HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 441 CS Rural Hospitals
SPONSOR(S): Brown and others
TIED BILLS: None. **IDEN./SIM. BILLS:** CS/SB 250 (s)

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Standards (Sub)	8 Y, 0 N	Rawlins	Collins
2) Health Care	21 Y, 0 N w/CS	Rawlins	Collins
3) State Administration		Brazzell	Everhart
4) Commerce & Local Affairs Approp. (Sub)			
5) Appropriations			

SUMMARY ANALYSIS

This bill changes the definition of “rural hospital” to provide that a hospital that received funding under the Medicaid disproportionate share/financial assistance program for rural hospitals on July 1, 2002, will continue to be a rural hospital through June 30, 2012, provided certain conditions are met. It also provides that an acute care hospital that meets the criteria shall be designated a rural hospital upon application to the Agency for Health Care Administration (AHCA).

This bill allows a rural hospital to construct a replacement facility without obtaining a certificate of need (CON), provided the replacement hospital is within 10 miles of the current hospital and is within the current primary service area, which the bill defines.

This bill authorizes a rural hospital to contract with the Department of Management Services in order to purchase coverage in the state group health insurance plan for the hospital’s employees and family members at the same premium cost as that for retirees and surviving spouses. The hospital is responsible for collecting any required employee contribution, making the employer contribution, and paying an annual administrative fee.

This bill takes effect on July 1, 2003.

See “Fiscal Comments” and “Drafting Issues or Other Comments” sections of bill analysis.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. DOES THE BILL:

1. Reduce government?	Yes[]	No[x]	N/A[]
2. Lower taxes?	Yes[]	No[]	N/A[x]
3. Expand individual freedom?	Yes[x]	No[]	N/A[]
4. Increase personal responsibility?	Yes[]	No[]	N/A[x]
5. Empower families?	Yes[x]	No[]	N/A[]

For any principle that received a "no" above, please explain:

The designation of "rural hospital" allows a rural hospital to rely on state and federal appropriations for financial assistance. This bill also permits the expansion of government-negotiated contracts for health insurance to cover private-sector entities.

B. EFFECT OF PROPOSED CHANGES:

Rural Hospital Status

Background:

Part III of ch. 395, F.S., governs rural hospitals. Florida law defines a rural hospital as a licensed acute care hospital having 100 or fewer licensed beds and an emergency room, which is either:

- The sole provider in a county with a population density no greater than 100 persons per square mile;
- At least 30 minutes of travel time from any other acute care hospital in the same county;
- Supported by a tax district or subdistrict;
- In a constitutional charter county with a population of over 1 million persons that has imposed a local option health service tax and in an area that was directly impacted by a catastrophic event on August 24, 1992, for which the Governor of Florida declared a state of emergency and which has 120 beds or less;
- In a service area of population density of 100 persons or below; or
- Designated as a Critical Access Hospital by the Department of Health.

Population densities must be based upon the most recently completed United States census. Currently there are twenty-nine (29) hospitals listed as rural hospitals.[1]

Rural hospitals may suffer financial hardships due to small community sizes, lack of health insurance in their communities, overall lower incomes in their communities, lower levels of Medicare reimbursement, outdated/aging physical plants, and constantly increasing costs due to technological innovations and costs of pharmaceuticals and other supplies.

Benefits of status as a rural hospital include:

[1] Baptist Medical Center – Nassau, Fernandina Beach; Calhoun Liberty Hospital, Blountstown; Campbellton-Graceville Hospital, Graceville Desoto Memorial Hospital, Arcadia; Doctor's Memorial Hospital – Bonifay, Bonifay; Doctor's' Memorial Hospital, Inc., Perry; Ed Fraser Memorial Hospital, MacClenny; Fishermen's Hospital, Marathon; Florida Hospital Flagler, Palm Coast; Florida Hospital Wauchula, Wauchula Gadsden Community Hospital, Quincy; George E. Weems Memorial Hospital, Apalachicola; Glades General Hospital, Belle Glade; Gulf Pines Hospital, Port St. Joe; Healthmark Regional Medical Center, Defuniak Springs; Homestead Hospital, Homestead; Hendry Regional Medical Center, Clewiston; Jackson Hospital, Marianna; Jay Hospital, Jay; Madison County Memorial Hospital, Madison; Mariners Hospital, Tavernier; Nature Coast Regional Hospital, Williston; Northwest Florida Community Hospital, Chipley; Ramadan Hand Institute/Lake Butler Hospital, Lake Butler; Shands at Lake Shore, Lake City; Shands at Live Oak, Live Oak; Shands at Starke, Starke; South Lake Hospital, Clermont; and Trinity Community Hospital, Jasper.

