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/CS/SB 162

SPONSOR: Banking and Insurance Committee, Health, Aging and Long-Term Care Committee and Senator Cowin

SUBJECT: Grounds for Disciplinary Actions Against Allopathic and Osteopathic Physicians; Modifying Requirements Relating to Rendering of Adverse Determinations by Managed Care Organizations

DATE: April 10, 2000 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Carter/Munroe	Wilson	HC	Favorable/CS
2.	Deffenbaugh	Deffenbaugh	BI	Favorable/CS
3.				
4.				
5.				

I. Summary:

CS/CS/SB 162 requires health maintenance organizations (HMOs) to ensure that only a medical or osteopathic physician licensed in Florida or who has an active, unencumbered license in another state with similar licensing requirements, may render an adverse determination regarding services provided by a Florida-licensed physician.

The HMO must submit to the treating provider and the subscriber written notification regarding the HMO's adverse determination within 2 working days after the subscriber or provider is notified of the adverse determination. The written notification must: (1) identify the physician making the adverse determination, (2) include the utilization review criteria or benefits provisions on which the adverse determination is based, (3) be signed by either the physician who renders the adverse determination or by an authorized representative of the HMO, and (4) include information about the appeal process for challenging adverse determinations.

This bill substantially amends section 641.51, Florida Statutes.

II. Present Situation:

Regulatory Requirements for Quality Assurance Programs and Second Medical Opinion for Health Maintenance Organizations

Health maintenance organizations (HMOs) are regulated under ch. 641, F.S., by the Department of Insurance (DOI) and the Agency for Health Care Administration (AHCA). Generally, DOI regulates contractual, financial, and other operational requirements relating to HMOs under parts I and II, respectively, of ch. 641, F.S., while AHCA regulates HMOs under part III of ch. 641, F.S. Quality requirements for HMOs under part III of ch. 641, F.S., include, among others: an

internal quality assurance program; accreditation; and demonstration, to AHCA's satisfaction, of the HMO's capability to provide health care services of a quality consistent with the prevailing standards of medical practice in the community.

As specified in s. 641.51, F.S., the internal quality assurance program must, at a minimum, provide:

- a written statement of goals and objectives which stress health outcomes as the principal criteria for the evaluation of the quality of care rendered to subscribers;
- a written statement describing how state-of-the-art methodology has been incorporated into an ongoing system for monitoring of care which is individual case oriented and, when implemented, can provide interpretation and analysis of patterns of care rendered to individual patients by individual providers;
- written procedures for taking appropriate remedial action whenever, as determined under the quality assurance program, inappropriate or substandard services have been provided or services which should have been furnished have not been provided; and
- a written plan for providing review of physicians and other licensed medical providers which includes ongoing review within the organization.

In addition to the quality assurance program requirements, s. 641.51, F.S., explicitly prohibits HMOs, their respective boards of directors, officers, and administrators from modifying the proper course of treatment of a subscriber as determined through the professional judgment of a Florida-licensed physician. Such treatment may, however, be modified if it is determined that the treatment is inconsistent with the prevailing standards of medical practice in the community or with an organization's utilization management program.

Under s. 641.51(4), F.S., HMOs are required to give their subscribers *the right* to a second medical opinion when the subscriber disputes the HMO's or the physician's opinion of denial of the reasonableness or necessity for surgical procedures or is subject to a serious injury or illness. A subscriber may select a physician under contract with or employed by the HMO or a noncontract physician who is located in the same geographical service area of the HMO. The HMO may charge the subscriber fees for the services of a contracted or staff physician rendering a second medical opinion that are consistent with the subscriber fees (typically a nominal $5 or $10 charge) for referral contract physicians and must pay all charges which are usual, reasonable, and customary in the community for services by a noncontract physician rendering a second medical opinion. The subscriber may be required to pay up to 40 percent of the amount due a noncontract physician. The HMO may conduct any tests that are deemed necessary for the subscriber by a noncontract physician. HMOs are authorized to deny reimbursement when the subscriber seeks more than three second medical opinions in a year if such subsequent referral costs are deemed by the HMO as evidence that the subscriber has unreasonably over utilized the second opinion privilege, and the subscriber may appeal the denial of reimbursement through the internal and external grievance processes. Once the HMO's physician, having factored in the second medical opinion, renders his or her professional judgment concerning the treatment of the subscriber, it is controlling as to the treatment obligations of the HMO. The subscriber is responsible for any unauthorized treatment obtained.

