STORAGE NAME: h0961.hcs
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HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE SERVICES
ANALYSIS

BILL #: HB 961

RELATING TO: Health Care Services

SPONSOR(S): Rep. Lacasa

COMPANION BILL(S): SB 2126 (s), HB 1615 (c), SB 1114 (c)

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) HEALTH CARE SERVICES
(2) HEALTH CARE LICENSING & REGULATION
(3) HEALTH & HUMAN SERVICES APPROPRIATIONS
(4)
(5)

I. SUMMARY:

HB 961 requires that at least one-third of Statewide Provider and Subscriber Assistance Panel members be physicians licensed under ch. 458 or ch. 459, F.S., and requires, if a grievance before the panel involves an adverse determination as defined in s. 641.47, F.S., that at least one of the physicians on the panel be in the same specialty as that forming the subject of the grievance or have training and experience in the procedure in question.

The bill provides for patient choice in the selection of a physician under an HMO, managed care provider organization, prepaid health plan, accountable health partnership, health insurance policy, health care services plan, or any other contract which provides payment for medical expense benefits or procedures. The bill also prohibits denial of reimbursement to the provider of such services, provides for the reimbursement rates for such services, makes the subscriber responsible for physician services not reimbursed by such coverage plans, and imposes certain penalties for violation of these provisions.

For every adverse determination made by an HMO regarding any subscriber, the bill requires the HMO medical director to document and sign the subscriber's medical records setting forth the facts regarding the HMO's adverse determination and the rationale for such decision. The bill stipulates that the rendering of such an adverse determination by an HMO medical director constitutes the practice of medicine as defined in s. 458.305, F.S.

The bill's effective date is October 1, 1999.

The bill has an unknown fiscal impact on state and local governments.

II. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

Statewide Provider and Subscriber Assistance Panel

Section 408.7056, F.S., 1998 Supplement, provides for the Agency for Health Care Administration (AHCA) to implement the Statewide Provider and Subscriber Assistance Program to provide assistance to subscribers and providers with grievances that have not been resolved by the accountable managed care entity to the satisfaction of the subscriber or provider. The program is required to consist of one or more review panels that meet as often as necessary to consider and recommend to AHCA any actions AHCA or the Department of Insurance should take concerning individual cases heard by the panel.

According to s. 408.7056(11), F.S., the review panel shall consist of members employed by AHCA or the department, chosen by their respective agencies, and AHCA may contract with a medical director and a primary care physician who shall provide additional technical expertise to the review panel. At this time the panel is composed of six members, three from the Department of Insurance and three from AHCA. The agency has elected to include a licensed physician as one of its members, and the department has elected to include a consumer advocate as one of its members. According to AHCA, a specialty physician has not been included on the panel due to lack of funding.

If a health maintenance organization disagrees with the agency's or the department's final actions resulting from a panel hearing, the health maintenance organization can elect to go to the Division of Administrative Hearings for a summary hearing in accordance with s. 120.574, F.S. Summary hearings under this section are not judicial reviews of the findings and recommendations of the panel, but instead are hearings "de novo." These hearings allow the parties to start anew with the presentation of facts to an administrative law judge as if there had been no review and recommendation by the panel.

Section 408.7056, F.S., establishes certain types of grievances that the panel is precluded from hearing, including grievances relating to a managed care entity's refusal to accept a provider into its network of providers, Medicare appeals that do not involve a quality of care issue, and grievances limited to seeking damages for pain and suffering, lost wages, or other incidental expenses. The section does not clearly specify that the panel has no jurisdiction to award expenses beyond the contractual obligations of the health plan, such as accrued interest on outstanding claims, nor does it state that the panel cannot hear grievances of subscribers in Medicare health maintenance organizations while the internal grievance process is ongoing.

Approximately 4.4 million Floridians are enrolled in health maintenance organizations, including 343,000 in Medicaid HMOs and more than 3 million in commercial HMOs. According to AHCA statistics, nearly 65 percent of all cases heard by the panel are found in favor of the consumer.

Community Health Purchasing Alliances/Accountable Health Partnerships

In 1993, the Florida Legislature established Community Health Purchasing Alliances, or 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 (chapter 93-129, L.O.F.; ss. 408.70-408.706, F.S.). CHPAs make health insurance plans available to small employers, as that term is defined in s. 627.6699, F.S. (1 to 50 employees), including sole proprietors and self-employed individuals.

The Agency for Health Care Administration is responsible for implementation and oversight of the statewide system of CHPAs, including technical and legal assistance, liaison functions, and designation and re-designation of Accountable Health Partnerships. In order for insurance plans to be offered through the CHPA, the plans have to qualify as Accountable Health Partnerships (AHPs), which must be formed by an insurer or health maintenance organization (HMO) authorized by the Department of Insurance. An "accountable health partnership" is defined in s. 408.701(1), F.S., as "an organization that integrates health care providers and facilities and assumes risk, in order to provide health care services, as certified by (AHCA) under s. 408.704." These plans undergo review by AHCA, and a determination is made as to suitability for CHPA participation based on a plan's service provider network and service capability.