State level:

- Eligibility to participate in the rural hospital Medicaid disproportionate share (DHS)[2] and financial assistance programs under s. 409.9116, F.S.
- Receipt of a rural special Medicaid payment.
- Exemption of inpatient and outpatient rates from ceilings.

Federal level:

- Access to grants from funding of up to $775,000 per state per year, to improve rural health systems with an emphasis on improving Emergency Medical Services.

Although the criteria to be considered in defining a rural hospital exist in law, there currently is no timetable for evaluating whether hospitals continue to meet the criteria. The Agency for Health Care Administration (AHCA) recommends evaluation every 10 years.

Proposed Changes:

The bill amends ss. 395.602 and 408.07, F.S., to change the definition of rural hospital to provide that a hospital that received funding under the Medicaid disproportionate share/financial assistance program for rural hospitals for a quarter beginning no later than July 1, 2002, is deemed to have been a rural hospital and will continue to be a rural hospital through June 30, 2012, provided the hospital continues to have 100 or fewer licensed beds and an emergency room, or is in a constitutional charter county with a population of over 1 million persons that has imposed a local option health service tax and in an area that was directly impacted by a catastrophic event on August 24, 1992, for which the Governor of Florida declared a state of emergency and which has 120 beds or less…(s. 395.602(2)(e), F.S.). The bill provides that an acute care hospital that has not previously been designated as a rural hospital and that meets the criteria shall be granted the designation upon application to AHCA.

Certificate of Need

Background:

The Certificate-of-Need (CON) regulatory process under chapter 408, F.S., requires that before specified health care services and facilities may be offered to the public they must be approved and need determined by the Agency for Health Care Administration (AHCA). Section 408.036, F.S., specifies which health care projects are subject to review. Certain projects are subject to full comparative review, but statute permits other projects to be given an expedited review. One such project which may receive expedited review is the replacement of a health care facility when the proposed project site is located in the same district and within a 1-mile radius of the replaced facility. Still other projects may be exempt from full comparative review upon request.

The CON Workgroup[3] recently studied the process and produced a final report in December 2002 which includes a recommendation to create a new exemption from CON review for the replacement of a statutory rural hospital within the same district, under certain conditions. The bill seeks to implement this recommendation.

Proposed Changes:

[2] What is Medicaid disproportionate share? Federal law requires state Medicaid programs to "take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs" when determining payment rates for inpatient hospital care. Expenditures for DSH have increased significantly in recent years: Between 1990 and 1996, for example, DSH payments grew nationally from $1.4 billion to $15 billion. By 1996, DSH payments accounted for 1 of every 11 (federal and state) dollars spent on Medicaid.

[3] Section 15 of Chapter 2000-318, Laws of Florida, established a workgroup on CON to study issues pertaining to the CON program, including the impact of trends in health care delivery and financing.

The bill creates s. 395.6061, F.S., to permit a rural hospital to construct a replacement facility without obtaining a CON, provided the replacement hospital is within 10 miles of the current hospital and within the current primary service area. The amendment defines "service area" as the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period.

State Employee Health Insurance Program

Background:

Officers and employees of agencies of the State of Florida are given the opportunity to receive employee benefits such as health, prescription drug, life, dental, and vision insurance products under a cafeteria plan consistent with Section 125, Internal Revenue Code.[4] Persons eligible to enroll include state officers and employees, surviving spouses of deceased state officers and employees, retired state officers and employees, terminated employees and individuals with continuation coverage, e.g., COBRA, and eligible dependents.

By law, the governing body of a small county or small municipality or the district school board of a small county may apply for participation in the state group health insurance program,[5] with extensive terms and conditions to which a small county, small municipality or district school board must agree before being authorized to participate in the state group health insurance program. Currently, participation in the state group health insurance program is limited to government employees.

Proposed Changes:

The bill creates s. 395.6063, F.S., to permit a statutory rural hospital to contract with the Department of Management Services in order to purchase coverage in the state group health insurance plan for the hospital's employees and family members at the same premium cost as that for retirees and surviving spouses. Currently, this is the same rate as that paid by active employees. The hospital is responsible for collecting any required employee contribution, making the employer contribution, and paying an annual administrative fee of not less than $2.61 per enrollee per month.

The bill takes effect July 1, 2003.

C. SECTION DIRECTORY:

Section 1. Amends s. 395.602, F.S., revising the definition of rural hospital, provides circumstances under which a rural hospital may continue their rural hospital designation through June 30, 2012, and allows for additional hospitals to be designated as a rural hospital.

Section 2. Amends s. 408.07, F.S., providing that a rural hospital replacement facility is not subject to CON review.

