By the Committee on Health, Aging and Long-Term Care; and Senators Clary and Saunders

317-1997B-99

A bill to be entitled

An act relating to managed health care; amending s. 408.05, F.S., relating to the State Center for Health Statistics; requiring the Agency for Health Care Administration to publish health maintenance organization report cards; amending s. 408.7056, F.S.; excluding certain additional grievances from consideration by a statewide provider and subscriber assistance panel; revising the membership of the panel; amending s. 627.6471, F.S.; requiring preferred provider organization policies that require a referral for services to conform to certain requirements imposed on exclusive provider organization contracts; amending s. 641.31, F.S., relating to health maintenance contracts; providing for a point-of-service benefit rider on a health maintenance contract; providing requirements; providing restrictions; authorizing reasonable copayment and annual deductible; providing exceptions relating to subscriber liability for services received; amending s. 641.3155, F.S., relating to health maintenance organization provider contracts and payment of claims; requiring health maintenance organizations to reconcile retroactive reductions of payment to specific claims; requiring providers to reconcile retroactive demands for underpayment or nonpayment to specific claims; providing an exception; providing for the contract to

specify the look-back period; providing for an advisory group established in the Agency for Health Care Administration; requiring a report; amending s. 641.51, F.S.; requiring that health maintenance organizations provide additional information to the Agency for Health Care Administration indicating quality of care; removing a requirement that organizations conduct customer satisfaction surveys; revising requirements for preventive pediatric health care provided by health maintenance organizations; amending s. 641.58, F.S.; providing for moneys in the Health Care Trust Fund to be used for additional purposes; providing an appropriation; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (a) of subsection (5) of section 408.05, Florida Statutes, 1998 Supplement, is amended to read:

408.05 State Center for Health Statistics.--

(5) PUBLICATIONS; REPORTS; SPECIAL STUDIES.--The center shall provide for the widespread dissemination of data which it collects and analyzes. The center shall have the following publication, reporting, and special study functions:

(a) The center shall publish and make available periodically to agencies and individuals health statistics publications of general interest, including HMO report cards; publications providing health statistics on topical health policy issues;~~,~~ publications that ~~which~~ provide health status

profiles of the people in this state; ~~,~~ and other topical health statistics publications.

Section 2. Subsections (2) and (11) of section 408.7056, Florida Statutes, 1998 Supplement, are amended to read:

408.7056 Statewide Provider and Subscriber Assistance Program.--

(2) The agency shall adopt and implement a program to provide assistance to subscribers and providers, including those whose grievances are not resolved by the managed care entity to the satisfaction of the subscriber or provider. The program shall consist of one or more panels that meet as often as necessary to timely review, consider, and hear grievances and recommend to the agency or the department any actions that should be taken concerning individual cases heard by the panel. The panel shall hear every grievance filed by subscribers and providers on behalf of subscribers, unless the grievance:

(a) Relates to a managed care entity's refusal to accept a provider into its network of providers;

(b) Is part of an internal grievance in a Medicare managed care entity or a reconsideration appeal through the Medicare appeals process which does not involve a quality of care issue;

(c) Is related to a health plan not regulated by the state such as an administrative services organization, third-party administrator, or federal employee health benefit program;

(d) Is related to appeals by in-plan suppliers and providers, unless related to quality of care provided by the plan;

(e) Is part of a Medicaid fair hearing pursued under 42 C.F.R. ss. 431.220 et seq.;

(f) Is the basis for an action pending in state or federal court;

(g) Is related to an appeal by nonparticipating providers, unless related to the quality of care provided to a subscriber by the managed care entity and the provider is involved in the care provided to the subscriber;

(h) Was filed before the subscriber or provider completed the entire internal grievance procedure of the managed care entity, the managed care entity has complied with its timeframes for completing the internal grievance procedure, and the circumstances described in subsection (6) do not apply;

(i) Has been resolved to the satisfaction of the subscriber or provider who filed the grievance, unless the managed care entity's initial action is egregious or may be indicative of a pattern of inappropriate behavior;

(j) Is limited to seeking damages for pain and suffering, lost wages, or other incidental expenses, including accrued interest on unpaid balances, court costs, and transportation costs associated with a grievance procedure;

(k) Is limited to issues involving conduct of a health care provider or facility, staff member, or employee of a managed care entity which constitute grounds for disciplinary action by the appropriate professional licensing board and is not indicative of a pattern of inappropriate behavior, and the agency or department has reported these grievances to the appropriate professional licensing board or to the health facility regulation section of the agency for possible investigation; or

(l) Is withdrawn by the subscriber or provider. Failure of the subscriber or the provider to attend the hearing shall be considered a withdrawal of the grievance.