Other subscriber protections provided under s. 641.51, F.S., include requiring organizations to: (1) develop and maintain a policy for determining when exceptional referrals to out-of-network specially qualified providers should be provided for unique medical needs, subject to financial arrangements being agreed to prior to the rendering of services; (2) develop and maintain written policies and procedures for standing referrals to subscribers with chronic and disabling conditions which require ongoing specialty care; (3) allow for completion of active treatment of a condition for which a subscriber is receiving care when a contract between the organization and the subscriber's treating physician is terminated for any reason other than for cause until the subscriber (unless abusive, noncompliant, or in arrears in payments) selects another treating provider, or during the organization's next open enrollment period, whichever is longer, but not longer than 6 months after termination of the contract, or through completion of postpartum care for a subscriber who has initiated a course of prenatal care, such treatment is governed by terms of the terminated contract provided that changes made within 30 days before termination must be mutually agreed to for the continuing treatment period; (4) release certain specified indicator data to AHCA, in accordance with agency data reporting requirements, relating to access and quality of care; (5) adopt, by specified dates, recommendations for preventive pediatric health care consistent with health checkups for children who receive services through the Medicaid program; and (6) allow female subscribers, without prior authorization, but coordination with the primary care physician may be required, to visit a contracted obstetrician/gynecologist for one annual visit and medically necessary follow up care detected at that visit.

Adverse Determinations by Managed Care Organizations

Subsection 641.47(1), F.S., defines the term "adverse determination" to mean

> *a coverage determination by an organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the organization's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and coverage for the requested service is therefore denied, reduced, or terminated.*

An adverse determination may be the basis for a grievance. Requirements relating to the HMO subscriber grievance reporting and resolution process are contained in s. 641.511, F.S. Under this section, an HMO must maintain records of all grievances and submit a report to AHCA annually that delineates the total number of grievances handled, a categorization of the cases underlying the grievances, and the resolution of the grievances. Also, HMOs are required to send AHCA quarterly reports required for the Statewide Provider and Subscriber Assistance Program under s. 408.7056(3), F.S. HMO subscribers, or providers on behalf of subscribers, who want to challenge an adverse determination must first appeal the decision through the HMO's grievance procedure. Once the internal grievance process has been exhausted without satisfaction, subscribers, or providers on behalf of subscribers, may appeal the adverse determination through the state's external grievance process administered through the Statewide Provider and Subscriber Assistance Panel, created under s. 408.7056, F.S.

The Agency for Health Care Administration is required to investigate unresolved quality-of-care grievances received from HMO annual and quarterly grievance reports as well as subscriber appeals of grievances that have been reviewed through the subscriber's HMO's full grievance

procedure. Although AHCA may investigate a subscriber complaint prior to completion of an HMO's consideration through its grievance procedure, AHCA must advise subscribers that it is unable to review such a complaint as a grievance until the HMO's internal grievance process has been completed. If a subscriber's grievance is unresolved to the satisfaction of the subscriber after completion of their HMO's internal grievance procedure, AHCA may then review the grievance and refer it to the Statewide Provider and Subscriber Assistance Program for review and recommendations.

The law does not specify who is authorized to make an adverse determination on behalf of the HMO, nor does it specify how an HMO must conduct its utilization review. Other than regulation of private (independent) utilization review agents, Florida law is silent on how utilization review is to be conducted.

The utilization review process generally involves two steps. First, a review agent applies a predetermined set of utilization review criteria to the facts presented by the treating physician. If the treatment given or proposed by the physician meets the criteria, then HMO coverage is approved. If the criteria are not met, then the matter is referred to a utilization review administrator who consults with the treating physician about the particular facts of the case. Once the administrator makes a determination regarding medical necessity or appropriateness, HMO coverage is approved or denied. Most of the time, the review agents initially reviewing a case are not physicians. In some instances, the administrators making the final coverage determination are lay employees of the HMO or utilization review agency hired by the HMO. However, in the vast majority of cases they are physicians, since the accrediting organizations which require this. The accreditation standards are discussed later in this section of the Issue Paper.

