SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based only on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/SB's 2472 and 1892

SPONSOR: Health, Aging and Long-Term Care Committee; Senator Clary; and Senator Saunders

SUBJECT: Managed Health Care

DATE: April 17, 1999 REVISED: 04/21/99

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Carter	Wilson	HC	Favorable/CS
2.	Peters	Hadi	FP	Fav/1 amendment
3.				
4.				
5.				

I. Summary:

Committee Substitute for Senate Bills 2472 and 1892 requires the State Center for Health Statistics in the Agency for Health Care Administration (AHCA or agency) to publish health maintenance organization report cards and clarifies that the Statewide Provider and Subscriber Assistance Panel may not hear a grievance that is part of an internal grievance 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 changes the composition of and increases the number of participants on the Statewide Provider and Subscriber Assistance Panel to include a consumer and a physician, appointed by the Governor, and physicians with relevant expertise to review subscriber cases on a rotating basis.

The bill amends the law to require preferred provider organization policies that require referrals to conform to requirements imposed on exclusive provider organization policies and to allow HMO subscribers point-of-service benefits by authorizing HMOs to offer point-of-service benefit riders to HMO contracts. A procedure for reconciling retroactive HMO and provider demands for payments or refunds is added to the "prompt payment" law to require that such reconciliations be based on specific claims and to allow for the contract to specify the look-back period. The Director of the Agency for Health Care Administration is required to establish an advisory group to study and make recommendations on specified subjects relating to claims payment.

The list of access and quality-of-care indicators for which HMOs must submit data to AHCA is expanded to require measures of management of chronic disease, preventative health care for adults and children, prenatal care measures, and child health checkup measures. The requirement that HMOs, individually, conduct standardized consumer satisfaction surveys of their membership at intervals specified by AHCA for submission to AHCA and used to make comparative findings is repealed. As provided in the quality assurance program requirements, reference to early periodic screening, diagnosis, and treatment requirements is changed to child health checkup requirements. An appropriation of $1,439,000 from the Health Care Trust Fund to AHCA is provided for Fiscal Year 1999-2000.

This bill amends ss. 408.05, 408.7056, 627.6471, 641.31, and 641.3155, Florida Statutes (F.S.), 1998 Supplement, and ss. 641.51 and 641.58, F.S., and creates two undesignated sections of law.

II. Present Situation:

Health maintenance organizations (HMOs) provide a comprehensive range of health care services for a prepaid premium. The Department of Insurance (DOI) regulates HMO finances, contracting, and marketing activities under part I of chapter 641, F.S. The Agency for Health Care Administration regulates the quality of care provided by HMOs under part III of chapter 641, F.S. The Statewide Provider and Subscriber Assistance Program, as established under s. 408.7056, F.S., 1998 Supplement, is jointly administered and staffed by DOI and AHCA.

The agency has worked with the HMO industry and with national accreditation organizations to develop rules for implementing quality-of-care regulations under part III of chapter 641, F.S. The agency has also established a consumer hotline which responds to quality-of-care complaints. Despite these efforts, quality-of-care issues continue to surface.

Health maintenance organizations operating in the state are experiencing continuously increasing member enrollments and expanded market shares. The growth in the industry has been accompanied by a growth in the number of complaints about services received or the perceived denial of services or denial of timely provided services. Moreover, providers and consumers are more vocal about their concerns. Providers complain that "managed care" means not only managing the care that patients receive, but also managing the providers who render that care. Consumers want lower health care costs, but they also want access to high-cost specialized care and are voicing concerns about quality-of-care problems.

The Statewide Provider and Subscriber Assistance Program

The Agency for Health Care Administration is required, under s. 408.7056, F.S., 1998 Supplement, to adopt and implement a program to provide assistance to subscribers and providers, including those whose grievances are not resolved by the managed care entity to the satisfaction of the subscriber or provider. The Statewide Provider and Subscriber Assistance Program is the mechanism established by AHCA for purposes of grievance resolution. Initially, when created in 1985, the program was named the Statewide Subscriber Assistance Program. It was designed to operate through a panel comprised of employees of DOI and, originally, the Department of Health and Rehabilitative Services. In 1993, the program was moved from the Department of Health and Rehabilitative Services to AHCA, and was renamed the Statewide Provider and Subscriber Assistance Program. The program's jurisdiction was expanded to cover providers with accountable health partnerships and entities created to deliver health care services to employees of employer members of community health purchasing alliances. Changes to the law enacted in 1998, remove accountable health partnerships from the program's jurisdiction.

