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HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE SERVICES
ANALYSIS

BILL #: HB 371

RELATING TO: Prepaid Limited Health Service Organizations

SPONSOR(S): Representative Ogles

TIED BILL(S):

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

(1) HEALTH CARE SERVICES
(2) INSURANCE
(3)
(4)
(5)

I. SUMMARY:

HB 371 eliminates the requirement for *exclusive* provider contracts in the law regulating the operation of prepaid limited health service organizations by modifying the definition of the term "prepaid limited health service organization" to allow for the provision of limited health services through a *panel* of providers. The bill requires prepaid limited health service organizations to disclose to their subscribers any limitations on services being received from a nonpanel provider, and contains language that clarifies the intent to *not prohibit* prepaid limited health service organizations from authorizing services from a *nonpanel* provider. This would mean that a prepaid limited health service organization would be authorized to offer contracts (policies) that allow the subscriber (policyholder) to choose *any provider* for limited health services, which may be subject to a fee schedule or dollar limitation on specified services.

The bill's effective date is October 1, 2000.

The bill will have no fiscal impact on local or state government, other than the nominal costs to the Department of Insurance associated with approving forms and rates for those prepaid limited health service organizations which intend to offer health care services via nonpanel providers.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes []	No []	N/A [x]
2.	Lower Taxes	Yes []	No []	N/A [x]
3.	Individual Freedom	Yes []	No []	N/A [x]
4.	Personal Responsibility	Yes []	No []	N/A [x]
5.	Family Empowerment	Yes []	No []	N/A [x]

For any principle that received a "no" above, please explain:

B. PRESENT SITUATION:

Prepaid Limited Health Service Organizations

Background

Chapter 636, F.S., created by chapter 93-148, *Laws of Florida*, provides for the Department of Insurance to license and regulate prepaid limited health service organizations. These organizations are similar to health maintenance organizations (HMOs), but are limited to the provision of one of the following services: ambulance, dental care, vision care, mental health, substance abuse, chiropractic, 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 prepaid limited health service organization, 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.

Prepaid limited health service organizations are required 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 [s. 636.016(2), F.S.]. Under current law, a prepaid limited health service organization contract, certificate of coverage, or application may not be delivered in Florida unless the forms and rates have been filed with the department by or on behalf of the prepaid limited health service organization 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 prepaid limited health service organization must file a notice of the change with the department at least 30 days prior to the effective date of the change and provide at least 30 days' written notice to subscribers before implementing any approved change in rates [s. 636.018(1)(a), F.S.].

Exclusive Provider Panels

Pursuant to subsection 636.003(9), F.S., a prepaid limited health service organization provides or arranges for the provision of a limited health service to enrollees through an

exclusive panel of providers. Exclusive providers are providers of health care that have entered into a written agreement with the prepaid limited health service organization to provide benefits to subscribers for alternative or reduced rates of payment. According to representatives with the Department of Insurance, six or seven years ago the department approved forms to allow a large dental care prepaid limited health service organization to utilize nonpanel providers. However, since that time the department has expressed concerns about the legality of allowing this practice and has considered withdrawing its approval of the subject forms.

Financial Requirements

Present law expressly allocates financial liability to the prepaid limited health service organization for services rendered to a prepaid limited health service organization subscriber by a provider under contract with the prepaid limited health service organization, 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 prepaid limited health service organization from a subscriber in good standing, except for copayments or deductibles [s. 636.035, F.S.]. Each prepaid limited health service organization must maintain minimum surplus requirements in an amount which is the greater of $150,000 or 10 percent of total liabilities [s. 636.045, F.S.]. Furthermore, for solvency protection purposes, each prepaid limited health service organization must deposit with the department cash or securities which are equal to the market value of $50,000 [s. 636.046, F.S.]. Assets, liabilities, and investments of prepaid limited health service organizations are governed by the provisions applicable to HMOs under s. 641.35, F.S.

Chapter 99-393, L.O.F., amending s. 641.31, F.S., was enacted authorizing an HMO to offer as a rider to a contract for comprehensive health services a point-of-service benefit whereby HMO subscribers could choose to receive services from a provider with whom the HMO does not have a contract (exclusive of a referral for such services), if certain solvency and other conditions were met. To offer a point-of-service rider, an HMO is required to meet the following requirements: (1) it must be licensed in Florida for at least 3 years; (2) the HMO must have a minimum surplus of $5 million; and, (3) premiums paid for the point-of-service riders must not exceed 15 percent of the HMO's total product premium. Subscribers in HMOs must pay a reasonable copayment per visit for services provided by a noncontract provider. Although HB 371 is similar to last year's HMO bill in that it allows prepaid limited health service organizations to cover health care services by noncontract providers, Department of Insurance officials do not believe it is necessary to require any specific, additional solvency conditions for prepaid limited health service organizations offering such contracts. Under current law noted above, prepaid limited health service organizations must already meet certain solvency requirements and, unlike HMOs, prepaid limited health service organizations are much more limited in scope regarding the health services they provide. Additionally, the prepaid limited health service organization contract may have a dollar limitation on specified services, which would limit its financial exposure.

C. EFFECT OF PROPOSED CHANGES:

See SECTION-BY-SECTION ANALYSIS which follows.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 636.003(9), F.S., defining the term "prepaid limited health service organization," to delete the word "exclusive" in reference to the panel of providers through which a prepaid limited health service organization renders services to its subscribers. The effect of the change is to authorize prepaid limited health service organizations to offer their services through *a panel of providers*, but not necessarily exclusively through those providers.

Section 2. Amends s. 636.016, F.S., providing requirements for prepaid limited health service organization contracts, to amend subsection (2) to include among the list of limitations on services or kinds of services that such an organization is providing in the contract, certificate, membership card, or member handbook *limitations on services being received from a nonpanel provider*. Subsection (8) is amended with clarifying language that states that *nothing in this subsection is intended to otherwise prohibit the prepaid limited health service organization from authorizing services from a nonpanel provider*.

Section 3. Provides that the bill shall take effect October 1, 2000.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

N/A

2. Expenditures:

The Department of Insurance will experience nominal costs associated with approving forms and rates for those prepaid limited health service organizations which intend to offer health care services via nonpanel providers.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

N/A

2. Expenditures:

N/A

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

This bill may increase the cost of premiums paid by prepaid limited health service organization subscribers who choose to purchase contracts that cover limited health care services from nonpanel providers. The bill may also increase subscribers' out-of-pocket expenses for utilizing nonpanel providers because these providers may charge more for their services than panel providers.

The bill will benefit nonpanel prepaid limited health service organization health care providers who will be allowed to offer services to subscribers.

The Department of Insurance does not believe it is necessary to require any specific, additional solvency conditions for prepaid limited health service organizations offering such contracts.

D. FISCAL COMMENTS:

N/A

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 action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

The bill does not reduce the authority that counties or municipalities have to raise revenues in the aggregate.

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:

A. CONSTITUTIONAL ISSUES:

N/A

B. RULE-MAKING AUTHORITY:

N/A

C. OTHER COMMENTS:

N/A

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

N/A

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

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