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HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE SERVICES
ANALYSIS

BILL #: HB1927

RELATING TO: Health Care

SPONSOR(S): Rep. Eggelletion

COMPANION BILL(S): SB 1892 (i) SB 2472 (s)

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) HEALTH CARE SERVICES
(2) HEALTH & HUMAN SERVICES APPROPRIATIONS
(3)
(4)
(5)

I. SUMMARY:

HB 1927 makes several changes relating to the Statewide Provider and Subscriber Assistance Panel. These provisions include:

- Precluding the Statewide Provider and Subscriber Assistance Panel from hearing grievances that are part of an internal grievance process in a Medicare managed care entity;
- Including accrued interest on unpaid balances, court costs, and transportation costs associated with grievance procedures in the list of incidental expenses that cannot form the basis for grievances before the panel;
- Expanding panel membership to include: a consumer; a physician as a standing member, and rotating physicians who provide specific expertise as appropriate to the case being heard; and
- Changing the current panel summary hearing process before the Division of Administrative Hearings with regard to the agency's or department's final action resulting from a panel hearing to a judicial review process.

With regard to quality assurance programs, HB 1927 provides that chronic disease management measures, preventive health care for adults and children, prenatal care measures, and child health checkup measures will become required data to be released to the agency as indicators of access and quality of care. The bill deletes requirements that each managed care organization conduct a standardized customer satisfaction survey that is consistent with surveys required by accrediting organizations.

Finally, HB 1927 creates a Health Care Information Council, to be located for administrative purposes only in the Agency for Health Care Administration, but independent from the agency, to publish the health maintenance organization report card. The council is to act in an advisory capacity to the Governor, the Legislature, the Department of Insurance, and the Agency for Health Care Administration on matters of health care accountability and consumer information.

According to the Agency for Health Care Administration, this bill will require expenditures from the Health Care Trust Fund of approximately $2.1 million per year.

II. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

Section 408.7056, F.S., 1998 Supplement, provides for the Agency for Health Care Administration to implement the Statewide Provider and Subscriber Assistance Program to provide assistance to subscribers and providers with grievances that have not been resolved by the accountable managed care entity to the satisfaction of the subscriber or provider. The program shall consist of one or more review panels that meet as often as necessary to consider and recommend to the agency any actions the agency or the Department of Insurance should take concerning individual cases heard by the panel.

According to s. 408.7056(11), F.S., 1998 Supplement, the review panel shall consist of members employed by the agency or department, chosen by their respective agencies, and the agency may contract with a medical director and a primary care physician who shall provide additional technical expertise to the review panel. At this time the panel is composed of six members, three from the department and three from the agency. The agency has elected to include a licensed physician as one of its members, and the department has elected to include a consumer advocate as one of its members. According to the agency, a specialty physician has not been included on the panel due to lack of funding.

If a health maintenance organization disagrees with the agency's or the department's final actions resulting from a panel hearing, the health maintenance organization can elect to go to the Division of Administrative Hearings for a summary hearing in accordance with s. 120.574, F.S. Summary hearings under this section are not judicial reviews of the findings and recommendations of the panel, but instead they are hearings "de novo." These hearings allow the parties to start anew with the presentation of facts to an administrative law judge as if there had been no review and recommendation by the panel.

Section 408.7056, F.S., 1998 Supplement, establishes certain types of grievances that the panel is precluded from hearing including grievances relating to a managed care entity's refusal to accept a provider into its network of providers, Medicare appeals that do not involve a quality of care issue, and grievances limited to seeking damages for pain and suffering, lost wages, or other incidental expenses. The section does not clearly specify that the panel has no jurisdiction to award expenses beyond the contractual obligations of the health plan, such as accrued interest on outstanding claims, nor does it state that the panel cannot hear grievances of subscribers in Medicare health maintenance organizations while the internal grievance process is ongoing.

Approximately 4.4 million Floridians are enrolled in health maintenance organizations, including 343,000 in Medicaid HMOs and more than 3 million in commercial HMOs. According to the agency statistics, nearly 65 percent of all cases heard by the panel are found in favor of the consumer.

HMO Regulation

Chapter 641, F.S., relates to health care services programs. Part I of this chapter, consisting of ss. 641.17-641.3923, F.S., is the "Health Maintenance Organization Act," under which the Department of Insurance regulates HMOs. Section 641.315, F.S., addresses HMO provider contracts. Subsection (2) of this section specifies that no subscriber of an HMO is liable to any provider of health care services for any services covered by the HMO. Subsection (3) of this section specifies that no provider of services, or any representative of such provider, shall collect or attempt to collect from an HMO subscriber any money for services covered by an HMO and no provider or representative of such provider may maintain any section at law against a subscriber of an HMO to collect money owed to such provider by an HMO.

