SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based only on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS for CS/SB 2154, CS/SB 1900, and SB 282

SPONSOR: Health, Aging and Long-Term Care Committee, Banking and Insurance Committee, and Senators Latvala, Brown-Waite, Silver and others

SUBJECT: Health Care

DATE: April 25, 2000 REVISED: _____ _____ _____ _____

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

I. Summary:

The Committee Substitute for CS/SB 2154, CS/SB 1900, and SB 282 is given the popular title "Health Care Protection Act of 2000." It combines provisions from several health care and health insurance bills relating to: assessments on certain health care entities to fund the Public Medical Assistance Trust Fund; Medicaid reimbursement limits on hospital outpatient services; the certificate-of-need program; mandated health insurance benefits; consumer-assistance notices by physicians and hospitals and a consumer assistance program; small employer health alliances; the Employee Health Care Access Act and rating restrictions on small group insurance; regulation of health maintenance organizations; health maintenance organization subscribers' rights; civil liability of health maintenance organizations; mandatory use of "hospitalists" by health maintenance organizations; and adverse determinations by health maintenance organizations.

The committee substitute amends the following sections of the *Florida Statutes* (F.S.): 216.136, 240.2995, 240.2996, 240.512, 381.0406, 395.3035, 395.701, 395.7015, 400.471, 408.032, 408.033, 408.034, 408.035, 408.036, 408.037, 408.038, 408.039, 408.040, 408.044, 408.045, 408.7056, 408.904, 409.905, 409.908, 409.912, 440.11, 624.215, 627.4301, 627.654, 627.6571, 627.6699, 641.27, 641.28, 641.31, 641.315, 641.3155, 641.3903, 641.3917, 641.51, and 651.118.

The committee substitute creates s. 641.275, F.S., and twelve undesignated sections of law.

The committee substitute repeals the following sections of the *Florida Statutes*: 400.464(3), 408.70(3), 408.701, 408.702, 408.703, 408.704, 408.7041, 408.7042, 408.7045, 408.7055, and 408.706.

II. Present Situation:

The Public Medical Assistance Trust Fund

Chapter 395, F.S., delegates authority to the Agency for Health Care Administration (AHCA or agency) to license and regulate hospitals, ambulatory surgical centers, and mobile surgical facilities. Part IV of chapter 395, F.S., consisting of ss. 395.701 and 395.7015, F.S., relates to the Public Medical Assistance Trust Fund (PMATF) which is created in s. 409.918, F.S. Revenues collected from assessments on the specified health care providers under Part IV of chapter 395, F.S., are used to fund Medicaid-reimbursed hospital inpatient services. Through use of such trust fund moneys, the State is able to avoid use of general revenue to pay for Medicaid services provided to medically indigent State residents. According to AHCA, the assessments, combined with revenues from cigarette taxes and interest earnings are fully utilized each year in the General Appropriations Act.

Specified Health Care Facilities are Subject to the PMATF Assessment

Section 395.701, F.S., was originally enacted in 1984 to impose an assessment of 1.5 percent against the annual net operating revenue of each state-licensed hospital. The funds generated through the assessment were to be used to expand Medicaid coverage and equalize the financial burden of indigent health care among hospitals. Assessments are deposited into the PMATF. The Health Care Board was empowered to fine or penalize hospitals that failed to comply with, or otherwise violated, the assessment payment requirement. Chapter 98-89, Laws of Florida (L.O.F.) abolished the Board. Enforcement authority relating to the assessment was transferred to AHCA. There are currently 256 hospitals subject to the PMATF assessment according to AHCA.

Section 395.7015, F.S., was originally codified in statute as s. 395.1015, F.S., as created by s. 177 of ch. 91-112, L.O.F., which for the first time extended PMATF assessments to four additional types of health care providers: clinical laboratories, ambulatory surgical centers, diagnostic imaging centers, and freestanding radiation therapy centers. As a result, more than 800 additional health care facilities were made subject to the PMATF assessment. Section 52 of ch. 92-289, L.O.F., redesignated s. 395.1015, F.S., as s. 395.7015, F.S. Administrative rule 59B-6.009(2), Florida Administrative Code (F.A.C.), defines "freestanding" to mean that the health care entity bills and receives revenue which is not directly subject to the hospital PMATF assessment, and that the health care entity is not a department or other subdivision of a hospital.

Under s. 395.7015, F.S., an annual assessment is imposed on ambulatory surgical centers and mobile surgical facilities, licensed under s. 395.003, F.S.; certain clinical laboratories, licensed under s. 483.091, F.S.; freestanding radiation therapy centers providing treatment through the use of radiation therapy machines that are registered under s. 404.22, F.S.; 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 physicians who meet certain specified state licensure requirements. Chapter 98-192, L.O.F., exempted hospital outpatient radiation therapy services from the assessment and repealed the assessment on freestanding radiation therapy centers, contingent on the receipt of federal confirmation that these changes would not adversely affect the use of the remaining assessments as state match for the Medicaid program. According to AHCA, there are currently 382 diagnostic

imaging centers, 254 ambulatory surgical centers, and 345 clinical laboratories subject to the PMATF assessment.

How Is the PMATF Assessment Implemented?

The agency imposes an assessment of 1.5 percent against the annual net operating revenue of each health care entity that is subject to the PMATF assessment. Within four months (120 days) after the end of each health care entity's fiscal year, each entity that is subject to the PMATF assessment must report its *actual experience* in the preceding calendar year based upon reports developed by the abolished Health Care Board. The agency, within six months of the end of the health care entity's fiscal year, must certify the amount of the assessment to each such entity based on its determination of the entity's net operating revenue. The assessment must be payable to and collected by the agency in equal quarterly amounts on or before the first day of each calendar quarter, beginning with the first full calendar quarter following the certification.

"Net operating revenue" is defined by paragraph 395.7015(1)(a), F.S., and administrative rule 59B-6.009(5), F.A.C., to mean gross revenue less deductions from revenue. For health care entities using a cash basis of accounting, net operating revenue means the amount of gross revenue collected. Paragraph 395.7015(1)(b), F.S., and administrative rule 59B-6.009(3), F.A.C., define "gross revenue" to mean the sum of daily service charges, ambulatory service charges, ancillary service charges, and other operating revenue. This amount includes all revenue to the health care entity, excluding documented physician professional fees, revenues received for testing or analysis of samples received from outside the state or from product sales outside the state, and revenue unrelated to the operation of the health care entity as provided in rules 59B-6.012 and 59B-6.013, F.A.C. Paragraph 395.7015(1)(c), F.S., defines "deductions from revenue" to mean reductions from gross revenue resulting from inability to collect payment of charges. Such reductions include: bad debts; contractual adjustments; uncompensated care; administrative, courtesy, and policy discounts and adjustments; and other such revenue deductions, and includes the offset of restricted donations and grants for indigent care.

Effect on the State of Exempting or Eliminating from Assessment Some, But Not All, Health Care Entities That Are Subject to the PMATF Assessment

Chapter 98-192, L.O.F., codified as s. 395.7015, F.S., provides an exemption from the assessment on hospital net operating revenues for outpatient radiation therapy services provided by a hospital and provides for the elimination of the assessment on freestanding radiation therapy centers. The exemption and elimination are both *contingent* upon AHCA receiving written confirmation from the federal Health Care Financing Administration (HCFA) that these changes to the law would not adversely affect the use of the remaining assessments as state match for the Medicaid program. According to AHCA, it initiated efforts to obtain such confirmation on July 7, 1998, when it submitted a letter to HCFA requesting HCFA to confirm that the provisions of chapter 98-192, L.O.F., would have no impact on *the permissibility under federal rules of the remaining assessments*. On December 17, 1998, HCFA requested additional information from AHCA. The agency responded to HCFA's request for additional information on March 8, 1999. Prior to the 1999 Regular Legislative Session, the agency had not received HCFA's confirmation and, therefore, the assessment on the contingently exempted outpatient radiation therapy services

and the contingently eliminated assessment on freestanding radiation therapy centers remained in effect.

Confirmation from HCFA that the exemption and elimination from the PMATF assessment, as enacted in 1998, was significant. Following was an explanation, provided by the agency, of what such confirmation meant to the State.

Section 1903(w) of the Social Security Act specifies the treatment of revenues from provider-related donations and health care-related taxes in determining a state's medical assistance expenditures for which federal financial participation (match funds) are available. Title 42, part 433 of the Code of Federal Regulations (CFR) relates to health care-related provider taxes and donations. Section 42 CFR 433.55 defines a "health care-related tax" as a licensing fee, assessment, or other mandatory payment that is related to: (1) health care items or services; (2) the provision of, or the authority to provide, the health care items or services; or (3) the payment for the health care items or services.

Section 42 CFR 433.56 lists 19 separate classes of health care items or services for purposes of applying the provider donations and provider taxes provisions of federal rules. (See the Senate Staff Analysis for CS/SB 954 for a complete list of the classes.) Taxes that pertain to each class *must apply to all items and services within the class*, regardless of whether the items and services are furnished by or through a Medicaid-certified or licensed provider. Before calculating federal financial assistance, HCFA will deduct from a state's expenditures for medical assistance those funds from health care-related taxes received by a state or unit of local government if the taxes are not *permissible* health care-related taxes, as specified by federal law and federal regulations.

"*Health care-related taxes are permissible under federal regulation if the taxes are broad-based, uniformly imposed, and do not violate hold harmless provisions.*" A health care-related tax is considered broad based if the tax is imposed on at least all health care items or services in the class or providers of such items or services furnished by all non-federal, non-public providers in the state, and is imposed uniformly. (See the Senate Staff Analysis for CS/SB 954 for further discussion of a provider tax being uniformly imposed.)

Section 3 of chapter 99-356, L.O.F., modified the contingent effective date enacted in 1998 for the removal of the annual PMATF assessment on outpatient radiation therapy services and freestanding radiation therapy centers. If HCFA notifies AHCA, in writing, between April 15, 1999, and November 15, 1999, that the removal of the assessment violates federal regulations, then the removal of the assessment is repealed. The repeal would only take effect upon the date that the Secretary of State receives notification from AHCA of the federal determination. Before ch. 99-356, L.O.F., took effect (July 1, 1999), AHCA received confirmation on May 28, 1999 from HCFA that the changes would not adversely affect the use of the remaining assessments as state match for the Medicaid program and the exemption and elimination of the PMATF assessment were subsequently implemented retroactive to July 1, 1998.

Public Medical Assistance Trust Fund Task Force

Section 192, ch. 99-397, L.O.F., provided for the establishment of a 7-member task force to review sources of funds deposited into the PMATF. The task force had to consider and make specific recommendations to the Legislature, and provide an analysis of the budgetary impact of any exemptions from, inclusions within, or modifications to existing PMATF assessments, concerning, but not limited to:

- Whether any provisions of PMATF laws should be revised;
- Whether annual PMATF assessments are equitably imposed;
- Whether additional exemptions from, or inclusions within, the assessments are justified;
- The extent to which federal law and regulations applicable to PMATF assessments allow state flexibility in modifying existing assessments; and
- The extent to which PMATF revenue could be increased by modifications of the PMATF assessments imposed under the following provisions of law: s. 210.20, F.S., 1998 Supplement, relating to the state's cigarette tax revenues; s. 395.1041, F.S., 1998 Supplement, relating to hospital emergency services; s. 408.040, F.S., 1998 Supplement, relating to certain specific certificate-of-need activities pertaining to modification of a CON; and s. 408.08, F.S., 1998 Supplement, relating to certain health care providers, health care facilities, and health insurers for which AHCA is authorized to conduct certain business transaction reviews.

The task force completed a report by December 1, 1999, of its findings and recommendations which includes proposed legislation. The PMATF task force report included thirteen findings and seven recommendations:

- The State should work toward repeal of the PMATF assessment, if the lost revenue is replaced from another source.
- Such repeal should occur in stages.
- Phase one should be implemented in Fiscal Year 2000-2001 by repealing the assessment on: ambulatory surgical centers; diagnostic imaging centers; clinical laboratories; and hospital-based outpatient services.
- The State should seek approval from federal authorities for exemption of hospital outpatient services to ensure federal financial participation is not jeopardized.
- The $85 million in revenue lost through the phase one repeal should be replaced in order to maintain the federal financial participation.
- The replacement funds should come from tobacco funds or whatever other revenue source the Legislature finds appropriate. Tobacco funds represent a particularly appropriate funding source because of the health-related nature of the settlement.
- The annual cap on hospital outpatient services for adults under the Medicaid program should be raised from $1,000 to $2,000.

Annual Cap on Hospital Outpatient Services for Adults

Sections 408.90 - 408.908, F.S., create the MedAccess program to offer basic, affordable health care services to those Floridians who have not had access to the private health insurance market. Section 408.904, F.S., sets the benefits that are to be provided under the program. Under this section, hospital outpatient services are capped at $1,000 per calendar year per member. The MedAccess program has not been funded and 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 outpatient services to $1,000 per fiscal year per adult recipient except for renal dialysis services and for other exceptions made by AHCA. The agency has listed the criteria for the exceptions in administrative rule 59G-4.160(5), F.A.C. The criteria for the exceptions made by the agency are for services that may be safely performed in the outpatient setting and are more cost-effective when done in the outpatient setting rather than in the inpatient setting.

