**STORAGE NAME**: h3731.hcs
**DATE**: March 13, 1998

**HOUSE OF REPRESENTATIVES**
**COMMITTEE ON**
**HEALTH CARE SERVICES**
**BILL RESEARCH & ECONOMIC IMPACT STATEMENT**

**BILL #**: HB 3731

**RELATING TO**: Health Insurance

**SPONSOR(S)**: Rep. Byrd

**COMPANION BILL(S)**: SB 1752 (Similar)

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

(1) HEALTH CARE SERVICES
(2) HEALTH AND HUMAN SERVICES APPROPRIATIONS
(3)
(4)
(5)

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I. SUMMARY:

HB 3731 revises standards for the operation of prepaid limited health service organizations (PLHSOs) as follows. The bill:

- Requires a PLHSO which offers dental services to have a Florida licensed dentist as the dental director.
- Requires each PLHSO to make available to each subscriber, upon request, a detailed description of the process used to authorize and cover services, determine medically necessity, or examine qualifications and credentials of providers.
- Revises current law which specifies that a subscriber is not liable to any health care provider for services covered under the PLHSO contract, nor can a provider attempt to collect from a PLHSO subscriber. The bill limits this provision to providers under contract and in good standing with the PLHSO.
- Requires each PLHSO to establish a subscriber grievance process and specifies procedures and time frames for review of grievances.
- Prohibits health insurers which authorize treatment outside an exclusive panel of providers, from refusing to pay benefits to a provider solely because the provider is not under contract with the health insurer.

The fiscal impact of this legislation has not been determined.

II. SUBSTANTIVE RESEARCH:

A. PRESENT SITUATION:

Chapter 636, F.S., created by chapter 93-148, Laws of Florida, provides for the Department of Insurance (DOI or department) to license and regulate prepaid limited health service organizations. These organizations are similar to health maintenance organizations, but are limited to the provision of the following services: ambulance, dental care, vision care, mental health, substance abuse, chiropractic care, podiatric care, and pharmaceutical. Prepaid limited health service organizations may not offer inpatient or surgical hospital services or emergency services, except as such services are incidental to a limited health service. Through a PLHSO, subscribers receive services from providers such as physicians, dentists, health facilities, or other persons or institutions which are licensed in Florida to deliver limited health services, as defined in subsection 636.003(7), F.S.

As provided under s. 636.005, F.S., prepaid limited health service organizations must be incorporated, and they may be either a for-profit or not-for-profit corporation. Such an organization may be incorporated in a state other than Florida, if it maintains a certificate of authority or license in that state to provide the same services which it intends to provide in Florida at the time it applies for a certificate of authority from DOI. Section 636.006, F.S., prohibits PLHSOs from engaging in the insurance business.

Subsection 636.016(2), F.S., requires PLHSOs to provide each subscriber with a contract, certificate, membership card, or member handbook which must clearly state all of the services to which a subscriber is entitled under the contract and must include a clear and understandable statement regarding any limitations on the services or kinds of services to be provided. Section 636.018, F.S., provides for changes in rates and benefits, material modifications, and the addition of limited health services. Paragraph 636.018(1)(a), F.S., provides that a PLHSO contract, certificate of coverage, or application may not be delivered in Florida unless the forms and rates have been filed with DOI by or on behalf of the PLHSO and have been approved by the department. To change contract terms or any documents that are made part of the contract and provided to subscribers, a PLHSO must file a notice of the change with DOI at least 30 days prior to its effective date and provide at least 30 days' written notice to subscribers before implementing any approved change.

Section 636.035, F.S., expressly allocates financial liability to the PLHSO for services rendered to a PLHSO subscriber by a provider under contract with the PLHSO, and requires that such contracts state so explicitly. Under this provision a physician, dentist, health care institution, or other provider is prohibited from collecting or attempting to collect money for services covered by a PLHSO from a subscriber in good standing, except for copayments or deductibles. Section 636.038, F.S., requires every PLHSO to establish and maintain a complaint system providing reasonable procedures for resolving written complaints initiated by enrollees and providers. This section does not preclude an enrollee or a provider from filing a complaint with the department or limit the department's ability to investigate such complaints.

B. EFFECT OF PROPOSED CHANGES:

A PLHSO which offers dental services will be required to have a Florida licensed dentist as the dental director. PLHSO subscribers will have access to detailed information used by the organization to authorize and approve access to services. Also, subscribers will be liable for payment if the subscriber seeks care from a provider not under contract with the PLHSO. A comprehensive grievance process will be available to PLHSO subscribers. Providers not under contract with an insurance company may be reimbursed when serving patients who are subscribers with the insurance company.

C. APPLICATION OF PRINCIPLES:

1. Less Government:

a. Does the bill create, increase or reduce, either directly or indirectly:

(1) any authority to make rules or adjudicate disputes?

The Department of Insurance will be given additional authority to address grievances of PLHSO subscribers.

(2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

Yes, PLHSOs will have additional requirements relating to providing information to subscribers and addressing subscriber grievances.

(3) any entitlement to a government service or benefit?

No.

b. If an agency or program is eliminated or reduced:

(1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

N/A

(2) what is the cost of such responsibility at the new level/agency?

N/A

(3) how is the new agency accountable to the people governed?

N/A

2. Lower Taxes:

a. Does the bill increase anyone's taxes?

No.

b. Does the bill require or authorize an increase in any fees?

No.

c. Does the bill reduce total taxes, both rates and revenues?

No.

d. Does the bill reduce total fees, both rates and revenues?

No.

e. Does the bill authorize any fee or tax increase by any local government?

No.

3. Personal Responsibility:

a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

No.

b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

Yes, through premiums.

4. Individual Freedom:

a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs?