Section 3. Creates s. 395.6025, F.S., revising the definition of rural hospital as it relates to the CON review process.

Section 4. Creates s. 395.6063, F.S., allowing any rural hospital to participate in the state self-insured health plan, covering hospital employees and qualified family members at the same premium cost as that of retirees and surviving spouses, requiring the hospital to collect premiums or other remuneration from employees, and requires the hospital to make employer contributions.

Section 5. Provides for an effective date of July 1, 2003.

[4] s. 110.123, F.S.
[5] s. 110.1228, F.S.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   See "Fiscal Comments."

2. Expenditures:

   According to the Department of Management Services (DMS), under the current benefit design and funding structure, for Fiscal Year 2003-2004, the State Employees' Group Health Self-Insurance Trust Fund deficit equates to an annual loss of approximately $938 per subscriber. Therefore, for each additional enrollee under this legislation, the FY 03-04 Trust Fund deficit would be increased by approximately $938. Depending on other factors, the adverse impact could be greater. However, approaches to addressing this issue are under consideration this year by this Legislature and this might not be a factor by the time this program were implemented.

   According to DMS, there are many uncertain factors with extending health insurance benefits to eligible participants of these rural hospitals. DMS would need a determination of these factors to calculate the State's administrative costs and impact on future State premium costs. For instance, the rate of participation and level of service utilization or risk profile of these newly-eligible enrollees is unknown.

   See "Fiscal Comments."

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   See "Fiscal Comments."

2. Expenditures:

   See "Fiscal Comments."

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Private for-profit and not-for-profit rural hospitals would be eligible for the special funding arrangements available to rural hospitals under DSH and the rural special Medicaid payment and the Medicare Rural Hospital Flexibility Program.

As well, eligible for-profit and not-for-profit hospitals may be able to extend to their employees the same health benefits that are currently provided to state employees.

D. FISCAL COMMENTS:

A preliminary review by AHCA of whether the existing rural hospitals would continue to meet the criteria for designation as a rural hospital using the 2000 Census data revealed that two providers potentially would no longer meet the rural hospital definition. The projected total loss for one provider would be $931,298 and the projected total loss for the other provider would be $843,580.

If the two providers did not qualify as "rural hospitals," the appropriated monies for rural DSH and rural SMP would be redistributed among the remaining rural hospitals. If the existing DSH and SMP programs remained at their current levels, the redistribution could result in an increase of up to 6.5 percent for some providers. Therefore, the loss of revenue to the facilities would not necessarily translate into a savings to the state as the funds would be redistributed (assuming total funding at current levels).

If the two providers did not qualify as “rural hospitals”, Medicaid would save approximately $448,202 per year in program expenditures by not exempting them from ceilings. A reduction in Medicaid expenditures would also reduce the amount of Federal Title XIX match by approximately $264,081 per year, resulting in a net state general revenue savings of approximately $184,121.

According to the Department of Management Services, although an administrative fee is provided for, the bill does not provide budget authority and appropriations for additional full time equivalent (FTE) positions that may be required for DMS administration of the program.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenues.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Chapters 395 and 408, F.S., provide rulemaking authority for the Agency for Health Care Administration; however, this bill does not provide rulemaking authority for the Department of Management Services.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The state employee group health insurance program operates in compliance with federal law and provides that employer-paid premiums are not considered constructive compensation subject to tax. The plan includes only tax-supported agencies. The inclusion of non-governmental agencies, especially those organized on a proprietary basis, may jeopardize that status and result in significant penalties to the insured population retroactively or prospectively.

According to the Department of Management Services:

- Any new subscribing entity to the state health plan will be governed by its operating parameters and will be assigned a separate risk pool for premium calculation. This premium will be likely close to that charged existing employer-participants. The incidence of payment will vary by employer based on its own personnel policies but the total premium will reflect the very generous benefit features provided.

- To effectuate the bill, the state group health insurance program may need to be modified into a multiple employer welfare arrangement. Such a modification is prohibited by Section 624.438, F.S.

- The legislation creates a potential conflict with section 110.123, F.S. The state group insurance program is designed to provide various insurance coverages to officers and employees of “state agencies.” As used in s. 110.123, F.S., the term “state agency” means an executive agency of state government. Except for those few hospitals that are state institutions, hospitals, including rural hospitals, are not state agencies. Rather, they are usually supported by a special taxing district, by local governments or operated as a private enterprise.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On March 12, 2003, the Subcommittee on Health Standards adopted a strike-all amendment to HB 441. The amendment was technical in nature, creating a new section of law in lieu of amending existing law, conforming the bill to the senate companion.

On March 19, 2003, the Health Care Committee adopted the amendment recommended by the Subcommittee and reported the bill favorably with a committee substitute.