Managed care entities subject to the Statewide Provider and Subscriber Assistance Program must comply with quality-of-care-health-services standards established in chapter 409, F.S., relating to Medicaid; chapter 627, F.S., relating to insurance regulation of exclusive provider organizations and other providers; or chapter 641, F.S., relating to prepaid health clinics and HMOs. They are required to submit a quarterly report of all unresolved subscriber and provider grievances to

AHCA and DOI. These reports must include a listing of the number and the nature of all subscriber and provider grievances not resolved to the subscriber's or provider's satisfaction after the grievance has been completely processed through the managed care entity's internal grievance procedure. The agency is required to notify all subscribers and providers included in the quarterly reports of their right to file an unresolved grievance with the panel.

The Statewide Provider and Subscriber Assistance Program was redesigned by changes enacted in 1998 to consist of one or more panels that meet as often as necessary to timely review, consider, and hear grievances and recommend to AHCA or DOI any actions that should be taken concerning individual cases heard by the panel. As provided under subsection 408.7056(11), F.S., 1998 Supplement, a panel consists of three employees from AHCA and three employees from DOI, chosen by their respective agencies. Additionally, AHCA may contract with and must select a medical director from a state-licensed HMO and may contract with a primary care physician to provide the panel with technical expertise. At present, one panel exists. Panel members from AHCA include: the manager of the Managed Care Commercial Compliance [Unit], a physician consultant, and a senior management analyst [II] assigned to the director's office in State Health Purchasing. Panel members from DOI include: the chief of staff, deputy insurance commissioner, and the consumer advocate. Although AHCA has elected to include a licensed physician as one of its members and DOI has elected to include a consumer advocate as one of its members, there is no statutory requirement to do so. The panel is supported by eight staff persons, two of which are registered nurses.

The panel must hear every grievance filed by subscribers and providers on behalf of subscribers, unless the panel is prohibited by of one of the twelve restrictions imposed by law. The panel may not review, consider, or hear a grievance if it:

1. Relates to a managed care entity's refusal to accept a provider into its network of providers;
2. Is part of a reconsideration appeal through the Medicare appeals process which does not involve a quality-of-care issue;
3. Is related to a health plan not regulated by the state such as an administrative services organization, third-party administrator, or federal employee health benefit program;
4. Is related to appeals by in-plan suppliers and providers, unless related to the quality of care provided by the plan;
5. Is part of a Medicaid fair hearing pursued under federal law;
6. Is the basis for an action pending in state or federal court;
7. Is related to an appeal by nonparticipating providers, unless related to the quality of care provided to a subscriber by the managed care entity and the provider is involved in the care provided to the subscriber;
8. Was filed before the subscriber or provider completed the entire internal grievance procedure of the managed care entity, the managed care entity has complied with its timeframes for completing the internal grievance procedure, and the subscriber's life is not in imminent and emergent jeopardy so as to necessitate emergency action;
9. Has been resolved to the satisfaction of the subscriber or provider who filed the grievance, unless the managed care entity's initial action is egregious or may be indicative of a pattern of inappropriate behavior;
10. Is limited to seeking damages for pain and suffering, lost wages, or other incidental expenses;

11. Is limited to issues involving conduct of a health care provider or facility, staff member, or employee of a managed care entity which constitute grounds for disciplinary action by the appropriate professional licensing board and is not indicative of a pattern of inappropriate behavior, and AHCA or DOI has reported these grievances to the appropriate professional licensing board or to the health facility regulation section of AHCA for possible investigation; or
12. Is withdrawn by the subscriber or provider. Failure of the subscriber or the provider to attend the hearing is deemed a withdrawal of the grievance.

