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HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE LICENSING & REGULATION
ANALYSIS

BILL #: HB 2339

RELATING TO: Comprehensive Health Care (Patient Protection Act of 2000)

SPONSOR(S): Representatives Feeney, Waters, Peaden, Fasano and others

TIED BILL(S): None

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:

(1) HEALTH CARE LICENSING & REGULATION YEAS 10 NAYS 2
(2) HEALTH & HUMAN SERVICES APPROPRIATIONS
(3)
(4)
(5)

I. SUMMARY:

The Patient Protection Act of 2000:

- Streamlines certificate of need review processes for introduction of new health care services and exempts certain projects from review;
- Eliminates 1.5% assessment on outpatient services and increases cap on Medicaid payments for adult hospital outpatient services from $1,000 to $1,500;
- Prevents health maintenance organization contracts from prohibiting physicians from providing inpatient services to their patients in a contracted hospital;
- Requires adverse determinations to be made by an allopathic or osteopathic physician and requires notice to patient of reason for denial of care;
- Creates grant program to address disparities in racial and ethnic health outcomes;
- Creates Florida Commission on Excellence in Health Care to facilitate development of comprehensive statewide strategy for improving health care delivery systems;
- Addresses issues relating to insurance coverage available to small employers, repeals existing provisions relating to community health purchasing alliances, and authorizes carrier to issue group policies to small employer health alliances;
- Solidifies existing patient protection provisions into one section to increase public awareness of protections available in other sections of the law;
- Requires providers, under contract with a health maintenance organization, to post and prominently display notice of addresses and toll-free telephone numbers of grievance and complaint sections of the health maintenance organizations, the Agency for Health Care Administration, and the Department of Insurance;
- Revises methodology for small employer health benefit plans;
- Revises Medicaid eligibility determinations, increases annual outpatient cap, addresses Medicaid fraud issues, provides rulemaking authority, and amends other provisions; and
- Requires assessment of impact of current mandated health coverages.

The bill specifies appropriations in an amount of $10.291 million to conduct the three studies and reviews. In addition to the specified appropriations, the fiscal impact of this bill is estimated to be $102.36 million based on the tax cuts and the increased patient services caps.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1. Less Government Yes [x] No [x] N/A []

Yes: The bill exempts certain projects from certificate of need review and streamlines the review processes for additional projects. It also creates a workgroup which may recommend further reductions in government oversight of health care projects.

No: The bill grants rulemaking authority to several state agencies and creates the Racial and Ethnic Health Disparities: Closing the Gap Act which provides authority to the Department of Health to administer a new program. The bill also requires the Department of Insurance to collect information and monitor premiums charged to employers.

2. Lower Taxes Yes [x] No [] N/A []

The bill eliminates the 1.5% assessment on outpatient services provided to patients by hospitals, ambulatory surgical centers, clinical laboratories, and diagnostic imaging centers. It also exempts certain projects from certificate of need thereby reducing the costs of new health care projects.

3. Individual Freedom Yes [x] No [] N/A []

The bill encourages private consumer and professional organizations and associations to participate in determining how medical errors can be avoided and which other health care projects can be eliminated from certificate of need review. Communities will determine which projects can be sustained in the local area instead of government making these decisions. This bill also prohibits a health maintenance organization from preventing a patient's primary care provider from treating the patient in the hospital without notice to the patient at the time he or she chooses to participate in a plan and chooses a primary care provider.

4. Personal Responsibility Yes [x] No [] N/A []

The bill requires a study of mandated health benefits which may result in future elimination of some or all benefits mandated by the government. The bill also requires health maintenance organizations to provide patients with information necessary to file a complaint or grievance against the organization.

5. Family Empowerment Yes [x] No [] N/A []

The bill requires health maintenance organizations to provide a written explanation to the patient and the patient's treating practitioner when the organization denies medical care to the patient. This will provide the patient and the patient's family with the necessary information to appeal an arbitrary or bad decision regarding a denial of care. The bill also requires the organization to provide the information necessary to file a complaint or grievance against the organization.

B. PRESENT SITUATION:

CERTIFICATE OF NEED

Section 408.032(2), F.S., defines "certificate of need" as a written statement issued by the Agency for Health Care Administration (agency) evidencing community need for a new, converted, expanded or otherwise significantly modified health care facility, health service, or hospice. The purpose of the CON process is to avoid costly duplication of services and unnecessary capital expenditures as it relates to hospitals, nursing homes, acute care hospital services, psychiatric or rehabilitative beds, and tertiary health services. As part of the CON review process, the financial feasibility of a project is assessed, the under served population group is determined, and the overall reasonableness of proposed revenues and expenses is evaluated. Applicants generally propose a specified level of care to indigent and Medicaid patients as a condition placed upon the award of a CON. These activities are consistent with the agency's mission to champion accessible, affordable, quality health care for all Floridians. The agency is charged with carrying out the CON review process on the applicable facilities.

Hospitals - Currently, s. 408.036, F.S., requires hospitals to make application for the establishment of new hospitals and the addition of beds to existing hospitals. The agency publishes a need for acute care hospital beds twice a year for the 11 planning districts. Hospitals can respond to published need, or demonstrate special circumstances unique to their hospital and the service area. In order to determine future bed need, the agency has to establish a complete inventory of acute care beds and look at the current and projected utilization of each hospital in the respective service area. All proposals are evaluated against statutory, rule, and local health plan CON review criteria.

Overall, most Floridians have adequate geographical access to acute care hospital services. The statewide average acute care bed occupancy rate remains low at 50%. The CON program lacks authority to de-license underutilized beds. However, in some areas of the state a few hospitals have experienced increasing occupancy rates especially during the winter season.

Over the past five years, the agency reviewed 37 proposals to add general acute care beds to existing hospitals. A total of 1,214 new acute care beds were proposed, at a cost of $306 million. During the same time period, the agency reviewed 17 proposals for new acute care hospitals excluding replacement facilities. A total of 815 new acute care beds were proposed, at a cost of $826 million.

According to the agency, the CON review for acute care beds was originally implemented when reimbursement for acute care services was cost-based and fears of over utilization were prevalent. These market conditions have clearly changed, and better cost control mechanisms have been implemented. However, nearly 60% of all hospital care is funded by Medicare and Medicaid, and the CON program ensures public input into the allocation of resources.

Nursing Homes - Section 408.036, F.S., requires CON review of proposals to establish new nursing homes, and proposals to add beds to existing nursing homes. The agency publishes a need for nursing home beds twice a year for 38 planning areas. Nursing home applicants generally respond to published need. In order to determine future bed need, the agency has to establish a complete inventory of nursing home beds and look at the current and projected utilization of all nursing homes in the respective service area. Future bed need is primarily determined based on population growth in each respective service area.

Since it takes about three years to establish a new facility, bed need is projected three years into the future. All proposals are evaluated against statutory, rule, and local health plan CON review criteria. The construction of state veterans' nursing homes is exempted from CON review provided certain conditions are met.

The primary rationale for nursing home market controls is to contain capacity, ensure access to care regardless of income, promote the location of nursing homes in areas with need, ensure efficient occupancy levels, and avoid costs associated with duplicative services and facilities. Additionally, the CON program allows the state to assess the financial soundness of a potential provider and to evaluate his/her past quality of care record.

According to the agency, Florida's CON program for nursing homes has been one of the most effective CON programs. Most Floridians have adequate geographic access to nursing home care. At the same time, Florida has maintained one of the lowest nursing home bed-to-population ratios in the country, while several other states had to resort to moratoria to contain the bed supply. Florida has approximately 29 beds per 1,000 65+ population compared to the national average of 50 beds.

It is in the interest of most growing states to control the nursing home bed supply, since nearly 50% of all nursing home care is funded by Medicaid and another 15% by Medicare. Florida's annual Medicaid nursing home budget exceeds $1 billion even with the low bed ratio and an overall low nursing home utilization rate.

Over 330 nursing homes have received CONs predicated on the condition that they provide a specified level of care to Medicaid patients. This is an important program feature in view of recent events in Florida when a nursing home attempted to evict Medicaid patients.

Over the past 5 years, the agency has reviewed 220 proposals for new freestanding nursing homes. A total of 20,998 new nursing home beds were proposed, at a cost of $1.4 billion. During the same period, there were 216 proposals to add beds to existing nursing homes. A total of 8,220 new nursing home beds were proposed, at a cost of $454 million. Thus, there were 5,844 new nursing home beds proposed in an average year.

Other current provisions - Current statutes specifically require review of any increase in the number of psychiatric or rehabilitation beds at hospitals. Also, a review of the establishment of tertiary health services is required. Currently, tertiary health services with dedicated inpatient beds include Level II neonatal intensive care, Level III neonatal intensive care, specialty burn units, and comprehensive rehabilitation.

Except for proposals from rural hospitals under specified circumstances, the agency also reviews proposals to establish or expand hospital-based skilled nursing units (SNUs).

PUBLIC MEDICAL ASSISTANCE

Public Medical Assistance Trust Fund (PMATF) - The 1984 Florida Legislature enacted the "Health Care Access Act" and the "Public Medical Assistance Act" which included the establishment of s. 395.701, F.S. This section imposes upon each hospital in Florida an assessment in an amount equal to 1.5 percent of the hospital's net operating revenue. The assessment is determined by the hospital budget review section within the Agency for Health Care Administration (AHCA) based on the financial reports each hospital is required

to file with the agency. Within six months after each hospital's fiscal year end, budget review certifies the assessment to the agency's Bureau of Finance and Accounting.

The 1991 Florida Legislature created s. 395.7015, F.S., that imposed an annual assessment equal to 1.5 percent of the annual net operating revenues of certain health care entities. Section 395.7015, F.S., originally imposed the assessment on the following entities: ambulatory surgical centers and mobile surgical facilities licensed under s. 395.003, F.S.; clinical laboratories licensed under s. 483.091, F.S., (with certain exclusions); freestanding radiation therapy centers providing treatment through the use of radiation therapy machines that are registered under s. 404.22, F.S., and rules 10D-91.902, 10D-91.903, and 10D-91.904 of the Florida Administrative Code; and diagnostic imaging centers that provide specialized services for the identification or determination of a disease through examination and also provide sophisticated radiological services which are rendered by a physician licensed under ss. 458.311, 458.313, 458.317, 459.006, 459.007, or 459.0075, F.S.

Chapter 98-192, L.O.F., provided an exemption from the assessment on hospital net operating revenues for outpatient radiation therapy services provided by a hospital and provided for the elimination of the assessment on freestanding radiation therapy centers. The exemption and elimination were contingent upon AHCA receiving written confirmation from the federal Health Care Financing Administration (HCFA) that the changes would not adversely affect the use of the remaining assessments as state match for the Medicaid program. AHCA received such confirmation from HCFA, and the exemption and elimination were implemented.

Section 409.918, F.S., establishes the Public Medical Assistance Trust Fund. All assessments collected pursuant to ss. 395.701 and 395.7015, F.S., are deposited into the PMATF. The assessments, combined with the projected revenues from hospital assessments, cigarette taxes, and interest earnings are fully utilized each year in the General Appropriations Act.

The Social Services Estimating Conference met on November 1, 1999 and on February 18, 2000, and adopted the following estimates for the Public Medical Assistance Trust Fund for fiscal year 2000-01, in millions:

Estimated revenues:	Nov. 1, 1999	Feb. 18, 2000
Assessments on hospitals	$248.0	$248.8
Assessments on other health care entities	15.0	15.5
Cigarette tax distribution to PMATF	109.0	113.5
Interest	3.9	2.7
Total estimated revenues	$377.8	$380.5
Estimated expenditures:		
Hospital inpatient services	$377.6	$380.3
Administration	0.2	0.2
Total estimated expenditures	$377.8	$380.5
Estimated ending cash balance	$0	$0

PMATF Task Force - Section 192, ch. 99-397, L.O.F., created a seven-member task force appointed by the Governor, the Speaker of the House of Representatives, and the President of the Senate to review the sources of funds deposited in the PMATF and to determine:

- Whether any revisions of ss. 395.701, 395.7015, and 409.918, F.S., were needed;
- Whether the assessments are equitably imposed;
- Whether additional exemptions from, or inclusions within, the assessments are justified; and
- The extent to which modifications in other statutory provisions requiring deposit of certain revenue into the PMATF could result in increased trust fund revenue.

The task force was also directed to provide an analysis of the budgetary impact of any recommended exemptions from, inclusions within, or modifications to existing assessments.

The task force heard public testimony from representatives of the facilities subject to the assessment and found that, "None supported the assessment, but all of the representatives of facilities participating in the Medicaid program agreed that they could not support repeal or reduction of the assessment unless the lost revenues were replaced from another funding source."

The task force reported that hospitals in Florida are facing increasing financial problems, "particularly [from] the impact of the federal Balanced Budget Act of 1997. The B.B.A. included reductions in the expected Medicare/Medicaid payments for the years 1998 to 2002. The majority of these reductions are in the Medicare program and affect inpatient hospital, outpatient, skilled nursing, home health, psychiatric, long term care, and managed care services."

The Florida Hospital Association estimates a five-year reduction of $3.9 billion in payments to the state's hospitals. Hospital representatives testified that the impact of these reductions is just beginning to be felt and that unless Congress provides some relief, the nation will face an epidemic of facility closures. Also, the assessment is based on net operating revenues. Some facilities are operating at a loss and are still subject to the assessment.

The task force reported that ambulatory surgical centers, diagnostic imaging centers, and clinical laboratories had the same concerns as the hospitals, and that "the tax was a huge burden on small businesses in the state and reduced their ability to invest in new technology and services."

The task force concluded that the PMATF assessment is fundamentally unfair for the following reasons:

- It is not uniformly applied to all health care entities;
- Responsibility for indigent care is a broader societal problem and should be borne by all, not just those that provide or receive health care; and
- Economic factors that existed when the assessment was instituted in 1984, and expanded in 1991, were different from today's and consequently a larger burden is now placed on the taxed entities.

MedAccess and Medicaid Adult Outpatient Care - Section 408.904, F.S., provides that anyone enrolled in the MedAccess program is entitled to any covered service furnished within this state by a participating provider including up to $1,000 per calendar year for hospital outpatient services. (MedAccess has never been implemented.)

Section 409.905(6), F.S., requires AHCA to pay for preventive, diagnostic, therapeutic, or palliative care and other services provided to a Medicaid recipient in the outpatient portion of a hospital. Payment is limited to $1,000 per state fiscal year per adult recipient.

Section 409.908(1)(a), F.S., limits Medicaid reimbursement for hospital outpatient services to $1,000 per fiscal year per adult recipient except for renal dialysis services and for other exceptions made by AHCA. The exceptions are for services that can be safely performed in the hospital outpatient setting and are more cost-effective when done in the outpatient setting rather than in the inpatient setting.

The agency indicated that the last increase in the cap for hospital outpatient services occurred in 1987. Over the past thirteen years, the cost of medical care has risen substantially, while the level of reimbursement for hospitals providing outpatient care to adults who are eligible under Medicaid has not changed.

