STORAGE NAME: h0159a.in.doc
DATE: March 8, 2001

HOUSE OF REPRESENTATIVES
COMMITTEE ON
INSURANCE
ANALYSIS

BILL #: HB 159

RELATING TO: Health Maintenance Organizations

SPONSOR(S): Representative Rubio

TIED BILL(S):

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

(1) INSURANCE YEAS 12 NAYS 2
(2) COUNCIL FOR HEALTHY COMMUNITIES
(3)
(4)
(5)

I. SUMMARY:

Adverse determinations are decisions made by health maintenance organizations (HMOs) to modify, reduce, or terminate a course of treatment. Currently, all Florida-licensed physicians and out of state physicians with a license comparable to a Florida license may make an adverse determination.

This bill requires HMOs to use active Florida licensed physicians to make adverse determinations. Out of state physicians and physicians with inactive or encumbered Florida licenses could not make adverse determinations.

The bill, as amended, takes effect on January 1, 2002.

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:

What is an Adverse Determination?

An adverse determination is a decision made by a health maintenance organization ("HMO") either modifying or reversing a plan subscriber's prescribed course of treatment. An HMO may make an adverse determination if the course of treatment is medically unnecessary, inappropriate, ineffective, or otherwise does not meet the HMO's medical requirements.[1]

How does an HMO make an Adverse Determination?

The internal process that an HMO uses to review its care decisions varies between organizations. The process typically starts with a primary care physician's treatment decision or referral to a specialist. After the initial decision is made regarding health care, certain limitations in the plan subscriber's contract of service or certain HMO policy decisions (such as an access policy to MRI scanning equipment, or referrals to "non-par" or non participating treatment centers) may require review by the HMO Medical Director or her physician designee. Some procedures and treatment plans may also require authorization by the medical director before being performed. These decisions are made by the director on behalf of the HMO and can be made in consultation with a known specialist in the field.

As an example, the following is a typical process indicative of the overall system:

> A plan subscriber's physician is concerned with her symptoms and refers her to a heart specialist. The heart specialist decides that a heart transplant is in order. The HMO has

[1] Florida Statutes define an "Adverse Determination" to be

> "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."

Section 641.47(1), F.S.

a policy to review any major surgeries involving organ transplants. A consultation will usually take place with the medical director of the HMO and the physician or specialist by mail, fax, or telephone regarding the circumstances of the case. The decision is then reviewed by the HMO's medical director to determine whether the procedure meets the standards for referral (including referral to a specific facility or specialist), the standards for medical necessity, the location of the surgery (par or non-par facility), and the level of care authorized in the subscriber's contract of service. The medical director will then either approve the treatment decision and authorize it or render an adverse determination and decline treatment or modify treatment. If the Medical Director does render an adverse determination, the director must notify the patient in writing.[2]

How does a Subscriber appeal an HMO's decision?

A plan subscriber unsatisfied with the determination may appeal to the HMO's internal appellate body or review panel within thirty days of the decision. Florida law requires HMOs to have an internal process for handling grievances and subscriber complaints and provides specific regulations for reviewing adverse determinations.[3]

If the internal process does not resolve the case, the plan subscriber may appeal to a state board of assistance called the "Statewide Provider and Subscriber Assistance Program." This appellate body is established by Florida law and seats four adjudicators: a member of the Agency for Health Care Administration, a member of the Department of Insurance, a physician appointed by the governor (as a standing member) and other physicians to rotate in according to area of expertise, and a member of the consumer public appointed by the governor.[4] HMOs are required to give notice to the subscriber, in her copy of the organization's final decision about the adverse determination, that the subscriber may request review from the Statewide Provider and Subscriber Assistance Program.[5] The subscriber must meet certain criteria to bring her case before the

---

[2] Section 641.51(4), F.S.

[3] Section 641.511(4)(a) – (d), F.S. provides:

(a) "… A majority of the [review] panel shall be persons who previously were not involved in the initial adverse determination. A person who previously was involved in the adverse determination may appear before the panel to present information or answer questions. The panel shall have the authority to bind the organization to the panel's decision.'

(b) 'An organization shall ensure that a majority of the persons reviewing a grievance involving an adverse determination are providers who have appropriate expertise. An organization shall issue a copy of the written decision of the review panel to the subscriber and to the provider, if any, who submits a grievance on behalf of a subscriber. In cases where there has been a denial of coverage of service, the reviewing provider shall not be a provider previously involved with the adverse determination.'

(c) 'An organization shall establish written procedures for a review of an adverse determination. Review procedures shall be available to the subscriber and to a provider acting on behalf of a subscriber.'

(d) 'In any case when the review process does not resolve a difference of opinion between the organization and the subscriber or the provider acting on behalf of the subscriber, the subscriber or the provider acting on behalf of the subscriber may submit a written grievance to the Statewide Provider and Subscriber Assistance Program."

[4] Section 408.7056(11), F.S.

[5] Section 641.511(10), F.S.

Statewide Provider and Subscriber Assistance Program including having gone through the entire internal HMO grievance process (exhaustion of HMO administrative remedy) and keeping her complaint out of the state and federal courts.[6] In addition, the subscriber has available to her binding arbitration, if the contract of service provides for it instead of appealing to the Statewide Provider and Subscriber Assistance Program.[7]

What kinds of medical treatments are subject to Adverse Determination decisions?

All treatment decisions theoretically are subject to adverse determinations. Most adverse determinations however are made regarding procedures that are required by HMO policy to go through a review process before being approved, such as surgery or an expensive medical test.

