STORAGE NAME: h1927s1.hcs
DATE: April 5, 1999

HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE SERVICES
ANALYSIS

BILL #: CS/ HBs 1927 & 961

RELATING TO: Managed Health Care

SPONSOR(S): Committee on Health Care Services, Reps. Eggelletion & Lacasa

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

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) HEALTH CARE SERVICES YEAS 15 NAYS 0
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I. SUMMARY:

Committee Substitute for House Bills 1927 & 961 requires the State Center for Health Statistics to publish and make available to the public HMO report cards.

The bill clarifies that the Statewide Provider and Subscriber Assistance Panel is 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 are also included in the list of incidental expenses that cannot form the basis for grievances before the panel. The bill expands the membership requirements for the panel to include: a consumer, appointed by the Governor; a physician, appointed by the Governor, as a standing member; and physicians who have expertise relevant to the case to be heard, on a rotating basis.

The bill authorizes an HMO to offer as a rider to a contract for comprehensive health care services a point-of-service benefit, whereby HMO subscribers may choose to receive services from a provider with whom the HMO does not have a contract, exclusive of a referral for such services. To offer such a rider, the HMO must have been licensed in Florida for at least 3 years and have a minimum surplus of $5 million; and the HMO's point-of-service business must not exceed 15 percent of the HMO's total product premium. The point-of-service plan can include copayments and annual deductibles, and must be filed with and approved by DOI.

The bill provides that chronic disease management measures, preventive health care for adults and children, prenatal care measures, and child health checkup measures are required data to be released to the agency as indicators of access and quality of care.

In addition, the bill requires that conducting an annual health maintenance organization member satisfaction survey and contracting with physician consultants for the Statewide Provider and Subscriber Assistance Panel be added to the list of AHCA's authorized uses of regulatory assessment revenues deposited into the Health Care Trust Fund.

Further, the bill: provides that any retroactive reductions of payments or demand for refund of previous overpayments which are due to retroactive review of coverage decisions or payment levels and any retroactive demands by providers for payment due to underpayments or non-payments for covered services must be reconciled to specific claims unless the parties agree to other reconciliation methods and terms; allows the look back period to be specified by the terms of the contract; and requires the Agency for Health Care to establish an advisory group to study and make recommendations relating to payment of claims.

The bill provides for an appropriation of $1,439,000 from the Health Care Trust Fund to the Agency for Health Care Administration for purposes of implementing the provisions of the bill.

II. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

Statewide Provider and Subscriber Assistance Panel

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. Any entity that is issued a certificate of authority under part 1 of chapter 641, F.S., and that is otherwise in compliance with that part may enter into contracts in Florida to provide an agreed-upon set of comprehensive health care services to subscribers in exchange for a prepaid per capita sum or prepaid aggregate fixed sum. Such entities must give their subscribers a copy of the applicable health maintenance contract, certificate, or member handbook that contains all pertinent provisions and disclosures required under s. 641.31, F.S., 1998 Supplement.

These provisions and disclosures, generally, relate to: (1) regulating the rates HMOs charge subscribers and disclosure of the rates charged; (2) regulating amendments or changes to the HMO contract, certificate, or member handbook provided to an HMO's subscribers; (3) regulating the content of HMO contracts, certificates, and member handbooks given to subscribers that contain consumer information about HMO products requiring clear delineation of covered services, including understandable statements of any limitations on the services or kinds of services to be provided; (4) specifying what information and within what time period HMO contracts may require subscribers to

notify the HMO of the birth of a child; (5) specifying the conditions for the provision of emergency services and care; (6) requirements for Medicare and Medicaid HMOs; (7) mandating, for contracts providing maternity care, certain service or benefit alternatives, such as a nurse midwife and birth center services options to hospitals or, for contracts which provide anesthesia coverage, benefits, or services, the option to receive such a service from a state-licensed certified registered nurse anesthetist, if requested and available; (8) restrictions on limitations that an HMO may impose on its subscribers; (9) mandating certain specific coverage or benefits as, for example, diabetes, osteoporosis, and cleft lip and cleft palate for children, when the contract covers children under the age of 18 years; and (10) requirements or limitations, when the contract provides coverage, benefits, or services, pertaining to breast cancer inpatient hospital treatment and other services incidental to breast cancer treatment, dermatological services, and dental treatment when a condition, left untreated, is likely to result in a medical condition.