The Panel must process and act on grievances filed within specified timeframes

As amended by chapter 98-10, Laws of Florida, s. 408.7056, F.S., 1998 Supplement, imposes various timeframes for the processing and consideration of grievances. The agency must review all grievances within 60 days after receipt and make a determination whether the grievance must be heard. Once AHCA notifies the panel, the subscriber or provider, and the managed care entity that the grievance will be heard by the panel, the panel must hear the grievance either in the network area or by teleconference no later than 120 days after the date the grievance was filed. The panel must issue a written recommendation, supported by findings of fact, to the provider or subscriber, to the managed care entity, and to AHCA or DOI no later than 15 working days after hearing the grievance. If at the hearing the panel requests additional documentation or additional records, the time for issuing a recommendation is tolled (stopped as to the running of the 15-day time limit) until the information or documentation requested has been provided to the panel. The proceedings of the panel are not subject to the Administrative Procedure Act.

If AHCA receives a properly filed grievance with a proper patient authorization, it may request the subscriber's medical records. A custodian of the subscriber's medical records is allowed 10 days to provide the records to AHCA. The agency may impose a fine of up to $500 per violation on a custodian of a properly requested subscriber medical record for failure to timely comply with the request, and each day of violation is considered a separate offense.

Grievances that AHCA determines pose an immediate and serious danger to a subscriber's health must be given priority over other grievances, and the panel may meet at the call of its chairperson but not later than 45 days after the date the grievance is filed, unless the subscriber waives this time requirement. Moreover, when AHCA determines that the life of a subscriber is in imminent and emergent jeopardy, the chairperson of the panel may convene an emergency hearing, within 24 hours after notification to the managed care entity and the subscriber, to hear the grievance even if the subscriber has not completed the managed care entity's internal grievance procedure. The panel must issue a written emergency recommendation, supported by findings of fact, after it hears the grievance, to the managed care entity, to the subscriber, and to AHCA or DOI for the purpose of deferring the imminent and emergent jeopardy to the subscriber's life. Within 24 hours after AHCA or DOI receives the panel's emergency recommendation, it may issue an emergency order to the managed care entity. The emergency order remains in force until: (1) the grievance has been resolved by the managed care entity; (2) medical intervention is no longer necessary; or (3) the panel has conducted a full hearing and issued a recommendation to AHCA or DOI, and AHCA or DOI has issued a final order.

The panel must make recommendations to AHCA or DOI after hearing a grievance. The recommendations may include specific actions that the managed care entity must take to comply with state regulatory requirements. If AHCA or DOI issues a proposed order which only requires the managed care entity to take a specific action, the proposed order is subject to a summary hearing under s. 120.574, F.S., of the Administrative Procedure Act, unless all the parties agree otherwise. This hearing is a de novo (new, as if initiating a legal action) presentation of the facts of the case, and is not a judicial review of the findings and recommendations of the panel. A managed care entity that does not prevail at the summary hearing, however, is made liable to pay AHCA's or DOI's reasonable costs and attorney's fees incurred in the proceedings.

A managed care entity, subscriber, or provider that is affected by a panel recommendation may furnish to AHCA or DOI written evidence in opposition to the recommendation or findings of fact of the panel within 10 days after receipt of the panel's recommendation, or 72 hours after receipt of a recommendation in an expedited grievance. No later than 30 days after the issuance of the panel's recommendation and, for an expedited grievance, no later than 10 days after the issuance of the panel's recommendation, AHCA or DOI may reject all or part of the panel's recommendation or adopt all or part of the panel's recommendation or findings of fact in a proposed order or an emergency order, as provided under the Administrative Procedure Act, which it must issue to the managed care entity. Such orders may impose fines or sanctions, including fines for nonwillful violations of $2,500 per violation with a maximum aggregate of $25,000 and willful violations of $20,000 per violation with a maximum aggregate of $250,000. All fines collected must be deposited in the Health Care Trust Fund. The agency or the department may consider the following factors when determining any fine or sanction to be imposed: (1) the severity of the noncompliance, including the probability that death or serious harm to the health or safety of the subscriber will result or has resulted, the severity of the actual or potential harm, and the extent to which laws regulating HMOs were violated; (2) actions taken by the managed care entity to resolve or remedy any quality-of-care grievance; (3) any previous incidents of noncompliance by the managed care entity; or (4) any other relevant factors AHCA or DOI considers appropriate in a particular grievance.

Grievance categories and Panel workload

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. One grievance, characterized as an emergency, was heard in January 1999, under the timeframes established in statute in 1998. It was considered within 24 hours and a decision was rendered within 48 hours.

