the funds.

An agent licensed under the Insurance Code may either directly or indirectly represent the PSO in the solicitation, negotiation, effectuation, procurement, receipt, delivery, or forwarding of any PSO's subscriber's contract or collect or forward any consideration paid by the subscriber to the PSO.

The PSO must have a grievance procedure that will facilitate the resolution of subscriber grievances through a formal and informal process. (Medicare+Choice grievance procedures are governed by federal law.)

Section 641.819, F.S., requires a PSO, like an HMO, as a condition for maintaining eligibility for the certificate of authority to meet all conditions required to be met under this part and the rules adopted under this part for the initial application for and the issuance of the certificate under s. 641.817, F.S.

Section 641.821, F.S., requires a PSO offering a Medicare+Choice plan to meet surplus requirements that are consistent with the federal rules on solvency standards established by the U.S. Department of Health and Human Services, pursuant to s. 1856(a) of the Balanced Budget Act of 1997. (See Present Situation for discussion of solvency requirements.)

Section 641.4612, F.S., requires a PSO, like an HMO, 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. 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. (Same requirements for HMOs.)

Section 641.823, F.S., provides conditions for the revocation or cancellation of a certificate of authority, suspension of enrollment of new subscribers, and terms of suspension. The denial or revocation of a health care provider certificate is deemed to

be an automatic and immediate cancellation of the certificate. The department is authorized to suspend enrollment of new subscribers if the PSO, like an HMO, is not operating in compliance with this part, the plan is not actuarially sound, the PSO has engaged in deceptive, misleading, or unfair practices with respect to advertising, or the PSO is insolvent. The department is required to calculate and publish on an annual basis, the medical loss ratios of all licensed PSOs.

Section 641.825, F.S., authorizes the department to require a PSO, like an HMO, to submit any contract for administrative services or contract-management services or any contract with an affiliated entity. The department is authorized to require the PSO to cancel such a contract if it determines such fees to be paid by the PSO are so unreasonably high as compared with similar contracts entered into by the PSO or other PSOs or that the contract is detrimental to the subscribers, investors, or creditors of the PSO.

Section 641.827, F.S., requires every PSO, like an HMO, to file, upon request by the department, financial statements for all contract providers of the comprehensive health care services who have assumed, through capitation or other means, more than 10 percent of the health care risks of the PSO.

Section 641.829, F.S., authorizes the department to impose a fine upon the PSO, in lieu of revocation or suspension, as provided for an HMO.

Section 641.831, F.S., provides that each acquisition of a PSO is subject to s. 628.4615, F.S. Section 628.451, F.S., governs any merger or consolidation of a PSO organized as a for-profit and s. 628.471, F.S., governs any merger or consolidation of a PSO organized as a not-for-profit, as required of HMOs.

Section 641.833, F.S., requires a PSO to file an annual report with the department within 3 months after the end of its fiscal year in a form prescribed by the department. (Similar to HMO.)

Section 641.8135 F.S., authorizes the department to examine transactions, assets, and records of any PSO, like an HMO, as often as it deems necessary for the protection of Medicare beneficiaries, but not less frequently than once every 3 years. The department is authorized to engage outside sources to conduct audits or examinations. Expenses of such examinations may not exceed $20,000 for any 1-year period. In lieu of an examination, the department may accept an independent audit report on the financial statements prepared in accordance with statutory accounting principles.

Section 641.837, F.S., provides that the prevailing party in any civil action brought to enforce the terms and conditions of a PSO contract, as applicable to an HMO contract, may recover reasonable attorney’s fees and court costs.

Section 641.839, F.S., authorizes the department to seek both temporary and permanent injunctive relief when a PSO is: 1) engaging in any activity prohibited by this part or any rule adopted under this part; 2) being operated by any person or entity without a certificate of authority, unless a waiver has been granted by the U.S. Department of Health and Human Services, pursuant to s. 1855 (a)(2) of the Balanced Budget Act of 1997; or 3) renewing, issuing, or delivering a PSO contract or contracts without a subsisting certificate of authority, unless a waiver has been granted by the U.S.