In-Home Physician Services - According to the Agency for Health Care Administration, the field of in-home care has grown rapidly in size, complexity, and importance. Home health care offers the advantages of maintaining individuals in the community as part of an intact family, often delaying or preventing reliance on institutional care. Improved technology has allowed more complex care to be provided in the home, extending the capabilities of health care professionals in the management of these individuals.

However, physicians often cite the current Medicaid reimbursement rate as a disincentive to more widespread involvement. The inability of medically complex individuals to receive in-home care requires them to rely on an ambulance with paramedic staff for transportation to the doctor's office.

HOSPITALISTS

The "Hospitalist" Concept - The hospitalist "specialty" is simultaneously an old and a new health care delivery concept. The term "hospitalist," according to the National Association of Inpatient Physicians (NAIP), is a physician dedicated to the care of hospitalized patients. Hospitalists coordinate all aspects of an inpatient's care, including regular visits to the bedside, ordering tests and medications, integrating recommendations from specialists, and updating the family until the patient is discharged, when care is transferred to the patient's primary care physician. Generally, throughout the literature, others describe hospitalists as licensed physicians who devote a minimum of 25 percent of their practice to management or coordination of adult hospital inpatient care, nursing home care, or rehabilitative care. The concept is old in the sense that for more than 20 years pediatric practice in the United States has involved consultation with physicians specializing in hospital-based care of children, referred to as "intensivists" rather than "hospitalists." It is a relatively new concept when applied to adult health care.

According to the NAIP, an organization that represents the interests of hospitalists, the term "hospitalist" is merely "a job description." Hospitalists may be allopathic or osteopathic physicians. Approximately 55 percent of hospitalists are trained in general internal medicine; 35 percent are trained in an internal medicine subspecialty, most commonly pulmonary or critical care medicine; about six percent are trained in family practice; and the remainder are mostly pediatric hospitalists trained as pediatricians. There is no separate specialty board certification currently available for hospitalists.

The National Association of Inpatient Physicians estimates that there are, nationally, 5,000 physicians currently practicing as hospitalists, an increase from an estimated 300 in 1995. The estimated number of hospitalists practicing in Florida is 300, and they are located in all regions of the state.

During the final few days of the 1999 Legislative Session, language that purported to prohibit health maintenance organizations (HMOs) from mandating the use of hospitalists was amended onto Committee Substitute for Senate Bill 2554, relating to insurance contracts. The adopted language stated *"[n]o health maintenance organization's contract shall prevent a subscriber from continuing to receive services from the subscriber's contracted primary care physician or contracted admitting physician during an inpatient stay.*" Another related provision stated: "*a health maintenance organization shall not deny payment to a contract primary care physician or contract admitting physician for inpatient hospital services provided by the contracted physician to the subscriber."* The language was amended out of the legislation by the House of Representatives and, therefore, did not become law.

The 1999 proposed legislative language was in reaction to an effort to require use of hospitalists for the delivery of adult inpatient hospital care, except obstetrics and gynecology, as announced in a letter dated February 12, 1999, from Prudential HealthCare-South Florida (PHC) to its physician providers. In a letter addressed to "Dear Colleague," the company's medical director for South Florida notified the plan's network of physicians " . . . that beginning March 15, 1999, IntensiCare Corporation, a hospital management company, will begin a transition towards principal responsibility for all PHC members during the time of confinement in an acute or sub-acute setting." The transition was to proceed in two phases. Phase One starting on March 15th at nine named facilities and "all sub-acute facilities," and Phase Two starting on June 15th "at all other PHC contracted hospitals and will continue at all sub-acute facilities." Plan providers were instructed that "[a]ccording to the above-noted schedule, when a PHC member needs inpatient or sub-acute care, the medically necessary admissions will be approved to the appropriate facility by one of our participating 'Hospitalists.'" The letter goes on to state three anticipated benefits to result from this change and then: "We will be communicating this information of enhanced acute care to our members, through our customary publications, as well as our Member Services. Please join us in optimizing the benefits of this program by sharing this information with your Prudential patients."

The apparently unilateral and mandatory approach employed by the company catapulted a legislatively "invisible" issue, up to that point, into the legislative deliberations during the final days of the 1999 Legislative Session that ended April 30. The company's actions seem to have solidified opposition to the mandatory use of hospitalists. To date, while other HMOs in Florida have announced plans to implement a hospitalist program, no others are known to be pursuing a mandatory policy.

As a result of the concept of "hospitalists" being raised during the latter part of the 1999 session and because little was known about the extent of the use of hospitalists in the state, the Senate President assigned as an interim project of the Senate Health, Aging and Long-Term Care Committee a study of the emerging physician specialty "hospitalists." The report from that interim project, Interim Project Report 2000-56, September 1999, served as the source of most of the information presented in this portion of this analysis. For this project, Senate staff indicated that they relied primarily on discussions with and interviews of representatives of family practice physicians, the managed care industry, the hospital industry, and representatives of hospitalists. Additionally, Senate staff requested representatives of managed care organizations to inquire of their membership about their intent to implement hospitalist services as a feature of their health care service delivery. Hospitalists publish information about issues of professional interest on the Internet. Senate staff used some of these Internet sites in developing an understanding of hospitalists within the context of their interim project.

Senate staff research identified 7 major findings, as presented in their project report:

- *Mandating* that a hospitalist deliver all adult inpatient hospital care *is* universally opposed by representatives of all physician organizations, including the representatives of hospitalists, as well as other participants in the health care system such as patients and hospitals.
- Use of hospitalists in the delivery of adult inpatient hospital, nursing home, and sub-acute care services is *anticipated* to result in significant efficiencies and *cost savings*, and early results when examined by interested parties, seem to indicate that such anticipation may be correct; however, while use of hospitalists is growing rapidly, the experience is so limited and the time frame so short that no meaningful determination about cost trends can be made at this time.
- Hospitalist proponents insist that hospitalists improve the *quality of care* of hospital, nursing home, and sub-acute care services because of their focused expertise; more immediate availability to the patient and staff; higher volume of setting-specific experience; and greater familiarity with the institutional personnel and settings in which they practice, relative to physicians caring for few patients on an infrequent basis in, generally speaking, unfamiliar settings.
- Use of hospitalists may exacerbate the *communication problems* that already exist between primary care physicians (PCPs) and the specialists who provide most adult inpatient hospital treatment.
- Use of hospitalists may force patients to take on a more formal responsibility in coordinating their health care between hospital services received and physician office services received to ensure *continuity of care*. This may be necessary because, if the patient's PCP is not the admitting physician, such physician may not have the ability to access the patient's hospital record, which is the hospital's property, leaving PCPs to rely on the patient care summaries provided by the hospitalists attending to the patient.
- To the extent that PCPs limit, or are limited in, hospital, nursing home, or sub-acute care experience, they may find it increasingly difficult to resume such practices and may be limiting their *future ability to be credentialed* to work in such settings due to the loss of skills necessary for working in such environments.
- The catalysts for launching hospitalist programs are prompted by a *variety of motivations* and business arrangements.

Among the extensive supporting information contained in its report, Senate staff included the following:

> The National Association of Inpatient Physicians, founded in 1997, has published a position statement strongly opposing mandatory implementation of hospitalist programs. In addition to its position statement, NAIP's co-presidents John Nelson, M.D. and Winthrop Whitcomb, M.D., on behalf of the board of directors, on May 3, 1999, sent a letter to the American Association of Health Plans and the Health Insurance Association of America to oppose, "in the strongest terms possible, the imposition of mandatory hospitalist programs by [managed care] organizations on patients and primary care physicians." They sent the same letter, on June 9, 1999, to the Blue Cross and Blue Shield Association and, on July 21, 1999, to Prudential HealthCare-South Florida and Cigna Healthcare of Texas. The stated basis of their opposition was, " . . . we believe that the success of the hospitalist model fundamentally depends on the ability of the primary physician, with whom the patient has a long-standing and trusting relationship, to endorse both the individual hospitalist and the hospitalist model of care to a patient."

> John R. Nelson, M.D., Co-president of the National Association of Inpatient Physicians advocates voluntary use of hospitalists by the primary care physician. He believes that "hospitalists need to earn referrals, not be assured of them through managed care mandates." [Senate staff telephone interview, August 12, 1999]

Summary information from the Senate report indicated that:

> [a]t this time, the only public policy issue that has crystallized relating to hospitalists is how managed care organizations are implementing hospitalist requirements. The issue is whether or not a hospitalist program is being implemented on a mandatory basis or a voluntary basis.
>
> Hospitalists are not a creation of managed care. Hospitalists are creatures of modern medical economics. Since 1997, growth in the number of hospitalists and the use of hospitalists has escalated rapidly.

Health Maintenance Organizations and Provider Contracts - 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 the business aspects of HMOs. The Department of Insurance issues a certificate of authority to do business in Florida if the organization applying meets the requirements of s. 641.22, F.S. Specifically, the department reviews the financial and business aspects of HMOs such as actuarial soundness, minimum surplus, insurance and reinsurance, and blanket fidelity bond requirements, as well as managerial aspects of HMOs such as non-discriminatory practices and subscriber grievance procedures.

As a condition of receiving a certificate of authority to do business from the Department of Insurance, an HMO must receive a health care provider certificate from the Agency for Health Care Administration. Part III of chapter 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 by issuing health care provider certificates to HMOs which meet certain requirements.. Any entity that is issued a health care provider certificate under part III of chapter 641 and that is otherwise in compliance with the certificate of authority to do business 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.

Section 641.31, F.S., sets certain requirements HMOs must meet when contracting with subscribers and provides for certain coverage that must be included in the contract. Among the provisions included are those relating to rates charged, contract amendments, services, subscriber grievances, dependent coverage, including adoption, emergency services and care, preexisting conditions, open enrollment, disease-specific conditions, and point-of-service provisions.

Requirements for contracts and billings between an HMO and its contract and non-contract providers are established in s. 641.315, F.S. Among the provisions included are those relating to obligations for fees, liability for covered services, collection of money for services, contract terms, notice of cancellation, provider-patient communication, exclusive provider contracting, and contract termination.

Section 641.3155, F.S., relates to HMO provider contracts and payment of claims. Specifically addressed are time frames for payment of uncontested claims, contesting of claims, prompt payment, and payment reconciliation.

In general, current Florida law does not address the authority of an HMO to include or prohibit any provider contract element relating to the provision of inpatient hospital services.

ADVERSE DETERMINATIONS

Definitions:

An "adverse determination" is defined in s. 641.47(1), F.S., as 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 requirement 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 "organization" is defined in s. 641.47(13), F.S., as a health maintenance organization or prepaid health clinic.

"Clinical review criteria," as defined by s. 641.47(4), F.S., means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by the organization to determine, for coverage purposes, the necessity and appropriateness of health care services.

The "practice of medicine" is defined in s. 458.305(3), F.S., to include the diagnosis, treatment, operation, or prescription for any human disease, pain, injury, deformity, or other physical or mental condition.

Likewise, the "practice of osteopathic medicine" is defined in s. 459.003(3), F.S., to include the diagnosis, treatment, operation, or prescription for any human disease, pain, injury, deformity, or other physical or mental condition, which practice is based in part upon educational standards and requirements which emphasize the importance of the musculoskeletal structure and manipulative therapy in the maintenance and restoration of health.

Current Laws and Issues - Section 641.51(1), F.S., requires health maintenance organizations and prepaid health clinics to ensure that the health care services provided to subscribers (patients) are rendered under reasonable standards of quality of care consistent with the prevailing standards of medical practice in the community. Section 641.51(2), F.S., requires health maintenance organizations and prepaid health clinics to have an ongoing internal quality assurance program for its health care services. The quality assurance program must include a written plan for providing review of physicians and other licensed medical providers. Furthermore, s. 641.51(3), F.S., prohibits modification of the treating physician's professional judgment concerning the proper course of treatment unless the course of treatment prescribed is inconsistent with the prevailing standards of medical practice in the community. However, it does not restrict utilization management programs established by organizations.

These sections do not require the adverse determination to be made by or reviewed by a Florida licensed physician. Moreover, the current definitions of the "practice of medicine" and the "practice of osteopathic medicine" do not specifically include the rendering of an adverse determination. The Florida Board of Medicine has argued that the rendering of an adverse determination is or should be the practice of medicine since such decisionmaking

is based on medical judgment and expertise to determine medical necessity, appropriateness, and effectiveness of a treatment plan proposed by the treating physician and because it is necessary for the person making the adverse determination to render an expert opinion as to whether the treatment prescribed falls below the standard of care.

Pursuant to s. 641.495(11), F.S., every organization providing health care services to patients in Florida is required to designate a medical director who is an allopathic or osteopathic physician licensed in Florida. However, although the law requires the organization to designate a Florida physician as medical director, it does not require the Florida licensed medical director to perform any specific functions such as reviewing or making adverse determinations for Florida patients.

The requirements for licensure in Florida as an allopathic or osteopathic physician are found in chapters 458 and 459, F.S., respectively. The state of Florida has been a leader in strengthening the requirements for licensure of physicians. For example, in 1997, Florida passed laws requiring physicians to report disciplinary actions taken against them, all criminal convictions, and liability claims resulting in payment of more than $5,000. These laws, ss. 455.565-455.5656, F.S., also required all physicians to be fingerprinted and background screened. Indeed, Florida is sometimes criticized for its extensive review of applications and stringent licensure requirements. However, Florida patient advocacy groups support careful and thorough review in order to promote patient safety.

According to information provided by the Federation of State Medical Boards, the licensure requirements differ between Florida and other states with regard to physician licensure. Some states with severe physician shortages have lower standards than Florida in order to attract physicians to that state. Some of the differences relating to background screening include:

- Florida is one of only 6 states that require fingerprinting and national criminal background checks.

- Not all states review the applicant's substance abuse, psychiatric, or other impairment history prior to licensure.

- Not all states check malpractice histories prior to licensure. Only half of the states, including the state of Florida, check the applicant's professional liability record.

- Florida is one of only 10 states that verifies that the physician carries malpractice insurance or is otherwise financially capable of paying medical malpractice judgments. Florida is one of only 8 states that review delinquent child support payments owed by the applicant and is one of only 7 states that review delinquent educational loans owed by the applicant in order to determine personal responsibility and judgement.

- Florida is one of only 17 states that verify licensure to prescribe, dispense, and administer controlled substances with the United States Drug Enforcement Administration.

- Not all states verify credentials through the national data banks. Not all states check data files of the U.S. Military and F.B.I. Most states do not check data files of hospitals where the practitioner has privileges, local medical societies, professional societies, and specialty boards, but Florida does.

- Florida is one of only 25 states that profile practitioners and make those profiles available to the public.

News articles continue to point out the need for the laws to be changed in order to hold organizations accountable for bad decisions. According to the Center for Patient Advocacy, most Americans are prohibited under federal law from suing their health maintenance organization in civil court for medical malpractice, fraud, or death if they are covered by an employer-funded health maintenance organization. The Center for Patient Advocacy believes that the laws regarding accountability for medical decisions must be changed to protect patients.