Medicaid Cost-Effective Purchasing

Section 409.912, F.S., requires AHCA to purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. The agency must maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies to facilitate the cost-effective purchase of a case-managed continuum of care. The agency must also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high cost services. The agency is authorized to enter into agreements with any public or private entity on a prepaid or fixed-sum basis for the provision of health care services to Medicaid recipients.

Certificate-Of-Need Regulation

Beginning in the late 1960's, the federal government began regulating market entry of health care providers through certificate-of-need (CON) regulation. The State of Florida, in compliance with federal law, enacted CON regulation in the early 1970's. In regulating market entry, CON is a pre-requisite to licensure. The federal government repealed its CON requirements in 1981.

Certificate-of-need regulation was enacted when the health care marketplace was operating exclusively on a fee-for-service basis. Medicare and Medicaid reimbursed health care facilities on a cost basis that included, as continues today in a modified form, reimbursement for capital infrastructure costs. Cost containment mechanisms such as capitated reimbursements, diagnosis-related groups, or procedures used by managed care organizations to control costs were not a part of general business practices. Indeed, only the few professionals and academicians who closely followed health care economics were aware of the structural economic problems that were emerging that would result in rapid escalation of health care costs and rapid increases in the rate of health care inflation apart from the nation's overall inflation rate.

Under Florida's CON regulation, before a person (natural or corporate) may be granted a state license to operate a nursing home, hospital, home health agency, intermediate care facility, or hospice, or is authorized to provide certain services in a health care facility, the person must apply to AHCA for state recognition of market need for such a facility or service. Furthermore, once awarded a CON, as provided under ss. 408.031- 408.045, F.S., the Health Facility and Services Development Act, and granted a license to operate, the person may need to subsequently obtain another CON before proceeding with the implementation of a business decision, such as pursuing conversion from one type of facility to another type of facility or offering a new service.

The state's CON regulation is designed to achieve four main policy objectives: (1) containing increases in overall health care expenditures, (2) ensuring a minimum level of quality of health care, (3) ensuring access to health care goods and services for insured and uninsured individuals, and (4) ensuring the availability of health care services by discouraging monopolies and promoting competition. Through control of the supply of health care facilities and services, CON regulation attempts to minimize the costs of excess supply, help prevent non-price competition, and slow the proliferation of new technology before its usefulness has been established. Additionally, CON regulation is designed to promote equal service and equal geographic access to quality health care, assure and reward quality care, and encourage responsiveness to community interests.

Certificate-of-Need Review

There are three levels of review to which a CON application may be subjected, based on statutory requirements. The most thorough scrutiny of a CON application is referred to as comparative review as provided in s. 408.036(1), F.S. Such review requires AHCA to compare the applications submitted, in accordance with statutory review criteria as provided in s. 408.035, F.S., and a review process as provided in s. 408.039, F.S., during a batching cycle in response to a need for a specified type of health care facility or health service, as indicated by AHCA in documents it publishes on a periodic basis.

Certain projects are expressly made subject to an expedited review process, as provided in subsection 408.036(2), F.S. An applicant applying to establish or modify a project that must undergo expedited review is not required to comply with some of the application time frames and requirements that projects which are subject to comparative review must meet. Such applicants may submit applications at any time, unlike applicants for projects regulated under comparative review that must submit applications during batching cycles specified by AHCA. Consequently, although projects that are subject to expedited review must meet all other requirements that projects subject to comparative review must meet, expedited review projects, generally, experience a shorter approval or denial period, from submission of the application through final AHCA processing, than projects that undergo comparative review.

Health care services or projects that are otherwise subject to CON review may be exempted from review, as provided in subsection 408.036(3), F.S. This provision is comprised of an enumeration of services and projects that AHCA is required to exempt from review based upon the request of the service provider or health care facility operator when supported by documentation required by AHCA.

Certificate-of-Need Conditions

As provided in s. 408.040, F.S., AHCA may approve a CON application, with conditions. For CON applicants, AHCA includes Form CON-1, Schedule C in the application packet for the applicant to indicate whether, or to what extent, it is willing to meet the stated local health council preference, if any, for providers to make a stated amount of services available to Medicaid recipients who seek services in the area where the applicant intends to operate. Once a condition is imposed on a CON, it continues in effect for the duration of the facility's or service's existence under that CON.

A condition may require the health care provider who will license and operate the facility or provide a service, such as hospice, to provide service to a needy population group, most typically Medicaid recipients (in recent years). Such a condition may require provision of a minimum of three percent of a provider's total annual facility patient days to Medicaid recipients or charity care or 30 percent of the local market's total Medicaid patient days, for example. Conditions are usually imposed only on CONs pursued through the comparative review process. The CON program reported that for at least the past 10 years, it has not awarded a nursing home CON that did not impose a condition that the applicant certify a portion of its beds for Medicaid reimbursement. While not all CON conditions are imposed on nursing homes and not all CON conditions pertain to the Medicaid program, the majority of CON conditions currently in effect are applicable to Medicaid nursing home beds.

Mandated Health Insurance Benefits

State laws frequently require private health insurance policies and HMO contracts to include specific coverages for particular treatments, conditions, persons, or providers. These are commonly referred to as *mandated health benefits*. Mandated health benefits are estimated to 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) generally preempts state regulation of these plans.[1]

In 1987, the Legislature called for a systematic review of current and proposed mandated benefits. At that point, the Legislature had approved 16 mandated benefits. Since that time, 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, submission of an impact analysis for any proposed mandated benefit by proponents prior to consideration, does not appear to have been used frequently.[2]

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

[1]29 U.S.C. s. 1001, et. seq.

[2]Staff of the House Committee on Insurance could confirm only 4 instances since 1987 in which the required study was completed for a mandated benefit.

"cut in half" to entice one-third of these respondents back into the marketplace, according to at least one study.

It is not always apparent in statute which health plans are subject to which state-mandated health benefits. For instance, the statute may refer to "an insurer" but then in describing those covered refer to "subscriber," a term associated with HMOs. As a result, estimates for the number of mandated health benefits in Florida vary, ranging from 44 to 51. Of these, 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.[3]

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,[4] the Legislature authorized insurers and HMOs to offer "basic" and "standard" small employer group plans and exempted these two plan types from mandated coverages not expressly made applicable to these plans in law. For the period ending December 31, 1998, these two plan types accounted for only $139 million in earned premium or just over eight 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.

Although mandated health benefits apply only to private insurer and HMO health plans, there are instances when Floridians receive 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.

[3]BlueCross BlueShield Association, State Legislative Health Care and Insurance Issues: 1998 Survey of Plans.

[4]Section 627.6699, F.S.

[5]Note: The actual terms of the coverage may vary. House 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.

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.

While a comprehensive study of the cumulative cost of mandated health benefits in Florida has not been identified, 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.

The Legislature has established requirements in s. 624.215, F.S., specific to consideration of legislation proposing mandated health benefits in Florida.[6] Proponents of a particular mandated

[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 benefit must prepare a report assessing the social and financial impacts of the proposal and submit the report to AHCA 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;
- 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.

A survey conducted by staff of the House Committee on Insurance found 20 states have special statutory provisions for managing mandated benefits legislation and 28 do not.

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."

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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.

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.

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

Community Health Purchasing Alliances

In 1993, the Florida Legislature established community health purchasing alliances (CHPAs) as state-chartered, nonprofit private organizations, intended to pool purchasers of health care together in organizations that broker health plans at the lowest price and enable consumers to make informed selections of health plans. *See* chapter 93-129, *Laws of Florida*, codified as ss. 408.70-408.706, F.S. Community health purchasing alliances make available health insurance plans to small employers, as that term is defined in s. 627.6699, F.S., who have 1 to 50 employees, including sole proprietors and self-employed individuals.

The agency 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. In order for an insurance plan to be offered through the CHPA, the plan must qualify as an accountable health partnership (AHP), which must be formed by an insurer or HMO authorized by the Department of Insurance. The law also authorizes CHPAs to provide coverage to Medicaid recipients and state employees, but that authority has never been exercised, as the Legislature has never taken the steps needed to fully implement this aspect of the law.

The law created eleven CHPAs, one for each of AHCA's eleven health service planning districts. There are now seven individual CHPAs, due to merger of certain districts. Each CHPA operates under the direction of an appointed 17-member board of directors. The original law that provided for appointment of members by designated public officials was repealed (due to a Sunset provision and failure of the Legislature to reenact). The repeal allows the boards, as nonprofit associations, to provide for appointment of board members in their articles of incorporation and bylaws. At this time, all of the CHPA boards' articles and bylaws continue to provide for appointment of members in the manner that was statutorily directed. The boards appoint executive directors who serve as the CHPAs' chief operating officers. In addition to the executive director, each CHPA employs from one to three full-time staff and all but one contract with a third-party administrator.

Community health purchasing alliances act as clearing-houses for health insurance plans that qualify as AHPs. Community health purchasing alliances choose AHPs via requests for proposals. The CHPAs offer several benefit plans. Within these plans an individual can choose different types of coverage, such as an HMO or a preferred provider plan. All CHPA plans are sold through authorized insurance agents.

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

The legislative Office of Program Policy Analysis and Government Accountability (OPPAGA) has issued reports on CHPAs and their activities. OPPAGA's report, *The Follow-Up Report on the Status of Community Health Purchasing Alliances in Florida*, Report No. 98-14, October 1998, states that the CHPAs continue to have a small impact in reducing the number of uninsured Floridians. Limitations cited in the report include:

- The CHPAs inability to negotiate or select health plans that offer the most competitive products and prices; and

- The 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 should consider the following policy options, including:

- 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.

- Enable CHPAs to appoint their agents.

Employee Health Care Access Act

In 1992, the Employee Health Care Access Act (act) was enacted to require insurers in the small group market to guarantee the issue of coverage to any small employer that applies for coverage, regardless of the health condition of the employees. (s. 627.6699, F.S.) In 1993, the act was expanded to cover employers with one employee, including sole proprietors and self-employed individuals.

The act further requires that policies issued to small employers have premiums established on a "modified community rating" basis. Rates may be based only on age, gender, family composition, tobacco usage, and geographic location [s. 627.6699(3), F.S.]. Rates may not be based on the health status or claims experience of any individual or group, or any other factor.

An insurer or HMO that writes small group policies in Florida (a "small employer carrier") must elect to either be a risk-assuming carrier and assume all risk or be a reinsuring carrier and have the option of reinsuring identified high-risk individuals or groups with a reinsurance pool [s. 627.6699(9), F.S.]. The reinsurance pool is funded through premiums paid by the reinsuring carrier and assessments on insurers. Risk-assuming carriers are not subject to losses in the reinsurance pool [s. 627.6699(11), F.S.].

Small group carriers are required to offer a "standard" and "basic" policy to small employers. 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 statute specifies certain mandated benefits that apply to both the standard and basic policy and a Health Benefit Plan Committee is created to develop and modify the standard and basic benefit plans. Small group carriers are required to offer all health benefit plans (not just the basic and standard plans) on a guaranteed-issue basis, but additional or increased benefits may be added to the standard health benefit plan by rider and such riders may be medically underwritten.
The act defines the term "small employer" to mean, "in connection with a health benefit plan with respect to a calendar year and a plan year, any person, sole proprietor, self-employed individual, independent contractor, firm, corporation, partnership, or association that is actively engaged in business, has its principal place of business in this state, employed an average of at least 1 but not more than 50 eligible employees on business days during the preceding calendar year, and employs at least 1 employee on the first day of the plan year. For purposes of this section, a sole proprietor, an independent contractor, or a self-employed individual is considered a small employer only if all of the conditions and criteria established in this section are met."
[s. 627.6699(3)(v), F.S.]

The act defines the term "self-employed individual" to mean "an individual or sole proprietor who derives his or her income from a trade or business carried on by the individual or sole proprietor

which results in taxable income as indicated on IRS Form 1040, schedule C or F, and which generated taxable income in one of the 2 previous years." [s. 627.6699(3)(u), F.S.]

The Small Group Market in Florida

The Senate Banking and Insurance Committee prepared an interim report, *Review of Florida's Health Insurance Laws Relating to Rates and Access to Coverage*, (Report No. 2000-04; August 1999). The report included information regarding the small group market in Florida. As of March 31, 1999, approximately 1.73 million persons were insured under small group policies in Florida, as compared to 1.71 mil. at the end of 1998, 1.6 mil. in 1997, 1.45 mil. in 1996, and 1.30 mil. in 1995. The number of small group carriers dropped from 116 carriers in 1997 to 90 carriers in 1998, but remained at 90 carriers in 1999.

The following table from the interim report shows the average annual rate increases for small group coverage in Florida for the 3-year period, 1995-1997, weighted for market share for the leading thirteen health insurers[7] representing 79.8 percent of the small group market and the six HMOs[8] representing 83.6 percent of the small group HMO market in 1997. These rate increases have been substantial, averaging over 17 percent a year for small group insurers and nearly 10 percent a year for small group HMOs.