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. 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.

In 1998, the Legislature passed language in ch. 98-79, L.O.F, which created prompt payment of claims requirements that are similar to the requirements for health insurers in s. 627.613, F.S. Section 641.3155, F.S., 1998 Supplement, requires HMOs to pay all non-contested claims for services or goods provided under contract, within 35 days from the date the HMO receives the claim. When contesting or denying a claim, HMOs are required to provide notice within 35 days after receipt of the claim and additional information may be requested. Upon receipt of the requested information, the HMO must pay or deny the contested claim with 45 days. Like s. 627.613, F.S., s. 641.3155, F.S., requires HMOs to pay or deny claims no later than 120 days after receiving the claim, and overdue claim payments bear simple interest at the rate of 10 percent per year.

State Center for Health Statistics

Section 408.05, F.S., requires the Agency for Health Care Administration to establish a State Center for Health Statistics. According to the section, the center "shall establish a comprehensice health information system to provide for the collection, compilation, coordination, analysis, indexing, dissemination, and utitilization of both purposefully collected and extant health-related data and statistics." The center is required to provide widespread dissemination of the data it collects and analyzes, and specific requirements regarding publications, reports, and special studies are established within s. 408.05(5), F.S.

B. EFFECT OF PROPOSED CHANGES:

The State Center for Health Statistics will be required to publish and make available to the public HMO report cards.

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, appointed by the Governor; a physician, appointed by the Governor, as a standing member; and physicians who have expertise relevant to the case to be heard, on a rotating basis.

An HMO subscriber, or other covered person, will have the ability to choose, by rider, to receive services from, at the time of service receipt, a health care provider with whom the HMO does not contract for services, and the rider may not require a referral from the HMO for point-of-service benefits.

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.

Conducting an annual health maintenance organization member satisfaction survey and contracting with physician consultants for the Statewide Provider and Subscriber Assistance Panel will be added to the list of AHCA's authorized uses of HMO regulatory assessment revenues deposited into the Health Care Trust Fund.

Any retroactive reductions of payments or demand for refund of previous overpayments which are due to retroactive review of coverage decisions or payment levels and any retroactive demands by providers for payment due to underpayments or non-payments for covered services will be required to be reconciled to specific claims unless the parties agree to other reconciliation methods and terms. The look-back period may be specified by the terms of the contract.

The Agency for Health Care Administrative will be required to establish an advisory group to study and make recommendations on: (1) trends and issues relating to legislative, regulatory or private-sector solutions for timely and accurate submission and payment of health claims; (2) development of certain electronic billing and claims processing for providers and health care facilities; (3) the form and content of claims; (4) measures to reduce fraud and abuse relating to the submission and payment of claims.

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?

No.

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

The State Center for Health Statistics will be required to publish and make available to the public HMO report cards, and the Agency for Health Care Services will be required to establish an advisory group to study and make recommendations on: (1) trends and issues relating to legislative, regulatory or private-sector solutions for timely and accurate submission and payment of health claims; (2) development of certain electronic billing and claims processing for providers and health care facilities; (3) the form and content of claims; (4) measures to reduce fraud and abuse relating to the submission and payment of claims.

(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?

N/A

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

N/A

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

N/A

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

N/A

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

N/A

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?

Health maintenance organization subscribers could potentially see premium rates increase, and pay providers directly for a portion of care rendered if the subscriber seeks care from a provider outside a health benefit plan's provider panel.

4. Individual Freedom:

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

Yes. Health maintenance organization subscribers would have complete choice in selecting physician providers for a price.

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?

N/A

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 408.05, 408.7056, 641.31, 641.51. and 641.58, F.S.

E. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 408.05, F.S., 1998 Supplement, relating to State Center for Health Statistics, to include HMO report cards in the list of health statistics publications the State Center for Health Statistics must publish and make available to the public.

Section 2. 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.

Section 3. Creates subsection (36) of s. 641.31, F.S., 1998 Supplement, relating to health maintenance contracts. The following paragraphs are created:

Paragraphs (a) and (b) are created to authorize an HMO to offer a point-of-service benefit through a point-of-service rider to its contract providing comprehensive health care services, if it meets three conditions: (1) is licensed to do business in Florida, (2) has been licensed to do business in Florida for a minimum of 3 years, and (3) maintains a minimum surplus of $5 million, inclusive of the surplus requirements of s. 641.225, F.S., 1998 Supplement, at all times that it has riders in effect.