Part III of ch. 641, F.S., consisting of ss. 641.47-641.75, F.S., authorizes the Agency for Health Care Administration to regulate HMO quality of care. Before receiving a license from the Department of Insurance, an HMO must receive a Certificate of Authority from AHCA. Among the requirements for the certificate is the requirement that the HMO must designate a medical director who is licensed under ch. 458 or ch. 459, F.S. (s. 641.495(11), F.S.).

Section 641.51, F.S., requires all health maintenance organizations to ensure that the health care services provided to subscribers are rendered under reasonable standards of quality of care

consistent with the prevailing standards of medical practice in the community. Under the section, each managed care organization is required to conduct its own standardized customer satisfaction survey. The organizations must submit the survey data to the agency, which in turn makes comparative findings available to the public.

Health maintenance organizations are also required under this section to release to the agency data which are indicators of access and quality care. Section 641.51(8), F.S., states that the indicators must: relate to access and quality of care measures; be consistent with data collected pursuant to accreditation activities and standards; and be consistent with frequency requirements under the accreditation process.

Section s. 641.58, F.S., provides for an annual regulatory assessment to be imposed upon every health maintenance organization in the state not to exceed 0.1 percent of the gross amount of premiums collected by each organization on contracts or certificates issued to subscribers in the state. This assessment is to be paid annually to the agency and deposited into the Health Care Trust Fund. According to s. 641.58(4), F.S., the moneys from the Health Care Trust Fund are to be used to defray the expenses of the agency in the discharge of its administrative and regulatory powers and duties under part III, ch. 641, F.S

B. EFFECT OF PROPOSED CHANGES:

The Statewide Provider and Subscriber Assistance Panel will be precluded from hearing grievances that are part of an internal grievance process in a Medicare managed care entity. Accrued interest on unpaid balances, court costs, and transportation costs associated with grievance procedures will be included in the list of incidental expenses that cannot form the basis for grievances before the panel.

Membership requirements for the panel will be expanded to include: a consumer; a physician as a standing member; and rotating physicians who provide specific expertise as appropriate to the case being heard.

The current panel summary hearing process before the Division of Administrative Hearings with regard to the agency's or department's final action resulting from a panel hearing will be changed to a judicial review process.

Chronic disease management measures, preventive health care for adults and children, prenatal care measures, and child health checkup measures will become required data to be released to the agency as indicators of access and quality of care.

Requirements that each managed care organization conduct a standardized customer satisfaction survey that is consistent with surveys required by accrediting organizations will be deleted.

The Health Care Information Council will be created administratively in the Agency for Health Care Administration but will be independent from the agency to publish the health maintenance organization report card. The council will also act in an advisory capacity to the Governor, the Legislature, the Department of Insurance, and the Agency for Health Care Administration on matters of health care accountability and consumer information.

C. APPLICATION OF PRINCIPLES:

1. <u>Less Government:</u>

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

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

The current panel summary hearing process before the Division of Administrative Hearings with regard to the agency's or department's final action resulting from a panel hearing will be changed to a judicial review process.

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

The Health Care Information Council will be created administratively within the Agency for Health Care Administration and will be responsible for conducting annual member satisfaction surveys of health maintenance organizations.

(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?

The subscribers may experience an increase in premiums and health maintenance organizations may incur increased regulatory assessments due to requirements that funding

for services previously provided by the organizations themselves will now be required by the agency for council activities.

4. Individual Freedom:

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

      No.

   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:

Sections 408.7056, 641.51, and 641.58, F.S.

E. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 408.7056, F.S., 1998 Supplement, relating to the Statewide Provider and Subscriber Assistance Program. The following subsections are amended:

Subsection (2) is amended to preclude the Statewide Provider and Subscriber Assistance Panel from hearing grievances that are part of an internal grievance process in a Medicare managed care entity, and to provide that incidental expenses that cannot form the basis for grievances before the panel include: accrued interest on unpaid balances; court costs; and transportation costs associated with grievance procedures.

Subsection (11) is amended to expand the membership requirements for the panel to include: a consumer; a physician as a standing member; and rotating physicians who provide specific expertise as appropriate to the case being heard.

Subsection (14) is amended to change the current summary hearing process before the Division of Administrative Hearings to a judicial review process.