Small Group Rates — Average Annual Rate Increase
Leading Florida Carriers (1995-1997)

Year	Small Group Insurance	Small Group HMO
1995	21.16%	9.03%
1996	17.18%	7.12%
1997	14.06%	11.50%
3-Year Cumulative Total	61.93%	30.23%
Average Annual Change	17.43%	9.20%

The following table shows the most current rate filings that had been approved by the Department of Insurance (DOI) for small group insurers and small group HMOs, as of August 1, 1999, and the average premium per covered employee for a sample 10-life group developed by the department. Small group premiums are continuing to increase at significant levels. Unlike previous years, HMOs are experiencing rate increases comparable with health insurers.

[7] Blue Cross & Blue Shield of Florida (17.18% market share), Principal Mutual Life Insur. Co. (13.53%), John Alden Life Insur. Co. (12.46%), Humana Health Insur. Co. of Fla. (8.48%), United HealthCare Insur. Co. (7.41%), PFL Life Insur. Co. (2.01%), and Time Insur. Co. (1.84%).

[8] Health Options (18.39% market share), Humana Medical Plan (18.04 %), United HealthCare Plans of Fla. (15.13%), Principal Health Care of Fla. (13.9%), Prudential Health Care of Fla. (13.9%), and Neighborhood Health Partnership (4.2%).

MOST RECENT FLORIDA SMALL GROUP RATE FILINGS
(APPROVED AS OF 8/1/99)

Company	Percentage Increase	Annual (& Monthly) Premium After Increase (Avg.)
Small Group Major Medical —Indemnity:		
Principal Life Ins. Co.	22.0%	$5,291 ($441)
Anthem Health and Life Ins. Co.	11.2%	$5,463 ($455)
Blue Cross/Blue Shield	14.6%	$4,953 ($413)
Aetna Life Ins. Co.	13.1%	$6,269 ($522)
Humana Health Ins. Co. of Fla.	12.0%	$5,189 ($432)
PM Group Life Ins. Co.	0.7%	$4,048 ($337)
Prudential Life Ins. Co.	14.0%	$3,587 ($299)
Anthem Health and Life Ins. Co.	11.8%	$5,173 ($431)
New England Life Ins. Co.	0.0%	$5,117 ($426)
Trustmark Ins. Co.	10.0%	$6,568 ($547)
Principal Life Ins. Co.	17.0%	$6,221 ($518)
United Wisconsin Ins. Co.	23.0%	$3,241 ($270)
Small Group HMO (Out of CHPA)		
HIP Health Plan of Florida	18.1%	$4,558 ($380)
Aetna US HealthCare	20.1%	$4,139 ($345)
Health Options	24.1%	$4,773 ($398)
Healthplan Southeast	8.3%	$4,155 ($346)
Well Care HMO	2.9%	$4,475 ($373)
Florida Health Care Plan	19.5%	$4,121 ($343)
Foundation HealthCare	14.7%	$3,522 ($294)
American Medical HealthCare	25.4%	$3,634 ($303)
Physicians HealthCare Plans	29.1%	$5,239 ($437)
Health First Health Plan	10.9%	$3,689 ($307)

Source: Department of Insurance

Federal HIPAA Requirements

In 1996, the federal Health Insurance Portability and Accountability Act (HIPAA) was enacted to provide guaranteed availability and renewability of health insurance coverage for certain employees and individuals, and to increase portability through the limitation on preexisting

condition exclusions. HIPAA requires small employer carriers to guarantee the issuance of coverage to small employers with 2 to 50 employees.

HIPAA allows each state the option to enact and enforce the federal provisions or fall back to federal enforcement. HIPAA specifies that the federal provisions pertaining to health insurers generally do not preempt state regulation. However, if the state's statutory provisions prevent the application of a federal requirement, HIPAA preempts the statutes and the federal requirements prevail. At a minimum, each state must ensure that its provisions comport with HIPAA and do not diminish the federal requirements. However, each state is permitted to adopt provisions that expand or provide more favorable treatment for the individual.

Consumer and Provider Reactions to Managed Care

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

What is "Managed Care?"

Managed care refers to a variety of methods of financing and organizing the delivery of comprehensive health care in which an attempt is made to control costs and improve quality by controlling the provision of services. All forms of managed care represent attempts to control costs by modifying the behavior of health care providers, although they do so in different ways. Most forms also restrict the access of insureds to providers who are not affiliated with a particular plan. Primary care physicians assume broader roles in these systems to direct health care and to refer to other providers. Methods for controlling access to, and costs of care include prior, concurrent, and retrospective review of the medical necessity and appropriateness of services or site of services; contracts with selected health care providers; financial incentives or disincentives related to the use of specific providers, services, or service sites; controlled access to and coordination of services by a case manager; and disease management programs. Contracts between HMOs and health care providers will typically provide for a fixed, per patient fee, regardless of the services provided, referred to as a per capita fee arrangement. This provides an economic incentive to a provider to limit services to those that are medically necessary.

The term, *managed care organization* is not a licensure category under Florida law. One statute defines the term *managed care entity* for the purpose of the statewide panel that is created to help resolve grievances against such entities. This law, s. 408.7056, F.S., defines *managed care entity* to mean the following four organizations, each of which provide services or compensation *only* if

the insured or subscriber obtains services or treatment from an exclusive list of providers (referred to as contract providers), subject to certain exceptions: (1) *HMOs*, certified under parts I and III of chapter 641, F.S.; (2) *prepaid health clinics* certified under parts II and III of chapter 641, F.S., which limit services to physician care, but not including hospital inpatient services (and which serve a very limited market in Florida); (3) *prepaid health plans* authorized under s. 409.912, F.S., which are entities that contract with AHCA to serve Medicaid recipients, pursuant to statutory criteria similar to an HMO; and (4) *exclusive provider organizations* (EPOs), which are authorized health insurers which limit coverage to services or treatment from network providers, very similar to an HMO. In addition to obtaining a certificate of authority as a health insurer from DOI, the EPO insurer must have its plan of operation approved by the AHCA to determine the adequacy of the provider network and assurance of quality of care, also similar to an HMO.

In addition to these four entities, a health insurer that sells a *preferred provider contract* may be considered to be a "managed care" plan. This is a health insurance policy that provides greater benefits if an insured obtains services from a network provider, and lesser benefits (greater deductibles and coinsurance) if the insured obtains services from a non-network provider. The insurer must have these policies approved by DOI, but not AHCA. There is not a separate license that is issued to a health insurer for this purpose, but such plans are referred to as preferred provider organizations, or PPOs. There is one statute that regulates PPO contracts, s. 627.6471, F.S., which limits the amount of the difference between the network and non-network deductible and coinsurance that the insurer may impose, and other requirements.

Generally, an *indemnity* health insurance policy that provides the same reimbursement for health care expenses, regardless of the provider chosen, is not considered a managed care plan. Yet, even these insurers may use cost containment measures such as utilization review and fee schedules that could be categorized as managed care techniques.

Health Maintenance Organizations

According to DOI, as of December 1999, approximately 4.9 million Floridians were enrolled in HMOs, including 425,000 in Medicaid HMOs, 805,000 in Medicare HMOs and more than 3.7 million in commercial HMOs. Under present law, DOI regulates HMO finances, contracting, and marketing activities under part I of chapter 641, F.S., while AHCA regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a Certificate of Authority from DOI, an HMO must receive a Health Care Provider Certificate from AHCA. Any entity that is issued a Certificate under part III of chapter 641 and that is otherwise in compliance with the licensure provisions under part I may enter into contracts in Florida to provide an agreed-upon set of comprehensive health care services to subscribers in exchange for a prepaid per capita sum or prepaid aggregate fixed sum.

Section 641.19(13), F.S., provides the following definition of health maintenance organization:

> (13) "Health maintenance organization" means any organization authorized under this part which:

(a) Provides emergency care, inpatient hospital services, physician care including care provided by physicians licensed under chapters 458, 459, 460, and 461, ambulatory diagnostic treatment, and preventive health care services;

(b) Provides, either directly or through arrangements with other persons, health care services to persons enrolled with such organization, on a prepaid per capita or prepaid aggregate fixed-sum basis;

(c) Provides, either directly or through arrangements with other persons, comprehensive health care services which subscribers are entitled to receive pursuant to a contract;

(d) Provides physician services, by physicians licensed under chapters 458, 459, 460, and 461, directly through physicians who are either employees or partners of such organization or under arrangements with a physician or any group of physicians; and

(e) If offering services through a managed care system, then the managed care system must be a system in which a primary physician licensed under chapter 458 or chapter 459 and chapters 460 and 461 are designated for each subscriber upon request of a subscriber requesting service by a physician licensed under any of those chapters, and is responsible for coordinating the health care of the subscriber of the respectively requested service and for referring the subscriber to other providers of the same discipline when necessary. Each female subscriber may select as her primary physician an obstetrician/gynecologist who has agreed to serve as a primary physician and is in the HMO's provider network.

Under part III of ch. 641, F.S., an HMO is required, as a condition of doing business in Florida, to be accredited within 1 year of receiving its certificate of authority from DOI. Accreditation must be maintained as a condition of doing business in the state. HMOs must undergo an accreditation assessment at least every 2 years, or more frequently if AHCA deems additional assessments are necessary. According to AHCA, as of February 14, 2000, there were 30 HMOs in Florida. Of that number, 15 are using the National Committee for Quality Assurance (NCQA) for accreditation, 13 are using the Accreditation Association for Ambulatory Health Care (AAAHC), 1 is using the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and 1 HMO is due for initial accreditation and will be using NCQA.

Specific Requirements for HMOs

Current Florida law includes the following requirements for HMOs, among many others. Note that the following is a summary only and that the referenced statutes provide the specific requirements and limitations. Such provisions require HMOs to:

- ensure that health cares services provided to subscribers are rendered under reasonable standards of quality of care consistent with the prevailing standards of medical practice in the community, as required by s. 641.51, F.S.;

- have a quality assurance program for health care services, as required by s. 641.51, F.S.;

- not modify the professional judgment of a physician unless the course of treatment is inconsistent with the prevailing standards of medical practice in the community, as required by s. 641.51, F.S.;

- not restrict a provider's ability to communicate information to the subscriber/patient regarding medical care options that are in the best interest of the subscriber/patient, as required by s. 641.315(8), F.S.;

- provide for standing referrals to specialists for subscribers with chronic and disabling conditions, as required by s. 641.51, F.S.;

- allow a female subscriber to select an obstetrician/gynecologist as her primary care physician, as required by s. 641.19(13)(e), F.S.;

- provide direct access, without prior authorization, for a female subscriber to visit a obstetrician/gynecologist, as required by s. 641.51(10), F.S.;

- provide direct access, without prior authorization, to a dermatologist, as required by s. 641.31(33), F.S.;

- not limit coverage for the length of a stay in a hospital for a mastectomy to any time period that is less than that determined to be medically necessary by the treating physician, as required by s. 641.31(31), F.S.;

- not limit coverage for the length of a maternity or newborn stay in a hospital or for follow-up care outside the hospital to any time period less than that determined to be medically necessary by the treating provider, as required by s. 641.31(18), F.S.;

- not exclude coverage for bone marrow transplant procedures determined by AHCA to not be experimental, as required by s. 627.4236, F.S.;

- not exclude coverage for drugs on the ground that the drug is not approved by the U.S. Food and Drug Administration, as required by s. 627.4239, F.S.;

- give the subscriber the right to a second medical opinion as required by s. 641.51(4), F.S.;

- allow subscribers to continue treatment from a provider after the provider's contract with the organization has been terminated, as required by s. 641.51(7), F.S.;

- establish a procedure for resolving subscriber grievances and expedited review of urgent subscriber grievances, as required by s. 641.511, F.S.;

- notify subscribers of their right to a review of an unresolved grievance by the Statewide Provider and Subscriber Assistance Panel, as required by s. 408.7056, F.S.;

- provide, without prior authorization, coverage for emergency services and care, as required by s. 641.513, F.S.;

- not require or solicit genetic information or use genetic test results for any insurance purposes, as required by s. 627.4301, F.S.;

- pay, contest, or deny claims within the time periods required by s. 641.3155, F.S.; and

- provide information to subscribers regarding benefits, limitations, resolving grievances, emergency services and care, treatment by non-contract providers, list of contract providers, authorization and referral process, the process used to determine whether services are medically necessary, quality assurance program, prescription drug benefits and use of a drug formulary, confidentiality and disclosure of medical records, process of determining experimental or investigational medical treatments, and process used to examine qualifications of contract providers; as required by ss. 641.31, 641.495, and 641.54, F.S.

The enforcement of the above provisions depends on the particular requirement, but one or more of the following methods of enforcement apply to each of these requirements: (1) a condition of issuance or renewal of an HMO's certificate of authority issued by DOI; (2) a condition of issuance or renewal of an HMO's provider certificate issued by AHCA; (3) administrative penalties, including fines issued by DOI or AHCA; and (4) private actions in state or federal court to enforce the terms of the HMO contract.

