CHAMBER ACTION

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The Committee on Health Policy (Saunders) recommended the following amendment:

Senate Amendment (with title amendment)

On page 5, line 6, through

page 11, line 21, delete those lines

and insert: by a hospital or the Department of Health which have been approved for such status after July 1, 2007, are not exempt from the surplus and other financial requirements of part I of chapter 641. Provider service networks not operated by a hospital or the Department of Health which were approved on or before July 1, 2007, shall be required by the agency to comply with the surplus and other financial requirements of part I of chapter 641 before July 1, 2010. For provider service networks not operated by a hospital or the Department of Health which seek compliance with this paragraph, the minimum surplus amount is the greater of $3 million, 10 percent of total liabilities, or 2 percent of total annualized premium, notwithstanding part I of chapter 641. Medicaid recipients assigned to a provider service network shall be

chosen equally from those who would otherwise have been assigned to prepaid plans and MediPass. The agency is authorized to seek federal Medicaid waivers as necessary to implement the provisions of this section. Any contract previously awarded to a provider service network operated by a hospital pursuant to this subsection shall remain in effect for a period of 3 years following the current contract expiration date, regardless of any contractual provisions to the contrary. A provider service network is a network established or organized and operated by a health care provider, or group of affiliated health care providers, including minority physician networks and emergency room diversion programs that meet the requirements of s. 409.91211, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers and may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the provider service network organization.

(49) The agency shall contract with established minority physician networks that provide services to historically underserved minority patients. The networks must provide cost-effective Medicaid services, comply with the requirements to be a MediPass provider, and provide their primary care physicians with access to data and other management tools necessary to assist them in ensuring the

appropriate use of services, including inpatient hospital services and pharmaceuticals.

(a) The agency shall provide for the development and expansion of minority physician networks in each service area to provide services to Medicaid recipients who are eligible to participate under federal law and rules. The agency shall further require that each minority physician network that has been approved for designation or expansion after July 1, 2007, meet the requirements of part I of chapter 641 as a condition of such designation or expansion. Minority physician networks that were approved on or before July 1, 2007, shall be required by the agency to comply with the surplus and other financial requirements of part I of chapter 641 before July 1, 2010. For minority physician networks that seek compliance with this paragraph, the minimum surplus amount is the greater of $3 million, 10 percent of total liabilities, or 2 percent of total annualized premium, notwithstanding part I of chapter 641.

(53)(a) The agency may not enter into a contract with a managed care plan that is eligible to receive an assignment of Medicaid recipients which is to be effective in any county if such contract would cause the county to contain fewer than 20,000 recipients subject to mandatory Medicaid managed care enrollment per each managed care plan eligible to receive an assignment of Medicaid recipients residing in the county. For purposes of this subsection, the term "mandatory Medicaid managed care enrollment" has the same meaning as in s. 409.9122, and the terms "managed care plan" and "assignment" have the same meaning as in s. 409.9122(2)(f), except that, for purposes of this subsection, the term "managed care plan" does not include a Children's Medical Services Network that is

contracted under paragraph (4)(i) or an entity that is contracted to provide integrated long-term care services under subsection (5).

(b) A contract in effect before July 1, 2007, is not rendered invalid by paragraph (a) and may be renewed notwithstanding paragraph (a). However, paragraph (a) applies if such contract terminates or lapses after July 1, 2007.

(c) Paragraph (a) does not apply in a county containing fewer than two managed care plans eligible to receive assignments of Medicaid recipients residing in the county. This subsection does not prohibit the agency from contracting with at least two managed care plans per county which could otherwise be certified to contract for Medicaid services.

Section 2. Paragraph (e) of subsection (3) of section 409.91211, Florida Statutes, is amended to read:

409.91211 Medicaid managed care pilot program.--

(3) The agency shall have the following powers, duties, and responsibilities with respect to the pilot program:

(e) To implement policies and guidelines for phasing in financial risk for approved provider service networks over a 3-year period. These policies and guidelines must include an option for a provider service network to be paid fee-for-service rates. For any provider service network established in a managed care pilot area, the option to be paid fee-for-service rates shall include a savings-settlement mechanism that is consistent with s. 409.912(44). This model shall be converted to a risk-adjusted capitated rate no later than the beginning of the fourth year of operation, and may be converted earlier at the option of the provider service

network. For a provider service network not operated by a hospital or the Department of Health which is approved by the agency for designation after July 1, 2007, the applicant shall meet the initial surplus and other financial requirements of chapter 641. Provider service networks not operated by a hospital or the Department of Health which were approved on or before July 1, 2007, shall be required by the agency to comply with the surplus and other financial requirements of part I of chapter 641 before July 1, 2010. For provider service networks not operated by a hospital or the Department of Health which seek compliance with this paragraph, the minimum surplus amount is the greater of $3 million, 10 percent of total liabilities, or 2 percent of total annualized premium, notwithstanding part I of chapter 641. Federally qualified health centers may be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid primary care services.

Section 3. Subsections (1), (2), and (6) of section 641.225, Florida Statutes, are amended to read:

641.225 Surplus requirements.--

(1)(a) Until July 1, 2010, each health maintenance organization receiving a certificate of authority on or before July 1, 2007, shall at all times maintain a minimum surplus in an amount that is the greater of $1.5 million ~~$1,500,000~~, ~~or~~ 10 percent of total liabilities, or 2 percent of total annualized premium.

(b) After June 30, 2010, each health maintenance organization receiving a certificate of authority on or before July 1, 2007, shall at all times maintain a minimum surplus in the amount of $5 million, 10 percent of total liabilities, or 2 percent of total annualized premium, whichever is greater.