No.

b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

No.

5. Family Empowerment:

a. If the bill purports to provide services to families or children:

(1) Who evaluates the family's needs?

N/A

(2) Who makes the decisions?

N/A

(3) Are private alternatives permitted?

N/A

(4) Are families required to participate in a program?

N/A

(5) Are families penalized for not participating in a program?

N/A

b. Does the bill directly affect the legal rights and obligations between family members?

N/A

c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

(1) parents and guardians?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. STATUTE(S) AFFECTED:

ss. 636.003, 636.009, 636.016, 636.035, 636.038, 627.638, F.S.

E. SECTION-BY-SECTION RESEARCH:

**Section 1.** Amends s. 636.003, F.S., relating to definitions, to add a new definition for the term “adverse determination”.

**Section 2.** Amends s. 636.009(1)(m), F.S., relating to the issuance of a certificate of authority, to require that a PLHSO which offers dental services must have a dental director licensed under chapter 466, F.S.

**Section 3.** Amends s. 636.016, F.S., relating to PLHSO contracts, to require each PLHSO to make available to each subscriber, upon request, a description of the process used to authorize and refer services, determine whether services are medically necessary, determine when alternative services are applied, or examine the qualifications and credentials of providers under contract with the organization. A PLHSO is required to immediately report to the department changes in this process or changes to the definition of “medically necessary” or “alternative services”.

**Section 4.** Amends s. 636.035, F.S., relating to provider arrangements. Current law states that no subscriber of a PLHSO is liable to any provider for services covered under the PLHSO contract. In addition, no provider may collect or attempt to collect any money for services covered by a PLHSO. This section revises current law by making these provisions applicable **only** when the provider is under contract with the PLHSO.

**Section 5.** Substantially rewords s. 636.038, F.S., to establish subscriber grievance reporting and resolution requirements. Current law requires every prepaid limited health service organization to establish and maintain a complaint system providing reasonable procedures for resolving written complaints initiated by enrollees and providers. This section replaces current law with a detailed grievance procedure as follows:

Subsection (1). Requires each PLHSO to have a grievance process, to advise subscribers that grievances must be filed within 1 year after the date of occurrence, and that the subscriber may submit the grievance to the department after receiving a final disposition of the grievance from the PLHSO. Each PLHSO is required to maintain records of all grievances and file a report annually with the department.

Subsection (2). Requires each PLHSO to respond to grievances within a reasonable time, to notify a subscriber of the opportunity to file a grievance at any time, and to assist a subscriber in filing a grievance.

Subsection (3). Requires each PLHSO's grievance procedure to include: an explanation of how to file a grievance; a toll-free phone number for filing a grievance and the names and addresses of persons or departments where a grievance may be filed; a process for acknowledging a grievance and notifying the subscriber of the final decision; and a procedure for filing a grievance for persons not able to write.

Subsection (4). Specifies grievance procedures for subscribers with an adverse determination (denial of service by PLHSO). An internal review panel must review the decision if requested within 30 days after denial. A majority of panel members must be different persons from those who served on the grievance panel, and must have appropriate expertise. If the subscriber is not satisfied with the final outcome of the review, the subscriber may appeal to the department.

Subsection (5). Specifies a 60 day limit on completion of grievance procedure, or 90 days if the grievance involves collection of information outside the service area.

Subsection (6). Requires to have an expedited review on urgent grievances, which must occur within 72 hours of request.

Subsection (7). Requires the department to investigate all unresolved grievances.

Subsection (8). Requires the department to advise subscribers with a grievance to follow the formal grievance review process, but does permit the subscriber to submit a copy of the grievance to the department at any time, which the department may investigate.

Subsection (9). Requires each PLHSO to advise subscribers in a final decision letter that the subscriber may request review by the department. The request for review by the department must be submitted within 1 year of receipt of the decision.

Subsection (10). Authorizes the department to impose administrative sanctions for failure to comply with this section.

**Section 6.** Amends s. 627.638, F.S., relating to direct payment for hospital and medical services, to prohibit a health insurer which covers medical care by providers outside an exclusive panel from refusing to pay solely because the health care provider in not under contract with the insurer.

**Section 7.** Provides an effective date of October 1 of the year in which it is enacted.

III. FISCAL RESEARCH & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

None.

2. Recurring Effects:

   See fiscal comments.

3. Long Run Effects Other Than Normal Growth:

   None.

4. Total Revenues and Expenditures:

   See fiscal comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

   None.

2. Recurring Effects:

   None.

3. Long Run Effects Other Than Normal Growth:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

   PLHSOs will face additional costs in complying with the provisions of this act, including establishing a grievance panel, employing a dental director (for dental service plans), and paying claims to non-contract providers.

2. Direct Private Sector Benefits:

   Subscribers to PLHSOs will have more consumer protections.

3. Effects on Competition, Private Enterprise and Employment Markets:

   None.

D. FISCAL COMMENTS:

The Department of Insurance indicates it will need two FTEs to implement the provisions of the bill related to the grievance process. The department has provided no actual cost data related to these positions at the time this research was completed.

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

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that municipalities or counties have to raise revenues.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

None.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

The sponsor has proposed a delete all amendment which does the following:

Requires each PLHSO to make available to all subscribers a description of the authorization and referral process for services and a description of the process used to analyze the qualifications and credentials of providers. Certain literature provided to subscribers must include the address of the department and the department's toll-free consumer hot line.

Specifies that a subscriber is liable for payment if care is sought from a provider who is not under contract with the PLHSO. Current law provides that the subscriber is not liable for payment to contract or non-contract providers for covered services.

Requires each PLHSO to report annually to the department the total number of grievances handled by class of grievance and the final disposition of all grievances.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

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