Statewide Provider and Subscriber Assistance Program

Section 408.7056. F.S., requires AHCA to establish a program to provide assistance to subscribers and providers, including those whose grievances are not resolved by a managed care entity (see definition on page 14, above) to the satisfaction of the subscriber or provider. Grievances that are submitted to the program and determined by AHCA to meet the criteria for consideration are heard by a 7-member panel. The panel consists of three members employed or contracted by AHCA (the manager of the Managed Care Commercial Compliance Unit, a physician consultant employed by the Department of Health, and a senior management analyst); three members employed by DOI (the DOI chief of staff, the deputy insurance commissioner, and the consumer advocate); and a consumer appointed by the Governor (but no consumer member currently sits on the panel). The physician member is appointed by the Governor. Additionally, physicians who have expertise relevant to the case under consideration, must be appointed on a rotating basis. The specialist physician member is chosen from a list of 45 physicians who have agreed to participate as needed. The agency may contract with a medical director and a primary care physician to provide the program panel with technical expertise.

All panel hearings are conducted by video conference from the Department of Management Services (DMS) Center in Tallahassee to various DMS Centers located in the state. Hearings are held at least 3 days each month. Hearings are public, unless a closed hearing is requested by the subscriber or a portion of a hearing may be closed by the panel when deliberating information of a sensitive personal nature such as information from medical records.

Following its review, the panel must make a recommendation to AHCA or DOI. The recommendation may include specific actions the managed care entity must take to comply with state laws or rules regulating such entities. A managed care entity, subscriber, or a provider acting

on behalf of a subscriber that is affected by the panel's recommendation may within 10 days (72 hours for expedited grievances) after receipt of the recommendation furnish AHCA or DOI, as appropriate, written evidence in opposition to the panel's recommendation or finding of fact. The agency or DOI has the discretion to adopt all, part, or none of the panel's recommendation and must do so within 30 days after the panel issues the recommendation or findings of fact by issuing a proposed order or an emergency order, in accordance with the Administrative Procedure Act. Such an order may impose a fine or sanctions, as prescribed by state law, on the managed care entity against which the grievance was filed.

A managed care entity may appeal to the Division of Administrative Hearings (DOAH) a proposed or emergency order issued by AHCA or DOI against it when the order only requires the entity to take a specific action, unless all parties agree otherwise. The Division of Administrative Hearings must hold a summary hearing for consideration of such orders. If the managed care entity does not prevail in its appeal to DOAH, it must pay AHCA's or DOI's reasonable costs and attorney's fees incurred as a result of the proceeding. Subscribers are not permitted to appeal panel recommendations to DOAH.

The types of grievances filed by subscribers include (1) excluded benefits, (2) medical necessity, (3) unauthorized out-of-network provider, (4) formulary, (5) billing, (6) contract interpretation, and (7) enrollment/disenrollment. The agency reports that 49 percent of cases have been found in favor of the subscriber since 1994, for cases heard through February 1999. More recently, AHCA reports that 38 percent of cases were found in favor of the subscriber in fiscal year 1998-99, and that 53 percent of cases were found in favor of the subscriber in the current 1999-00 fiscal year through the end of February 2000.

Managed care entities have appealed 11 orders, according to agency records. Of these 11 appealed orders, 2 cases were settled before trial in favor of the HMO; 5 cases were settled before trial in favor of the subscriber; 1 case was settled during the trial, in favor of the subscriber; 1 case was adjudicated in favor of the subscriber; and 2 cases were dismissed because the HMO was placed in receivership.

Current Liability of Managed Care Plans

Lawsuits filed against any person or organization seeking to hold that person or organization liable for harmful conduct are typically based on common law theories of liability recognized by the courts. In addition, state and federal statutes create various causes of action that may not otherwise be recognized under common law. Lawsuits against managed care plans based on common law theories of liability face various legal obstacles, but an increasing number of cases throughout the country have been successful in overcoming such obstacles. A few states have enacted statutory causes of action against managed care plans.

In some states, managed care plans can avoid lawsuits under state laws that prohibit the "corporate practice of medicine," interpreted by many courts as barring suits against HMOs and other health plans on the ground that HMOs and other corporations cannot be sued for medical malpractice if they are prohibited from "practicing medicine."

In 1961, Florida authorized licensed health care professionals to practice under a corporate entity with the passage of the Professional Services Corporation Act codified in chapter 621, Florida Statutes. The Professional Services Corporation Act [s. 621.15, F.S., (1961)] provided that all laws in conflict with the act are repealed, and in effect, it repealed any statute which prohibited professions from practicing under a corporate entity. Under this chapter, a "professional service corporation" is defined to mean a corporation which is organized for the sole and specific purpose of rendering professional services and which has as its shareholders only other professional corporations, professional limited liability companies, or individuals who themselves are duly licensed or otherwise legally authorized to render the same professional service as the corporation. Under the Professional Services Corporation Act, all shareholders must be licensed members of the profession or otherwise legally authorized to render the same specific professional services as those for which the corporation was incorporated, but does not specifically require the officers or directors of corporations to be members of the same profession.

In Florida there is no legal ban on the corporate practice of medicine. It is unclear whether a court at some future date, may interpret the medical practice act and the practice acts of other health care professionals listed in s. 641.51(3), F.S., to recognize a ban on the corporate practice of medicine.

Theories of liability that have been pursued against HMOs and managed care entities in other states, with varying degrees of success, include: (1) medical malpractice or other direct negligence liability for acts of the entity, particularly utilization review activities, (2) vicarious liability for acts of individuals, either through "respondeat superior" or ostensible agency, (3) direct corporate liability for a non-delegable duty, and (4) intentional misrepresentation or fraud. There has been no Florida appellate court decision that has held an HMO liable in a civil negligence or malpractice action, but cases from other jurisdictions have done so under various theories.

The states of Texas, California, and Georgia have enacted statutes creating specific causes of action against HMOs and other health plans. Texas was the first state to enact such a law, in 1997, followed by California and Georgia in 1999. These laws give individuals the right to sue health insurance carriers, HMOs, and managed care entities if their failure to exercise ordinary care results in patient injury. Such health plans are liable for damages for harm to an insured or enrollee proximately caused by the entity's failure to exercise ordinary care. Additionally, the entity is liable for damages for harm proximately caused by the health care treatment decisions made by its employees, agents, ostensible agents, or representatives who are acting on its behalf.

The current Florida law, s. 624.155, F.S., provides a statutory civil remedy cause of action against *insurers*, enacted in 1982 ("civil remedy statute"). This section authorizes any person to bring a civil action against an insurer for violation of specified practices, most of which are prohibited practices listed in the Unfair Insurance Trade Practices section of the Insurance Code, plus other acts specified in the section. One of the acts which gives rise to a civil action against an insurer is the following:

> *Not attempting in good faith to settle claims when, under all the circumstances, it could and should have done so, had it acted fairly and honestly toward its insured and with due regard for her or his interests*. [s. 624.155(1)(b)1., F.S.]

An insurer found in a suit under the civil remedy statute to be in violation of any of the specified acts is liable for damages, court costs, and reasonable attorney's fees incurred by the plaintiff. The courts have construed recoverable damages under this section to include "those damages which are the natural, proximate, probable, or direct consequence of the insurer's bad faith actions . . ." *McLeod v. Continental Ins. Co.*, 591 So.2d 621 (Fla. 1992). The statute provides that punitive damages may not be awarded unless the acts giving rise to the violation occur with such frequency as to indicate a general business practice and are willful, wanton and malicious, or in reckless disregard for the rights of any insured. The statute requires that 60 days written notice be provided to the insurer and that no action shall lie if the damages are paid or the circumstances giving rise to the violation are corrected within this 60-day period.

However, with regard to health plan liability under the Florida civil remedy statute, two important restrictions apply. First, the statute has *no applicability to HMOs*, since it applies only to acts against an "insurer" (and s. 641.201, F.S., exempts HMOs from Insurance Code provisions outside of chapter 641). Secondly, even as to health insurers, an important exemption applies:

> *This section shall not be construed . . . to create a cause of action when a health insurer refuses to pay a claim for reimbursement on the ground that the charge for a service was unreasonably high or* ***that the service provided was not medically necessary****.* [s. 624.155(5), F.S., (boldface added)]

In 1996, the Florida Legislature passed CS/HB 1853 which created a statutory cause of action against HMOs, similar to the civil remedy statute applicable to insurers, discussed above. This bill was vetoed by Governor Chiles on May 28, 1996. The Governor's veto message stated that one of his top priorities was to bring spiraling health care costs under control and that much of the success for achieving modest health care cost increases during the previous 2 years was due to the expansion of managed care and its cost discipline principles. Governor Chiles acknowledged that an expanded remedy may be needed, but questioned "whether opening up the issue to resolution through the tort system through suits for compensatory and punitive damages is in the best interest of the consumer and is best for Florida's health care system as whole. . . . I believe that it is not." The Governor recommended that instead, the Statewide Subscriber Assistance Panel be strengthened to handle grievances more quickly and to penalize HMOs which do not provide services as ordered by the Panel. In 1998, legislation was enacted towards this goal. (See "Statewide Provider and Subscriber Assistance Panel," above.)

Award of Attorney's Fees to Prevailing Party (s. 641.28, F.S.)

Currently, s. 641.28, F.S., provides that in any civil action brought to enforce the terms and conditions of an HMO contract, the prevailing party is entitled to recover reasonable attorney's fees and court costs. In comparison, the current law in s. 627.428, F.S., provides that upon the rendition of a judgment by the courts of this state against an insurer and in favor of any named or omnibus insured or the named beneficiary under a policy, the court shall award a reasonable attorney's fee to the insured or beneficiary. However, no attorney's fee is allowed for suits based on claims arising under life insurance policies or annuity contracts if the suit was filed prior to expiration of 60 days after proof of the claim was duly filed with the insurer.

Policy Issues Raised by Managed Care Liability Laws

The groups supporting the passage of the liability laws seek to achieve several objectives: (1) *Health plan accountability.* Supporters assert that managed care plan's decisions to deny or delay coverage influence physicians' willingness to provide treatment and when these decisions injure plan participants, plans should be held accountable. (2) *Equitable treatment*. Supporters see no justification for treating managed care plans differently from other businesses, which can be held responsible for conduct that injures customers. (3) *Injury prevention as well as compensation*. Supporters hope that the threat of litigation can encourage more appropriate managed care decisions about what is "medically necessary."

The groups opposing passage of managed care liability law raise the following concerns: (1) *Cost impact.* Opponents argue that managed care plan premiums would increase substantially because the threat of liability would force plans to cover inappropriate care and because of the potential that juries might make large financial awards because they view managed care plans as having "deep pockets." (2) *Current state of the market is fragile*. Cost and premium increases are already occurring, making managed care coverage increasingly less affordable to persons and businesses and threatening the solvency of existing HMO plans in the state. (3) *Inappropriateness of negligence remedies.* Opponents assert that seeking financial awards for negligence under tort law is not the best way to remedy disputes over plan coverage. Other mechanisms exist today, particularly the Statewide Provider and Subscriber Assistance Panel, as a more effective, timely, and cost-efficient way to address adverse decisions by managed care entities and other consumer grievances.

ERISA Preemption

The Employee Retirement Income Security Act of 1974 (ERISA), limits the remedies available to persons covered under private sector employer plans and preempts certain state laws. Therefore, civil remedies in state courts, whether pursued under common law theories of liability or pursuant to a statutory cause of action, may be preempted by the federal ERISA law.

ERISA was enacted by Congress primarily to regulate employer pension programs. Congress provided a uniform body of laws for "employee benefit plans," which focuses on pension and retirement programs, but includes employer-sponsored insurance plans. All employer-sponsored health insurance and HMO plans, whether self-insured or fully insured, are covered by ERISA, except that the act does not apply to governmental plans and church plans. The act also has no application to individual health insurance plans.

Congress furnished ERISA with a civil enforcement clause which provides a remedy in federal court for denied employee benefits. Employees and enrollees are provided with a federal cause of action to either obtain the actual benefit that was denied, payment for the benefit, or a decree granting the administration of future benefits. State tort remedies, on the other hand, allow for pain and suffering, lost wages and cost of future medical services.

ERISA expressly preempts state laws in two ways. ERISA, in s. 502(a), authorizes a claimant to file an action in federal court to recover a benefit, enforce rights, or clarify future benefits under the terms of an employee benefit plan. This federal remedy preempts state laws that provide alternate enforcement mechanisms for employees to obtain ERISA plan benefits. If a claim

challenges a denial of benefits due under the terms of the plan, courts have generally determined that the claim is preempted. But, this may depend upon the theory of liability that is pursued.

A state law may also be preempted by ERISA if it "relates to" an employee benefit plan under section 514(a). However, this section is limited by section 514(b)(2) which preserves any state law "which regulates insurance." The U.S. Supreme Court, in *Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. 724 (1985), held that a state mandated benefit requirement for health insurance policies was not preempted by ERISA. The Court stated that the regulation of substantive terms of insurance contracts is within the savings clause as that "which regulates insurance."