Under current Florida law, persons other than Florida licensed physicians can determine whether a patient will receive a health care service determined by the treating physician to be medically necessary and appropriate. Florida law requires organizations to be accredited pursuant to s. 641.512(1)(a), F.S., and the accrediting standards require a physician to sign off on treatment denials. However, Florida law does not specifically require the treatment denial to be made by a licensed physician. In some cases, adverse determinations are rendered by nurses who would not be permitted to testify in Florida courts as to the standard of care for a physician. In other cases, adverse determinations are rendered by persons located outside of Florida who may or may not be health care practitioners and cannot be held accountable by any regulatory board. If Florida was to notify the state of residence of the practitioner rendering the adverse determination, that state would not be able to take action against the practitioner unless that state had a law specifically including adverse determinations in the definition of the practice of medicine or in a specific ground for discipline. That state would be powerless to hold the practitioner accountable in the same manner as Florida regulatory boards and Florida patients are now powerless to take action against the person making the wrong decision.

RACIAL & ETHNIC HEALTH DISPARITIES:

Background

According to the American Medical Association:

Despite extensive...legislative and advocacy efforts, startling disparities in health care access continue both in big cities and rural areas, with millions of Americans uninsured and underserved. Ignorance of cultural issues, lack of knowledge, language differences, prejudice, bigotry--whether on the part of the physician or the patient--all serve as barriers to access to effective health care for every American. [*Source: American Medical Association, The Reporter, October 1999.*]

According to the Centers for Disease Control and Prevention:

By the end of year 2000, racial minorities -- African Americans, Asian and Pacific Islander Americans, and Native Americans -- will make up more than 17 percent of the U.S. population. Persons of Hispanic origin, who may be of any race, will make up more than 11 percent.

Compared to the nation as a whole, minority populations, particularly African Americans, suffer higher rates of morbidity and mortality. Native Americans and Hispanics also have worse health outcomes than the total population. Although Asian American and Pacific-

Islanders overall have reasonably good health indicators, some subgroups within these populations have very poor health status indicators.

The health status of the nation as a whole has improved significantly during this century. Advances in medical technology, lifestyle improvements, and environmental protections have all led to health gains. Yet these changes have not produced equal benefit in some racial and ethnic populations.

Health disparities among minority populations are generally based on differences in economics, education, and other social conditions, and behavioral factors such as lifestyle and health practices. Minority populations are disproportionately represented among the economically disadvantaged in the United States. The impact of institutionalized racism on health has not been adequately assessed; however, relationships between negative health outcomes, economic deprivation, and lack of adequate access to quality health care have been extensively investigated and documented.

Research and health promotion have increasingly targeted minority ethnic and racial populations in efforts to understand the dimensions of existing problems and work to reduce or eliminate health disparities. But the task is not easy; the problems are of longstanding duration and multi-faceted complexity. Racial and ethnic minority populations differ from one another in social and cultural characteristics, and there is diversity within each racial and ethnic population. Although the increased focus in recent years on health initiatives targeting minority populations has produced some measurable health gains, in many instances the gap in health status continues to widen. [*Source: Centers for Disease Control and Prevention, Office of the Associate Director for Minority Health*.]

According to the Florida Department of Health:

Culturally and ethnically diverse communities are Florida's fastest growing population segments. Yet, Florida's ability to affect improvements in many important health outcomes measurements --such as the incidence of infant mortality, cardiovascular disease, cancer, and diabetes--has fallen short of our state's identified strategic plan goals. The lagging rate of improvements in these communities demands attention.

- Infant mortality rates are nearly doubled for African Americans compared to whites.
- Hispanic whites are 25 percent more likely than non-Hispanic whites to have diabetes.
- Native American youth are 34 percent more likely to be current smokers than non-Hispanic white youth.
- African Americans are nearly six times as likely to die of AIDS than whites.
- The death rate for cancer among African American men is about 50 percent higher than for white men.
- Hispanics are 26 percent more likely than non-Hispanic whites to be obese.
- African Americans are 77 percent more likely to be obese than non-Hispanic whites.
- African Americans are nearly twice as likely to die of stroke than whites.

Federal Initiatives - The Office of Minority Health (OMH) was created by the U.S. Department of Health and Human Services (HHS) in 1985 as a result of the Report of the Secretary's Task Force on Black and Minority Health. The Office of Minority Health Resource Center (OMH-RC) was created in 1987. OMH-RC serves as a national resource and referral service on minority health issues. The center collects and distributes information on a wide variety of health topics, including substance abuse, cancer, heart

disease, violence, diabetes, HIV/AIDS, and infant mortality. The Resource Center also facilitates the exchange of information on minority health issues. Unlike a clearinghouse, OMH-RC offers customized database searches, publications, mailing lists, referrals, and more regarding American Indian and Alaska Native, African American, Asian American and Pacific Islander, and Hispanic populations. The OMH advises the Secretary of HHS and the Office of Public Health and Science (OPHS) on public health issues affecting American Indians and Alaska Natives, Asian Americans, Native Hawaiians and Other Pacific Islanders, Blacks/African Americans, and Hispanics/Latinos. The mission of OMH is to improve the health of racial and ethnic populations through the development of effective health policies and programs that help to eliminate disparities in health.

In February 1998, President Clinton announced Healthy People 2010 program, as part of his Initiative on Race, in an effort to make the elimination of disparities in health outcomes for racial and ethnic minorities in this country a national priority. Later that year, Congress approved the funding for the initiative. The Healthy People 2010 program is a national health promotion and disease prevention initiative that brings together national, state, and local government agencies; nonprofit, voluntary, and professional organizations; businesses; communities; and individuals to improve the health of all Americans, eliminate disparities in health, and improve years and quality of healthy life.

[*Source: U.S. Department of Health and Human Services, Office of Minority Health, website:* http://www.omhrc.gov/AboutOMH.HTM]

In 1998, the Clinton Administration, via the Health and Human Services Minority HIV/AIDS Initiative, declared HIV/AIDS to be a severe and ongoing health crisis in racial and ethnic minority communities. The initiative began in Fiscal Year 1999 with $156 million, which increased to $250 million in Fiscal Year 2000. The Administration has requested $274 million for Fiscal Year 2001. This initiative provides funds for grants to community-based organizations, research institutions, minority-serving colleges and universities, health care organizations, and state and local health departments through six federal agencies – the Office of Minority Health, Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration, National Institutes of Health, Indian Health Services, and Health Resources and Services Administration.

The Division of Diabetes Translation (DDT) is a part of the National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services (DHHS). The division focuses on the following: to understand the problem; to determine the elements of good preventive care; to identify groups at risk for complications or that have low levels of preventive care; and to communicate this information to providers of care, policy makers, intervention program specialists, and others. The division does not support the direct provision of services, but facilitates the efficient, fair, and effective availability of these services to all Americans impacted by diabetes. The division does not do laboratory research and does not routinely fund individual investigators. Significant activities of the division include:

- The National Hispanic/Latino Diabetes Initiative for Action (NH/LDIA), to serve as a blueprint for the DDT to frame interdisciplinary, culturally relevant approaches to control diabetes and its complications in the U.S. Hispanic/Latino community; because it is also a long-range "road map," the initiative is comprehensive in scope; and
- Project DIRECT is a multiyear community diabetes demonstration project, funded primarily by the Centers for Disease Control and Prevention (CDC). DIRECT is an acronym for "Diabetes Intervention Reaching and Educating Communities Together." To reduce the burden of diabetes and its complications in an African-American community through a community diabetes demonstration project.

Florida Governmental Programs - The State of Florida supports minority and ethnic health care through a variety of funding programs throughout the various agencies. The following programs were specifically created to focus on minority and ethnic health issues:

Minority HIV/AIDS Task Force: The Task Force was created by section 200, chapter 99-397, Laws of Florida. Appointed by the Secretary of the Department of Health, the members of the Task Force are commissioned to develop specific recommendations for consideration by the Governor, the Legislature, and the department. These recommendations are primarily designed to address ways to strengthen HIV/AIDS prevention, early intervention and treatment efforts in the state's African-American, Hispanic, and other minority communities. The Task Force is also intended to assist the department in conducting a Black Leadership Conference on HIV/AIDS. The legislation further required the development and implementation of a statewide HIV/AIDS media campaign that is directed towards minorities.

Department of Health, Bureau of HIV/AIDS: This bureau provides a coordinated approach to prevent to spread of HIV/AIDS and provide care and treatment to those already infected. Due to the disproportionate affect of HIV/AIDS on minority communities, the bureau has implemented several initiatives towards culturally and ethnically diverse communities, including the following: Florida Black Leadership Conference on HIV/AIDS; Florida HIV/AIDS Minority Network; Minority HIV/AIDS Task Force; 7 Regional Minority HIV/AIDS coordinators; and The Church as a Change Agent Workshops. In addition, the HIV/AIDS funding targeted to Minority Communities program has funded the following: 40 prevention contracts, Targeted Outreach to Pregnant Women Act, AIDS Drugs Assistance Programs, Aids Insurance Continuation Programs, Housing Opportunities for Persons with AIDS, and outpatient medical care, pharmaceuticals, dental services, and case-management. Other HIV/AIDS funding allocations have provided training, workshops, and conferences; seroprevalence studies and surveillance activities; collaborative activities between HIV prevention, alcohol, drug abuse, and mental health; peer education projects at three Department of Corrections facilities; statewide condom and literature purchase; and community planning.

Office of Equal Opportunity and Minority Affairs: This office, in addition to its responsibilities for planning, directing, coordinating, and assuring statewide compliance with federal and state civil rights laws and policies relating to the provision of equal opportunities in employment with the Department of Health, is also responsible for development, coordination and supervision of the staff of the minority population outreach program and coordinates the activities of the Minority Health Council of the Tobacco Pilot Program.

In 1999, the office, in conjunction with the U.S. Department of Health and Human Services, sponsored the Inaugural Interagency Minority Health Symposium. The goal of the symposium was to bring together government and community leaders to find more effective ways to address the health care needs of Florida's culturally and ethnically diverse communities. The discussion focused on six major areas of health disparity: maternal/infant mortality, vaccinations, HIV/AIDS, diabetes, chronic cardiovascular diseases, and cancer. State agencies with programs that target minority populations included: Department of Agriculture and Consumer Services, Department of Community Affairs, Department of Corrections, Department of Children and Family Services, Department of Education, Department of Elderly Affairs, Department of Environmental Protection, Department of Insurance, Department of Juvenile Justice, Department of Management Services,

Department of Veterans Affairs, Agency for Health Care Administration, and the Commission for the Transportation Disadvantaged.

The Sickle Cell Education and Counseling Program: This program, located in the Department of Health, provides sickle cell education and counseling of individuals, families, and the general public in Florida. The purpose of this educational effort is to reduce pediatric and adult morbidity and mortality by increasing community awareness of the disease, by identifying available medical and supportive resources to this population and to promptly place those with sickle cell disease in a system of care. This is accomplished through contracts with multiple community providers.

The Bureau of Tuberculosis & Refugee Health: This bureau, located within the Department of Health, provides time-limited health care services to refugees. Within 90 days of arrival, refugees are eligible to receive a domestic health assessment. For the first eight months in the United States, refugees are eligible for Medicaid or refugee medical assistance. After 8 months, refugees access health care services as any other individual would. The current $700,000 funding is from the Office of Refugee Resettlement in Washington via a Preventive Health Services for Refugees Grant for FY 99-00. In addition, the Department of Children and Family Services, Refugee Services funds two positions. In 1998, over $2,000,000 in Refugee Medical Assistance funds was reimbursed to county health departments for the provision of refugee health assessments.

The Community Environmental Health Program: In 1998, s. 381.1015, F.S., was created providing for the Community Environmental Health Program and the Community Environmental Health Advisory Board. The program recognizes that racial minorities and low-income populations experience higher than average exposures to selected pollutants. While exposure does not always result in immediate or acute health effect, high exposures, and the possibility of chronic effects, is a cause for concern. In 1999, the Legislature identified six pilot projects, listed in s. 381.102, F.S., to demonstrate techniques and coordinate with existing resources and programs to ensure health care for residents through disease prevention and health promotion. These pilot projects are located in low-income communities. A report to the Legislature and Governor is due on January 1, 2001, regarding the findings, accomplishments, and recommendations of the pilot projects.

Front Porch Florida: In 1999, s. 14.2015, F.S., was created to form the Front Porch Florida program, an urban revitalization initiative that was designed to build on the strengths of Florida's urban core communities, including the Urban Core Brownfield Cleanup Program.

The Center for Environmental Equity and Justice: In 1998, s. 760.854, F.S., was created to form The Center for Environmental Equity and Justice at the Florida Agricultural and Mechanical University within the Environmental Sciences Institute. The purpose of the center is to conduct and facilitate research, develop policies, and engage in education, training, and community outreach with respect to environmental equity and justice issues.

The following programs, while not created to specifically focus on minority and ethnic health issues, contain elements or programs which focus on minority and ethnic health issues:

- The Florida KidCare Act (ss. 409.810-409.820, F.S.);
- Healthy Families Florida (s. 409.153, F.S.), a partnership between the Ounce of Prevention Fund, a not for profit organization, and the Florida Department of Children and Family Services; and

- The Florida Commission for the Transportationally Disadvantaged (ss. 427.011-427.017, F.S.).

MEDICAL ERRORS

State Regulatory Oversight of Health Care and Related Insurance Carriers - The Department of Health was created in 1996 to promote and protect the health of all residents and visitors in the state through organized state and community efforts as provided in s. 20.43, F.S. The duties and responsibilities delegated to the department by the Legislature include: disease and disability prevention; health program design; study of disease causes and formulation of preventive strategies; development of working associations with all agencies and organizations involved in health and health care delivery; analyze trends in the evolution of health systems and identify and promote the use of innovative, cost-effective health delivery systems; serve as the statewide repository of all aggregate data accumulated by state agencies related to health care, analyze that data, and provide issue periodic reports and policy statements; require that all aggregate data be kept in a manner that promotes easy utilization by the public, state agencies, and all other interested parties; biennially publish and annually update a state health plan that assesses current health programs, systems, and costs; make projections of future problems and opportunities; and recommend changes needed in the health care system to improve the public health.

As set forth in s. 20.43, F.S., the Department of Health and its 26 boards and councils are charged with regulating health care practitioners who provide health care services to the people of Florida in accordance with chapters 455-491, F.S., as necessary for the preservation of the health, safety, and welfare of the public. The department also regulates emergency medical service providers pursuant to chapter 401, F.S., such as paramedics and emergency medical technicians.

Moreover, the Department of Health is responsible for the state's public health system pursuant to chapter 381, F.S., which includes comprehensive planning, data collection, technical support, and health resource development functions such as state laboratory and pharmacy services, the state vital statistics system, the State Center for Health Statistics, emergency medical services coordination and support, and recruitment, retention, and development of preventive and primary health care professionals and managers.