Department of Health and Human Services, pursuant to s. 1855 (a)(2) of the Balanced Budget Act of 1997. (Similar to HMO.)

Section 641.841, F.S., requires each judgment or decree entered in any courts of this state against any PSO for the recovery of money must be fully satisfied within 60 days after the entry thereof, or in the case of an appeal from such judgment or decree, within 60 days after the affirmance of the judgment or decree by the appellate court. (Same requirements for HMOs.)

Section 641.843, F.S., provides that a delinquency proceeding under part I or chapter 631, F.S., or supervision by the department under ss. 624.80-624.87, F.S., constitute the sole and exclusive means of liquidating, reorganizing, rehabilitating, or conserving a PSO. (Same requirements for HMOs.)

Section 641.845 , F.S., requires each PSO to pay the department a nonrefundable application fee in the amount of $1,000 and an annual report filing fee of $150. (Same requirements for HMOs.)

Section 641.847, F.S., provides that the solicitation of subscribers by a PSO or its representatives does not violate any provision of law relating to solicitation or advertising by health professionals, if the PSO is operating pursuant to a subsisting certificate of authority or under the waiver granted by the U.S. Department of Health and Human Services. (Similar to HMO requirements.)

Section 641.849, F.S., relating to acquired immune deficiency syndrome (AIDS) and human immunodeficiency virus infection (HIV), provides standards and procedures for testing, notification of medical test results to an applicant, confidentiality of medical test results, and prohibits a PSO from excluding coverage of an individual because of a positive test result or a specific sickness or medical condition derived from an HIV infection, either as a condition for or subsequent to the issuance of a contract. (Same requirements for HMOs.)

Section 641.851, F.S., provides that each contract, form, or text of each advertisement must be printed in English and defines the term, “advertisement.” (Same requirements for HMOs.)

Section 641.853, F.S., establishes standards for marketing to persons eligible for Medicare, the format and manner for enrollment and disenrollment notification. In addition to the practices prohibited in s. 641.881 , F.S., a PSO or a representative of the PSO may not employ any method of marketing which has the effect of or tends to induce the purchase of health care plans through fraud, deceit, force, fright, threat, intimidation, or harassment to purchase or recommend the purchase of a PSO contract. (Marketing materials and applications must be approved by HHS.)

Sections 641.855-.861, F.S., requires a PSO to provide a copy of the applicable PSO contract to each subscriber. Each PSO contract, certificate, or member handbook must clearly state all the services the subscriber is entitled under Medicare+Choice contract and limitations on the services or kinds of services to be provided, including any copayment feature or schedule of benefits required by the contract. The subscriber must also receive a clear and understandable written description of the method for resolving subscriber grievances. (Federal law governs grievance procedures.)

Each Medicare Choice contract, certificate, or member handbook must disclose that emergency services and care will be provided without prior notification to and approval of the PSO to subscribers in emergency situations that do not permit treatment through the PSO's providers. A PSO is required to pay at least 75 percent of the reasonable charges for covered services and supplies. Payment may be subject to additional copayment provisions, not to exceed $100 per claim, if not inconsistent with federal rules established by the U.S. Department of Health and Human Services. (The definition of emergency situation differs from federal Medicare+Choice Program.)

The section also provides for certain services and coverages mandated for HMOs. However, federal law mandates certain items and services and HHS must approve any supplemental benefits.

Section 641.863, F.S., regarding provider contracts, provides that in the event a contract exists between a PSO and a provider, and the PSO fails to pay fees for services rendered to a subscriber, the PSO is liable for such fees. (Same requirements for HMOs.)

Section 641.865, F.S., prohibits the use of certain words and terms in the name of the organization. (Same requirements for HMOs.)

Section 641.867, F.S., requires that all assets, liabilities, and investments for PSOs that offer Medicare Choice plans must be consistent with federal rules on solvency standards.