Subsequent Supreme Court and federal appellate court decisions have involved a complicated and often conflicting analysis of whether a state law relates to an employee benefit plan and whether it is saved from preemption as regulating insurance, and other related theories of analysis. Some cases rely on the distinction made in the 1990 Supreme Court case of *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), in which the Court observed that Congress intended for ERISA to preempt state laws pertaining to the *administration* of employee-benefit plans while acquiescing to state regulation pertaining to the *quality of care* that the benefits provided.

The Supreme Court has more recently emphasized the traditional powers of the state, notably in the 1995 decision of *New York Conference of Blue Cross v. Travelers Insurance*, 514 U.S. 645 (1995). In *Travelers*, Justice Souter, writing for the Court, began his analysis of ERISA preemption by stating that in areas traditionally regulated by the states, the historic police powers of the states may not be superseded by the federal act unless this was the clear and manifest intent of Congress. The Court also stated that "nothing in the language or [ERISA] or in the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern."

The issue of whether the Texas Health Care Liability Act was preempted by ERISA was determined by the U.S. District Court for the Southern District of Texas in *Corporate Health Insurance Inc. v. The Texas Department of Insurance* (No. H-97-2072, 1998). The Court noted that state laws that provide alternate enforcement mechanisms for employees to obtain ERISA plan benefits are preempted, citing *Travelers*. However, the Court determined that the civil liability provision of the act provided a cause of action for challenging the *quality* of benefits received and that such a lawsuit would not create an alternate enforcement mechanism for employees to obtain ERISA benefits. Whether a claim is seeking a review of an adverse benefit determination or, instead, seeking to secure quality coverage should be determined on a case-by-case-basis, according to the Court. However, the Court also determined that the provisions for review of an adverse determination by an independent review organization improperly mandated the administration of employee benefits and were preempted by ERISA. But, the Court determined that such provisions were severable from the civil liability provisions of the act.

Health Maintenance Organization Contracts

Section 641.31, F.S., sets forth 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 between a HMO and its 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 a HMO to include or prohibit any provider contract element relating to the provision of inpatient hospital services.

The "Hospitalist" Concept

A "hospitalist," according to the National Association of Inpatient Physicians (NAIP), is a physician dedicated to the care of hospitalized patients. They 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 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 6 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 NAIP 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 intended to prohibit HMOs from mandating the use of hospitalists was amended by the Senate 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 bill by the House of Representatives and 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.[9] 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."

As a result of the concept of "hospitalist" 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.

Senate staff research identified seven 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 subacute 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 subacute care services* because of their focused expertise; more

[9] Aetna U.S. Healthcare bought Prudential last year and has decided to end the mandatory utilization of hospitalists effective March 27, 2000. Representatives with Aetna stated that it was "a business decision" to terminate the program.

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 subacute 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.

The Senate report contained the following recommendation:

> It may be premature for government to become involved in "resolving" how the use of hospitalists should proceed. Given the visible nature of such services to consumers, practitioners, and payers, there is a better chance, than in many other situations, that the marketplace will settle the issue of under what circumstances such a service may be acceptable. Therefore, at this time, staff recommends no legislation.

HMO Quality Assurance Programs

Quality requirements for HMOs under part III of ch. 641, F.S., include, among others: an internal quality assurance program; accreditation; and demonstration, to AHCA's satisfaction, of the HMO's capability to provide health care services of a quality consistent with the prevailing standards of medical practice in the community.

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

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

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

Adverse Determinations by Managed Care Organizations

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

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

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

The Agency for Health Care Administration is required to investigate unresolved quality-of-care grievances received from HMO annual and quarterly grievance reports as well as subscriber appeals of grievances that have been reviewed through the subscriber's HMO's full grievance procedure. Although AHCA may investigate a subscriber complaint prior to completion of an HMO's consideration through its grievance procedure, AHCA must advise subscribers that it is unable to review such a complaint as a grievance until the HMO's internal grievance process has been completed. If a subscriber's grievance is unresolved to the satisfaction of the subscriber after completion of their HMO's internal grievance procedure, AHCA may then review the grievance and refer it to the Statewide Provider and Subscriber Assistance Program for review and recommendations.

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

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

Regulation of Private Utilization Review Agents

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

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

Accreditation Requirements Relating to Adverse Determinations

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

III. Effect of Proposed Changes:

Section 1. Provides a short title, the "Health Care Protection Act of 2000."

Sections 2.-9. & 56. Amend provisions relating to assessments against certain health care entities for the PMATF, annual reimbursement limits on hospital outpatient services under the MedAccess program and the Medicaid program, and cost-effective purchasing of health care by the Medicaid program.

Section 2. Amends s. 395.701(2), F.S., relating to annual assessments on hospital net operating revenues to fund public medical assistance, to maintain the current 1.5 percent of net operating

revenue on inpatient hospital services and reduce the annual PMATF assessment on outpatient hospital services to 1.0 percent of the annual net operating revenue.

Section 3. Amends s. 395.7015(2), F.S., relating to the annual assessment on the revenue of certain health care entities to fund public medical assistance, to reduce the assessment to 1.0 percent of the annual net operating revenues of affected health care entities to fund the PMATF.

Section 4. Amends s. 408.904 (2)(c), F.S., relating to benefits covered by the MedAccess program, to increase the annual reimbursement limit on certain hospital outpatient services for persons covered by the MedAccess program from $1,000 to $1,500 per calendar year per member.

Section 5. Amends s. 409.905(6), F.S., relating to mandatory Medicaid program services, to increase the annual reimbursement limit on hospital outpatient services for adults covered by the Medicaid program from $1,000 to $1,500 per state fiscal year per recipient.

Section 6. Amends s. 409.908(1)(a), F.S., relating to Medicaid program reimbursement of providers, to increase the Medicaid reimbursement limit for hospital outpatient services provided to covered adults from $1,000 to $1,500 per state fiscal year per recipient.

Section 7. Adds paragraph (e) to s. 409.912(3), F.S., relating to requirements for AHCA to make cost-effective purchasing of health care goods and services for Medicaid recipients, to authorize AHCA to contract with and to reimburse an entity located in Pasco County or Pinellas County that provides in-home physician services to Medicaid recipients with degenerative neurological diseases to test the cost-effectiveness of enhanced home-based medical care. This provision expires on July 1, 2002.

Section 8. Creates an undesignated section to direct the Legislature to appropriate each fiscal year an unspecified, but sufficient, amount from the General Revenue Fund to the PMATF to replace the funds lost due to the reduction by this act in the assessment on hospitals under s. 395.701, F.S., and other health care entities as provided under s. 395.7015, F.S., and to maintain federal approval of the reduced amount of funds deposited into the PMATF as state matching funds for the Medicaid program. The section provides an appropriation in an unspecified amount from the General Revenue Fund to the PMATF to provide for the increased reimbursement to hospitals for hospital outpatient care.

Section 9. Creates an undesignated section to appropriate $28.3 million from the General Revenue Fund to AHCA to fund the fiscal year 2000-2001 reduction in assessments deposited into the PMATF. The reduction in PMATF revenue is a result of the decreased assessment rates to be imposed on the annual net operating revenues of hospitals and other health care entities, as provided for elsewhere in the bill. This appropriation may be reduced by an amount equal to any similar appropriation for the same purpose which is contained in other legislation adopted during the 2000 legislative session and which becomes a law.

Section 56. Provides an effective date of July 1, 2000, except that the amendment to s. 395.701, F.S., by the bill shall take effect only upon the receipt by AHCA of written confirmation from the

Health Care Financing Administration that the changes contained in the amendment will not adversely affect the use of the remaining assessments as state match for the Medicaid program.

Sections 10-26. Amend provisions relating to the Certificate-Of-Need (CON) program.

Section 10. Amends s. 400.471, F.S., providing for licensure of home health agencies, to delete the requirement that a CON be obtained as a prerequisite to licensure as a Medicare-certified home health agency.

Section 11. Amends s. 408.032, F.S., providing definitions used in CON regulatory law, to: add a definition of the terms "exemption" and "mental health services;" modify the definition of the terms "health care facility" and "health services;" and delete the terms "home health agency," "institutional health service," "intermediate care facility," "multifacility project," and "respite care."

Section 12. Amends s. 408.033, F.S., relating to local and state health planning, to delete references to the state health plan.

Section 13. Amends s. 408.034, F.S., providing AHCA's duties and responsibilities pertaining to CON regulation, to delete a cross reference to part IV of chapter 400, F.S., relating to licensure regulation of home health agencies, and to acknowledge exemption under CON regulation as a valid basis for the issuance of a license to certain health care facilities and health service providers.

Section 14. Amends s. 408.035, F.S., providing review criteria for the CON program, to delete obsolete CON review criteria and revise other criteria, generally simplifying the review of CON applications.

Section 15. Amends s. 408.036, F.S., relating to projects subject to CON review, to revise the requirements relating to projects that are--

- subject to CON *comparative review* by: (a) deleting language relating to nursing home conversions, (b) restricting reviewability of increases in licensed bed capacity to increases in the *total licensed bed capacity* of a health care facility, (c) deleting review of the establishment of a Medicare-certified home health agency, (d) adding a reference to *hospice inpatient facilities* and providing a cross reference to s. 408.043, F.S., relating to special provisions for hospice applications, (e) deleting a requirement for a health care facility or an HMO to obtain a CON to operate a Medicare-certified home health agency or a hospice, (f) deleting the requirement for a CON for certain acquisitions by or on behalf of a health care facility or HMO, (g) deleting a requirement for review of an acquisition of existing health care facilities under certain conditions, (h) deleting reviewability of certain CON-approved project cost increases, and (i) adding a list of beds and services that are subject to CON review before an increase in the number of beds may be implemented;

- subject to CON *expedited review* by: (a) deleting certain cost overruns, (b) deleting combination of nursing home beds or services authorized by two or more CONs issued for the same planning subdistrict, (c) deleting division into two or more nursing home facilities of beds or services authorized by one CON, (d) adding conversion of mental health services

beds, licensed under chapter 395, F.S., the hospital licensure law, or hospital-based distinct part skilled nursing unit beds to general acute care beds and the conversion of mental health services beds between or among the licensed bed categories defined as beds for mental health services or the conversion of general acute care beds to beds for mental health services, subject to the caveat that such conversions will not result in establishing a new bed category at the hospital but will apply only to categories of beds licensed at that hospital and subject to the requirement that applicants must license and operate such converted beds for 12 months before they will attain eligibility to apply for conversion of more beds of the same type, and (e) authorizing AHCA to reduce application content requirements for an expedited review; and

- *exempt* from CON review by: (a) revising language and deleting obsolete language; (b) deleting initiation or expansion of obstetric services; (c) deleting respite care services; (d) deleting home health services provided by a rural hospital; (e) deleting establishment of a Medicare-certified home health agency by a continuing care retirement community or a residential facility that serves only retired military personnel, the dependents, and the surviving dependents of deceased military personnel; (f) deleting language making the exemption of Medicare-certified home health agencies contingent upon the development of certain factors; (g) deleting expenditures by or on behalf of a health care facility to provide a health service exclusively on a outpatient basis; (h) revising language relating to delicensure of beds to replace a reference to *bed classification* with a reference to *category of beds*; (i) deleting obsolete language that prohibited the grant of a CON exemption until rules have been adopted or March 1, 1998, whichever came first; (j) adding the combination within one nursing home facility of the beds or services authorized by two or more CONs issued within the same planning subdistrict; (k) adding the division into two or more nursing home facilities of beds or services authorized by one CON issued in the same planning district; (l) adding the addition of a limited number of hospital beds, except for beds for tertiary services, under certain circumstances, including temporary beds to alleviate high seasonal occupancy or emergency situations; and (m) adding the addition of a limited number of community nursing home beds under certain circumstances.

The bill specifies that a request for exemption may be made at any time and is not subject to the batching requirements for CON comparative review. A request for exemption must be supported by documentation required by rules adopted by AHCA. The agency is directed to assess a $250 fee for each exemption request. Other technical and conforming changes to existing law are made.

Section 16. Amends s. 408.037, F.S., providing requirements for the contents of a CON application, to delete a reference to the state health plan.

Section 17. Amends s. 408.038, F.S., providing for CON application fees, to make conforming changes to existing law by replacing references to *department* with *agency*.

Section 18. Amends s. 408.039, F.S., relating to the CON review process, to make conforming changes to existing law by replacing references to *department* with *agency*.

Section 19. Amends s. 408.040, F.S., providing for conditions on a CON and AHCA compliance monitoring of such conditions, to require that any conditions imposed on a CON appear on the

face of the CON when such conditions are based on statements of intent by an applicant in the application for the CON. Language is deleted that: (1) requires a CON for the construction of a new hospital or for the addition of beds to include a statement of the number of beds approved by category of service, (2) specifies the designation of approved beds as general beds that are not covered by any specialty-bed need methodology, (3) refers to a multifacility project to conform to changes made elsewhere in the bill that delete similar references, and (4) provides guidelines for determining the validity period of a CON for which an application has been filed to divide the CON to cover two or more facilities or consolidate two or more CONs. Other technical and conforming changes to existing law are made.