STATEWIDE PROVIDER AND SUBSCRIBER ASSISTANCE PROGRAM CASELOAD (1993-March 1999)

YEAR	***NUMBER OF CASES OPENED***
1993-1994	108
1994-1995	149
1995-1996	128
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.

Prior to December 1, 1998, no mandatory timeframes existed for scheduling grievances for hearing before the panel. Grievances were scheduled as received and staff availability permitted. The program was not assigned staff prior to October 30, 1998. Section 3 of chapter 98-10, Laws of Florida, appropriated to AHCA six full-time staff positions and $308,830 from the Health Care Trust Fund to fund staffing for the program for 9 months during Fiscal Year 1998-1999.

Regulation of HMO contracts

Any entity that is issued a certificate of authority under part I 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 of the content of HMO contracts, certificates, and member handbooks given to subscribers that contains 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 or a licensed 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.

Florida law provides timeframe guidelines for payment of HMO provider claims

Section 641.3155, F.S., 1998 Supplement, requires an HMO to reimburse all claims or any portion of any claim, made by a contract provider for services or goods provided under a contract with the HMO, which the HMO does not contest or deny, within 35 days after the HMO receives the claim. If the claim, or a portion of a claim, is contested by the HMO, it must formally notify the contract provider within 35 days after the HMO's receipt of the claim. Such notification must identify the contested portion of the claim and the specific reason for contesting or denying the claim, and may include a request for additional information.

If the HMO requests additional information, the provider must provide the information within 35 days after the request is received. When the HMO receives the additional information that it requested from the contract provider, the HMO must pay or deny the contested claim, or portion of the contested claim, within 45 days after it receives such information.

In any event, an HMO must pay or deny a claim no later than 120 days after receiving it. Payment of the claim is considered made on the date the payment is received, electronically transmitted, or otherwise delivered. An overdue payment of a claim is subject to a penalty of simple interest at the rate of 10 percent per year.

HMOs must establish quality assurance programs

Section 641.51, F.S., requires HMOs to ensure that the health care services provided to subscribers shall be rendered under reasonable standards of quality of care consistent with the prevailing standards of medical practice in the community. As a means of achieving such an objective, each HMO must have an ongoing internal quality assurance program for its health care services that adheres to certain statutorily specified guidelines. Additionally, an HMO is prohibited from modifying the decisions about the proper course of treatment of a subscriber as determined through the professional judgment of the subscriber's state-licensed physician, unless the course of treatment prescribed is inconsistent with the prevailing standards of medical practice in the community. This prohibition is not a restriction on an HMO's utilization management program. Subsection 641.51(4), F.S., recognizes the right of subscribers to request a second medical opinion *in any instance in which the subscriber disputes the organization's or the physician's opinion of the reasonableness or necessity of surgical procedures or is subject to a serious injury or illness*.

Each HMO must release to AHCA data which are indicators of access and quality of care, in accordance with agency rules relating to data-reporting requirements. Three characteristics must be captured in such indicators; they must: (1) relate to access and quality-of-care measures; (2) be

consistent with data collected for accreditation purposes; and (3) be consistent with frequency requirements under the accreditation process. The agency is required to develop a uniform format for publication of the data, to be made available to the public through publication at least every 2 years, providing explanations of the data collected and the relevance of the data. Also, HMOs must conduct their own standardized customer satisfaction survey of their membership, in accordance with AHCA rule, at intervals specified by AHCA. The survey must be consistent with surveys required by accrediting organizations, but may contain 10 additional questions based on Florida-specific concerns. Survey data must be submitted to AHCA. Using the survey data submitted, AHCA must make comparative findings available to the public.

Another component of the quality assurance program requirements, as provided under s. 641.51(10), F.S., is the recommendations for preventive pediatric health care that HMOs must adopt. These recommendations must be consistent with the early periodic screening, diagnosis, and treatment (EPSDT) requirements developed for the Medicaid program. Each HMO must establish goals to have achieved 80 percent compliance with their own EPSDT-based recommendations by July 1, 1998, and 90 percent compliance by July 1, 1999, for their pediatric subscribers.

The agency may levy a regulatory tax on HMOs

In addition to any other license or excise tax imposed on an HMO, the agency may assess on every HMO authorized to engage in business in Florida, an annual regulatory assessment of up to 0.1 percent of the gross amount of premiums collected by each HMO on contracts or certificates issued to subscribers in Florida. The assessment is payable on or before April 1 and is calculated on the premiums collected during the preceding calendar year. Collected assessments must be deposited into the Health Care Trust Fund.