The Agency for Health Care Administration was created in 1992 and regulates health care facilities and managed care organizations which provide delivery mechanisms for health care in Florida in accordance with chapters 395, 401, 627, 636, and 641, F.S. Section 20.42, F.S., sets forth the organizational structure of the agency and lists the responsibilities of each division, two of which will be affected by this bill. The Division of Health Quality Assurance is responsible for the licensure and inspection of health facilities. The Division of Health Policy and Cost Control is responsible for health policy, the State Center for Health Statistics, the development of The Florida Health Plan, certificate of need, state and local health planning pursuant to s. 408.033, F.S., and research and analysis.

Thus, the Department of Health and the Agency for Health Care Administration have overlapping duties with regard to setting health policy, researching and analyzing data, and maintaining the State Center for Health Statistics. The department and agency also work closely together with respect to the licensure and regulation of health care practitioners. Although the statutory responsibility to license and discipline practitioners has been delegated to the Department of Health by the Legislature, the Legislature has also provided

in s. 20.43(3), F.S., that the "department may contract with the Agency for Health Care Administration who shall provide consumer complaint, investigative, and prosecutorial services required by the Division of Medical Quality Assurance, councils, or boards, as appropriate." Despite the permissive language used in s. 20.43(3), F.S., the funding for the complaint, investigative, and prosecutorial services is appropriated directly to the agency, instead of being appropriate to the department, in an amount of approximately $18 million per fiscal year.

Managed care organizations, indemnity insurers, and medical malpractice professional liability insurance are regulated by the Department of Insurance. There is overlap between the Department of Insurance and the Agency for Health Care Administration with regard to managed care organizations. 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 the business aspects of HMOs. The Department of Insurance issues a certificate of authority to do business in Florida if the organization applying meets the requirements of s. 641.22, F.S. Specifically, the department reviews the financial and business aspects of HMOs such as actuarial soundness, minimum surplus, insurance and reinsurance, and blanket fidelity bond requirements, as well as managerial aspects of HMOs such as non-discriminatory practices and subscriber grievance procedures.

As a condition of receiving a certificate of authority to do business from the Department of Insurance, an HMO must receive a health care provider certificate from the Agency for Health Care Administration. Part III of chapter 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 by issuing health care provider certificates to HMOs which meet certain requirements. Any entity that is issued a health care provider certificate under part III of chapter 641 and that is otherwise in compliance with the certificate of authority to do business 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.

Insurance carriers are regulated by the Department of Insurance in accordance with chapters 624-651, F.S. Medical malpractice is a tort and is governed by the provisions of chapter 766, F.S.

Private Sector Oversight of Health Care - The professional trade organizations provide ethical standards and goals, and in some instances, resolve conflicts or grievances against their members. For example, the American Medical Association established a Code of Ethics at its first official meeting in 1847 and then in 1996 also added Ethics Standards. The mission of these ethics standards is to promote patient care and the betterment of public health by optimizing ethics in medicine. Other affected health care associations have similar procedures and standards for their members.

The professional associations also are equipped to communicate with members through journals, newsletters, magazines, and other means of communication on a wide scale which is a key component of educating practitioners and providers of changes to statutes, rules, advances in technology, and standards of practice. The practice changes recommended by the Commission would need recognition and acceptance by, and the support of, the affected organizations in order to become implemented on a broad scale.

Recent Developments and Call for Study - Recent national reports estimate that between 44,000 and 98,000 patients die each year as the result of errors in hospitals. The cost to

the nation is estimated to be between $17 billion and $29 billion. Many of these errors could be prevented if the health care delivery system focused on error reduction and instituted quality improvement procedures on a broad scale. However, most efforts to improve the health care system have been fragmented or implemented on a limited scale.

Over the past decade, Florida's health care delivery system has made tremendous strides toward addressing the critical issues of access, quality, and cost containment. Floridians are living longer, healthier lives than ever before. However, the state's health care delivery system is under enormous strain, made evident by the number of documented adverse incidents. The human cost of these adverse incidents is significant and may be avoidable. No single practitioner, provider, or organization is at fault for these adverse incidents. Practitioners and other persons involved in the delivery of health care are human beings and human beings tend to make mistakes, especially while under time pressures and other constraints. Therefore, attempting to place blame on any particular component of the health care industry is pointless and destructive. Rather than reducing errors, a system of blame and punishment causes or encourages a system of nondisclosure. The current disciplinary and malpractice systems in Florida are blame and punishment systems which discourage early error detection, discourage admission of fault, and discourage sharing errors and corrective action plans with the entire industry.

The Department of Health and the Agency for Health Care Administration have proposed the formation of a Florida Commission on Excellence in Health Care to serve as the catalyst for the development of a comprehensive statewide strategy for health care delivery process improvement, quality measurement, data collection, and reporting standards. This commission, as envisioned by the department and agency, would consist of key stakeholders in health care, including consumers, health care practitioners and providers, health plans, professional associations, health care regulatory and policy-making bodies, and legislators. The commission would be funded by the Legislature to cover expenses associated with consumer member travel, travel expenses for staff and appointees of the department and agency, meeting costs, consultants, and document production and dissemination. It was anticipated that $100,000 will be necessary to cover the costs of this commission. Costs of the remaining commission members would be paid by the member or the member's sponsoring organization. Employees of the Department of Health and the Agency for Health Care Administration would provide staff expertise relating to meeting planning, research, policy and data analysis, legal issues, and regulatory implementation.

The department and agency recommended that the purpose of the commission should be to study errors in health care, practitioner and provider continuing competency, effectiveness of alternative treatments and services, technology and information systems, and quality of care in all practice settings. The commission would study national reports of medical errors, including but not limited to the Institute of Medicine's report, *To Err is Human: Building a Safer Health System.* The commission would also study our current disciplinary and medical malpractice systems and evaluate alternative systems for reimbursing the injured patient. The commission would be required to provide a report to the Legislature no later than February 1, 2001.

HEALTH ALLIANCES

Community Health Purchasing Alliances - In 1993, the Legislature created Community Health Purchasing Alliances, or CHPAs (commonly called "chippas"), via ch. 93-129, L.O.F., codified as ss. 408.70-408.706, F.S. These state-chartered, nonprofit private organizations were designed to pool purchasers of health care insurance together as

organizations that could foster health coverage purchasing to lower prices and enable purchasers to make informed choices regarding health plans. The goal of CHPAs was to make health insurance plans available to small employers, as that term is defined in s. 627.6699, F.S., that have 1 to 50 employees, including sole proprietors and self-employed individuals.

The Agency for Health Care Administration (AHCA) is responsible for implementation and oversight of the statewide system of CHPAs, including technical and legal assistance, liaison functions, and designation of accountable health partnerships (AHPs). In order for an insurance product to be offered through CHPAs, the product must qualify as an AHP, which must be formed by an insurer or health maintenance organization (HMO) authorized by the Department of Insurance. The CHPAs act as clearinghouses for health plans that qualify as AHPs. The AHPs are selected via a request-for-proposals process. CPHAs offer several benefit plans. Within these plans, an individual can select different types of coverage, such as HMOs and preferred provider organizations. All CHPA plans are sold through insurance agents.

The 1993 enabling legislation created 11 CHPAs, one for each of AHCA's health service planning districts. There are now seven CHPAs, due to mergers of certain CHPAs from neighboring regions. Each CHPA operates under the direction of an appointed 17-member board of directors. The original law that provided for appointment of board members by designated public officials was repealed due to a "sunset" provision and failure of the Legislature to reenact the provision. Thus, the boards, as nonprofit associations, provide for appointment of board members in their respective articles of incorporation and bylaws continue to provide for appointment of members in the manner that was statutorily directed. The boards appoint executive directors who serve as CHPAs' chief operating officers. Each CHPA also employs from one to three full-time staff, and all but one of the CHPAs contract with a third-party administrator.

As of February 2000, approximately 35,000 persons, including employees and their dependents, were insured through CHPAs, representing about 13,000 small employer groups. This represents a decrease from the 94,090 persons who were covered through CHPAs in December 1998. Only seven carriers remain as active AHPs in the CHPA market, and some of these are active in only certain districts. Fifteen carriers have discontinued their participation in AHPs in some or all of the CHPA districts.

The Office of Program Policy Analysis and Government Accountability (OPPAGA) has issued reports on the activities and effectiveness of CHPAs. The most recent OPPAGA report, "The Follow-Up Report on the Status of Community Health Purchasing Alliances in Florida," Report No. 98-14, October 1998, stated that the CHPAs continue to have a small impact in reducing the number of uninsured Floridians. Limitations of the CHPAs as cited in the report included:

- CHPAs' inability to negotiate or select health plans that offer the most competitive products and prices, and
- CHPAs' dependence on agents designated by health plans to sell CHPA products and to further improve access to affordable health care coverage.

The OPPAGA report recommended that the Legislature consider the following policy options:

- Allow CHPAs to negotiate with competing health plans and select those that offer the most competitive products and prices;

- Reduce AHCA's responsibilities to minimal oversight and coordination among CHPAs; and
- Enable CHPAs to appoint their agents.

It should also be noted that s. 408.7056, F.S., relating to the Statewide Provider and Subscriber Assistance Program, is physically located in the statutes in the middle of various CHPA provisions. As a result, the definitions used in this portion of ch. 408, F.S., are applicable to this program and the CHPAs.

Related Insurance Provisions

Association Health Plans- Part VII, ch. 627, F.S., establishes requirements for each of the types of groups to whom a health insurer may issue a group policy. A health insurer may not issue a policy to a group to cover members of that group unless it meets the requirements of one of the statutorily authorized groups. Under the provisions of s. 627.654, F.S., a group policy may be issued to an association (such as a trade association), including a labor union, which has a constitution and bylaws, at least 25 members, and has been organized and maintained in good faith for a period of 1 year for purposes other than that of obtaining insurance.

A policy issued to an association must allow all members of the association, or any class or classes of the association, to be eligible and acceptable to the insurer at the time of the issuance of the policy. Therefore, an association that has both large employers and small employers could not have an association health plan because all of its members would not be eligible for coverage. Because Florida law requires small employers to be covered pursuant to the small employer health insurance laws (the Employee Health Care Access Act, discussed below), large employers and small employer members could not be covered under the same group plan.

Guaranteed Renewability- Under the provisions of s. 627.6571, F.S., group health insurance policies must be guaranteed renewable, with certain exceptions. One exception is that if health insurance coverage is made available only through one or more bona fide associations, which in this context are defined as including a requirement that the association be formed for purposes other than obtaining insurance.

Small Employer Health Insurance- Section 627.6699, F.S., the Employee Health Care Access Act, applies to all health insurance plans that are sold to a small employer, defined as one with 1 to 50 employees, including sole proprietors and self-employed individuals. This act requires guaranteed issuance of coverage to all small employers, regardless of health condition. It also requires that rates be based on a modified community rating methodology, which prohibits insurers from basing rates on the health conditions or claims experience of any person insured under a small group policy. Rates for a small employer policy may be based only on the following factors: age, gender, geographic locations, tobacco usage, and family composition (size).

EMPLOYEE HEALTH CARE ACCESS

Florida's Small Group Insurance Reform -- The Employee Health Care Access Act- In 1992, the Legislature enacted reforms to the small group insurance market, called the Employee Health Care Access Act (the Act). An express purpose of the Act is to promote the availability of health insurance coverage to small employers regardless of their claims

experience or their employees' health status. The Act has three key components. These are:

- *Modified Community Rating* - Community rating is a method of developing health insurance rates which takes into account the medical and hospital costs in the entire community or area to be covered. Individual characteristics of the insured employer are not considered. Florida utilizes a variation on this method, which allows carriers to consider a limited set of individual characteristics relating to the individuals actually covered. These factors include age, gender, family composition, tobacco usage, and geographic location.[1] Florida's "modified community rating" method does not allow carriers to adjust premiums for an employer based on any other factors, including an employee's claims experience or health status.

- *Guarantee-Issue Requirements* - Under the Act, carriers are required to offer and renew certain health insurance plans, including basic and standard plans, for small employers regardless of claims experience or health status. For employers with one or two employees, Florida law requires carriers to offer, at a minimum, "standard" and "basic" plans. The "standard" policy is generally intended to be comparable to a major medical policy typically sold in the group market, with cost containment features intended to make the policy affordable. The "basic" policy includes certain standard policy benefits with certain restrictions on the benefits and utilization, as well as other features designed to lower the cost of this coverage. For employers with 3 to 50 employees, Florida law requires each carrier to offer, not only the standard and basic plans, but any other small employer group plans sold by that carrier.[2]

- *Exemption from Mandates* - Certain small employer policies are exempt from "mandated health benefits" (i.e., laws which require private insurer and HMO health plans to provide certain coverages) unless made applicable by the Legislature.[3]

Non-Elderly Uninsured Rate: Florida vs. U.S., 1989 - 1997 - According to the Employee Benefit Research Institute,[4] the uninsured rate within Florida's non-elderly population (ages 0-64) is higher in 1997 than it was in 1989. Florida's non-elderly uninsured rate also exceeds the national average.

	1989	1993	1997
Florida	20.5%	23.1%	23.7%
United States	15.7%	17.3%	18.2%

Carriers Offering Small Group Insurance in Florida - According to the Department of Insurance, as of the first quarter of 2000, there are 59 carriers offering small employer

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[1] Section 627.6699(3)(n), F.S.

[2] In addition to the basic and standard plans, small employer carriers typically offer additional plans with variations such as higher benefit levels or additional coverages.

[3] Since this bill focuses on the components relating to community rating and guaranteed availability of coverage, the issue of mandated health benefits will not be addressed in the Present Situation.

[4] Established in 1978, the Employee Benefit Research Institute is a nonprofit, nonpartisan organization which conducts policy research on economic security and employee benefits.

health benefit plans. This number reflects a continuing drop in recent years in the number of carriers offering small employer benefit plans. In 1997 there were 116 carriers, and in 1998 there were 90 carriers, offering small employer benefit plans in Florida.

MEDICAID ISSUES

Medicaid - Medicaid is a medical assistance program that pays for health care for the poor and disabled. The program is jointly funded by the federal government, the state, and the counties. The federal government, through law and regulations, has established extensive requirements for the Medicaid Program. The Agency for Health Care Administration is the single state agency responsible for administering the Florida Medicaid Program. The statutory provisions for the Medicaid Program appear in ss. 409.901 through 409.9205, F.S. The state budget for the program for the current fiscal year is $7,416,045,061, and the program anticipates serving 1,607,144 clients this year.

Adult Outpatient Hospital Services Cap - Section 409.905(6), F.S., requires AHCA to pay for preventive, diagnostic, therapeutic, or palliative care and other services provided to a Medicaid recipient in the outpatient portion of a hospital. Payment is limited to $1,000 per state fiscal year per adult recipient.

Section 409.908(1)(a), F.S., limits Medicaid reimbursement for hospital outpatient services to $1,000 per fiscal year per adult recipient except for renal dialysis services and for other exceptions made by AHCA. The exceptions are for services that can be safely performed in the hospital outpatient setting and are more cost-effective when done in the outpatient setting rather than in the inpatient setting.

