STORAGE NAME: h1927s1z.hcs ****FINAL ACTION****
DATE: June 2, 1999 ****SEE FINAL ACTION STATUS SECTION****

HOUSE OF REPRESENTATIVES
AS REVISED BY THE COMMITTEE ON
HEALTH CARE SERVICES
FINAL 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
(2) HEALTH AND HUMAN SERVICES APPROPRIATIONS YEAS 8 NAYS 0

I. FINAL ACTION STATUS:

06/18/99 Approved by Governor; Chapter No. 99-393

II. SUMMARY:

CS for HBs 1927 & 961 requires the State Center for Health Statistics to publish HMO report cards and 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 or a grievance that is limited to the incidental expenses of accrued interest on unpaid balances, court costs, and transportation costs associated with a grievance procedure. The bill expands the membership requirements for the panel to include: a consumer and a physician, as a standing member; appointed by the Governor; and physicians who have expertise relevant to the case to be heard, on a rotating basis.

Additionally, the bill: requires that any policy issued under s. 627.6471, F.S., which does not provide direct patient access to a dermatologist must conform to the requirements of s. 627.6472(16), F.S.; 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; requires that 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; establishes that 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 the Department of Insurance.

The bill: provides that certain retroactive reductions of payments or demand for refund of previous overpayments must be reconciled to specific claims unless the parties agree to other reconciliation methods and terms; provides for the creation of an advisory group to study and make recommendations relating to payment of health claims; 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; and 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: clarifies that distribution of the recovery in the independent cause of action to recover from liable third parties Medicaid benefits paid on behalf of unidentified recipients is not to a recipient unless the recipient is named in the proceeding in which the department prevailed and obtained a recovery; provides that area agencies on aging are subject to ch. 119, F.S., relating to public records, and ss. 286.011-286.012, F.S., relating to public meetings, when considering contracts requiring the expenditure of funds; requires AHCA to develop capabilities to identify actual and optimal practice patterns and provides for a related advisory panel. The bill limits the right of an insurance company or HMO to retroactively cancel a group health insurance policy due to nonpayment of premium by the employer and protects the employee's right to elect a conversion health insurance policy in this event.

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

III. 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.

Grievances considered by the panel break down, generally, as follows: excluded benefits, 31.4 percent; medical necessity, 28.6 percent; unauthorized out-of-plan services, 14.3 percent; unauthorized in-plan services, 14.3 percent; and billing disputes, contract interpretations, and enrollment/disenrollment disputes, 11.4 percent. Not all filed grievances are heard by the panel. Some grievances are determined to not be within the panel's jurisdiction, some are settled, and some grievances are withdrawn by the subscriber who filed it.

STATEWIDE PROVIDER AND SUBSCRIBER ASSISTANCE PROGRAM CASELOAD (1993-March 1999)	
Year	**No. of Cases Opened**
1993-1994	108
1994-1995	149
1995-1996	128

Year	No. of Cases Opened
1996-1997	214
1997-1998	202
1998-3/1999	173
Total Cases	**974**

Of the cases heard, 57 percent, or 555, have been decided in favor of the subscribers, and 43 percent, or 418, have been decided in favor of the HMO.

HMO Regulation

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.

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 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 comprehensive health information system to provide for the collection, compilation, coordination, analysis, indexing, dissemination, and utilization 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.

Direct Patient Access to a Dermatologist

Currently, section 627.6472, F.S., relating to exclusive provider organizations, provides in subsection (16) that an exclusive provider organizations which offer dermatological services shall provide direct patient access, for office visits and minor procedures and testing, to a dermatologist who is under contract with the exclusive provider organization. Direct patient access is defined as the ability of an insured to obtain such services without a referral or other authorization before receiving services.

Retroactive Cancellation of Group Health Insurance Contracts

Under Florida law, group health insurers are *not* required to provide advance notice to the group policyholder (the employer) or the certificate-holder (employee) that their insurance is canceled due to nonpayment of premium (s. 627.6645, F.S.). For other reasons, however, insurers must give the policyholder at least 45 days' advance notice of cancellation, expiration, non-renewal, or a change in rates of a policy. Upon receiving such notice, the policyholder must forward the notice to each certificate-holder covered under the policy. Insurers who bill certificate-holders directly for premiums must provide the 45 days' notice described above directly to each certificate-holder. If insurers fail to provide the 45 days' notice, the coverage shall remain in effect at the existing rate until 45 days after the notice is given or until the effective date of replacement coverage is obtained by the insured, whichever occurs first.