Section 20. Amends s. 408.044, F.S., authorizing injunctive action or other process by AHCA to restrain or prevent anyone pursuing a project that is subject to CON regulation who has not obtained a valid CON, to change the reference to *department* to *agency.*

Section 21. Amends s. 408.045, F.S., providing for a competitive sealed process relating to award of certain CONs, to make conforming changes to existing law by replacing references to *department* with *agency*.

Section 22. Creates a 30-member workgroup to study issues pertaining to the CON program, including the impact of trends in health care delivery and financing and implementation of the program. The Governor, President of the Senate, and the Speaker of the House of Representatives are each required to appoint 10 members to the workgroup as specified. The workgroup will be staffed by AHCA. It must select a chairperson by majority vote of a quorum (16 members) present, and is required to meet at least annually, at the request of the chairperson. Workgroup participants are made responsible for only the expenses that they generate individually through workgroup participation. The agency is made responsible for incidental expenses relating to production of required data or reports. The workgroup is required to submit an interim report by December 31, 2001, and a final report by December 31, 2002. The workgroup is abolished effective July 1, 2003.

Section 23. Amends s. 651.118, F.S., relating to sheltered community nursing home beds in continuing care facilities, to exclude up to five sheltered community nursing home beds designated for inpatient hospice care as a part of a contractual arrangement with a Florida-licensed hospice from the limitation, of up to 5 years after the issuance of the initial nursing home license, on the use of such sheltered beds for persons who are not residents of such a facility and who are not parties to a continuing care contract.

Section 24. Repeals subsection 400.464(3), F.S., requiring a CON as a prerequisite to licensure as a home health agency.

Section 25. Preserves the applicability, to a CON application, of the CON law in effect at the time the application was submitted when the application was submitted prior to the effective date of the bill and clarifies that such CON law governs such applications.

Section 26. Reduces the General Appropriations Act for FY 2000-2001 by 4 FT and $260,719 from the Health Care Trust Fund in AHCA to reflect savings resulting from sections 10 through 25 of the bill.

Sections 27-28. Create the Mandated Health Insurance Benefits and Providers Estimating Conference and amend existing provisions relating reports on proposed mandated health insurance benefits.

Section 27. Amends s. 216.136, F.S. to create the Mandated Health Insurance Benefits and Providers Estimating Conference, specify the duties of the conference, establish the relationship between legislative committees and the conference for purposes of analyzing legislative proposals to mandate benefits, and specify the principals of the conference.

Section 28. Amends s. 624.215, F.S., relating to proposals for legislation which mandates health benefit coverage, to specify that required reports be submitted to the Mandated Health Insurance Benefits and Providers Estimating Conference, rather than to AHCA and the legislative committees having jurisdiction, and to require a certified actuary to prepare portions of the required report. Legislative committees are prevented from considering a proposal that would mandate a health insurance benefit until the committee receives a report from the Mandated Health Insurance Benefits and Providers Estimating Conference.

Section 29. Creates a requirement, effective January 1, 2001, that medical and osteopathic physicians and hospitals provide a consumer-assistance notice to each person to whom medical services are being provided. The contents of the notice and the manner in which the notice is to be provided to patients is specified. The Agency for Health Care Administration is required to establish a consumer-assistance program.

Sections 30-41. Repeal the laws that establish CHPAs and authorize a health insurer to issue a group policy to a small employer health alliance organized as a not-for-profit corporation under chapter 617, F.S.

Section 30. Amends s. 408.7056, F.S., relating to the Statewide Provider and Subscriber Assistance Program, to move the definitions of the terms "agency," "department," "grievance," and "health care provider" or "provider" from s. 408.701, F.S. Currently, s. 408.701, F.S., contains definitions that are applicable to ss. 408.70-408.706, F.S. This is a conforming change to the repeal of s. 408.701 in section 40 of the bill. No changes are made to the definitions.

Section 31. Amends s. 627.654, F.S., relating to labor union and association groups, to add small employer health alliances. Currently, part VII of chapter 627, F.S., establishes requirements for each of the types of groups to which 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. Currently, s. 627.654, F.S., authorizes a group policy to be issued to an association, including a labor union, which has a constitution and bylaws, at least 25 members, *and which has been organized and maintained in good faith for a period of 1 year for purposes other than that of obtaining insurance*.

This section authorizes a new type of association policy, to be issued to a small employer health alliance (alliance) that is organized as a not-for-profit corporation under chapter 617, F.S. The alliance, itself, may be formed for purposes of obtaining insurance because there is no requirement otherwise (as there is for the current association group). But, the alliance must establish conditions of participation in the alliance by a small employer, including assurance that the small

employer is not formed for the purpose of securing health benefit coverage, and that the employees have not been added for the purpose of securing health benefit coverage.

The group policy issued to the alliance may insure a small employer, as defined in s. 627.6699, F.S., which is an employer with 1 to 50 employees, including sole proprietors and self-employed individuals. The policy may cover the employer's eligible employees and the spouses and dependents of such employees. If a small employer expands to more than 50 and less than 75 eligible employees, the small employer may purchase renewal coverage for not more than one additional year. A policy issued to an alliance must allow all small employer members of the alliance, or all of any class, to be eligible and acceptable to the insurer at the time of issuance of the policy.

The current law allows policies issued to labor union or association groups to insure the spouse or dependent children without the member being insured. (An insurer may allow this, but is not required to do so.) The current law is maintained, but not extended to a small employer alliance policy.

This section allows a single master policy issued to an association, labor union, or small employer health alliance to include more than one health plan from the same insurer or affiliated insurer group, as alternatives for an employer, employee, or member to select.

Section 32. Amends s. 627.6571, F.S., relating to guaranteed renewability of coverage. Currently, 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*, the insurer may discontinue coverage for an employer if its membership in the association ceases. *Bona fide association* is defined as including a requirement that the association be formed for purposes other than obtaining insurance. Since a small employer health alliance may be formed for the purpose of obtaining insurance, it would not meet the definition of a bona fide association. The bill provides a similar exception to the guaranteed-renewability requirements, by allowing an insurer to discontinue coverage for a small employer whose membership in the alliance ceases. Other similar changes are made in this section to apply the same requirements to an insurer relative to an alliance, as currently apply to the insurer relative to a bona fide association.

Section 33. Amends s. 627.6699, F.S., the Employee Health Care Access Act. This is the current law that applies to all health insurance plans that are sold to a small employer, with 1 to 50 employees, including sole proprietors and self-employed individuals. The current law 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 condition 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 five factors: age, gender, geographic location, tobacco usage, and family composition (size). The changes in this section are conforming changes to reflect the repeal of CHPAs in section 40 of the bill.

Section 41 - subsection (6) of s. 627.6699, F.S. This section does not specifically address whether the modified community rating provisions of s. 627.6699, F.S., would apply to a group policy

issued to an alliance. However, these small group rating provisions would apply, due to current s. 627.6699(4), F.S., which states that the section "applies to a health benefit plan that provides coverage to a small employer in this state, unless the policy is marketed directly to the individual employee, and the employer does not participate in the collection or distribution of premiums or facilitate the administration of the policy in any manner." Also, s. 627.6699(6)(d), F.S., provides that the section applies "to any health benefit plan provided by a small employer carrier that provides coverage to one or more employees of a small employer regardless of where the policy, certificate, or contract is issued or delivered, if the health benefit plan covers employees or their covered dependents who are residents of this state."

This section makes three changes to the rates that may be charged for small group policies, which would apply to small group policies sold to an association or alliance. First, it provides an additional factor that may be utilized in establishing rates, similar to a current rule adopted by the Department of Insurance. The section allows rates for a policy issued to a group association or alliance that reflect a premium credit for expense savings attributable to administrative activities being performed by the association or alliance, if these savings are specifically documented in the carrier's rate filing and are approved by the department. Any such credit may not be based on any factor related to the health status of the group. The section clarifies that these provisions do not exempt an alliance or association from licensure for any activities which require licensure under the Insurance Code.

The second change is an exception to the prohibition against small group carriers modifying the rates for a small employer for 12 months from the initial issue date or renewal date, unless the composition of the group changes or benefits are changed. This section would allow an insurer to modify the rate one time prior to 12 months after the initial issue date for a small employer who enrolls under a previously issued group policy that has a common anniversary date for all employers. This is intended to allow for master policies to be issued to an association or alliance that has a common anniversary date, but which allows small employers to enroll during the year. The insurer would be required to disclose in a clear and conspicuous manner the date of the first renewal and the fact that the premium may increase on that date. The insurer would also be required to demonstrate to the department that efficiencies in administration are achieved and reflected in the rates.

The third change is to delete the current provision that allows small group carriers who participate in CHPAs to apply a different community rate to business written in that program. This is a conforming change to the repeal of the CHPAs in section 40 of the bill. It is also worth noting that this provision is not retained and applied to the small employer health alliance or any other association group. This allowance to separately pool the experience of CHPA enrollees, apart from the carrier's other small group business, can result in either better or worse experience and, therefore, lower or higher rates, respectively, than for the carrier's small employer policies issued outside of CHPAs. This section would not allow such separate pooling for policies issued to an alliance or association. The insurer would be required to pool all of its small group business for rating purposes, both inside and outside of alliances and associations.

This section also requires a carrier issuing a group health insurance policy to a small employer health alliance or other group association to allow any of its licensed and appointed agents to sell

that policy and to pay such agent the insurer's usual and customary commission paid to any agent selling the policy.

Sections 34 through 39. Amend ss. 240.2995, F.S., relating to university health services support organizations; 240.2996, F.S., providing for confidentiality of information held by university health services support organizations; 240.512, F.S., establishing the H. Lee Moffitt Cancer Center and Research Institute; 381.0406, F.S., providing for rural health networks; 395.3035, F.S., relating to confidentiality of certain hospital records and meetings; and 627.4301, F.S., relating to genetic information for insurance purposes. All of these sections are amended to delete cross-references to sections that are repealed by section 40 of the bill. The cross-reference is either to the definition of *managed care* contained in s. 408.701, F.S., or to an *accountable health partnership* as provided in s. 408.706, F.S.

Additionally, ss. 240.2996, 240.512, and 395.3035, F.S., providing for exemptions from the public records laws, are amended to add a definition of *managed care*, which is the same definition that is currently incorporated by cross-reference to s. 408.701, F.S., which is repealed by section 40 of the bill.

Section 40. Repeals ss. 408.70(3), 408.701, 408.702, 408.703, 408.704, 408.7041, 408.7042, 408.7045, 408.7055, and 408.706, F.S., establishing and relating to CHPAs and Accountable Health Partnerships (AHPs). The legislative authority and requirements for the operations of the CHPAs, AHPs, and regulation of such entities by the Agency for Health Care Administration, would be repealed. The bill does not repeal subsections 408.70(1)-(2), which provide legislative findings related to the current health care system and legislative intent that a structured health care competition model, known as "managed competition," be implemented throughout the state to improve the efficiency of the health care market. Also, the bill does not repeal s. 408.7056, F.S., relating to the Statewide Provider and Subscriber Assistance Program.

As not-for-profit corporations formed under chapter 617, the current CHPAs would be authorized to continue to operate in that status, pursuant to their constitution and bylaws and the provisions of chapter 617, F.S. As not-for-profit corporations with members who are small employers, these alliances would be authorized by section 31 of the bill to be issued a group health insurance policy insuring its small employer members.

Section 41. Amends s. 627.6699 F.S., the Employee Health Care Access Act, to make the following changes. The provisions in subsection (6) relating to small employer health alliances are described above.

- *Basing Rates on Health Factors* -- This section eliminates the prohibition that rates for small employers not be based on the health status or claims experience of any individual or group and allows limited use of such factors. Small group carriers would be allowed to adjust a small employer's rate by plus or minus 15 percent, based on health status, claims experience, or duration of coverage. The renewal premium could be adjusted up to 10 percent annually (up to the total 15 percent limit) of the carrier's approved rate, based on these additional factors. Any adjustments in rates for claims experience or health status may not be charged to individual employees or dependents, but would be averaged over all of the employees of a particular small employer. For example, if the carrier's approved rate is $500 per month, the

carrier would be permitted to charge from $425 to $575 per month, based on health status factors.

The section requires small employer carriers to report information to the department on a semiannual basis, to enable the department to monitor the relationship of aggregate adjusted premiums actually charged policyholders by each carrier to the premiums that would have been charged by application of the approved rate. If the aggregate actual premium exceeds the premium that would have been charged under the approved rate by more than 5 percent, the carrier must use only *minus* adjustments (credits), beginning not more than 60 days after the report is sent to the department. For any subsequent reporting period, if the total aggregate premium actually charged does not exceed the premium that would have been charged under the approved rate by more than 5 percent, the carrier may apply both plus and minus adjustments.