The agency indicated that the last increase in the cap for hospital outpatient services occurred in 1987. Over the past thirteen years, the cost of medical care has risen substantially, while the level of reimbursement cap for hospitals providing outpatient care to adults who are eligible under Medicaid has not changed.

Medicaid Fraud and Abuse - The Legislature, the Attorney General's Office, and specifically the Medicaid Fraud Control Unit under the Attorney General, the Agency for Health Care Administration, the Office of Statewide Prosecutor, and the federal government have taken numerous steps over the past several years to combat fraud and abuse within the Florida Medicaid program. Past initiatives have included: claims payment analyses and controls, provider surety bonds and financial background checks, on-site provider visits, Level I and Level II criminal background checks, additional Medicaid Management Information System edits, and improved interagency coordination. Current initiatives include: pharmacy audits, including on-site audits and audits specific to overpayments, an explanation of medical benefits mailing to some recipients; pharmacy lock-in, whereby a federal waiver has been obtained to permit the state to lock-in an abusive Medicaid recipient to a single pharmacy; recipient fingerprinting demonstration project, at approximately 200 pharmacies to ensure that only the eligible recipient or an authorized representative is picking up prescribed drugs; enhanced claims analysis and automated fraud and abuse detection capabilities; additional pharmacy fraud and abuse controls, including surety bonds and on-site inspections prior to entering provider agreements; fraud detection system enhancements to identify patterns of fraud; and physician practice pattern review, including drug usage evaluation, prescribing profiles, physician education, and outcomes analysis.

As part of its fraud and abuse efforts, the agency has made two recommendations for revisions to s. 409.907, F.S., relating to Medicaid provider agreements, to aid in the prevention of fraud and abuse in the Medicaid program. The agency is proposing that, instead of a surety bond fixed at a flat amount of $50,000, the surety bond should be based on the amount of Medicaid billings submitted or anticipated to be submitted by a Medicaid provider, where appropriate. The agency currently requires a $50,000 surety bond from specific provider types, including durable medical equipment (DME) providers, home health agencies, home and community based providers who provide DME, physician groups and clinics where 50% or more of the practice is owned by non-physicians, specified transportation providers, and independent laboratories.

The agency is currently authorized to deny potential applicants based on 11 specific criteria, primarily related to being convicted of criminal offenses under either federal or state law. Secondly, the agency is requesting additional authority to deny Medicaid provider applications. This revision is designed to allow the agency the ability to make a determination regarding a provider applicant with whom the agency may have had prior experience, but for whom there may not necessarily be a criminal record, for instance.

Disproportionate Share Program - Currently under the Florida Medicaid program, there are seven separate programs specifically designed to provide enhanced Medicaid reimbursement for certain classes of hospitals rendering services to Medicaid recipients and indigent clients. These programs, their respective authorization, and current total funding (in millions) are as follows:

Statute	Program	Funding
s. 409.911	Regular hospitals	$153.4
s. 409.9112	Regional Perinatal Intensive Care Centers	$6.9
s. 409.9113	Teaching hospitals	$19.8
s. 409.9115	Mental health hospitals	$147.8
s. 409.9116	Rural hospitals	$9.8
s. 409.9117	Primary care hospitals	$6.5
s. 409.9118	Specialty (tuberculosis) hospital	$4.3
	TOTAL	$348.5

While the federal government, via the Balanced Budget Act of 1997, has imposed limits on the total amount of each state's Medicaid budget can flow through the disproportionate share program and specific limits on mental health disproportionate share, each state has the flexibility to array these expenditures as the state sees fit. One of the Governor's budget recommendations for fiscal year 2000-2001 is the creation of a children's hospital disproportionate share program, targeting specifically All Children's (Pinellas) and Miami Children's (Miami-Dade) hospitals.

Medicaid Prepaid Health Care Services - Section 409.912(2), F.S., authorizes AHCA to enter comprehensive risk contracts serving the general Medicaid population with entities certified by the Department of Insurance (DOI) under part I of ch. 641, F.S. By contrast, s. 409.912(4)(b), F.S., authorizes AHCA to contract with entities that only serve Medicaid members, and which entities are exempt from regulation by DOI under the provisions of part I of ch. 641, F.S. This exemption dates back to early attempts by Medicaid to contract with any entity willing to provide prepaid plan services to Medicaid recipients, and more recent Medicaid attempts to contract with specific publicly-funded entities for such services, namely a consortium of federally-funded community health centers. In the recent past,

AHCA has concluded that Medicaid recipients should have the benefit of the protections afforded every other citizen of Florida under part I of ch. 641, F.S., regardless of whether their health plan of choice offers commercial products or not.

Part I, ch. 641, F.S., encompasses a number of requirements which AHCA regards as critical to any sound and responsible risk-based contractor. These requirements include surplus requirements to promote fiscally sound plans, and requirements for subcontractors and regulations on marketers and marketing practices (historically a source of many complaints from Medicaid members).

The Department of Insurance is also tasked, through part I, ch. 641, F.S., with specific responsibilities in the event a health plan becomes insolvent. Those responsibilities include the provision of administrative supervision, rehabilitation, and potentially liquidation of an insolvent health plan. The Department of Insurance has the expertise and resources for these activities; AHCA does not. Dealing with insolvent contractors has presented problems for AHCA in the past since AHCA does not have the staff or experience necessary to competently administer the post-closure affairs of an insolvent plan.

Prior to the adoption of the requirements of s. 409.912(2), F.S., AHCA contracted with a number of Medicaid prepaid health plans that were not certified under part I, ch. 641, F.S. AHCA had two difficult experiences where AHCA was forced to terminate the contract due to the inability of the contractor to meet its current financial obligations. There were several other instances where only “last minute” mergers or acquisitions prevented the similar demise of health plans. Since AHCA began dealing only with DOI certified plans, AHCA has not had the frequency of this phenomenon, and with the cooperative working relationship between AHCA and DOI, AHCA has been much better able to deal with the consequences of the financial failure of contracted plans.

Budget Transfer Authority - Under s. 216.292, F.S., agencies may, following executive and legislative review and approval processes, transfer specific budgeted funds. This is a regular and ongoing process during any state fiscal year. On an ongoing basis, the Agency for Health Care Administration must seek such authority with sister agencies in order to meet certain programmatic and budget expectations. For example, the agency works very closely with the Department of Children and Family Services in ensuring adequate funding for targeted case management services rendered to those with mental health conditions. The agency reimburses for Medicaid targeted case management services to clients served by the Office of Alcohol, Drug Abuse and Mental Health in the Department of Children and Family Services and Children’s Medical Services in the Department of Health. Case management is defined as activities associated with ensuring access to necessary medical, social, educational, and other services required by the individual. The Medicaid appropriation for targeted case management for adults served by the Mental Health program is funded by federal funds, matching state general revenue funds appropriated directly to Medicaid, and by general revenue funds transferred from the Department of Children and Family Services if the state match requirement exceeds the general revenue appropriated in Medicaid. In prior years the General Appropriations Acts have included proviso permitting the transfer of general revenue funds from the Department of Children and Family Services.

The same is true with regard to the Assisted Living for the Elderly Medicaid waiver in conjunction with the Department of Elderly Affairs. The Assisted Living for the Elderly (ALE) Waiver is a home and community-based services program that was implemented statewide on February 1, 1995, for recipients who reside in qualified Assisted Living Facilities (ALFs). The Department of Elderly Affairs operates the waiver, and Medicaid provides federal

matching funds. The waiver includes case management and assisted living services. Assisted living services include: attendant call system, attendant care, behavior management, chore, companion services, homemaker, incontinence supplies, intermittent nursing, medication administration, occupational therapy, personal care, physical therapy, specialized medical equipment and supplies, speech therapy, and therapeutic social and recreational services. The Medicaid appropriation for the waiver is funded by federal funds and matching state general revenue funds appropriated directly to the Department of Elderly Affairs. Medicaid pays the waiver claims and bills the Department of Elderly Affairs for the state share.

One of the revisions sought as part of the Governor's budget recommendations for the 2000 session is authority for these type recurring transfers to take place apart from the s. 216.292, F.S., review process.

Medicaid Eligibility Determination - During the 1999 Legislative Session, a Reviser's Bill replaced the word "department," which referred to the Department of Children and Family Services (DCF), with the word "Agency," which referred to the Agency for Health Care Administration (AHCA), in certain sections of ch. 409, F.S. Specifically, s. 409.919, F.S., provides statutory authority for rulemaking in the Medicaid program. DCF performs Medicaid eligibility determinations through an interagency agreement with AHCA. Prior to the 1999 amendment to s. 409.919, F.S., DCF had rulemaking authority to adopt rules under which it would conduct Medicaid eligibility determinations. The result of the amendment to this section was to remove DCF's rulemaking authority to adopt rules under which to conduct Medicaid eligibility determinations.

The Department of Children and Family Services is currently involved in litigation in federal court regarding Medicaid-related disability determinations and it is anticipated that any settlement would necessitate adopting additional rules or revisions to existing rules to implement.

Medicaid School Health Services Certified Match Program and Developmental Research Schools - Sections 236.0812, 409.9071, and 409.908(21), F.S., authorize the school districts to certify to the Florida Medicaid program their expenditures for school health services rendered to Medicaid eligible students; AHCA in turn certifies these amounts to the Health Care Financing Administration; and HCFA provides federal matching funds for these expenditures. As established annually as part of the General Appropriations Act, there is an annual expenditure cap of $50 million on such certifications under this program. For the current fiscal year, the Social Services Estimating Conference meeting of February 18, 2000, projected an expenditure of $37.8 million under this program.

Developmental research schools, as authorized under s. 228.053, F.S., may be established by a state university to serve as a vehicle for the conduct of research, demonstration, and evaluation regarding management, teaching, and learning as part of the participating university's curriculum. Currently, developmental research schools exist at Florida Agricultural and Mechanical University (FAMU), Florida State University (FSU), Florida Atlantic University (FAU), and University of Florida (UF). The number of students in attendance ranges from around 500 students at FAMU and FAU, to over 1,000 students at FSU and UF.

Because the requirements for the certified school match program target school districts, and because developmental research schools are organizationally part of the universities with which they are affiliated and not part of the respective school district, the

developmental research schools have not been part of the Medicaid certified match program for school health services.

Care for Adult Ventilator Dependent Individuals - There is currently no statutory authorization for reimbursement for respiratory services for adult Medicaid recipients. Although respiratory equipment and supplies were made available to adult Medicaid recipients, effective October 1999, the professional services were not part of the authorization. Hospitals cannot discharge ventilator dependent adults who live alone or who cannot access professional respiratory care. Placements in skilled nursing facilities have been difficult, because no supplemental reimbursement is available to these facilities for this extra care. Hospitals are forced to keep these patients for 2 to 3 years, and sometimes for the rest of their lives. As a result, hospitals are absorbing costs in excess of one million dollars annually for each ventilator dependent person. At times, hospitals are able to establish an agreement with a nursing facility that allows the hospital to assist the nursing facility in the support of these patients. Some patients are relocated to other states, including Virginia, Maryland, and North Carolina, which becomes a hardship on families living in Florida. A recent survey, conducted by the Division of Vocational Rehabilitation, revealed that only 28 of 257 nursing facilities provide ventilator care.

Optional State Supplementation (OSS) Program - Optional State Supplementation is a means-tested General Revenue funded public assistance program which supplements the federal Supplemental Security Income (SSI) of indigent elderly and disabled Floridians. This supplement increases the recipients' income to assist in paying for supportive living arrangements in the community in order to prevent unnecessary institutionalization (nursing home or mental hospital). To qualify for this program, applicants must: (1) be over age 65 or disabled; and (2) have a monthly income below $697 and total assets under $2,000.

According to the Department of Children and Family Services, the average annual cost to the state for an OSS-qualified person to reside in a nursing home is $18,456. The annual cost to the State of Florida for the same individual to reside in an ALF is approximately $2,544 -- a savings of over $15,000 a year.

The two long term care environments used by OSS recipients are assisted living facilities (ALFs) and adult family care homes (AFCHs). To date, approximately 8,868 OSS recipients are cared for in assisted living facilities, and 372 are cared for in adult family care homes. Many ALF providers will not accept OSS clients because the reimbursement rate is lower than the actual cost to provide the care. The actual cost of care for these recipients, as determined by the Department of Children and Family Services and the OSS workgroup (established by the 1998 Legislature) is approximately $850 a month.

Each year the federal government provides a cost of living allowance increase (COLA) to Social Security recipients. Prior to 1994, the State of Florida, in effect, took this increase away from OSS recipients, by reducing the state's contribution in the amount of the COLA increase. Beginning in 1995, the Legislature set a new precedent and allowed the pass-through of this increase to the recipient, without reducing the state contribution. This pass-through is continued each year by placing proviso language in the General Appropriations Act.

MANDATED HEALTH COVERAGES

State laws frequently require private health insurance policies and health maintenance organization (HMO) contracts to include specific coverages for particular treatments,

conditions, persons, or providers. These are commonly referred to as "mandated [health] benefits." These mandated benefits affect plans covering an estimated 33 percent of all Floridians and 40 percent of insured Floridians. The nearly one-half of all Floridians who either are uninsured or covered under Medicare or Medicaid are not affected. Self-funded plans provided by employers also are similarly unaffected because the federal Employee Retirement Income Security Act of 1974 (ERISA) [29 U.S.C. s. 1001, et. seq.] generally preempts state regulation of these plans.

Recognizing that "most mandated benefits" contribute to the cost of health insurance yet acknowledging the social and health benefits of many of these mandates, the Legislature in 1987 called for a "systematic review of current and proposed" mandated benefits. At that point, the Legislature had approved 16 mandated benefits. In the 13 years since, the Legislature has approved an additional 35 mandated benefits. With a total of 51 mandated health benefits applicable either to private insurer or HMO health plans, Florida now has one of the nation's most extensive set of coverage requirements. The lone procedural requirement established for reviewing mandated benefits--that proponents submit an impact analysis for any proposed mandated benefit prior to consideration--has been largely ignored. Staff could confirm only 4 instances since 1987 in which the required study was completed for a mandated benefit.

In 1998, nearly a quarter of non-elderly Floridians were uninsured. According to the 1998 Health Confidence Survey sponsored by the Employee Benefit Research Institute, 48 percent of the uninsured nationwide cite cost as the primary reason for being uninsured. Costs would have to be "cut in half " to entice one-third of these respondents back into the marketplace, according to at least one study.

Number of Mandated Health Benefits - By some measures, Florida has more mandated benefits than nearly every other state. In preparing this report, committee staff identified 51 mandated health benefits applicable either to private insurer or HMO plans. Of the 51 mandated benefits, 40 apply to either private individual or group policies provided by insurers. Individual policies are subject to 34 and group policies to 39. Health maintenance organizations must comply with 39 mandated benefits.

In a separate count, BlueCross BlueShield Association placed the number of mandates in Florida statutes at 44--the second highest in the nation, compared to an average of 25 among all states [BlueCross BlueShield Association, State Legislative Health Care and Insurance Issues: 1998 Survey of Plans.]