(11) The panel shall consist of members employed by the agency and members employed by the department, chosen by their respective agencies; a consumer appointed by the Governor; a physician appointed by the Governor, as a standing member; and physicians who have expertise relevant to the case to be heard, on a rotating basis. The agency may contract with a medical director and a primary care physician who shall provide additional technical expertise to the panel. The medical director shall be selected from a health maintenance organization with a current certificate of authority to operate in Florida.

Section 3. Present subsection (5) of section 627.6471, Florida Statutes, is redesignated as subsection (6) and a new subsection (5) is added to that section to read:

627.6471 Contracts for reduced rates of payment; limitations; coinsurance and deductibles.--

(5) Any policy issued under this section which requires an insured to obtain a referral prior to receiving services must conform to the requirements of s. 627.6472(16).

Section 4. Subsection (36) is added to section 641.31, Florida Statutes, 1998 Supplement, to read:

641.31 Health maintenance contracts.--

(36)(a) Notwithstanding any other provision of this part, a health maintenance organization that meets the requirements of paragraph (b) may, through a point-of-service rider to its contract providing comprehensive health care services, include a point-of-service benefit. Under such a rider, a subscriber or other covered person of the health

maintenance organization may choose, at the time of covered service, a provider with whom the health maintenance organization does not have a health maintenance organization provider contract. The rider may not require a referral from the health maintenance organization for the point-of-service benefits.

(b) A health maintenance organization offering a point-of-service rider under this subsection must have a valid certificate of authority issued under the provisions of the chapter, must have been licensed under this chapter for a minimum of 3 years, and must at all times that it has riders in effect maintain a minimum surplus of $5 million.

(c) Premiums paid in for the point-of-service riders may not exceed 15 percent of total premiums for all health plan products sold by the health maintenance organization offering the rider. If the premiums paid for point-of-service riders exceed 15 percent, the health maintenance organization must notify the department and, once this fact is known, must immediately cease offering such a rider until it is in compliance with the rider premium cap.

(d) Notwithstanding the limitations of deductibles and copayment provisions in this part, a point-of-service rider may require the subscriber to pay a reasonable copayment for each visit for services provided by a noncontracted provider chosen at the time of the service. The copayment by the subscriber may either be a specific dollar amount or a percentage of the reimbursable provider charges covered by the contract and must be paid by the subscriber to the noncontracted provider upon receipt of covered services. The point-of-service rider may require that a reasonable annual deductible for the expenses associated with the

point-of-service rider be met and may include a lifetime maximum benefit amount. The rider must include the language required by s. 627.6044 and must comply with copayment limits described in s. 627.6471. Section 641.315(2) and (3) does not apply to a point-of-service rider authorized under this subsection.

(e) The term "point of service" may not be used by a health maintenance organization except with riders permitted under this section or with forms approved by the department in which a point-of-service product is offered with an indemnity carrier.

(f) A point-of-service rider must be filed and approved under ss. 627.410 and 627.411.

Section 5. Subsection (4) is added to section 641.3155, Florida Statutes, 1998 Supplement, to read:

641.3155 Provider contracts; payment of claims.--

(4) Any retroactive reductions of payments or demands for refund of previous overpayments which are due to retroactive review-of-coverage decisions or payment levels must be reconciled to specific claims unless the parties agree to other reconciliation methods and terms. Any retroactive demands by providers for payment due to underpayments or nonpayments for covered services must be reconciled to specific claims unless the parties agree to other reconciliation methods and terms. The look-back period may be specified by the terms of the contract.

Section 6. The Director of the Agency for Health Care Administration shall establish an advisory group composed of eight members, with three members from health maintenance organizations licensed in Florida, one representative from a not-for-profit hospital, one representative from a for-profit

hospital, one representative who is a licensed physician, one representative from the Office of the Insurance Commissioner, and one representative from the Agency for Health Care Administration. The advisory group shall study and make recommendations concerning:

(1) Trends and issues relating to legislative, regulatory, or private-sector solutions for timely and accurate submission and payment of health claims.

(2) Development of electronic billing and claims processing for providers and health care facilities that provide for electronic processing of eligibility requests; benefit verification; authorizations; precertifications; business expensing of assets, including software, used for electronic billing and claims processing; and claims status, including use of models such as those compatible with federal billing systems.