- *One-month Open Enrollment for One-Life Groups* -- This section excludes from the law's guaranteed-issue requirements employers with one employee, sole proprietors, and self-employed individuals. However, such individuals who are insured on July 1, 2000, would continue to be covered by the law's requirements that such polices be guaranteed-renewable. For employers with one employee, sole proprietors, and self-employed individuals, small employer carriers would be required to provide an annual open enrollment period during the month of August in each year. Coverage would begin on the following October 1, unless the insurer and the policyholder agree to a different date. Any such one-person small employer must not be formed primarily for the purposes of buying health insurance. If an individual hires his or her spouse and dependent children as employees, the entire family unit would be considered a one-person group, if the individual or his or her spouse has a normal work week of less than 25 hours. In other words, if both spouses are working full time, they would be counted as a two-person group.

  Since the federal HIPAA law definition of small employer covers 2 to 50 employees, this change does not affect Florida's compliance with the federal law. However, the criteria that the one-person small employer not be formed primarily for the purposes of buying health insurance may result in factual disputes, in the event of a carrier's denial of coverage based on such criteria, that will require departmental or judicial intervention to resolve.

- *Credit for Administrative Cost Savings* -- This section adds another rating factor that small group carriers may use, to provide a credit to reflect the administrative and acquisition expense savings resulting from the size of the group. In general, a carrier has higher administrative and acquisition costs for smaller size employers, although many carriers have reduced commissions for groups below a certain number of employers (a practice that the department has attempted to restrict as an unfair practice under s. 627.6699, F.S.). The section would allow the carrier to use this rating factor as a credit, based on its experience, subject to department approval. Industry sources state that this factor may result in a rate credit (differential) of between 3 to 5 percent for the larger groups, for example employers with 25 to 50 employees. This is also likely to result in an overall cost increase to the smaller size employers.

- *Composite Rating Prohibited* -- This section prohibits small group carriers from using a *composite rating methodology* for employers with fewer than 10 employees. This term is defined in the bill as averaging the impact of the rating factors for age and gender. Currently, the use of composite rating by a small group carrier is optional, under which the carrier sends a premium statement to the employer that lists the same (averaged) premium for all the employees. The section would *prohibit* composite rating for employers with fewer than 10 employees. Therefore, the premium statement sent to a small employer would be required to list the premium charged for each employee based on that employee's age and gender. In either case, the total premium billed to the employer is the same and it would appear to be within the discretion of the employer as to whether the premiums billed to each employee are equal (averaged) or would differ based on that employee's age and gender.

- *Family Size Rating Categories* -- This section specifies certain family-size categories that a small group carrier may use. The current law allows carriers to base rates on family size, but does not specifically limit the type or number of categories. However, the department has imposed certain restrictions in this regard, requiring that a carrier have only one category for dependent children, regardless of the number of dependent children. This section would specifically allow a small group carrier to have three categories for: one dependent child, two dependent children, and three or more dependent children, and further categorized for employees having a spouse and dependent children or employees having dependent children only. This section allows a carrier to use *fewer* rating categories for dependent children, but not a *greater* number of categories.

- *Clarification of Other Applicable Rating Laws* -- This section clarifies the applicability of additional rate filing procedures and standards for insurers and HMOs, respectively. It clarifies that the additional rating law procedures of ss. 627.410 and 627.411, F.S., apply to health insurance companies and that the rating law procedures of s. 641.31, F.S., apply to HMOs that sell small employer coverage.

Sections 42-44. Amend provisions relating to regulation of HMOs by the Department of Insurance.

Section 42. Amends s. 641.27, F.S., applying to departmental examinations, to specify that the payment must be made directly to the contracted examiner by the HMO in accordance with the rates and terms agreed to by the department and the examiner. Currently, the department may contract with qualified, impartial outside parties to perform audits or examinations of HMOs and the HMOs in turn pay the department which then compensates the outside party. This amendment streamlines this process by having the HMO pay the contracted examiner directly.

Section 43. Creates a new section which conforms state law to federal law by providing that the federal solvency requirements apply to an HMO that meets the federal definition of a "provider-sponsored organization," instead of the solvency requirements of ch. 641, F.S. This provision clarifies that such organizations may obtain an HMO certificate of authority in Florida, even if the state solvency requirements are not met. But, if the state solvency requirements are not met, the organization may only issue the Medicare+Choice contracts authorized by federal law.

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

Section 44. Creates a new section which makes applicable to HMOs the current holding company requirements that apply to insurance companies, which primarily require reporting certain information to the department. Currently, under Part IV of chapter 628, F.S., insurers that are members of an insurance holding company must register with the department and be subject to regulation with respect to their relationship with such holding company. The department has promulgated rules specifying reporting and other requirements and this amendment would apply these holding company provisions to HMOs.

Section 45. Creates s. 641.275, F.S., relating to subscriber's rights under a health maintenance contract. This section provides that it is the intent of the Legislature that the rights of subscribers who are covered under HMO contracts be recognized and summarized in a statement of subscriber rights, which this section provides. The section effectively re-states current law by stating that an HMO is prohibited from requiring a subscriber to waive his or her rights as a condition of coverage or treatment and must operate in conformity with such rights. The section requires each HMO to provide subscribers with a copy of their rights as set forth in this section in such form as approved by the department.

The 20 rights of HMO subscribers specified in this section are a summary of existing statutory requirements for HMOs. The section states that it provides a summary of selected statutory requirements for HMOs and does not alter the requirements of the cited statutory provisions. The Department of Insurance and the Agency for Health Care Administration are authorized to impose fines against an HMO for violations of these rights.

Sections 46-51. Provide for civil liability for HMOs.

Section 46. Amends s. 641.28, F.S., providing for award of attorney's fees in civil actions against HMOs. This section provides that if a civil action is filed against an HMO before or within 60 days after the subscriber or enrollee filed a notice of intent to sue with the Statewide Provider and Subscriber Assistance Program, pursuant to s. 408.7056, F.S., or a notice pursuant to s. 641.3917 (the new civil remedy created by section 48 of this bill), the *prevailing party* is entitled to reasonable attorney's fees and court costs. (Under current law, the prevailing party is entitled to reasonable attorney's fees in all cases.)

If, however, the civil action is filed later than 60 days after the subscriber or enrollee filed a notice pursuant to the cited sections, and the subscriber or enrollee prevails against the HMO, the court must award the subscriber or enrollee reasonable attorney's fees and court costs. (There would not be an award of attorney's fees to the prevailing HMO in the latter situation, as there would be under current law.)

Section 47. Amends s. 641.3903, F.S., relating to unfair methods of competition and unfair or deceptive acts or practices ("unfair trade practices"). This section adds to the list of prohibited unfair trade practices for an HMO, all of which are currently prohibited unfair trade practices for insurers in s. 626.9541, F.S.

Subsection (10) of s. 641.3903, F.S., is amended, relating to illegal dealings in premiums. This section would prohibit an HMO from terminating any HMO contract or coverage, or requiring consent to a rate increase, during the contract term for the purpose of offering to issue a similar contract with the same exposure at a higher premium rate or continuing an existing contract with the same exposure at an increased premium.

The section would also prohibit an HMO from issuing a nonrenewal notice or requiring consent to a rate increase, for the purpose of offering to issue a similar contract at a higher premium rate or continuing an existing contract at an increased premium without meeting any applicable notice requirements.

The section would prohibit an HMO from canceling or issuing a nonrenewal notice on any HMO contract unless the HMO complies with any applicable cancellation or nonrenewal provision required under the Florida Insurance Code.

Subsection (15) is added relating to refusal to cover. This provision precludes HMOs from refusing to cover individuals solely because of race, color, creed, marital status, sex, or national origin. It also precludes denial of coverage on the bases of residence, age, or lawful occupation of the individual, unless there is a reasonable relationship between the residence, age, or lawful occupation of the individual and the coverage issued or to be issued, or based on the fact that the enrollee or applicant had been previously refused insurance coverage or health maintenance organization coverage when the refusal to cover or continue coverage for this reason occurs with such frequency as to indicate a general business practice.

A violation of any of the provisions contained in the new subsections (10) and (15), as provided in this section of the bill, would give rise to a civil remedy cause of action, as specified in section 48 of the bill.

Section 48. Amends s. 641.3917, F.S., providing for HMO civil liability, to create a civil cause of action against HMOs. Any person to whom a duty is owed may bring a civil action against an HMO when the person suffers damages as a result of:

--the failure by the HMO to provide a covered service when in good faith the HMO should have done so had it acted fairly and honestly toward its subscriber or enrollee and with due regard for his or her interests *and*, in the independent medical judgment of a contract treating physician or other physician authorized by the HMO, the service is medically necessary; or

--a violation of s. 641.3903(5)(a), (b), (c)1.-7., (10) or (15), F.S., by the HMO.

The cited sections, above, are the unfair trade practices prohibited by the bill in section 47, summarized above, plus the unfair trade practices for HMOs in current law which are summarized below:

--attempting to settle claims on the basis of a document which was altered without the knowledge or consent of the subscriber [s. 641.3903 (5)(a), F.S.];

--making a material misrepresentation to the subscriber for the purpose of effecting settlement of claims on less favorable terms than those provided in the contract [s. 641.3903 (5)(b), F.S.];

--committing with such frequency as to indicate a general business practice any of the following: (1) failing to adopt and implement standards for the proper investigation of claims; (2) misrepresenting pertinent facts or contract provisions; (3) failing to acknowledge and act promptly upon communications with respect to claims; (4) denying claims without conducting reasonable investigations; (5) failing to affirm or deny coverage of claims within a reasonable time not to exceed 30 days after claims has been completed and documents pertinent to the claims have been requested in a timely manner and received by the HMO; (6) failing to promptly provide a reasonable explanation, in writing, to the subscriber of the basis, in the HMO contract, in relation to the facts or law for denial of a claim; (7) failing to provide, upon written request of a subscriber, itemized statements verifying that services and supplies were furnished where such statement is necessary for the submission of other insurance claims. [s. 641.3903(5)(c)1.- 7., F.S.] (See comments, below, regarding the bill's specific provision that a person pursuing a civil action under this section does *not* have to prove the acts were committed or performed with such frequency as to indicate a general business practice.)

However, this section specifies a significant exception:

This section shall not be construed to . . . create a cause of action when a health maintenance organization refuses to pay a claim for reimbursement on the grounds that the charge for a service was unreasonably high or that the service provided was not medically necessary. [s. 641.3917(5), F.S., as amended]

This raises a question as to the effect or purpose of the condition [in s. 641.3917(1)(b), F.S.] that the service be medically necessary in the independent medical judgment of a physician authorized by the HMO, in order to pursue an action for an HMO's failure to provide a covered service when in good faith the HMO should have done so had it acted fairly and honestly toward its subscriber and with due regard for his or her interests. One possible interpretation is that the bill does *not* create a cause of action for a service that has *been provided* if the HMO refuses to pay on the grounds that the service provided was not medically necessary, *but* that a cause of action may be pursued for a service that has *not yet been provided* due to an HMO refusing to authorize the service (and the other conditions of the statute are met for pursuing the action), regardless of the HMO's determination that the service is not medically necessary. This interpretation, if followed, would have a different result for HMOs as compared to the civil remedy statute applicable to insurers in s. 624.155, F.S. Although both statutes would have the same language stating that the statute does not create a cause of action if the insurer or HMO refuses to pay for a service on the grounds that the service was not medically necessary, HMOs would be exposed to potential liability for *refusing to authorize* a service that has not yet been performed. But, this distinction would be due to the contractual right of an HMO to require prior authorization of services.

A person pursuing a civil action under this section does not have to prove the acts were committed or performed with such frequency as to indicate a general business practice. This

specific provision would apparently control over the general provision in the unfair trade practice statutes that are cross-referenced [s. 641.3903(5)(c)1.- 7., F.S.], which require that the actions be committed with such frequency as to indicate a general business practice in order to be deemed a violation (that would authorize the department to seek administrative sanctions).

The plaintiff must give 60-days written notice of the violation to the HMO and to DOI. The department may return the notice for lack of specificity. This section requires the department to prepare a form for notice that includes the provision of the law the HMO allegedly violated, the facts and circumstances giving rise to the violation, and certain other information. If the damages alleged are paid or the circumstances giving rise to the situation are corrected within 60 days of the notice, the cause of action shall be extinguished.

The HMO is liable for the plaintiff's damages, court costs, and attorney's fees upon adverse adjudication at trial or upon appeal. Punitive damages shall not be awarded unless the acts giving rise to a violation occur with such frequency as to indicate a general business practice and are willful, wanton, and malicious or are in reckless disregard of the subscriber's rights. A person who sues for punitive damages must post, in advance, a sum for discovery costs. Thereafter, if no punitive damages are awarded, the costs are awarded to the HMO.

This section specifies that it does not authorize a class action suit against an HMO or a civil action against DOI or AHCA.

This section does not preempt any other remedy. Any person may obtain a judgment under either the common law remedy of bad faith or the remedy provided in this section, but is not entitled to a judgment under both remedies. Damages must be a reasonably foreseeable result of a specified violation of this section by the HMO and may include an award or judgment in an amount that exceeds contract limits.