The Reach of Mandated Health Benefits: Floridians Affected - An estimated 33 percent of all Floridians are covered under health plans subject to mandated health benefits. These Floridians are covered under a private insurer or HMO plan, other than a basic or standard small employer group plan. The other 67 percent are unaffected by mandated health benefits because they either are uninsured or covered under plans not subject to these mandates. These include Medicare or Medicaid plans, and self-funded ERISA plans provided by certain employers. Among insured Floridians, 40 percent are in plans subject to mandated health benefits.

Health Plans	Insured Floridians	% of all Floridians	Mandates applicable?
Insurer/HMO	40%	33%	Yes
Self-Funded Employer	26%	21%	No
Medicare	22%	18%	No
Medicaid	12%	10%	No

No health plan/uninsured	N/A	17%	N/A

In 1992, in the Florida Employee Health Care Access Act [s. 627.6699, F.S.], the Legislature authorized insurers and HMOs to offer "basic" and "standard" small employer group plans and exempted these 2 plan types from mandated coverages not expressly made applicable to these plans in law. For the period ending December 31, 1998, these 2 plan types accounted for only $139 million in earned premium or just over 8 percent of the more than $1.7 billion in premium earned for all small employer group plans, according to figures provided by the Department of Insurance. According to the Department of Insurance small employer enrollment report for the period ending June 30, 1999, the number of lives covered under a basic or standard plan was 276,000 of over 1.7 million individuals covered under a small employer group plan.

It is not always apparent in statute which health plans are subject to which state-mandated health benefits. The statutes can be inconsistent and confusing. For instance, the statute may refer to "an insurer" but then in describing those covered refer to "subscriber," a term associated with HMOs.

Availability of Generally-comparable Benefits - Although mandated health benefits apply only to private insurer and HMO health plans, committee staff found in many instances Floridians are receiving comparable benefits either under an exempt self-funded ERISA plan, or through Medicaid or Medicare.[5] However, these plans are either paid for by the general public, as in the case of Medicaid and Medicare, or funded voluntarily by those with the freedom to design a plan with benefits they are willing to purchase, such as an employer with a self-funded plan. In contrast, insurer and HMO plans are paid for by those securing the coverage, regardless of whether or not they want to purchase all of the mandated benefits.

The Cost of Mandated Health Benefits - The Legislature has recognized in legislative intent that "most mandates contribute to the increasing cost of health insurance premiums." Insurers and HMOs contend mandated benefits increase costs by: 1) increasing utilization of health care services; 2) giving providers of certain benefits pricing leverage; and 3) by requiring them to include additional benefits.

By stating that "most" mandates increase costs, that same legislative intent recognizes that some mandates may not increase premium costs. These could be of at least two types: one, a preventative care mandate, such as mammogram screening or well-child care; and two, a mandated treatment or provider substituting for a more expensive alternative. Certain mandated benefits may not necessarily reduce premium costs but may reduce the costs borne by the general public.

Calculating the cost of mandated health benefits can be difficult. Cost determinations are complicated by a lack of reported data, difficulty in calculating costs avoided, and failure to account for the cost of mandated benefits which would today be provided in the absence of a specific mandate.

Studies of the cost of mandated health benefits

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[5]Note: The actual terms of the coverage may vary. Committee staff did not analyze the details of the specific coverages or compare deductibles or co-payments, or determine the extent to which the coverages meet the letter of the benefit mandated on insurers and HMOs operating in the private market place. This information should therefore be considered only as a starting point in any comparison of benefits among the different sources of coverage.

Florida - Staff could not identify any comprehensive study of the cumulative cost of mandated health benefits in Florida.

Other States - Several states have calculated these costs. A 1996 U.S. General Accounting Office report on claims costs in 6 states cited studies as far back as 1988, revealing claims costs ranging from 5.4 percent in Iowa to 22 percent in Maryland. Costs vary based on the number and type of mandated benefits.

In Virginia, a state with extensive cost reporting requirements for insurers and HMOs, the average claim cost per group certificate for the 1997 reporting period was $263, accounting for 16.62 percent of total claims costs. The premium impact on group certificates for family coverage was 29.17 percent of overall average premium on a full cost (as opposed to marginal cost) basis. Virginia had 33 mandated benefits according to the 1998 BlueCross BlueShield report.

In Maryland, mandates were priced on a full cost and marginal cost basis. On a full cost basis, the estimated annual cost per policy for a group insurance policy was $604. The marginal cost came in at $148. This represents 15.4 percent and 3.8 percent of the average premium per policy. Maryland has 47 mandated benefits according to the 1998 BlueCross BlueShield report.

Maine calculates the cost impact of proposed mandated health benefits and also determines the cumulative costs of mandated benefits. As part of a December 22, 1999, report, the Maine Bureau of Insurance estimated the cumulative premium impact of 19 currently mandated benefits on group policies covering more than 20 employees to be 7.54 percent for fee-for-service plans, and 7.12 percent for managed care plans. For comparison purposes, the 1998 BlueCross BlueShield report showing Florida with 44 mandated benefits shows Maine with 31.

Mandated Benefits Review Process-

Florida -The Legislature has established requirements specific to consideration of legislation proposing mandated health benefits.[6] Proponents of a particular mandated health benefit must prepare a report assessing the social and financial impacts of the proposal and submit the report to the Agency for Health Care Administration and the relevant legislative committees. These include an assessment of the extent to which:

- The treatment or service is used by a significant portion of the population;
- The insurance coverage is generally available;
- Any general lack of availability of coverage causes persons to forego necessary treatment;
- Any general lack of availability of coverage results in unreasonable financial hardship;
- There is public demand for the treatment or service;

[6]With other types of legislation, special constitutional or statutory requirements exist. These include legislation proposing changes in the state retirement system, creation of a public records exemption or specialty license plate, and approval of a local bill or local government mandate. The Legislature uses an estimating conference to consider fiscal impacts on the state employees group health plan. Both the Senate and the House of Representatives adopt rules, jointly and separately, defining the process for considering certain types of legislation--for example, legislation affecting appropriations--or conducting other legislative business. Special requirements can also be found in policy statements of several standing committees specific to legislative consideration of certain types of legislation.

- The coverage is included in collective bargaining negotiations;
- Cost increase or decrease result from the treatment or service;
- Coverage will increase the appropriate uses of the treatment or service;
- The coverage will be a substitute for a more expensive treatment or service;
- The coverage will increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders; and,
- The coverage will impact the total cost of health care.

Although the Legislature has enacted approximately 35 mandated benefits enacted since 1987, staff could only identify 4 reports submitted for mandated health benefits enacted since that time.

Other States - A survey conducted by the committee staff found 20 states have special statutory provisions for managing mandated benefits legislation and 28 do not.

Impact analyses

The most common response of states has been to have an impact analysis conducted to assess the financial impact, social impact, and/or medical efficacy of the proposal. This is the case in 18 states. States typically require either a designated state agency or special review panel to conduct the review. In Maine, the review panel may contract with a private actuarial firm to complete the analysis. However, 7 states, including Florida, direct the proponents or sponsor of a mandates proposal to complete the analysis. One state, Pennsylvania, permits both proponents and opponents to submit information. Two states, Louisiana and Tennessee, direct fiscal committee staff to conduct the review. For the most part, states call for a similar impact analysis. All include a financial component. Fourteen, including Florida, must include an analysis of the social impact of the proposal. Seven require the analysis to consider the medical efficacy of the mandate as well. Virtually all states include a laundry list of specific criteria to examine in conducting the analysis.

Time frames for submitting an impact analysis vary among states: at the time the proposal is filed (e.g., Oregon); within 30 days after analysis is requested (e.g., South Carolina); 90 days prior to session (e.g., Washington); timely manner (e.g., Maine); or before being heard or before final passage by committee (e.g., Kentucky).

Only 5 states directly attempt to limit the prerogative of the legislature to act on mandates legislation based on whether or not an impact analysis has been submitted. Maine is the most direct: "a proposed mandate may not be enacted into law unless [the] review and evaluation . . . has been completed."

Review entities

Only 11 of the 48 states responding reported having either an ongoing permanent body or a state agency specifically charged with reviewing proposed mandated benefits.

Virginia and Maryland have standing commissions; Pennsylvania's Health Care Cost Containment Council must convene a Mandated Benefits Review Panel of 4 senior researchers to develop independently certified documentation for proposed mandates. The remaining states designate a state agency such as the Department of Insurance to review a proposed mandate if requested by either the appropriate legislative committee or, in some states, by the Governor's office. In Georgia, the Clerk of the House and the Secretary of the Senate must deliver any health insurance mandates bills to the Insurance Commissioner for a fiscal review within 5 days after first reading. Several state legislatures, Texas for

one, have enacted legislation creating a temporary committee to study the costs and benefits of proposed mandated benefits. Missouri, likewise, approved legislation for a one-time study of mandated benefits.

Limitations on enactment

Maryland and Oregon are 2 states with distinct limitations on legislative approval of mandated benefits legislation.

Maryland, at least in the small group market, is the only state staff could identify that has attempted to limit the cumulative cost of all mandated benefits to a specific dollar amount. In Maryland, insurance carriers can only sell one insurance product to small employers--the product developed by the Health Care Access and Cost Commission (HCACC). In 1993, the Maryland General Assembly enacted an "affordability" cap on mandates costs for the small group plan. The cap is set at 12 percent of the average wage in the state. If the HCACC finds the cumulative cost of approved mandates exceeds this amount, the HCACC must adjust the level of benefits or cost sharing arrangements under the plan so the cap is not exceeded in the future.

In 1999, the Maryland General Assembly considered a similar approach for the large group market by requiring a comparison of mandates costs to the average annual wage in Maryland and to health insurance premiums. However, an actual cap was not imposed and benefits adjustments were not provided for. Instead, the calculations are used as the basis for triggering further review by the HCACC. If the HCACC finds the full cost of mandated benefits exceeds 2.2 percent of the average wage in the state, then it must evaluate the social, medical, and financial impacts of each existing mandated benefit and report its findings to the General Assembly. The General Assembly can then use this information to decide whether or not to enact proposed mandates or repeal existing mandates.

The Oregon Legislature appears to be the only state which sunsets mandated benefits. Since 1985, Oregon law has provided for the automatic repeal of mandated benefits statutes 6 years from the effective date of the particular mandate. According to Oregon legislative staff, several mandates have expired under this law.

C. EFFECT OF PROPOSED CHANGES:

CERTIFICATE OF NEED

This bill amends the Certificate of Need (CON) statutes by identifying additional types of projects subject to **expedited** rather than competitive CON review. These projects include conversion of mental health services beds or hospital-based distinct part skilled nursing unit beds to acute care beds, conversion between or among the categories of mental health services beds, and conversion of acute care beds to mental health services beds.

It identifies several other types of currently reviewable projects that will become **exempt** from CON review. These include combination within one nursing home of the beds authorized by two or more CONs within the same planning subdistrict; division into two or more nursing homes in the same planning subdistrict of the beds authorized by a CON; addition of hospital beds in a number not to exceed 10 beds or 10 percent of the licensed capacity of the service being expanded, except beds for specialty burn units, neonatal intensive care units, or comprehensive rehabilitation, and provided there was a prior 12-

month occupancy of at least 80 percent in that service or at least 96 percent for hospital-based distinct part skilled nursing units; and addition of nursing home beds in a number not exceeding 10 beds or 10 percent of the licensed capacity of beds at the nursing home, whichever is greater, provided that the facility has been designated as a Gold Seal nursing home pursuant to s. 400.235, F.S., and there was a prior 12-month occupancy of at least 96 percent.

CON oversight is **eliminated** by this bill for provision of respite care, expenditure for outpatient services, Medicare certified home health agencies, acquisitions, and cost overruns. The bill also proposes a significant reduction and clarification of the review criteria used to evaluate applications for a CON and removes other obsolete provisions.

The bill creates a CON workgroup consisting of 30 members appointed by the Governor, the President of the Senate, and the Speaker of the House of Representatives to include representatives from health care provider organizations, health care facilities, individual health care practitioners, local health councils, consumer organizations, and persons with health care market expertise as a private-sector consultant. The workgroup is to study issues pertaining to the CON program, including the impact of trends in health care delivery and financing. The workgroup is to submit an interim report by December 31, 2001, and a final report by December 31, 2002. The workgroup is abolished on July 1, 2003.

PUBLIC MEDICAL ASSISTANCE

This bill repeals the assessments on the portion of hospitals' net operating revenues generated by outpatient services and repeals the entire assessment on ambulatory surgical centers, clinical laboratories, and diagnostic imaging centers.

The repeal of the assessments mentioned above will mean that approximately $85 million in revenues to the state will be lost. Repeal of the hospital assessment will result in lost revenue of $69.5 million. Repeal of the assessment on ambulatory surgical centers, clinical labs, and diagnostic imaging centers will result in $15.5 million of lost revenue. These revenues are used by the state to obtain federal Medicaid matching funds. If they are not replaced from an alternative funding source, the state will lose an additional $110.1 million of federal funds. This will require the Medicaid program to reduce services by $195.1 million.

In order to prevent the loss of federal matching funds, the bill requires the Legislature to appropriate sufficient funds to replace the revenue lost from repealing the assessment. The bill instructs the Legislature to look to either the General Revenue Fund or the Agency for Health Care Administration Tobacco Settlement Fund as an alternative funding source.

The bill provides authority for the agency to contract with an entity in Pasco or Pinellas County that provides in-home physician services to Medicaid recipients with degenerative neurological diseases, in order to test the cost-effectiveness of enhanced home-based medical care. The reimbursement for such services must be at a rate not less than comparable Medicare rates. The agency is authorized to apply for any federal waivers necessary to implement the program. The program will be repealed on July 1, 2002. It is assumed that the services will be required to be at least budget neutral under any federal waiver, therefore there is no fiscal impact on the Medicaid program.

HOSPITALISTS

The bill prohibits a health maintenance organization (HMO) contract from prohibiting or restricting a contracted primary care or admitting physician from providing inpatient services in a contracted hospital to the subscriber. It prohibits a contract between an HMO and a contracted primary care or admitting physician from containing any provision prohibiting such physician from providing inpatient services in a contracted hospital to a subscriber. It also requires an HMO to pay a contracted primary care or admitting physician, pursuant to such physician's contract, for providing inpatient services in a contracted hospital to a subscriber. In order for these provisions to apply, inpatient services must be determined by the organization to be medically necessary and covered services under the organization's contract with the contract holder.

ADVERSE DETERMINATIONS

This bill requires health maintenance organizations and prepaid health clinics to ensure that adverse determinations are only rendered by licensed allopathic or osteopathic physicians. This codifies into law existing accreditation standards for organizations. Florida law currently requires organizations to be accredited but does not specifically list all of the criteria that must be met in order for an organization to be accredited. This bill will clarify that organizations licensed in Florida can no longer use unlicensed persons, other non-physician health care practitioners, or non-practitioners to make these medical decisions. The Florida licensed medical director, required by current law, could be used to make these adverse determinations; however, the bill does not limit the decisionmaking to only Florida licensed allopathic or osteopathic physicians.