Insurance Policies

The provisions of ch. 627, F.S., relate to insurance coverage requirements, as part of the Florida Insurance Code. Part II of ch. 627, F.S., consisting of ss. 627.401-627.4301, F.S., relates to insurance contracts. Section 627.419, F.S., 1998 Supplement, relates specifically to construction of insurance policies.

HMO Regulation

Chapter 641, F.S., relates to health care services programs. Part I of this chapter, consisting of ss. 641.17-641.3923, F.S., is the "Health Maintenance Organization Act," under which the Department of Insurance regulates HMOs. Section 641.315, F.S., addresses HMO provider contracts. Subsection (2) of this section specifies that no subscriber of an HMO is liable to any provider of health care services for any services covered by the HMO. Subsection (3) of this section specifies that no provider of services, or any representative of such provider, shall collect or attempt to collect from an HMO subscriber any money for services covered by an HMO and no provider or representative of such provider may maintain any section at law against a subscriber of an HMO to collect money owed to such provider by an HMO.

Part III of ch. 641, F.S., consisting of ss. 641.47-641.75, F.S., authorizes the Agency for Health Care Administration to regulate HMO quality of care. Before receiving a license from the Department of Insurance, an HMO must receive a Certificate of Authority from AHCA. Among the requirements for the certificate is the requirement that the HMO must designate a medical director who is licensed under ch. 458 or ch. 459, F.S. (s. 641.495(11), F.S.).

B. EFFECT OF PROPOSED CHANGES:

HB 961 would:

- Require that at least one-third of Statewide Provider and Subscriber Assistance Panel members be physicians licensed under ch. 458 or ch. 459, F.S., and require, if a grievance before the panel involves an adverse determination as defined in s. 641.47, F.S., that at least one of the physicians on the panel be in the same specialty as that forming the subject of the grievance or have training and experience in the procedure in question.

- Provide for patient choice in the selection of a physician under an HMO, managed care provider organization, prepaid health plan, accountable health partnership, health insurance policy, health care services plan, or any other contract which provides payment for medical expense benefits or procedures. The bill would also prohibit denial of reimbursement to the provider of such services, provide for the reimbursement rates for such services, make the subscriber responsible for physician services not reimbursed by such coverage plans, and impose certain penalties for violation of these provisions.

- Require, for every adverse determination made by an HMO regarding any subscriber, the HMO medical director to document and sign the subscriber's medical records setting forth the facts regarding the HMO's adverse determination and the rationale for such decision. The rendering of such an adverse determination by a medical director would constitute the practice of medicine as defined in s. 458.305, F.S.

C. APPLICATION OF PRINCIPLES:

1. <u>Less Government:</u>

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

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

N/A

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

N/A

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

N/A

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?

Health coverage plan subscribers could potentially see premium rates increase, and pay providers directly for a portion of care rendered if the subscriber seeks care from a provider outside a health benefit plan’s provider panel.

4. Individual Freedom:

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

      Yes. Health care plan subscribers would have complete choice in selecting physician providers for a price.

   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:

Sections 408.7056(11), 408.706(11), 627.419, 641.315, 641.3151, and 641.495(11), F.S.

E. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 408.7056(11), F.S., 1998 Supplement, relating to the membership of the Statewide Provider and Subscriber Assistance Panel, to require that at least one-third of panel members be physicians licensed under ch. 458 or ch. 459, F.S. Language is also added to require, if a grievance before the panel involves an adverse determination as defined in s. 641.47, F.S., that at least one of the physicians on the panel shall be in the same specialty as that forming the subject of the grievance or have training and experience in the procedure in question.

Section 2. Amends s. 408.706(11), F.S., relating to community health purchasing alliances, accountable health partnerships, and designation of accountable health partnership district health care providers, to delete existing criteria for such designation, which are replaced with the following requirements. Notwithstanding any other provision of the law to the contrary, any subscriber to a health plan offered by or through an HMO, prepaid health plan, or accountable health partnership is entitled, at all times, to free, full, and absolute choice in the selection of a physician licensed under ch. 458 or ch. 459, F.S. Any health plan is expressly forbidden to contain any provision which would require or coerce a subscriber to the plan to use any physician other than the physician selected by the subscriber.