This section provides that it does not create a cause of action for medical malpractice. Also, this section does not apply to the provisions of medical care, treatment, or attendance pursuant to chapter 440, F.S., (the workers' compensation law).

Section 49. Amends s. 440.11, F.S., providing for exclusiveness of liability under the worker's compensation law. The bill provides that the liability of an HMO to an employee or to anyone entitled to bring suit in the name of the employee under the workers' compensation law shall be exclusive and in place of all other liability, notwithstanding the provisions of s. 641.3917, F.S., (the civil remedy statute created by section 48 of the bill). This is consistent with how the current law deals with liability of insurers under the insurer civil remedy statute, s. 624.155, F.S.

Section 50. Provides an explicit legislative finding that the provisions of this bill will fulfill an important state interest.

Section 51. Provides an appropriation of $112,000 from the Insurance Commissioner's Regulatory Trust Fund to the Department of Insurance and three positions to implement sections 46 through 49 of the bill.

Sections 52-54. Amend various HMO contract provisions to prohibit the mandatory use of "hospitalists" by HMOs.

Section 52. Amends s. 641.31, F.S., relating to HMO contracts, to add a new subsection (39) to prohibit an HMO contract from prohibiting or restricting a subscriber from receiving in-patient services in a contracted hospital from a contracted primary care or admitting physician, if such services are determined by the organization to be medically necessary and covered services under the organization's contract with the contract holder.

Section 53. Amends s. 641.315, F.S., relating to HMO provider contracts, to add a new subsection (11) to prohibit 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, if such services are determined by the organization to be medically necessary and covered services under the organization's contract with the contract holder.

Section 54. Amends s. 641.3155, F.S., relating to HMO provider contracts and payment of claims, to add a new subsection (5) to require 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, if such services are determined by the organization to be medically necessary and covered services under the organization's contract with the contract holder.

Section 55. Amends s. 641.51, F.S., relating to quality assurance program and second medical opinion requirements for HMOs. This section requires HMOs to ensure that only a medical or osteopathic physician licensed in Florida or who has an active, unencumbered license in another state with similar licensing requirements, may render an adverse determination regarding services provided by a Florida-licensed physician.

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

Section 56. Provides an effective date of July 1, 2000, and provides that the bill is applicable to contracts issued or renewed on or after that date, except as otherwise provided in the act. A contingent effective date is provided for the amendment to s. 395.701, F.S., contained in section 2 of the bill.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

Article VII, s. 18, Florida Constitution, requires that no county or municipality shall be bound by any general law requiring such local government to spend funds or to take action requiring the expenditure of funds unless the Legislature has formally determined that such law fulfills an important state interest and the law must pass by at least a 2/3 vote of the membership of each house of the Legislature.

To the extent that this bill mandates increases health insurance and health maintenance organization coverage costs, the bill may represent a mandate to counties and municipalities. Section 50 of the bill states that the Legislature finds that the provisions of this act will fulfill an important state interest.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Subsections 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

D. Other Constitutional Issues:

As pertains to sections 27 and 28 of the bill, containing provisions relating to the Mandated Health Insurance Benefits and Providers Estimating Conference, Article III, s. 4 of the *State Constitution*, provides that each *house* shall determine its rules of procedure. Further, as the Florida Supreme Court has ruled in a series of cases, one of which is *Neu v. Miami Herald Publishing Company*,[10] one legislative body cannot bind a future legislative body to an obligation. In *Neu*, which addressed the Public Meetings Law, the court stated " [a] legislature may not bind the hands of future legislatures by prohibiting amendments to statutory law."[11] Technically, the bill does not prohibit amendment to statutory law, but prohibits the *consideration of* a mandated health benefit proposal by the standing *committee* that has jurisdiction over the proposal prior to receipt of a report on the mandated benefit from the Mandated Health Insurance Benefits and Providers Estimating Conference. However, in that the bill attempts to limit the ability of future sessions of the Legislature to amend or create law related to mandated health insurance benefits prior to receiving the report, it would be ineffective. "The legislative power to deal with new situations as they

[10]462 So.2d 821 (Fla. 1985).

[11]*Ibid* at 824.

arise cannot thus be limited, even though their action expressly or impliedly repeals former legislative acts."[12]

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

Section 15. The Agency for Health Care Administration is required to assess a fee of $250 for each request for an exemption for projects already subject to this level of CON regulation and to add a limited number of hospital or nursing home beds as created under s. 408.036(3), F.S.

B. Private Sector Impact:

Sections 2-9. According to AHCA, the hospitals currently subject to the annual assessment will, in the aggregate, retain approximately $23,153,000 of net operating revenue that would have otherwise been collected and deposited in the PMATF. Hospital net operating revenues for inpatient services will remain subject to the 1.5 percent assessment. Net operating revenue retained by other health care entities ($1,165,667 by ambulatory surgical centers; $1,668,667 by diagnostic imaging centers; $2,332,333 by clinical laboratories) currently subject to the assessment will be approximately $5,166,667 based on the agency's estimates. The Agency for Health Care Administration estimates that a total of $28,319,667 in annual assessments on net operating revenue will not be collected and deposited in the PMATF under the provisions of the bill.

Sections 10-26. The repeal of comparative CON review under s. 408.036(1), F.S., for the affected projects will mean that instead of incurring application fees ranging from $5,000 to $22,000, applicants that are pursuing projects that will now be subject to CON exemption review will be required to submit an exemption request fee of $250. Applicants should obtain even more savings related to the other tangential and incidental costs of preparation of some CON applications. Such costs, reportedly, could reach into the hundreds of thousands of dollars. Additionally, the monetary costs of litigation can approach $5,000,000 along with extraordinary opportunity costs that could result in years of lost revenue, goodwill, brand development, and other business asset development as a consequence of impeded operation of the business or the service authorized by an awarded CON due to unresolved legal challenges.

Sections 30-40. Participation by insurers and small employers in CHPAs is declining, making it unlikely that all CHPAs will continue to be viable entities. Small employers would still be able to obtain coverage on a guaranteed-issue, modified community-rated basis outside of CHPAs, but most employers are experiencing significant rate increases. The bill is intended to more effectively pool groups of individuals employed by small employers (with 1 to 50 employees) and their dependents, into larger groups in order to facilitate a program of affordable group health insurance coverage. The bill does not provide any specific legal

[12] *Tamiami Trail Tours, Inc., et. al. v. Lee*, 194 So. 305 (Fla. 1940).

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 association, but the bill may provide an effective method of providing affordable group health insurance to small employers due to the following factors: the nonprofit nature of an alliance, the potential bargaining power generated by small employer participation, the allowance for one master policy to be issued to an alliance which may negotiate on behalf of its members, administrative cost savings that may be provided by the alliance, and the expertise of existing CHPA boards that may form an alliance.

The bill provides some degree of economic protection to insurance agents, by requiring a carrier issuing a group health insurance policy to an alliance or other group association to allow any of its licensed and appointed agents to sell that policy and to pay the agent the insurer's usual and customary commission paid to any agent selling the policy.

Section 41. The bill will result in higher rates for small employers with greater than average health claims costs and lower rates for small employers with less than average health claims costs, as compared to the rates that would be charged under the current law. It should be noted that allowing a 15 percent credit or surcharge results in about a 30 percent difference in the rates charged to one employer with the maximum credit, as compared to another employer with the maximum surcharge (who have identical characteristics other than health status, claims experience, or duration of coverage.)

Over the long-term, the effect on the total number of small employers who buy and maintain health insurance is likely to be neutral. For every employer who is able to afford coverage due to a premium credit, there is likely to be an employer who cannot afford the coverage due to a premium surcharge. The bill may impact an employer's hiring decisions, due to an employer's concerns about how the health status of employees will affect the employer's group health insurance premium.

The bill's limitation of guaranteed-issue for sole proprietors and self-employed individuals to an annual 31-day (August) open enrollment period may force persons with health problems to be uninsured until the open enrollment period. It may also reduce carriers' claims costs by limiting the effects of adverse selection, which could favorably impact rates for other small employer groups.

For employees who work for an employer with fewer than 10 employees, "composite rating" would be prohibited. This will not necessarily affect the premiums that are billed to each employee, because this appears to be within the discretion of the employer. However, it would enable the employer to charge each individual employee the rate associated with his or her age and gender. If this is the case, elderly and middle-age persons will be required to pay higher rates than younger employees which, in combination with an employer surcharge based on health status, could be significant.

Sections 46-51. Persons who suffer damages as a result of certain actions by HMOs will be entitled to recover actual damages and attorney's fees. HMO subscribers may also be more likely to have certain treatments and procedures authorized by HMOs due to the threat of liability.

The bill exposes health maintenance organizations to liability for certain actions. The costs of judgments or settlements of such lawsuits would result in higher premiums to policyholders. The threat of such lawsuits and potential liability may also result in a relaxation of cost containment measures utilized by HMOs and a greater allowance for policyholders and subscribers to obtain desired treatment, which would also increase costs and premiums. The threat of such costs may also reduce the number of managed care entities offering coverage in the state.

Sections 52-54. A health maintenance organization would be required to pay primary care physicians for their hospital-based services if such services are a part of the contract between the HMO and the primary care physician. These organizations may experience greater costs by not having the ability to utilize hospitalists to provide inpatient care, unless the primary care physician voluntarily agrees to such an arrangement.

Primary care physicians would be legally entitled to be remunerated by HMOs for providing hospital inpatient services.

Section 55. Any person who renders an adverse determination on behalf of a managed care organization must be a medical physician or osteopathic physician either licensed in Florida or in another state with similar licensing requirements. Any HMO that does not currently meet this requirement may incur additional costs in doing so. Also, the HMO would incur the costs of providing written notice to both the subscriber and the treating physician, including in the information required by the bill.

C. Government Sector Impact:

Sections 2-9. The Social Services Estimating Conference met on February 18, 2000, and adopted the following estimates for the PMATF for Fiscal Year 2000-2001:

PMATF
Estimates for Fiscal Year 2000-2001
(Source: Agency for Health Care Administration)

ESTIMATED REVENUES:	
Assessments on hospitals	$248,800,000
Assessments on other health care entities	15,500,000
Cigarette tax distribution to PMATF	113,500,000
Interest	2,700,000
Total Estimated Revenues	**$380,500,000**
ESTIMATED EXPENDITURES:	
Hospital Inpatient Services	$380,300,000
Administration	200,000

PMATF
Estimates for Fiscal Year 2000-2001
(Source: Agency for Health Care Administration)

Total Estimated Expenditures **$380,500,000**

The increase in the annual cap on hospital outpatient services from $1,000 to $1,500 will result in Medicaid reimbursement for hospital outpatient services to increase by an estimated $17,361,226 per year according to AHCA.

Section 9 of the bill contains an appropriation of $28.3 million from the General Revenue Fund to AHCA to replace the revenues lost due to the reduction of assessments on certain health care entities.

Sections 10-26. There is an estimated loss of $350,000 annually in CON fees and an estimated savings of $260,719 in expenditures in the Health Care Trust Fund by the elimination of 4 FTEs.

Agency for Health Care Administration	FY 2000-2001	FY 2001-2002
1. Recurring Revenues (loss of CON fees)	($350,000)	($350,000)
2. Expenditures (elimination of staff)		
Salaries and Benefits (4 FT)	($216,491)	($216,491)
Expenses (4 FT)	($44,228)	($44,228)
Total	($260,719)	($260,719)
NET (revenues minus expenditures)	($89,281)	($89,281)

Section 26 of the bill contains a reduction in the General Appropriations Act for Fiscal Year 2000-2001 of 4 FT and $260,719 from the Health Care Trust Fund in AHCA due to the provisions of sections 10-25 of the bill.

Sections 30-40. The Agency for Health Care Administration currently has 10 FTE employees assigned to the CHPA program, but all of these positions are deleted in the Governor's recommended budget and in both the current Senate and House budget bills, with a total reduction of $634,709 in salaries and expenses.

Section 41. The Department of Insurance may be required to expend additional resources reviewing and approving small group rate filings.

Sections 46-51. Section 51 appropriates three positions and $112,000 from the Insurance Commissioner's Regulatory Trust Fund to the Department of Insurance for the purposes of carrying out sections 46-49 of this act.

Sections 52-54. The Agency for Health Care Administration indicates that the provisions of these sections of the bill will have no fiscal impact on the agency.

The Division of State Group Insurance of the Department of Management Services indicates that the provisions of these sections of the bill will require the division to revise and renegotiate its current contracts with HMOs to explicitly prohibit any provision that restricts or prohibits a treating physician's ability to provide inpatient services to the provider's patients. (Currently, the division's HMO contracts are silent on this issue, making it clear that the relationship between the HMO and its providers are private, contractual matters to which the division is not a party.) The division also indicates that since there is no evidence of unmet needs in inpatient services under the State Group Insurance Program, the direct fiscal impact of this committee substitute is not expected to be significant. The Division of State Group Insurance also indicates that it will incur costs totaling $28,200 associated with a mail-out of additional member notification to all state group health insurance enrollees of benefit changes as a result of these changes.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.