The Department of Insurance must determine the amount of gross premiums each HMO collected and AHCA must determine on or before December 1 of each year the regulatory assessment percentage necessary to be imposed for the following calendar year. Collected revenue must be deposited in the Health Care Trust Fund and may be appropriated to defray costs of AHCA's Bureau of Managed Health Care in regulating HMOs. There is a $3 million surplus in the assessment trust fund account. The assessment rate for Fiscal Year 1998-1999 is .000318441 percent, which is a reduction from the assessment rate for Fiscal Year 1997-1998 of .0003339 percent. Expenses for which such funds may be spent include: maintaining of offices and necessary supplies, essential equipment and other materials, salaries and expenses of required personnel, and all other legitimate expenses relating to the discharge of the administrative and regulatory powers and duties delegated to the agency under part III of chapter 641, F.S.

Preferred Provider Organizations and Exclusive Provider Organizations

Section 627.6471, F.S., provides regulatory requirements relating to preferred provider organizations (PPOs), which are regulated by DOI. A preferred provider organization is comprised of health care providers with whom an insurer has *contracted directly or indirectly for alternative or reduced rates of payment* relative to other providers of health care that may be reimbursed for services under an insurance contract. Persons receiving health care services for

which reimbursement is made under a PPO contract are not required to obtain preauthorization for services.

An exclusive provider organization is one that conditions payment of benefits, in whole or in part, on the use of exclusive providers. Exclusive providers are providers of health care that have entered into a written agreement with an insurer to provide benefits under a health insurance policy issued under s. 627.6472, F.S., 1998 Supplement. Exclusive provider organizations are regulated by AHCA. Since an insurer may contract with an HMO as an exclusive provider, EPOs may, in some instances, require preauthorization for services. Preauthorization for basic dermatology services offered by an EPO may only be required as specified in criteria providing for direct patient access for such services. Generally, though, an EPO may not require preauthorization for up to five visits within a 12 month period for basic dermatology services, in accordance with s. 627.6472(16), F.S., 1998 Supplement.

III. Effect of Proposed Changes:

Section 1. Amends s. 408.05, F.S., 1998 Supplement, relating to the State Center for Health Statistics within AHCA, to add HMO report cards to the list of publications that the center is required to periodically 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, to: (1) preclude the program panel from hearing grievances that are part of an internal grievance process in a Medicare managed care entity; (2) specify types of incidental expenses that cannot form the basis for grievances before the panel to include accrued interest on unpaid balances, court costs, and transportation costs associated with grievance procedures; and (3) revise the composition of the panel to add a consumer, appointed by the Governor; a physician, appointed by the Governor; and physicians who have expertise relevant to the case to be heard by the panel, on a rotating basis.

Section 3. Amends s. 627.6471, F.S., relating to PPO regulation, to provide that a PPO policy that requires an insured to obtain a referral prior to receiving services must conform to requirements imposed on EPO policies, as specified in s. 627.6472, F.S., 1998 Supplement.

Section 4. Amends s. 641.31, F.S., 1998 Supplement, relating to HMO contracts, 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. This benefit will enable an HMO subscriber, or other covered person, to choose to receive services from, at the time of covered service, a health care provider with whom the HMO does not contract for services. The rider may not require a referral from the HMO for point-of-service benefits.

In addition to the surplus requirement, HMOs are restricted 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 rider premium volume exceeds the 15 percent

ceiling, the HMO must notify DOI and immediately cease, once it is known, offering the point-of-service rider until it returns to a state of compliance.

Despite restrictions on deductibles and copayments in the HMO regulatory law, an HMO that offers a point-of-service rider is authorized 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 amount 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.

A point-of-service rider issued, as authorized under this subsection, 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., 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 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. A rider authorized under this section must be filed with DOI, in accordance with s. 627.410, F.S., 1998 Supplement, and approved by the department, as required under s. 627.411, F.S. Riders authorized under this section are explicitly exempted from: (1) the protection of HMO subscribers from liability for payment to providers of health care services for services covered by the HMO and (2) the prohibition against a provider collecting, attempting to collect, or suing a subscriber to collect money owed for services covered by the subscriber's HMO. Clarifying language provides that an HMO may not use the term "point of service" except with riders permitted under this section or with forms approved by DOI pertaining to a point-of-service product that the HMO offers with an indemnity insurer.