A new paragraph (a) specifies that an HMO, managed care provider organization, prepaid health plan, or accountable health partnership may not deny payment to a physician licensed under ch. 458 or ch. 459, F.S., who has rendered covered services to a subscriber, based solely on the fact that the physician has not entered into a provider contract with the organization, plan, or partnership, as long as: that physician meets the HMO, managed care provider organization, prepaid health plan, or accountable health partnership's eligibility criteria; and under acceptable medical standards, the covered services provided by the physician were medically necessary such that the organization, plan, or partnership would be required to pay for services had they been performed by a contracted provider.

A new paragraph (b) requires reimbursement by an HMO, managed care provider organization, prepaid health plan, or accountable health partnership for services by a physician who does not have a contract with the organization, plan, or partnership to be the lesser of: 80 percent of the physician's charges; 80 percent of the highest rate paid by the organization, plan, or partnership to contracted physicians for the procedure performed; or the charge mutually agreed to by the organization, plan, or partnership and the physician within 30 days after the submittal of the claim. Further, the subscriber is made liable for all physician charges not covered by the HMO, managed care provider organization, prepaid health plan, or accountable health partnership under this paragraph.

A new paragraph (c) stipulates that an HMO, managed care provider organization, prepaid health plan, or accountable health partnership that violates the provisions of this section is subject to a civil fine in the amount of: up to $25,000 for each violation; or, if the AHCA Director determines that the entity has engaged in a pattern of violations of this subsection, up to a $100,000 fine for each violation.

Section 3. Amends s. 627.419, F.S., 1998 Supplement, relating to construction of health insurance policies, to add a new subsection (9) which imposes new requirements relating to provider choice, provider reimbursement, and applicable fines relating thereto. More specifically, the added language imposes the same requirements for health insurance policies, health care services plans, or other contracts which provide payment for medical expense benefits or procedures that are imposed for HMOs, managed care provider organizations, prepaid health plans, or accountable health partnerships under the provisions of section 2 of the bill.

Section 4. Amends s. 641.315, F.S., relating to HMO provider contracts. Subsection (2) is amended to specify that no subscriber of an HMO is liable to any provider of health care services <u>who is a contracted provider of that HMO</u> for any services covered by the HMO.

Subsection (3) is amended to specify that no provider of services who is a contracted provider of an HMO, or any representative of such provider, shall collect or attempt to collect from an HMO subscriber any money for services covered by an HMO and no contracted provider or representative of such provider may maintain any action at law against a subscriber of an HMO to collect money owed to such provider by an HMO.

Section 5. Creates s. 641.3151, F.S., relating to subscriber freedom of choice, to impose new requirements relating to provider choice, provider reimbursement, and applicable fines relating to an HMO or managed care provider organization that are imposed for HMOs, managed care provider organizations, prepaid health plans, or accountable health partnerships under the provisions of section 2 of the bill.

Section 6. Amends s. 641.495(11), F.S., 1998 Supplement, relating to issuance and maintenance of HMO certificates of authority by AHCA, to require, for every adverse determination made by an HMO regarding any subscriber, the HMO medical director to document and sign the subscriber's medical records setting forth the facts regarding the HMO's adverse determination and the rationale for such decision. The rendering of such an adverse determination by a medical director constitutes the practice of medicine as defined in s. 458.305, F.S. This referenced definition is: "the diagnosis, treatment, operation, or prescription for any human disease, pain, injury, deformity, or other physical or mental condition."

Section 7. Provides for an October 1, 1999, effective date.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

Unknown.

2. Recurring Effects:

Unknown.

3. Long Run Effects Other Than Normal Growth:

Unknown.

4. Total Revenues and Expenditures:

Unknown.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

Unknown.

2. Recurring Effects:

Unknown.

3. Long Run Effects Other Than Normal Growth:

Unknown.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

Unknown.

2. Direct Private Sector Benefits:

Unknown.

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

Unknown.

D. FISCAL COMMENTS:

N/A

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

A. APPLICABILITY OF THE MANDATES PROVISION:

The bill does not require counties or municipalities to spend funds or to take action requiring expenditure of funds. However, to the extent that local governments are dependent upon HMOs or other types of managed care plans for the health care benefits made available to local government employees, the bill could increase the costs of the availability of such services.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

The bill does not reduce the ability of counties and municipalities to raise revenue.

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

The bill does not reduce state tax shared with counties and municipalities.

V. COMMENTS:

It seems somewhat inconceivable that the Statewide Provider and Subscriber Assistance Panel could have a physician make-up such that the panel could include a representative sample of every physician specialty for addressing panel issues relative to adverse determinations, as required by section 1 of the bill. Alternatively, the bill could require that rotating physicians serve on the panel who provide specific expertise as appropriate to the case being heard, as is proposed in HB 1927.

The nature of this bill runs counter to the basic tenets of managed care or the management of health plan provider service delivery, and as such has potentially serious cost and service delivery implications to the health care delivery system as it exists today.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

N/A

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:

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