Health maintenance organizations have similar notice provisions to group health insurers under s. 641.3108, F.S. Health maintenance organizations are *not* required to provide advance notice to either the group contract holder (employer), or the subscriber (employee) that their coverage is canceled due to nonpayment of premium or termination of eligibility. However, for cancellation due to other reasons, HMOs, who contract directly with group contract holders, must provide these entities with 45 days' advance notice in writing prior to cancellation, expiration, or non-renewal of a contract and request that the notification be forward to all subscribers. All HMO contracts must contain the 45 days' notice requirements and the notice must contain the reasons for the cancellation, expiration, or non-renewal. Pursuant to s. 641.31, F.S., HMOs must provide 30 days' notice to contract holders of a

change in health insurance rates and the contract must allow a grace period of at least 10 days after the premium date, during which time the contract must stay in force. Health maintenance organizations that contract directly with subscribers must provide the notices as described above directly to each subscriber.

In January 1998, the Department of Insurance filed an administrative action against AvMed Health Plan (an HMO) for *retroactively* canceling the group health insurance coverage of employees who worked for a company which failed to pay its group HMO premiums. According to the petition filed by the department, the employer had fallen behind on paying the HMO for its group health contract, but during a 2 to 3 month period, the HMO continued to authorize doctors and hospitals to treat the employees. In August 1997, the HMO terminated the group coverage retroactively to May when the last premiums were paid. Employees were not provided written notification by the HMO prior to the contract being canceled. The HMO has billed employees for medical care provided after the May cancellation date. The Department of Insurance alleges that because the HMO failed to provide any of the employees with written notice of termination of their health insurance coverage as specified in their member handbook, the employees were illegally denied the opportunity to request continued health insurance coverage through a converted contract under s. 641.3922, F.S. Additionally, due to the fact that the HMO continued to authorize and preauthorize medical visits, the department contends that employees were misled into believing that they had health insurance.

Presently, insurers and HMOs issuing group policies in Florida must offer individual conversion policies or contracts to an employee or member whose eligibility for the group coverage terminates, as required by s. 627.6675, F.S., for insurers, and by s. 641.3922, F.S., for HMOs. The maximum premium for the policy is 200 percent of the *standard risk rate* as determined by the department.

Failure of an employee to obtain notice of cancellation of a group policy may result in the employee incurring medical bills that are not covered. It may also compromise the employee's ability to obtain an individual conversion policy or other replacement coverage, due to the fact that an employee has only 63 days after the date of termination of eligibility for group coverage to apply for an individual conversion policy (s. 627.6675, F.S., for group health insurance, and s. 641.3922, F.S., for group HMO contracts).

Medicaid Benefits Recovery From Liable Third Parties

According to section 409.910, F.S., it is the intent of the Legislature that Medicaid be the payor of last resort for medically necessary goods and services furnished to Medicaid recipients, and if benefits of a liable third party are available, Medicaid should be repaid in full and prior to any other person. Section 409.910(4), F.S. provides that after the department has provided medical assistance under the Medicaid program, it shall seek recovery of reimbursement from third-party benefits to the limit of legal liability and for the full amount of third-party benefits as to claims for which the agency has a waiver pursuant to federal law or situations in which a third party is liable and the liability or benefits available are discovered either before or after medical assistance has been provided by Medicaid. Recovery is limited to the amount of medical assistance by Medicaid. Section 409.910(7), F.S., provides for the parties from whom recovery of Medicaid benefits shall be collected directly.

Medicaid Cost-Effective Purchasing of Health Care

Section 409.912, F.S. provides that the Agency for Health Care Administration shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. Section 409.912 (13), F.S., requires the agency to identify health care utilization and price patterns within the Medicaid program which are not cost-effective or medically appropriate and assess the effectiveness of new or alternate methods of providing and monitoring services. The agency is permitted to use such methods as it considers appropriate.

Department of Elderly Affairs/Area Agencies on Aging

Section 20.41, F.S. provides that, as mandated by the Older Americans Act, the Department of Elderly Affairs shall designate and contract with area agencies on aging in each of the department's eleven planning and service areas. Area agencies on aging have responsibility for development of planning for all aging issues in each of the planning and service areas and are to ensure a coordinated and integrated provision of long-term care services to the elderly, as well as ensure the

provision of prevention and early intervention services. In addition, the role of area agencies on aging is to administer: the federally funded Older Americans Act program; the Emergency Home Energy Assistance for the Elderly Program (EHEAEP): the state funded Community Care for the Elderly (CCE); the Alzheimer's Disease Initiative (ADI); and the Home Care for the Elderly (HCE) programs.

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.

Any policy issued under s. 627.6471, F.S., which does not provide direct patient access to a dermatologist will be required to conform to the requirements of s. 627.6472(16), F.S.

The right of an insurance company or health maintenance organization to retroactively cancel a group health insurance policy due to nonpayment of premium by the employer and protect the employee's right to elect a conversion health insurance policy in this event will be limited.