(c) Each health maintenance organization receiving a certificate of authority after July 1, 2007, shall at all times maintain a minimum surplus in the amount of $5 million, 10 percent of total liabilities, or 2 percent of total annualized premium, whichever is greater.

(2) The office shall not issue a certificate of authority, except as provided in subsection (3), unless the health maintenance organization has a minimum surplus in an amount that ~~which~~ is the greater of:

(a) Ten percent of their total liabilities based on their startup projection as set forth in this part;

(b) Two percent of their total projected premiums based on their startup projection as set forth in this part; or

(c) Five million dollars ~~$1,500,000~~, plus all startup losses, excluding profits, projected to be incurred on their startup projection until the projection reflects statutory net profits for 12 consecutive months.

(6) In lieu of having any minimum surplus, the health maintenance organization may provide a written guarantee to assure payment of covered subscriber claims and all other liabilities of the health maintenance organization, provided that the written guarantee is made by a guaranteeing organization which:

(a) Has been in operation for 5 years or more and has a surplus, not including land, buildings, and equipment, of the greater of$5 million ~~$2 million~~ or 2 times the minimum surplus requirements of the health maintenance organization. In any determination of the financial condition of the guaranteeing organization, the definitions of assets, liabilities, and surplus set forth in this part shall apply,

except that investments in or loans to any organizations guaranteed by the guaranteeing organization shall be excluded from surplus. If the guaranteeing organization is sponsoring more than one organization, the surplus requirement shall be increased by a multiple equal to the number of such organizations.

(b) Submits a guarantee that is approved by the office as meeting the requirements of this part, provided that the written guarantee contains a provision which requires that the guarantee be irrevocable unless the guaranteeing organization can demonstrate to the office that the cancellation of the guarantee will not result in the insolvency of the health maintenance organization and the office approves cancellation of the guarantee.

(c) Initially submits its audited financial statements, certified by an independent certified public accountant, prepared in accordance with generally accepted accounting principles, covering its two most current annual accounting periods.

(d) Submits annually, within 3 months after the end of its fiscal year, an audited financial statement certified by an independent certified public accountant, prepared in accordance with generally accepted accounting principles. The office may, as it deems necessary, require quarterly financial statements from the guaranteeing organization.

Section 4. Subsection (2) of section 641.2261, Florida Statutes, is amended to read:

641.2261 Application of solvency requirements to provider-sponsored organizations and Medicaid provider service networks.--

(2) The solvency requirements <u>of this part</u> ~~in 42~~

~~C.F.R. s. 422.350, subpart H, and the solvency requirements established in approved federal waivers pursuant to chapter 409~~ apply to a Medicaid provider service network not operated by the Department of Health or a hospital licensed under chapter 395 if the network was approved for designation as a provider service network under chapter 409 after July 1, 2007. The solvency requirements of this part must be applied on or before July 1, 2010, to provider service networks not operated by the Department of Health or a hospital which were approved for designation on or before July 1, 2007. If at any time the solvency requirements of subpart H of 42 C.F.R. 422.350 and the solvency requirements established in approved federal waivers under chapter 409 exceed the requirements of this part, the federal requirements apply to provider service networks not operated by the Department of Health or a hospital licensed under chapter 395. The solvency requirements of subpart H of 42 C.F.R. 422.350 and the solvency requirements established in approved federal waivers under chapter 409, rather than the solvency requirements of this part, apply to a Medicaid provider service network operated by a hospital licensed under chapter 395. ~~rather than the solvency requirements of this part.~~

Section 5. The Office of Insurance Regulation shall develop a plan to implement a Risk-Based-Capital (RBC) method of ensuring the financial stability and solvency of organizations regulated by part I of chapter 641, Florida Statutes, based on the recommendations of the National Association of Insurance Commissioners contained in its Risk-Based Capital (RBC) for Health Organizations Model Act, except that no less than $5 million shall be required of health maintenance organizations for minimum surplus. The plan

must ensure that such standards are phased in and fully in effect by July 1, 2011. The office shall develop and submit the RBC implementation plan, including implementing legislation, to the President of the Senate, the Speaker of the House of Representatives, the Governor, and the Chief Financial Officer no later than January 1, 2008.

(Redesignate subsequent sections.)

================ T I T L E A M E N D M E N T ================

And the title is amended as follows:

On page 1, line 9, through

page 2, line 3, delete those lines

and insert:

networks not operated by a hospital or the Department of Health are not exempt from certain financial requirements; requiring such provider service networks to comply with certain financial requirements before a specified date; specifying minimum surplus amounts for such provider networks under certain circumstances; requiring minority physician networks to comply by a specified date with certain financial requirements based upon when each network was approved for designation or expansion; specifying minimum surplus amounts for minority physician networks under certain circumstances; restricting the agency's ability to contract with certain

managed care plans under certain conditions; defining the terms "mandatory Medicaid managed care enrollment," "managed care plan," and "assignment"; providing certain limitations regarding contracts with managed care plans for assignments of Medicaid recipients; amending s. 409.91211, F.S.; requiring certain provider service networks to meet certain financial requirements based upon when the network was approved by the agency for designation; specifying minimum surplus amounts for such provider service networks under certain circumstances; amending s. 641.225, F.S.; requiring health maintenance organizations to maintain a specified minimum surplus; amending s. 641.2261, F.S.; requiring Medicaid provider service networks to meet certain solvency requirements based upon certain criteria; requiring the Office of Insurance Regulation to develop a plan for a "Risk-Based-Capital" method concerning solvency of certain health maintenance organizations; specifying requirements concerning the contents of the plan; requiring the office to submit the plan, including implementing legislation, to the President of the Senate, the Speaker of the House of Representatives, the Governor, and the Chief Financial Officer by a time certain;