(3) The form and content of claims.

(4) Measures to reduce fraud and abuse relating to the submission and payment of claims.

The advisory group shall be appointed and convened by July 1, 1999, and shall meet in Tallahassee. Members of the advisory group shall not receive per diem or travel reimbursement. The advisory group shall submit its recommendations in a report, by January 1, 2000, to the President of the Senate and the Speaker of the House of Representatives.

Section 7. Subsections (8), (9), and (10) of section 641.51, Florida Statutes, are amended to read:

641.51 Quality assurance program; second medical opinion requirement.--

(8) Each organization shall release to the agency data that ~~which~~ are indicators of access and quality of care. The agency shall develop rules specifying data-reporting requirements for these indicators. The indicators shall include the following characteristics:

(a) They must relate to access and quality of care measures.

(b) They must be consistent with data collected pursuant to accreditation activities and standards.

(c) They must be consistent with frequency requirements under the accreditation process.

(d) They must include measures of the management of chronic diseases.

(e) They must include preventive health care for adults and children.

(f) They must include measures of prenatal care.

(g) They must include measures of health checkups for children.

The agency shall develop by rule a uniform format for publication of the data for the public which shall contain explanations of the data collected and the relevance of such data. The agency shall publish such data no less frequently than every 2 years.

~~(9) Each organization shall conduct a standardized customer satisfaction survey, as developed by the agency by rule, of its membership at intervals specified by the agency. The survey shall be consistent with surveys required by accrediting organizations and may contain up to 10 additional questions based on concerns specific to Florida. Survey data~~

~~shall be submitted to the agency, which shall make comparative findings available to the public.~~

(9)~~(10)~~ Each organization shall adopt recommendations for preventive pediatric health care which are consistent with the ~~early periodic screening, diagnosis, and treatment~~ requirements for health checkups for children developed for the Medicaid program. Each organization shall establish goals to achieve 80-percent compliance by July 1, 1998, and 90-percent compliance by July 1, 1999, for their enrolled pediatric population.

Section 8. Subsection (4) of section 641.58, Florida Statutes, is amended to read:

641.58 Regulatory assessment; levy and amount; use of funds; tax returns; penalty for failure to pay.--

(4) The moneys ~~so~~ received and deposited into the Health Care Trust Fund shall be used to defray the expenses of the agency in the discharge of its administrative and regulatory powers and duties under this part, including conducting an annual survey of the satisfaction of members of health maintenance organizations; contracting with physician consultants for the Statewide Provider and Subscriber Assistance Panel;~~the~~ maintaining ~~of~~ offices and necessary supplies, essential equipment, and other materials, salaries and expenses of required personnel;~~,~~ and discharging ~~all other legitimate expenses relating to the discharge of~~ the administrative and regulatory powers and duties imposed under this ~~such~~ part.

Section 9. There is appropriated to the Agency for Health Care Administration for fiscal year 1999-2000 $1,439,000 from the Health Care Trust Fund for 12 months of funding for the purpose of implementing this act.

Section 10. This act shall take effect upon becoming a law.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN COMMITTEE SUBSTITUTE FOR SB's 2472 and 1892

Adds to the responsibilities of the State Center for Health Statistics within AHCA publication of health maintenance organization report cards.

Designates the Governor to appoint the consumer member and the physician member added to the Statewide Provider and Subscriber Assistance Panel.

Deletes a revision to current law that would have required the Agency for Health Care Administration or the Department of Insurance to adopt the recommendations of the Statewide Provider and Subscriber Assistance Panel in a final order rather than a proposed order.

Provides that preferred provider organization policies that require a referral must conform to exclusive provider organization policy requirements.

Authorizes health maintenance organizations to offer point-of-service benefits through a point-of-service rider to their comprehensive health care services contracts. Provides restrictions and limitations on such riders. Requires $5 million surplus to cover riders and authorizes copayments and deductibles for point-of-service benefit riders.

Requires that retroactive payment demands by a health maintenance organization or a provider be reconciled to specific claims, and provides for the contract to specify the look-back period.

Directs the Director of the Agency for Health Care Administration to establish an advisory group to study and make recommendations relating to claims payment; deletes the provisions establishing and providing for funding of the Health Care Information Council; and provides an appropriation of $1,439,000 from the Health Care Trust Fund to the Agency for Health Care Administration for Fiscal Year 1999-2000.