Current law will be clarified to allow group insurers to contract with another insurer to issue conversion contracts on its behalf, provided that the other insurer is authorized in Florida and the policy has been approved by the Department of Insurance.

Current law will be clarified to provide that distribution of the recovery in the independent cause of action to recover from liable third parties Medicaid benefits paid on behalf of unidentified recipients is not to a recipient unless the recipient is named in the proceeding in which the department prevailed and obtained a recovery.

Area agencies on aging will be subject to ch. 119, F.S., relating to public records, and ss. 286.011-286.012, F.S., relating to public meetings, when considering contracts requiring the expenditure of funds.

The Agency for Health Care Administration will be required to develop capabilities to identify actual and optimal practice patterns, and the bill provides for a related advisory panel.

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; and (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 20.41, 408.05, 408.7056, 409.910, 409.912, 627.6471, 627.6645, 627.6675, 641.31, 641.3108, 641.3155, 641.3922, 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 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.

Section 3. Amends s. 627.6471, F.S., relating to contracts for reduced rates of payment; limitations; coinsurance and deductibles, to provide that any policy issued under this section which does not provide direct access to a dermatologist must conform to the requirements of s. 627.6472(16). This subsection shall not be construed to affect the amount the insured or patient must pay as a deductible or coinsurance amount authorized under section 627.6471, F.S.

Section 4. 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. The rider must include language provided under the state insurance code relating to health insurance policies that requires disclosure, as provided in s. 627.6044, F.S., and must comply with the copayment 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. Subsections 641.315(2) and (3), F.S., relating to HMO subscriber liability for covered services, do not apply to a point-of-service rider authorized under this subsection.

Paragraph (e) is created to provide that the term “point of service” may not be used by a health maintenance organization except with riders permitted under this s. 641.31, F.S. or with forms approved by the department in which a point-of-service product is offered with an indemnity carrier.

Paragraph (f) 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 5. Amends s. 641.3155, F.S., 1998 Supplement, relating to HMO 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 6. Requires the Director of the Agency for Health Care Administrative to establish an 8-member 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. The advisory group shall submit its recommendations in a report, by January 1, 2000, to the President of the Senate and the Speaker of the House of Representatives. The advisory group shall be appointed and convened by July 1, 1999, and shall meet in Tallahassee, and members shall not receive per diem or travel reimbursement.

Section 7. 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 HMO must adopt for preventive pediatric health care to "child health checkup" requirements.

Section 8. Amends s. 641.58, F.S., relating to regulatory assessments, 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 9. Amends s. 409.910, F.S., 1998 Supplement, relating to Medicaid third-party liability and recovery, to clarify legislative intent underlying the enactment of certain amendments to s. 409.910, F.S., and to provide that the provisions of s. 409.910(7), F.S., do not apply to any proceeds received by the state, or any agency thereof, pursuant to a final order, judgment, or settlement agreement, in any matter in which the state asserts claims brought on its own behalf, and not as a subrogee of a recipient, or under other theories of liability or in any matter in which the state asserted both claims as a subrogee and additional claims, except as to those sums specifically identified in the final order, judgment, or settlement agreement as reimbursements to the recipient as expenditures for the named recipient on the subrogation claim.

Section 10. Provides that the amendments to s. 409.910, F.S., 1998 Supplement, made by section 9 of this act are intended to clarify existing law and are remedial in nature. As a such, they are specifically made retroactive to October 1, 1990, and shall apply to all causes of action arising on or after October 1, 1990.

Section 11. Amends s. 627.6645(1), F.S., relating to notification of cancellation or non-renewal of group health insurance policies and time limits thereof, to prohibit a group health insurer from retroactively canceling a group contract, due to nonpayment of premium, *prior* to the date the notice of cancellation is mailed by the insurer to the employer, *unless* the notice is mailed within 45 days after the date the premium was due. Such notice must be mailed to the policyholder's (employer's) last address as a shown by the records of the insurer.

Section 12. Amends s. 627.6675, F.S., 1998 Supplement, relating to conversion of group health insurance policies. If termination of an employee's health insurance coverage under a group policy is due to nonpayment of premium by the employer (policyholder) and written notice of cancellation from the insurer was not provided to the employee (certificate-holder) by the employer, the following requirements apply:

-The 63-day time period within which the employee must apply for an individual conversion policy would *not* begin to run until the date the insurer or employer mails notice of cancellation to the employee or certificate-holder at the employee's last address as a shown by the record of the insurer.

-The premium for the conversion policy would be at the previous group rate for the time period prior to the date the insurer mails notice to the employee. For the period of coverage after such date, the premium for the converted policy would be subject to the requirements of current law which provide that such premium may not exceed 200 percent of the standard risk rate as established by the Department of Insurance.