Section 5. Amends s. 641.3155, F.S., 1998 Supplement, relating to HMO provider contracts and payment of provider claims, to require that an HMO must reconcile to specific claims any retroactive reductions on payments or demands for refund of overpayments resulting from retroactive review of coverage decisions or payment levels, unless the parties to the contract agree to other reconciliation methods and terms. Also, a provider must reconcile to specific claims any retroactive demands for payment resulting from underpayment or nonpayment for covered services, unless the parties agree to other reconciliation methods and terms. The look-back period for such retroactive reconciliations may be specified by the terms of the contract.

Section 6. The Director of the Agency for Health Care Administration is directed to establish an 8-member advisory group consisting of: three representatives of state-licensed HMOs, one representative of not-for-profit hospitals, one representative of for-profit hospitals, one licensed physician, one representative from the Office of the Insurance Commissioner, and one representative from AHCA. The advisory group is charged with studying and making recommendations relating to: (1) trends and issues pertaining to timely and accurate submission and payment of health claims regulated under chapter 641, F.S., including legislative, regulatory, or private-sector solutions for submission and payment of such health claims; (2) development of electronic billing and claims processing for providers and health care facilities that provide for

electronic processing of eligibility requests; benefit verifications; authorizations; pre-certifications; business expensing of assets, including software, used for electronic billing and claims processing; and electronic monitoring of claims status, including use of models such as those compatible with federal billing systems; (3) the form and content of claims; and (4) measures to reduce fraud and abuse relating to submission and payment of claims. The advisory group must be appointed and convened by July 1, 1999, and must present its recommendations by January 1, 2000, in a report submitted to the President of the Senate and the Speaker of the House of Representatives. All meetings of the advisory group must be held in Tallahassee. Neither *per diem* nor travel expenses may be reimbursed.

Section 7. Amends s. 641.51, F.S., providing quality assurance program and second medical opinion requirements for health maintenance organizations, to incorporate chronic disease management measures, preventive health care for adults and children, prenatal care measures and child health checkup measures in the data released to AHCA as indicators of access and quality of care. Language is deleted that requires managed care organizations to conduct standardized customer satisfaction surveys that are consistent with surveys required by accreditation organizations. The reference to the early periodic screening diagnosis and treatment requirements is changed to child health checkup requirements.

Section 8. Amends s. 641.58, F.S., providing guidelines relating to annual regulatory assessments on health maintenance organizations, 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 annual subscriber satisfaction surveys and OPS contracted physician consultants for the Statewide Provider and Subscriber Assistance Program.

Section 9. Provides 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 Fiscal Year 1999-2000.

Section 10. Provides for the bill to take effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Subsections 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

Subsection 641.58(1), F.S., authorizes AHCA to make an annual regulatory assessment, *not to exceed* 0.1 percent of the gross amount of premiums collected by each HMO on contracts or certificates issued to subscribers in Florida. Collected revenue must be deposited into the Health Care Trust Fund. The HMO assessment rate calculated by AHCA by December 1, 1998, as required by law, is .000318441 percent. The revenue collected from the levied assessment was payable by April 1, 1999, and must be used to cover the expenses of AHCA's Bureau of Managed Health Care for Fiscal Year 1998-1999 estimated at $3,351,645, or used for other HMO-related regulatory activities or functions. There is a trust fund surplus resulting from this assessment of approximately $3 million. Some of the surplus funds will be used to fund AHCA staff or contractors annual HMO subscriber satisfaction survey activities and the contracted OPS physician services obtained by the Statewide Provider and Subscriber Assistance Panel**,** as provided for in this bill.

B. Private Sector Impact:

The agency 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.

C. Government Sector Impact:

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

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

#1 by Fiscal Policy Committee:
Provides that a PPO policy that does not provide direct patient access to a dermatologist must conform to the requirements imposed on EPO policies, as specified in s. 627, F.S., 1998

Supplement. This shall not be construed to affect the amount the insured or patient must pay as a deductible or coinsurance amount authorized under this section.