Paragraph (c) is created to restrict HMOs in the volume of business that they may generate through point-of-service riders to 15 percent of total premiums for all health plan products sold by the HMO offering the rider. If the rider premium volume exceeds the 15 percent ceiling, the HMO must notify the Department of Insurance and immediately cease, once it is known, offering the point-of-service rider until it is in compliance with the rider premium cap.

Paragraph (d) is created to authorize an HMO that offers a point-of-service rider to require a subscriber to pay a reasonable copayment per visit for services provided by a noncontracted provider chosen at the time of the service by the subscriber. The copayment may either be a specific dollar among or a percentage of the reimbursable provider charges covered by the contract and must be paid by the subscriber to the noncontracted provider at the time that the subscriber receives the services. Additionally, the point-of-service rider may require a reasonable annual deductible for the expenses associated with the rider and may include a lifetime maximum benefit amount.

Paragraph (e) is created to require a point-of-service rider, as authorized under this subsection, to include language provided under the state insurance code relating to health insurance policies that requires disclosure, as provided in s. 627.6044, F.S., of any specific methodology, such as usual and customary charges, reasonable and customary charges, or charges based upon the prevailing rate in the community, used in the payment of claims. Also, such riders must comply with the copayment and deductible limits provided under s. 627.6471, F.S., which specifies how coinsurance and deductibles may be factored into payment for services rendered by providers participating in a preferred provider network.

Paragraph (f) is created to limit the use of the term “point of service” to riders authorized under this subsection.

Paragraph (g) is created to require point-of-service riders to be filed with the Department of Insurance, in accordance with s. 627.410, F.S., 1998 Supplement, and approved by the department, as required under s. 627.411, F.S.

Section 4. Amends s. 641.3155, F.S., relating to provider contracts and payment of claims, to provide that any retroactive reductions of payments or demand for refund of previous overpayments which are due to retroactive review of coverage decisions or payment levels and any retroactive demands by providers for payment due to underpayments or non-payments for covered services must be reconciled to specific claims unless the parties agree to other reconciliation methods and terms. The look-back period may be specified by the terms of the contract.

Section 5. Amends s. 641.51, F.S., relating to the HMO 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 6. Amends s. 641.58, F.S., relating to regulatory assessment, to add to the list of AHCA's authorized uses of regulatory assessment revenues deposited into the Health Care Trust Fund the expenditures relating to conducting an annual health maintenance organization member satisfaction survey and contracting with physician consultants for the Statewide Provider and Subscriber Assistance Plan.

Section 7. Provides that the Agency for Health Care Administrative is directed to establish an advisory group to study and make recommendations on: (1) trends and issues relating to legislative, regulatory or private-sector solutions for timely and accurate submission and payment of health claims; (2) development of certain electronic billing and claims processing for providers and health care facilities; (3) the form and content of claims; (4) measures to reduce fraud and abuse relating to the submission and payment of claims. This section shall take effect upon becoming a law.

Section 8. Provides for an appropriation of $1,439,000 from the Health Care Trust Fund to AHCA to fund implementation of the provisions of this bill for the 12 months of FY 1999-2000.

Section 9. Provides for the bill to take effect July 1, 1999, except as otherwise provided in the bill.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

   An amount of $1,439,000 is appropriated from the Health Care Trust Fund to AHCA for purposes of implementing the provisions of the bill.

2. Recurring Effects:

   Unknown.

3. Long Run Effects Other Than Normal Growth:

   Unknown.

4. Total Revenues and Expenditures:

   Unknown.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

   Unknown.

2. Recurring Effects:

   Unknown.

3. Long Run Effects Other Than Normal Growth:

   Unknown.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

   The Agency for Health Care Administration projects that this bill may increase costs of premiums paid by subscribers for health services received from HMOs. There was no estimate given of the amount of such an increase. A projected increase in HMO premiums may reasonably be anticipated as a result of consumers electing to purchase the point-of-service benefit rider authorized in section 3 of the bill. Increases in premiums related to the point-of-service benefit, rider, however, would affect only those consumers choosing to add the rider to their coverage and would not generally impact all HMO consumers.

2. Direct Private Sector Benefits:

   Unknown.

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

   Unknown.

D. FISCAL COMMENTS:

N/A

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

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties and municipalities to expend funds nor does it require them 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 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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