The bill also clarifies current law to allow group insurers to contract with another insurer to issue conversion contracts on its behalf, provided that the other insurer is authorized in Florida and the policy has been approved by the Department of Insurance pursuant to s. 627.410, F.S.

Section 13. Amends s. 641.3108, F.S., relating to notification of cancellation of health maintenance contracts, to prohibit an HMO from retroactively canceling a group contract, due to nonpayment of premium, *prior* to the date the notice of cancellation is mailed by the HMO to the subscriber, *unless* the notice is mailed within 45 days after the date the premium was due. Such notice must be mailed to the subscriber's last address as a shown by the records of the HMO. For group contracts issued to an employer, the notice requirements of this section are satisfied by providing notice to the employer [subsection (3)].

Section 14. Amends s. 641.3922(1), F.S., 1998 Supplement, relating to HMO conversion contracts and time limits thereof, to specify that if termination of an employee's health insurance coverage is due to nonpayment of premium by the employer (group contract holder) and written notice of cancellation from the HMO was not provided to the employee by the employer, the following requirements apply:

-The 63-day time period within which the employee must apply for an individual conversion contract would *not* begin to run until the date the HMO mails notice of cancellation to the employee at the employee's last address as a shown by the records of the HMO.

-The premium for the conversion contract would be at the previous group rate for the time period prior to the date the HMO mails notice to the employee. For the period of coverage after such date, the premium for the converted policy would be subject to the requirements of current law which provide that such premium may not exceed 200 percent of the standard risk rate as established by the Department of Insurance.

Section 15. Amends s. 20.41, F.S., relating to Department of Elderly Affairs, to provide that area agencies on aging are subject to ch. 119, F.S., relating to public records, and, when considering any contracts requiring the expenditure of funds, are subject to ss. 286.011-286.012, relating to public meetings.

Section 16. Amends s. 409.912, F.S., 1998 Supplement, relating to Medicaid cost-effective purchasing of health care, to provide that the responsibility of Agency for Health Care Administration under s. 409.912, F.S., dealing with health care utilization and price patterns within the Medicaid program, shall include the development of capabilities to identify actual and optimal practice patterns; patient and provider educational initiatives; methods for determining patient compliance with prescribed treatments; fraud, waste, and abuse prevention and detection programs; and beneficiary case management programs. Requires the practice pattern identification program to evaluate practitioner prescribing patterns based on national and regional practice guidelines, comparing practitioners to their peer groups. Provides for a 9-member advisory panel which, in conjunction with AHCA's Drug Utilization Review Board, is responsible for evaluating treatment guidelines and recommending ways to incorporate their use in the practice pattern identification program. Advisory panel members include: three physicians licensed under ch. 458 or ch. 459, F.S., appointed by the President of the Senate: three physicians licensed under ch. 458 or ch. 459, F.S., appointed by the Speaker of the House of Representatives, two pharmacists licensed under ch. 465, F.S., appointed by the Governor, and one dentist licensed under ch. 466, F.S., who is an oral surgeon. In addition, the agency: shall develop educational interventions designed to promote the proper use of medications by providers and beneficiaries; shall implement a pharmacy fraud, waste, and abuse initiative; and may apply for any federal waivers needed to implement s. 409.912(13)(b), F.S.

Section 17. 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 18. Provides for the bill to take effect upon becoming a law.

IV. 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 4 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.

   Insurers and HMOs will be required to expend funds and allocate administrative resources to meet the notice requirements imposed under this bill. These entities will need to continually maintain a current listing of all employees under the group plan with their addresses should employee notification of contract cancellation become necessary.

2. Direct Private Sector Benefits:

   Employees who are members of group health plans may benefit from the provision that protects their right to elect a conversion insurance policy under certain circumstances. Additionally, employees will be protected by the provision that limits the right of insurers and HMOs to retroactively cancel a group health insurance policy due to nonpayment of premium by an employer.

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

   Unknown.

D. FISCAL COMMENTS:

None.

V. 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.

VI. COMMENTS:

None.

VII. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On April 5, 1999, the Committee on Health Care Services unanimously passed a committee substitute which combined HB 1927 and HB 961.

On April 16, 1999, the Health and Human Services Appropriations Committee passed one technical amendment to the committee substitute. Additional amendments were passed on the floors of both the House and Senate. These amendments related to area agencies on aging with the Department of Elderly Affairs, Medicaid cost-effective purchasing of health care, Medicaid benefits recovery from liable third parties, and direct patient access to a dermatologist. The substance of HB 2071, relating to retroactive cancellation of group health insurance and HMO contracts, was also included in the amendments.

VIII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:	Staff Director:
Amy K. Guinan	Phil E. Williams

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

Prepared by:	Staff Director:
Lynn Dixon	Lynn Dixon

FINAL ANALYSIS PREPARED BY THE COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:	Staff Director:
Amy K. Guinan	Phil E. Williams