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 1534

SPONSOR: Banking and Insurance Committee and Senator Geller

SUBJECT: Health Maintenance Organizations

DATE: April 24, 2000 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Emrich	Deffenbaugh	BI	Favorable/CS
2.			HC	
3.			FP	
4.				
5.				

I. Summary:

Committee Substitute for Senate Bill 1534 revises several provisions relating to the regulation of health maintenance organizations (HMOs). The bill does the following:

- clarifies that certain provisions of the Insurance Code apply to HMOs;
- provides that the Department of Insurance may terminate an HMO contract if the contract is with an entity that is not licensed under state law, if such license is required, or is not in good standing with the applicable regulatory agency;
- authorizes HMOs to pay contracted examiners directly;
- provides for application of federal solvency requirements to provider-sponsored organizations;
- makes it a third-degree felony for an officer or director of an HMO to accept new or renewal subscriber contracts if the HMO is insolvent or impaired; and
- applies insurance holding company provisions to HMOs.

The bill amends the following sections of the Florida Statutes: 641.201, 641.234, and 641.27. The bill creates the following sections of the Florida Statutes: 641.226, 641.39, and 641.2011.

II. Present Situation:

Health Maintenance Organizations

Health maintenance organizations (HMOs) provide a comprehensive range of health care services for a prepaid premium. Such organizations stress preventive care and make efforts to avoid unnecessary hospitalization and expensive tertiary care. Subscribers must surrender certain freedom-of-choice selections of health care providers and health-care-related services. Subscriber choice is typically restricted to a "gatekeeper" physician (primary care physician) or other health care professional who is either an employee of, or has contracted to provide professional services

on behalf of, the subscriber's HMO. Furthermore, subscribers are restricted in their choice of hospitals and other health care delivery facilities that they may utilize.

According to the Department of Insurance (DOI), as of December 1999, approximately 4.9 million Floridians are enrolled in health maintenance organizations, including 425,000 in Medicaid HMOs, 805,000 in Medicare HMOs and more than 3.7 million in commercial HMOs. Under present law, DOI regulates HMO finances, contracting, and marketing activities under part I of chapter 641, F.S., while the Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a Certificate of Authority from the Department of Insurance, an HMO must receive a Health Care Provider Certificate from AHCA. Any entity that is issued a Certificate under part III of chapter 641 and that is otherwise in compliance with the licensure provisions under part I 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.

In regulating the financial operations of HMOs, DOI is responsible for ensuring that these entities are financially solvent and conduct their marketing activities in accordance with guidelines contained in chapter 641, F.S. A major role the department performs in the regulation of HMOs is to ensure that the contracts under which these entities provide services do not contain terms that are inconsistent, ambiguous, or misleading. Additionally, the department is charged with ensuring that rates charged to subscribers are not excessive, inadequate, or unfairly discriminatory. Agent activities, relating to solicitation of contracts to provide HMO services, and permissive handling of HMO assets and investments, among others, are under the department’s jurisdiction as well.

Specific requirements of the current law affected by the bill are addressed in the Effect of Proposed Changes, below.

III. Effect of Proposed Changes:

Section 1. Amends s. 641.201, F.S., to clarify that HMOs are exempt from all other provisions of the Florida Insurance Code (chapters 624-632, F.S.), except those provisions of the Code that are explicitly made applicable to HMOs. The current language in s. 641.201, F.S., has caused confusion because it provides that parts I and III of ch. 641, F.S., apply to HMOs, while the provisions of the Insurance Code do not apply to HMOs. There are several provisions in the Insurance Code which do in fact apply to HMOs and this amendment clarifies this issue.

Section 2. Amends 641.234, F.S., applying to HMO contracts. Currently, the department may require an HMO to submit to the department any contract for administrative services, contract with a provider other than an individual physician, contract for management services, and contract with an affiliated entity. The department may order the HMO to cancel the contract if it determines that the fees are so unreasonably high as compared with similar HMO contracts, that the contract is detrimental to the subscribers, stockholders, investors, or creditors.

The bill authorizes that the department may order such contracts to be canceled if the contract is with an entity that is not licensed under state law, if such license is required, or is not in good standing with the applicable regulatory agency.

Section 3. Amends s. 641.27, F.S., applying to departmental examinations. Currently, the department may contract with qualified, impartial outside parties to perform audits or examinations of HMOs and the HMOs in turn pay the department which subsequently compensates the outside examiner. This amendment streamlines this process by requiring that the payment to the contracted examiner must be made directly by the HMO in accordance with the rates and terms agreed to by the department and the examiner.

Section 4. Creates s. 641.226, F.S., which conforms state law to federal law by providing that the federal solvency requirements apply to an HMO that meets the federal definition of a "provider-sponsored organization," instead of the solvency requirements of ch. 641, F.S. This provision clarifies that such organizations may obtain an HMO certificate of authority in Florida, even if the state solvency requirements are not met. But, if the state solvency requirements are not met, the organization may only issue the Medicare+Choice contracts authorized by federal law.

Under the 1997 federal Balanced Budget Act, Congress created a new Medicare program called Medicare+Choice. This provision allows Medicare beneficiaries to elect to receive benefits through either the traditional Medicare program or through the new Medicare+Choice plan.

Section 5. Creates s. 641.39, F.S., to provide that it would be a third degree felony (up to 5 years in prison and a $5,000 fine) for any director or officer of an HMO (except with written permission of the Department of Insurance) to authorize or permit the HMO to solicit or accept new or renewal contracts after the director or officer knew, or reasonably should have known, that the HMO was insolvent or impaired, whether or not delinquency proceedings have been initiated. The term "impaired" means that the HMO does not meet the requirements of s. 641.225, F.S., which pertains to surplus requirements. This provision is similar to the criminal prohibition in the Insurance Code (s. 626.9541(1)(w), F.S.) which applies to officers or directors of insurance companies.

Section 6. Creates s. 641.2011, F.S., which makes applicable to HMOs the current holding company requirements that apply to insurance companies, which primarily require reporting certain information to the department. Currently, under part IV of chapter 628, F.S., insurers that are members of an insurance holding company must register with the department and be subject to regulation with respect to their relationship with such holding company. The department has promulgated rules specifying reporting and other requirements and this amendment would apply these holding company provisions to HMOs.

Section 7. Provides that the act shall take effect July 1, 2000.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

An HMO officer or director is subject to criminal penalties if he or she knowingly authorizes contracts with subscribers or providers when the HMO is insolvent or impaired. Outside examiners would receive payment for audits of HMOs more promptly under this bill. Health maintenance organizations could have their contracts canceled if such contract was with an unlicensed or unapproved entity.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.