Section 2. Amends s. 641.51, F.S., relating to the quality assurance program. The following subsections are amended:

Subsection (8) is amended to correct a grammatical mistake and to include chronic disease management measures, preventive health care for adults and children, prenatal care measures, and child health checkup measures as required data to be released to the agency as indicators of access and quality of care.

Subsection (9) is deleted to remove requirements that each managed care organization conduct a standardized customer satisfaction survey that is consistent with surveys required by accrediting organizations.

Subsection (10) is renumbered as subsection (9) and amended to change the title “early periodic screening diagnosis and treatment” requirements that each organization must adopt for preventive pediatric health care to “child health checkup” requirements.

Section 3. Amends s. 641.58, F.S., relating to the regulatory assessment. The following subsections are amended or created:

Subsection (4) is amended to include in the list of administrative functions for which the agency can use regulatory assessment funds deposited in the Health Care Trust Fund: a new Health Care Information Council; an annual health maintenance organization member satisfaction survey; and contracted physician consultants for the Statewide Provider and Subscriber Assistance Panel.

Subsection (8) is created to establish the Health Care Information Council to be administered by the Agency for Health Care Administration and to authorize the council to independently exercise its assigned duties.

Paragraph (8)(a) is created to provide that the council shall consist of 11 members, including the director of the Agency for Health Care Administration or the director’s designee, the Insurance Commissioner or the commissioner’s designee, 3 members appointed by the Governor, 3 members appointed by the President of the Senate, and 3 members appointed by the Speaker of the House of Representatives. The appointments must be made so as to achieve a balance among managed care organizations, providers, and consumers.

Paragraph (8)(b) is created to establish requirements for appointment of council members.

Paragraph (8)(c) is created to establish requirements for the election of a council chairperson and provide for the scheduling of council meetings.

Paragraph (8)(d) is created to provide that membership of the council does not disqualify a member from holding any other public office or being employed by a public entity except that a member of the Legislature may not serve on the council.

Paragraph (8)(e) is created to establish that members of the council shall serve without compensation but are entitled to reimbursement for per diem and travel expenses as provided by s. 112.061, F.S.

Subsection (9) is created to provide that the council shall employ an executive director and staff as is necessary, within the limits of legislative appropriations. Necessary consultants may also be retained. Neither the executive director nor any consultant may have been a contract vendor of the Department of Insurance or the Agency for Health Care Administration.

Subsection (10) is created to provide that the council shall act in an advisory capacity to the Governor, the Legislature, the Department of Insurance, and the Agency for Health Care Administration on matters of health care accountability and consumer information. The role of the council includes, but is not limited to: contracting with an independent contractor to administer an annual survey of member satisfaction for all health maintenance organizations, including the Medicare, Medicaid, and commercial product lines; selecting the instrument and the sampling design to meet the member satisfaction survey requirements of health maintenance organizations' accreditation organizations; producing an HMO report card; and making comparative survey results available to health maintenance organizations and the public.

Subsection (11) is created to provide that in addition to the member satisfaction survey results, the HMO report card must include benefit availability, physician qualifications, payment arrangements, copayments, and the quality indicators provided in s. 641.51(8)(d), (e), (f), and (g), as specified in section 2 of the bill.

Section 4. Provides for the act to take effect upon becoming a law.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

	FY 99-00	FY 00-01
AGENCY FOR HEALTH CARE ADMINISTRATION HEALTH CARE TRUST FUND		
Operating Capital Outlay (Health Care Information Council)	$ 31, 670	

2. Recurring Effects:

AGENCY FOR HEALTH CARE ADMINISTRATION HEALTH CARE TRUST FUND		
Total Salary & Benefits	$ 575,938	$ 593,216
Total Expenses	$ 224,290	$ 224,290
Other Personal Services	$1,379,000	$1,379,000

3. Long Run Effects Other Than Normal Growth:

None.

4. Total Revenues and Expenditures:

HEALTH CARE TRUST FUND TOTAL EXPENDITURES	$2,179,228	$2,196,503

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:

The bill may increase costs of premiums paid by subscribers for their health insurance.

2. Direct Private Sector Benefits:

None.

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

The health maintenance organization report card may lead to market consolidation among HMOs as subscribers move to those organizations with the highest ratings. Depending upon the extent to which it occurs, this consolidation may either improve market efficiency or may lead to oligopolies in health care. Smaller organizations are likely to be absorbed by or merged with larger ones.

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 revenue in the aggregate.

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:

None.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

None.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

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