Section 641.869, F.S., relating to the adoption of rules and penalty for violation, authorizes the department to promulgate rules that are necessary which are consistent with the federal rules governing the Medicare+Choice plan.

Section 641.871, F.S., governs the payments of dividends by the PSO. (Same requirements for HMOs.)

Section 641.873, F.S., relating to prohibited activities, to exempt PSOs that obtain a federal waiver from state certificate of authority requirements.

Section 641.875, F.S., authorizes the department to enter an immediate order to discontinue certain advertising by a PSO if it violates the provisions of this part.

Section 641.877, F.S., requires licensure and appointment of agents for PSOs. (Same requirements for HMOs.)

Sections 641.879 -.881, F.S., relating to unfair methods of competition and unfair or deceptive acts or practices, to prohibit a PSO from engaging in such activities. Provides some exemption for operating without a subsisting certificate for PSOs obtaining a federal waiver. (Similar to HMO.)

Section 641.883, F.S., provides general powers and duties of the department. (Same requirements for HMOs.)

Section 641.885, F.S., authorizes the department to conduct public hearings regarding a PSO engaging in unfair or deceptive acts or operating without a certificate of authority

and provides an exception licensure for PSOs obtaining a federal waiver. (Similar to HMO.)

Section 641.887, F.S., provides cease and desist and penalty orders and provides exception for PSOs operating under a federal waiver. (Same requirements for HMOs.)

Section 641.889, F.S., provides for appeals from the department. (Same requirements for HMOs.)

Section 641.891, F.S., provides penalty for violating cease and desist orders. (Same requirements for HMOs.)

Section 641.893, F.S., provides civil liability. (Same requirements for HMOs.)

Section 641.895, F.S., exempts PSOs from the provisions of s. 455.654, F.S., the "Patient Self-Referral Act of 1992" in serving Medicare+Choice enrollees.

Sections 3 and 4. Amends sections 641.227 and 641.316, F.S., regarding the Rehabilitative Administration Expense Fund and Fiscal Intermediary Services to provide applicability to PSOs.

Section 5. Amends s. 641.47, F.S., relating to definition relating to HMOS, to extend applicability to PSOs.

Section 6. Amends s. 641.48, F.S., to extend the application of part III of chapter 641, F.S., to PSOs. Part III presently requires HMOs and prepaid health clinics to obtain a health care provider certificate from the Agency for Health Care Administration as a condition precedent to obtaining a certificate of authority from the Department of Insurance.

Section 7. Amends s. 641.49, F.S., relating to certification of HMOs and prepaid health clinics as health care providers and the application procedure to extend the applicability to PSOs.

Section 8. Amends s. 641.495, F.S., relating to requirements for issuance and maintenance of a certificate to extend the applicability to PSOs and requires the agency to issue a certificate within 90 days after receipt.

Section 9. Amends s. 641.51, F.S., relating to quality assurance programs and second medical opinion requirements to extend the applicability to PSOs. (Federal law specifies elements of the program.)

Section 10. Amends s. 641.512, F.S., relating to accreditation and external quality assurance assessment to extend the applicability to PSOs. (Federal law specifies procedures.)

Section 11. Amends s. 641.513, F.S., relating to requirements for providing emergency services and care, to extend the applicability to PSOs.

Section 12. Amends s. 641.515, F.S., relating to investigations by the agency, to extend the applicability to PSOs.

Section 13. Amends s. 641.54, F.S., relating to information disclosure, to extend the applicability to PSOs.

Section 14. Amends s. 641.59, F.S., relating to psychotherapeutic services, records and reports, to extend the applicability to PSOs.

Section 15. Amends s. 641.60, F.S., relating to the Statewide Managed Care Ombudsman Committee, to extend the definition of managed care organization to PSOs.

Section 16. Provides that the act shall take effect October 1 of the year in which it is enacted.

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."

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

A "strike everything" amendment has been prepared for this bill which 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

extend 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.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by: Michael P. Hansen

Legislative Research Director: Michael P. Hansen