Regulation of Private Utilization Review Agents

Section 395.0199, F.S., provides for the registration of private (independent) utilization review agents. The purpose of the regulation is to "protect patients and insurance providers by ensuring that private review agents are qualified to perform utilization review activities and to make informed decisions on the appropriateness of medical care." However, the scope of s. 395.0199, F.S., is very limited and is not intended to regulate the activities of private review agents, health insurers, health maintenance organizations, or hospitals, except as expressly provided in this section, or authorize regulation or intervention as to the correctness of utilization review decisions of insurers or private review agents.

As provided in subparagraph 395.0199(5)(b)1., F.S., *at least* a licensed practical nurse or licensed registered nurse, or other similarly qualified medical records or health care professionals, may perform *initial review* when information is necessary from the physician or hospital to determine the medical necessity or appropriateness of hospital services. Subparagraph 395.0199(5)(b)2., F.S., requires that *at least* a licensed physician, or a licensed physician practicing in the field of psychiatry for review of mental health services, [make] an *initial denial determination prior to a final denial determination by the health insurer* which shall include the written evaluation and findings of the reviewing physician. However, subsection 395.0199(8), F.S., expressly *exempts* from the personnel requirements established by s. 395.0199, F.S., utilization review organizations or peer review organizations acting under contract on behalf of the Medicaid Program, Medicare

Program, state employees group insurance plan, worker's compensation plan, or private self-insured funds or service companies operating as insurance administrators.

Accreditation Requirements Relating to Adverse Determinations

A managed care organization regulated under part III of ch. 641, F.S., is required as a condition of doing business in Florida to be accredited within 1 year of receiving its certificate of authority from DOI. Accreditation must be maintained as a condition of doing business in the state. Such organizations must undergo an accreditation assessment at least every 2 years or more frequently if AHCA deems additional assessments necessary.

Accreditation through the National Committee for Quality Assurance, a national accreditation organization, generally, requires a managed care organization to meet certain specific requirements relating to denial notices. Denials are one type of adverse determination. An accredited organization must document *and* communicate the reasons for each denial. To this end, managed care organizations must: (1) make a physician reviewer available, to discuss with the subscriber's provider by telephone, determinations based on medical necessity; (2) send written notification to members and practitioners of the reasons for each denial, including specific utilization review criteria or benefits provisions used in the determination; and (3) include information about the appeal process in all denial notifications.

Concerns About Managed Care

Managed care has become a dominant force in the financing and delivery of health care in this country. As an increasing number of persons receive health care through managed care plans, public attention has been focused on some of the problems consumers have with such plans. Although surveys reflect that a majority of consumers are satisfied with their plans, some express concern that plans' methods of managing care and controlling costs limit access to needed services. Some of these concerns, reflected by common features of legislative proposals under consideration or adopted during the past few years, include: (1) increased access to specialists; (2) requirements for the organizations to establish internal and external appeals processes; (3) empowering subscribers to sue the organizations for failure to provide necessary services; (4) elimination of barriers to emergency room access; (5) prohibiting managed care organizations from interfering with the discussion of health care alternatives by prohibiting inclusion of so-called "gag clauses" in the plan contract; and (6) establishing certain due process protections for providers whose contracts are terminated.

III. Effect of Proposed Changes:

Section 1. Amends s. 641.51, F.S., relating to quality assurance program and second medical opinion requirements for health maintenance organizations (HMOs). The bill requires HMOs to ensure that only a medical or osteopathic physician licensed in Florida or who has an active, unencumbered license in another state with similar licensing requirements, may render an adverse determination regarding services provided by a Florida-licensed physician.

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Section 4. Provides for an effective date of July 1, 2000.

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:

None.

B. Private Sector Impact:

Any person who renders an adverse determination on behalf of a managed care organization must be a medical physician or osteopathic physician either licensed in Florida or in another state with similar licensing requirements. Any HMO that does not currently meet this requirement may incur additional costs in doing so. Also, the HMO would incur the costs of providing written notice to both the subscriber and the treating physician, including in the information required by the bill.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None

VIII. Amendments:

None.