The bill requires organizations to provide the facts and documentation to the patient and treating physician to support and explain the denial of care. It requires the organization to notify the patient and treating physician in writing within 2 working days of the reasons for the adverse determination so that medical care will not be unnecessarily delayed. The notification must include the utilization review criteria or benefits provisions used by the physician and be signed by an authorized representative of the organization or the physician rendering the adverse determination. The signed notification will then be available as proof of the decision and the basis for that decision. The signed notification may be used later as evidence against the physician or organization in a legal proceeding to determine if the adverse determination was below the standard of care. Lastly, the notification must include information regarding the process for appealing the adverse determination so that the patient and treating physician will know how to file a complaint or grievance against the organization.

RACIAL & ETHNIC HEALTH DISPARITIES

The bill creates the "Reducing Racial and Ethnic Health Disparities: Closing the Gap Act" to be administered by the Department of Health. The bill provides the duties and responsibilities of the department. Authorizes the appointment of an ad hoc advisory committee. Provides criteria and procedures for awarding grants to local individuals, entities, and organizations to address the disparities in racial and ethnic health outcomes. Requires local matching funds and allows for in-kind contributions based on county population. Provides for dissemination of 1-year grant awards beginning no later than January 1, 2001, subject to specific appropriation. Provides for annual applications for grant renewal. Provides a $10,000,000 appropriation.

MEDICAL ERRORS

This bill creates the Florida Commission on Excellence in Health Care based on the proposal by the Department of Health and the Agency for Health Care Administration to facilitate the development of a comprehensive statewide strategy for improving health care delivery systems through meaningful reporting standards, data collection and review, and quality measurement. The Commission will also study whether the current practitioner and facility regulatory systems are effective in promoting patient safety. A report to the Legislature is due no later than February 1, 2001.

The Commission will be jointly chaired by the Secretary of the Department of Health and the Executive Director of the Agency for Health Care Administration. Membership on the Commission includes representatives from all facets of health care, including the regulatory boards and agencies, health care practitioner trade associations, health facility trade organizations, managed care organizations, risk management organizations, health care lawyer organizations, professional liability insurance industry, consumer advocacy organizations, and the Legislature. The Commission will be staffed by employees of the Department of Health and the Agency for Health Care Administration. The Commission is terminated June 1, 2001.

HEALTH ALLIANCES

The bill will:

- repeal the CHPA statutes, presumably requiring small employers insured through CHPAs to find health insurance elsewhere;[7]
- allow a "small employer health alliance" to be formed by an organization for the purpose of negotiating with one or more insurers to provide a group policy to cover small employers that are members of that organization; and
- permit insurers to establish rates for policies issued to "small employer health alliances" which incorporate premium credits attributable to the administrative savings resulting from pooling.

EMPLOYEE HEALTH CARE ACCESS

Modified Community Rating - The "modified community rating" component of the Act would be revised to permit small employer carriers to adjust premium rates based on additional factors such as employees' claims experience, health status, or duration of coverage. Rate adjustments made pursuant to these factors would be subject to the following limitations.

Per employer — Up to 15% deviation from carrier's approved rate;

Up to 10% change annually on renewal; and

[7] Small employers covered through a CHPA would not necessarily have to obtain coverage elsewhere -- the former CHPA could form a "small employer health alliance" and negotiate new coverage.

Must be applied uniformly to all employees and dependents

All employers — Up to 5% deviation (in the aggregate) from carrier's approved rate

Small employer carriers would also be permitted to credit a small employer's premiums based on certain administrative and acquisition expense savings realized by the carrier.

Instead of being required to use one rating category for all dependent children, small employer carriers would be permitted to use rating methodologies that include separate rating categories depending on the number of dependent children.

Guarantee-Issue Requirements - The guarantee-issue requirements of the Act would also be revised so that, instead of needing 3 employees, employers with only 2 employees would have access to all small employer health plans offered by small employer carriers. For employers with only one employee, carriers would only be required to offer the basic and standard plans during a one-month open enrollment period in August. A person, his or her spouse, and his or her dependent children would count as a single employee if such person and spouse are employed by the same employer.

MEDICAID ISSUES

The bill addresses a number of different Medicaid topics. These include budget issues relating to the annual adult hospital outpatient cap, a children's hospital disproportionate share program, and specified fund transfer authority; Medicaid fraud issues specific to denial of provider applications; a pilot project specific to adult ventilator dependent adults; authorization for laboratory schools to participate in the Medicaid certified school match program; and Medicaid eligibility rulemaking authority for the Department of Children and Family Services. The bill repeals s. 409.912(4)(b), F.S., relating to AHCA's ability to contract for prepaid health care services with entities that provide only Medicaid services on a prepaid basis, and which are exempt from part I of ch. 641, F.S. The bill also provides, in statute, for the ongoing adjustment in Optional State Supplementation based on the federal benefits rate, rather than re-authorizing such adjustments in each year's General Appropriations Act.

MANDATED HEALTH COVERAGES

The bill would appropriate $200,000 from the Insurance Commissioner's Regulatory Trust Fund to the Office of Legislative Services for the purpose of implementing the legislative intent expressed in s. 624.215(1) for a "systematic review of current ... mandated coverages. The review would consist of an assessment of the impact of current mandated coverages using the guidelines provided in s. 624.215(2).

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Provides a short title, citing this act as the "Patient Protection Act of 2000."

Section 2. Amends s. 400.471, F.S., to delete the requirement for CON approval as a prerequisite for licensure of a Medicare certified home health agency.

Section 3. Amends s. 408.032, F.S., providing definitions of "exemption" and "mental health services," and deleting the definitions of "home health agency," "institutional health service," "intermediate care facility," "multifacility project," and "respite care."

Section 4. Amends s. 408.033, F.S., deleting references to the state health plan.

Section 5. Amends s. 408.034, F.S., deleting a reference to Medicare certified home health agencies.

Section 6. Amends s. 408.035, F.S., deleting obsolete review criteria and clarifying other criteria.

Section 7. Amends s. 408.036, F.S., clarifying "capacity," specifying types of beds subject to review, and eliminating CON review for Medicare certified home health agencies, acquisitions, and cost overruns. Deletes review of cost overruns, combination of nursing home certificates of need, and creates new category of review. Provides for exemptions, procedures, and fees.

Section 8. Amends s. 408.037, F.S., to delete a reference to the state health plan.

Section 9. Amends s. 408.038, F.S., to replace "department" with "agency."

Section 10. Amends s. 408.039, F.S., to replace "department" with "agency" and to clarify procedures to intervene in administrative hearing.

Section 11. Amends s. 408.040, F.S., to require conditions imposed on CON to be stated on face of CON. Deletes obsolete reference to psychiatric or rehabilitation beds. Modifies Medicaid patient condition from percentage of beds to percentage of days.

Section 12. Amends s. 408.044, F.S., to replace "department" with "agency."

Section 13. Amends s. 408.045, F.S., to replace "department" with "agency."

Section 14. Creates a CON workgroup consisting of 30 members, to study issues pertaining to the CON program. Requires the workgroup to submit an interim report by December 31, 2001, and a final report by December 31, 2002. Abolishes the workgroup effective July 1, 2003.

Section 15. Amends s. 651.118, F.S., to provide that five-year limit does not apply to up to five sheltered beds designated for inpatient hospice care as part of a contract with a licensed hospice.

Section 16. Amends s. 395.701(2), F.S., relating to PMATF hospital assessments, to eliminate the 1.5 percent annual assessment on hospital outpatient services. Provides that the annual assessment on hospitals to fund the PMATF is based on the annual net operating revenues for inpatient services only.

Section 17. Provides that the amendment to s. 395.701, F.S., shall only take effect upon AHCA receiving written confirmation from HCFA that the changes contained in the amendment will not adversely affect the use of the remaining assessments as state match in obtaining federal funds for the Medicaid program.

Section 18. Amends s. 408.904(2)(c), F.S., relating to hospital outpatient services as a covered service under the MedAccess program, to increase the cap on outpatient services provided to adults under MedAccess from $1,000 to $1,500 per year. [Note: This program has not yet been implemented.]

Section 19. Amends s. 409.912, F.S., relating to AHCA's authority to contract for cost-effective health care services, to allow AHCA to contract with an entity in Pasco or Pinellas county that provides in-home physician services to Medicaid patients with degenerative neurological diseases. Provides that the entity providing the services is to be reimbursed at a rate not less than comparable Medicare reimbursement rates. Allows AHCA to apply for federal waivers necessary to implement the program. Provides for repeal of the section on July 1, 2002.

Also, amends subsection (9) of s. 409.912, F.S., relating to waivers as a cost-effective means of purchasing health care under Medicaid, to direct the Department of Elderly Affairs to transfer to the Agency for Health Care Administration any unexpended funds for the Assisted Living for the Elderly Medicaid waiver, notwithstanding the provisions of s. 216.292, F.S., relating to the nontransferability of appropriated funds by state agencies. Such funds must, in turn, be used by the agency to fund Medicaid-reimbursed nursing home care.

Section 20. Requires the Legislature to appropriate each fiscal year funds from either the General Revenue Fund or the Agency for Health Care Administration Tobacco Settlement Trust Fund to the PMATF in an amount sufficient to replace the funds lost due to the repeal of the assessment on hospital outpatient services and other health care entities. Requires the Legislature to maintain federal approval of the monies collected under the reduced assessment to be used as state match for the state's Medicaid program.

Section 21. Amends s. 641.31(39), F.S., to prohibit a health maintenance organization contract from including terms restricting a subscriber (patient) from receiving inpatient services in a contracted hospital from a contracted primary care or admitting physician so long as the services are determined by the organization to be medically necessary and covered services under the contract. Applies to all contracts entered into or renewed on or after July 1, 2000.

Section 22. Amends s. 641.315, F.S., to restrict contracts between health maintenance organizations and contracted primary care or admitting physicians from including any provision that prohibits the physician from providing inpatient services in a contracted hospital to a subscriber (patient) so long as the services are determined by the organization to be medically necessary and covered services under the contract. Applies to all contracts entered into or renewed on or after July 1, 2000.

Section 23. Amends s. 641.3155, F.S., to require a health maintenance organization to pay a contracted primary care physician or admitting physician, pursuant to contract, for providing inpatient services in a contracted hospital to a subscriber (patient) so long as the services are determined by the organization to be medically necessary and covered services under the contract. Applies to all contracts entered into or renewed on or after July 1, 2000.

Section 24. Amends s. 641.51(4), F.S., to require organizations to only allow licensed physicians to render adverse determinations and to ensure that patients and treating physicians are notified of the basis for the adverse determination, including the facts,

criteria, and benefits provisions used, and the process for appealing such adverse determination.

Section 25. Creates s. 381.7351, F.S., creating the “Reducing Racial and Ethnic Health Disparities: Closing the Gap Act”, ss. 381.7351-381.7356, F.S.

Section 26. Creates s. 381.7352, F.S., providing legislative findings and intent that recognizes that certain racial and ethnic populations in Florida continue to have significantly poor health outcomes. Acknowledges that local governments and communities are best equipped to identify the health education, health promotion, and disease prevention needs of the racial and ethnic populations in those communities, and to mobilize the community to address these disparities and evaluate the effectiveness of the outcomes.

Section 27. Creates s. 381.7353, F.S., relating to the “Reducing Racial and Ethnic Disparities: Closing the Gap grant program” (program), administration of the program, and duties of the Department of Health.

Section 28. Creates s. 381.7354, F.S., relating to eligibility.

Section 29. Creates s. 381.7355, F.S., relating to project requirements and review criteria.

Section 30. Creates s. 381.7356, F.S., relating to local matching funds and grant awards.

Section 31. Creates the Florida Commission on Excellence in Health Care. Provides findings and intent, definitions, duties and responsibilities, membership, organization, meeting procedures, staffing, and evidentiary prohibitions.

Section 32. Amends subsection (1) of s. 408.7056, F.S., relating to definitions that are specifically applicable to the Statewide Provider and Subscriber Assistance Program, to add definitions of the following terms: “agency,” “department,” “grievance procedure,” and “health care provider.”

Section 33. Amends s. 627.654, F.S., relating to the basis upon which insurance can be offered through labor union and association groups, to expand the applicability of this section to include small employer health alliances.

Section 34. Amends s. 627.6571, F.S., relating to guaranteed renewability of coverage, to: provide an exception to the guaranteed renewability requirements specific to a small employer whose membership in the alliance ceases; and incorporate coverage modifications for alliances consistent with current provisions applicable to bona fide associations.

Section 35. Amends s. 627.6699, F.S., relating to the Employee Health Care Access act.

Sections 36-41. Amends various sections of statute, relating to the indicated topic, to incorporate conforming revisions that either delete reference to the CHPA terms, "accountable health partnership" or "managed care" as those terms are defined in s. 408.701, F.S., or, where appropriate, to add a definition of “managed care” as defined in s. 408.701, F.S.:

s. 240.2995	University health support organizations
s. 240.2996	University health support organizations; confidentiality of information

s. 240.512	H. Lee Moffitt Cancer Center and Research Institute
s. 381.0406	Rural health networks
s. 395.3035	Confidentiality of hospital records and meetings
s. 627.4301	Genetic information for insurance purposes

Section 42. Creates s. 641.185, F.S., to provide standards to be followed by the Department of Insurance and the Agency for Health Care Administration in exercising their powers and duties, in exercising administrative discretion, in administrative interpretations of the law, in enforcing its provisions, and in adopting rules relating to health maintenance organizations. Specifies that this section does not create a cause of action against a health maintenance organization by a patient or health care provider.

Section 43. Creates s. 641.511(11), F.S., to require health care providers who contract with health maintenance organizations to post a consumer notice in the reception area of the provider which provides the addresses and telephone numbers of the health maintenance organization's grievance department, the Agency for Health Care Administration, the Statewide Provider and Subscriber Assistance Program, and the Department of Insurance. Provides rulemaking authority to the Agency for Health Care Administration to implement this section.

Section 44. Amends s. 627.6699, F.S., relating to the Employee Health Care Access Act.

Section 45. Amends s. 409.212, F.S., to add as a new subsection (6) authorization for the ongoing adjustment in the optional state supplementation rate based on the cost of living adjustment to the federal benefits rates.

Section 46. Amends subsections (3), (15), and (18) of s. 409.901, F.S., relating to Medicaid definitions, to substitute "department" for "agency" for purposes of submission of applications for medical assistance under Medicaid and add Social Security Administration for purposes of submission of applications for Supplemental Security Income.

Section 47. Amends s. 409.902, F.S., relating to the designation of a single state agency for purposes of the Medicaid program to designate that the Department of Children and Family Services is responsible for Medicaid eligibility determinations, including policies, rules, and the agreement with the Social Security Administration for Medicaid eligibility determinations for Supplemental Security Income recipients.

Section 48. Amends s. 409.903, F.S., relating to mandatory payments for Medicaid eligible persons, to incorporate conforming references to the Department of Children and Family Services and Social Security Administration.

Section 49. Amends subsection (6) of s. 409.905, F.S., relating to the hospital outpatient services requirements as part of mandatory Medicaid services, to increase the annual adult outpatient services cap from $1,000 to $1,500.

Section 50. Amends subsection (5) of s. 409.906, F.S., relating to case management services as an optional Medicaid service, to specifically authorize the Department of Children and Family Services to transfer general funds to the Agency for Health Care Administration to cover state match requirements exceeding the amount specified in the General Appropriations Act for targeted case management services, notwithstanding the provisions of s. 216.292, F.S., relating to the non-transferability of appropriated funds by state agencies.

Section 51. Amends subsections (9) and (10) of s. 409.907, F.S., relating to Medicaid provider agreements, to: authorize the agency to deny a provider agreement if the agency determines that such denial is in the best interest of the agency, and in so doing deletes the limitation that such denials be based solely on the grounds contained in subsection (10) of this section, but instead can also be based on, but not limited to, current availability of care, services, or supplies, taking into account geographic location and reasonable travel time; and specify that the factors listed be used in *considering*, rather than *denying*, provider participation in Medicaid.

Section 52. Amends s. 409.908(1)(a), F.S., relating to Medicaid hospital reimbursement, to increase the annual adult hospital outpatient services reimbursement cap from $1,000 to $1,500.

Section 53. Creates s. 409.9119, F.S., to provide for a children's hospital disproportionate share program. Specifically included are: guidelines and requirements for creation of this program; an exemption from contributions from counties under Medicaid matching fund requirements; factors to be used in determining amounts to be earned by children's hospitals and additional amounts to be paid to hospitals; and compliance requirements for receipt of funds.

Section 54. Amends s. 409.919, F.S., relating to Medicaid rules, to require the Department of Children and Family Services to adopt rules to comply with sections 409.901-409.906, F.S., and other provisions necessary for Medicaid eligibility determination.

Section 55. Authorizes developmental research schools to participate in the Medicaid certified school match program.

Section 56. Directs the Agency for Health Care Administration to submit to the Health Care Financing Administration a waiver request for a pilot project to implement a coordinated system of care for adult ventilator dependent patients. The pilot will use a network of skilled nursing facilities that agree to participate on a capitated basis. Evaluation must focus on overall cost-effectiveness and participant outcomes. Waiver submission and preliminary and final report timeframes are specified.

Section 57. Repeals s. 395.7015, F.S., to eliminate the 1.5 percent annual assessment on ambulatory surgical centers and mobile surgical facilities, clinical laboratories, and diagnostic imaging centers. Repeals s. 400.464(3), F.S., relating to home health agency licenses provided to CON exempt entities. Repeals the following sections of statute relating to CHPAs:

s. 408.70(3)	Legislative intent specific to community health purchasing alliances
s. 408.701	Community health purchasing; definitions
s. 408.702	Community health purchasing alliance; establishment
s. 408.703	Small employer members of community health purchasing alliances; eligibility requirements
s. 408.704	Agency duties and responsibilities related to community health purchasing alliances
s. 408.7041	Antitrust protection
s. 408.7042	Purchasing health care for state employees and Medicaid recipients through community health purchasing alliances
s. 408.7045	Community health purchasing alliance marketing requirements
s. 408.7055	Practitioner advisory groups

s. 408.706 Community health purchasing alliances; accountable health partnerships

Repeals paragraph (b) of subsection (4) of s. 409.912, F.S., relating to Medicaid's authority to contract for prepaid health care services with entities that provide only Medicaid services on a prepaid basis, and which are exempt from part I of ch. 641, F.S.

Section 58. Appropriates each year from either the General Revenue Fund or the Agency for Health Care Administration Tobacco Settlement Trust Fund an amount sufficient to provide for the increased reimbursement to hospitals for hospital outpatient care provided to adults under Medicaid.

Section 59. Provides an appropriation from the General Revenue Fund to the Department of Health of $10 million to be used to establish and implement the Reducing Racial and Ethnic Health Disparities: Closing the Gap grant program, including the funding of one full-time-equivalent position.

Section 60. Appropriates $91,000 in nonrecurring general revenue from the General Revenue Fund to the Department of Health to cover the costs of the Commission relating to travel, consultants, and reproduction and dissemination of documents.

Section 61. The bill would appropriate $200,000 from the Insurance Commissioner's Regulatory Trust Fund to the Office of Legislative Services for the purpose of implementing the legislative intent expressed in s. 624.215(1) for a systematic review of current mandated health coverages. The review would consist of an assessment of the impact of current mandated coverages using the guidelines provided in s. 624.215(2), F.S.

Section 62. Provides an effective date of July 1, 2000, except as otherwise provided.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

CON - The Agency for Health Care Administration estimates a loss of $350,000 annually in lost CON fees.

PMATF - The repeal of the assessment on ambulatory surgical centers and mobile surgical facilities, clinical laboratories, and diagnostic imaging centers and the reduction of the assessment on hospitals will result in lost revenue by the state of $85 million. These funds will have to be replaced in order to retain the current level of federal matching funds for the state's Medicaid program. The bill requires the Legislature to appropriate the necessary funds from either the General Revenue Fund or the Agency for Health Care Administration Tobacco Settlement Trust Fund to the Public Medical Assistance Trust Fund.

2. Expenditures:

CON - The agency estimates that approximately $276,276 will be saved annually by the elimination of 4 FTEs.

Minority Health - The Department of Health estimates the following expenditures:

Non-Recurring or First Year Start-up Effects:

	Amount Year 1	Amount Year 2
EXPENSE:		
Professional Package @ $4,189	$4,180	
Total Expense	$4,180	
OCO:		
Computers 1 @ $3,300	$3,300	
Total OCO	$3,300	
Total Non-Recurring	$7,480	

Recurring or Annualized Continuation Effects:

Salaries/Benefits:		
Senior Management Analysis II 1 @ $40,491/$55,607	$40,491	$55,067
Total Salaries/Benefits	$40,491	$55,067
EXPENSE:		
Professional package Maximum Travel 1 @ $16,505	$16,605	$16, 505
Statewide Conference	$7,000	$7,000
Ad Hoc Advisory Committee Travel Costs @ $5,000/meeting 4 meeting/year	$20,000	
6 meeting/year	$30,000	
Counties, Communities or Neighborhoods grant awards	$ 9,908,524	$ 9,890,888
Total Expense	$ 9,952,029	$ 9,944,393
Total Recurring Costs	$ 9,952,520	$10,000,000
Total Non-recurring and Recurring costs	$10,000,000	$10,000,000

Commission on Excellence - The costs of travel for the consumer members, staff, and members appointed by the department or agency, consultant fees and travel, and document reproduction and dissemination are anticipated to be less than $100,000.

Hospitalists - The Agency for Health Care Administration indicates that this bill will have no fiscal impact on the agency. The Department of Management Services has indicated that the direct fiscal impact of this bill is not significant.

Health Alliances - The Agency for Health Care Administration currently has 10 full time equivalent positions associated with the CHPA program. All of these positions are deleted in the Governor's recommended budget and in both the current House and Senate appropriations proposals, with a total reduction of $634,709 in salaries and expenses. For this reason, this bill does not have an associated fiscal impact savings.

Employee Health Care - The fiscal impact of this bill on the Department of Insurance is indeterminate. See Fiscal Comments.

Medicaid - The increase in the cap on hospital outpatient services for adults under Medicaid is estimated by AHCA to cost $26.9 million. The state will provide $11.7 million and the federal government will provide $15.2 million in matching funds. The bill appropriates from either the General Revenue Fund or AHCA Tobacco Settlement Trust Fund sufficient dollars to cover the increased reimbursement to health care providers due to the increase in the hospital outpatient cap for adults.

Mandated Health Coverages -

	FY 2000-01	FY 2001-02
Insurance Commissioner's Regulatory Trust Fund	$200,000	N/A

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

Minority Health - Local government applicants for these grant funds must allocate matching funds in instances where their population is greater than 50,000.

2. Expenditures:

Medicaid - The increase in the annual cap on Medicaid hospital outpatient services for adults from $1,000 to $1,500 is estimated by AHCA to cost $17.36 million. The state will provide $7.53 million and the federal government will provide the remaining $9.83 million in matching funds. These funds are included in the Governor's budget recommendations for FY 2000-2001. The children's hospital disproportionate share program is anticipated to require $642,000 in state funds, which would be derived from local government via inter-governmental agreements, which would draw down $1,224,513 in federal matching funds, for a total of $1.9 million. These funds are included in the Governor's budget recommendations for FY 2000-2001. An existing disproportionate share program will need to be reduced by an equal amount of funding. The bill provides authority for the agency to apply for a federal waiver to implement a pilot project for adult ventilator dependent persons. It is assumed that the services will be required to be at least budget neutral under any federal waiver, therefore there is no fiscal impact on the Medicaid program.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

CON - According to the agency, the elimination of CON review eliminates fees that range from $5,000 to $22,000 per project. The fee for a letter of exemption is only $250.

PMATF - According to information provided by the Agency for Health Care Administration, assessments on hospitals will be decreased by an estimated $69.5 million per year and Medicaid reimbursements for hospital outpatient services will increase by an estimated $26.9 million per year. Other health care entities will benefit from an elimination of the $15.5 million PMATF assessment.

Hospitalists - Since this bill does not change current practice for most hospitals and managed care organizations, there should be no fiscal impact on the private sector.

Adverse Incidents - Florida law currently requires organizations to be accredited pursuant to s. 641.512(1)(a), F.S., and the accrediting standards require a physician to sign off on treatment denials. Pursuant to s. 641.495(11), F.S., every organization providing health care services to patients in Florida is required to designate a medical director who is an allopathic or osteopathic physician licensed in Florida. Therefore, if the organization is currently meeting accreditation requirements or if the organization uses the physician that they have already designated as medical director to render these adverse determinations, the fiscal impact to the organization should be minimal.

Commission on Excellence - Travel and related expenses of most of the members will be paid by the sponsoring organizations.

Health Alliances - The bill would repeal CHPAs, presumably requiring small employers currently insured through CHPAs to find health insurance elsewhere (unless the CHPA formed a "small employer health alliance" and negotiated new coverage). The bill would not create any special protections to assist these small employers in finding new coverage. But, as with any employer whose insurer discontinues coverage, state laws enacted in accordance with the federal Health Insurance Portability and Accountability Act (i.e., limitations on the application of preexisting condition exclusions) could assist these small employers in finding new coverage. Without CHPAs, small employers could still obtain coverage on a guaranteed-issue, modified community-rated basis either directly from a small employer carrier or through an alliance established pursuant to this bill. The bill does not provide any specific legal advantage to the former CHPAs that could be issued an alliance group policy, as compared to other alliance or association groups, such as a local Chamber of Commerce associations.

Employee Health Care - The bill requires small employer carriers to semiannually report premium information to the Department of Insurance on forms adopted by the Department. Small employer carriers could incur costs in complying with this reporting requirement.

Medicaid - Entities that provide in-home physician services to Medicaid patients with degenerative neurological diseases will be able to contract with the agency and will be reimbursed at a rate not less than comparable Medicare reimbursement rates. Some providers wishing to enter or continue Medicaid provider agreements can expect to face higher surety bond requirements. This should be viewed as a cost of doing business. Adult Medicaid recipients using hospital outpatient services will have more of such services available to them.

D. FISCAL COMMENTS:

PMATF- The Agency for Health Care Administration suggests that the elimination of the assessment on outpatient hospital services should create a more equitable financial situation between hospital providers and other non-hospital providers of outpatient services.

Minority Health - According to the Department of Health, ten million dollars will be appropriated from the General Revenue Fund to the Department of Health to reduce the health status outcomes gap between minorities and non-minorities. The administration of this program will require one professional, highly trained, highly experienced individual. This administration by the Senior Management Analyst II will include:

- Publicizing availability of funds to Florida counties and communities;
- Overseeing review of competitive proposals and award funds;
- Providing technical assistance and training to include an annual statewide "best practices" meeting;
- Developing uniform data reporting requirements for evaluation and accountability purposes;
- Developing a monitoring process to evaluate progress;
- Coordinating with existing community-based programs;
- Providing staff support to the ad hoc advisory committee.

Commission on Excellence - An eventual cost savings to the public and private sectors may be realized in the form of decreased medical expenses associated with treating the patient's injury caused by the medical error and decreased malpractice insurance premiums.

Employee Health Care - The bill requires small employer carriers to semiannually report information to the Department of Insurance for the purpose of monitoring the premiums charged to employers. The Department of Insurance could incur increased costs in collecting this information and monitoring premiums charged by small employer carriers. The exact amount of these costs is unknown.

Medicaid - The creation of the pilot program for in-home physician services is estimated to be budget neutral.

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

A. APPLICABILITY OF THE MANDATES PROVISION:

The bill does not require a county or municipality to expend funds or to take any 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 state tax shared with counties or municipalities.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

None.

B. RULE-MAKING AUTHORITY:

This bill provides rulemaking authority to the Agency for Health Care Administration. It also implies rulemaking responsibilities for the Department of Health with regard to Racial & Ethnic Health Disparities although express rulemaking authority is not provided. The bill provides rulemaking authority to the Department of Insurance relating to Employee Health Care Access. It also restores rulemaking authority to the Department of Children and Family Services with regard to Medicaid eligibility determinations.

C. OTHER COMMENTS:

None.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On April 13, 2000, the Committee on Health Care Licensing and Regulation adopted nine amendments without objection that are traveling with the bill:

- Amendment 1 allows the agency to base surety bond amounts on the potential reimbursement to be received from the Medicaid program rather than a set amount of $50,000.
- Amendment 2 restores existing law that was stricken in the original bill which requires the agency to specify the reasons a Medicaid provider license is denied.
- Amendment 3 is a technical title amendment to delete reference to a certificate of need review of hospices that is not included in the body of the bill.
- Amendment 4 revises the definition of “health care provider” to exclude insurance carriers in the section relating to the Commission on Excellence.
- Amendment 5 requires providers to post addresses and toll-free telephone numbers for the Agency for Health Care Administration, the Department of Insurance, and the Statewide Provider and Subscriber Assistance Program. It requires the provider to include in the notice that the address and telephone number of the grievance department of the organization will be provided upon request so that providers do not have to list all of the addresses and telephone numbers of every organization with whom they contract since some providers contract with more than one hundred organizations. A technical amendment to the amendment was adopted to insert the word “the” that had been inadvertently omitted.

- Amendment 6 changes terminology of “medical doctor” and “doctor of osteopathy” to “allopathic or osteopathic physician” which reflects the most current terminology used nationwide. It also requires the identification of the physician who rendered the adverse determination on the written notification to the patient and treating physician.

- Amendments 7, 8, and 9 add seven more members to the Commission on Excellence in Health Care for a total of forty members.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE LICENSING & REGULATION:

Prepared by:	Staff Director:
Wendy Smith Hansen	Lucretia Shaw Collins