Who can make Adverse Determinations?

Currently, only physicians licensed in Florida or physicians licensed in a state with licensing requirements similar to Florida's may make adverse determination decisions on behalf of an HMO.[8]

Under Florida law, a physician may either hold an active license or an inactive license to practice medicine[9]. An active license entitles a physician to care for Florida patients and may only be held by physicians who continuously render medical services to Florida patients. An inactive license does not entitle a physician to provide medical care and is held by either retired physicians or physicians who choose not to practice.

The Florida Board of Medicine and the Florida Board of Osteopathic Medicine (the "Boards" or "Board") are the administrative bodies charged with regulating physician care. When a physician violates the rules regulating professional physician conduct, or has allegedly committed malpractice, the Board governing the physician's license[10] may pursue administrative action against the physician through a hearing. The Board, if it determines that misconduct occurred, may discipline a physician by "encumbering" the physician's license. Typical encumbrances include fining the physician or suspending the physician's practice for a set time period.[11] Encumbrances are removed when the administrative fine is paid or the disciplinary period is over.[12]

---

[6] See Section 408.7056(2)(a) – (l) for all limitations on standing in matters before the Statewide Provider and Subscriber Assistance Program.

[7] Section 641.511(3)(e), F.S. Section 641.511(3), F.S., details the requirements for an organization's general grievance procedure.

[8] Section 641.51(4), F.S.

[9] See Chapters 458 (allopathic) and 459 (osteopathic), F.S., for more detailed information about physician licensing requirements.

[10] The Florida Board of Medicine regulates allopathic physicians licensed under Chapter 458, F.S., and the Florida Board of Osteopathic medicine regulates osteopathic physicians licensed under Chapter 459, F.S.

[11] See Section 458.331(2)(a) – (j), F.S., for possible administrative penalties against allopathic physicians and Section 459.015(2)(a) – (j), F.S., for possible administrative penalties against osteopathic physicians.

[12] See Section 458.331(4), F.S., concerning reinstatement of allopathic licenses and Section 459.015(4), F.S., concerning reinstatement of osteopathic licenses.

Florida law allows both active Florida license holders and inactive Florida license holders, regardless of current encumbrances, to render adverse determinations on behalf of an HMO.[13]

Out of state physicians who do not hold a Florida license are not subject to regulation or disciplinary measures by the Boards. Allegations of misconduct or malpractice by Florida patients against specific doctors must be brought before the State Board of Medicine in the physician's state of licensure rather than before the local Florida Boards.[14]

Florida law allows out of state physicians to make adverse determination decisions about Florida patient care only if they hold an active license from their state[15] and their state's licensing requirements are similar to Florida's. The Department of Health is the administrative agency responsible for determining if a state's requirements are similar to Florida's.[16]

Can out of state physicians practice in Florida?

No. Florida does not allow physicians from other states to practice medicine unless they obtain a Florida license. Florida does not have a reciprocity rule or other law allowing out of state physicians to practice in Florida.

How many HMOs use out of state physicians to make Adverse Determinations?

According to HMOs, adverse determinations in cases involving special treatments, placements in specialized out of state health care facilities, or complex procedures, are sometimes made by out of state specialist physicians who have expertise in the specific medical area. According to the Agency for Health Care Administration's ("AHCA's") HMO Section, only 1 out of the 29 operating HMOs in Florida makes all of its utilization review decisions out of state.[17] That HMO operates mainly along the I-4 corridor.[18]

C. EFFECT OF PROPOSED CHANGES:

HMOs no longer would be allowed to have out of state physicians without a Florida license, physicians with an inactive Florida license, or physicians with an encumbered Florida license render adverse determination decisions regarding Florida patient care. Only physicians with active and

---

[13] Section 641.51(4), F.S.

[14] Currently, according to AHCA's legal section, HMOs cannot be sued vicariously for medical malpractice. A suit against an HMO must deal with issues regarding ERISA (the federal "Employee Retirement Income Security Act of 1974") and whether the rendering of an administrative decision is or is not the practice of medicine. Therefore, state courts may not provide an avenue of relief against out of state physicians.

[15] Id.

[16] Though the Department of Health has not exercised administrative authority by rule to make these decisions, The Board of Medicine, charged with regulating Florida's allopathic physicians and a subunit of the Department, has said that the Department would be the administrative agency responsible for deciding if a state's licensure is equivalent to Florida's.

[17] Interview with Tom Warring, Section Chief, AHCA HMO Section (Mon. Feb. 19, 2001, 12:27 p.m.).

[18] The HMO, One Health Plan has 10,594 subscribers in mostly the Tampa and Orlando areas and a statewide HMO market share of 0.3%. Market Data is current through September 1, 2000 as reported to the Department of Insurance.

unencumbered Florida licenses would be allowed to review patient treatments and make adverse determinations.

There is no effect on the subscriber grievance process, the definition of adverse determination, or the type of procedures subject to adverse determinations.

HMOs will have to either locate medical specialists in Florida to consult with regarding treatment decisions, or have to approve decisions made by out of state specialists regarding treatments with a determination from an active Florida physician.

D. SECTION-BY-SECTION ANALYSIS:

N/A

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

N/A

2. Expenditures:

N/A

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

N/A

2. Expenditures:

N/A

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

According to AHCA, overall, HMOs in Florida employ active, unencumbered physicians to review patient services and make adverse determination decisions. Larger HMOs will likely not experience much fiscal impact due to the availability of in state physician resources at their disposal. Smaller HMOs may experience a larger fiscal impact if they employ out of state physicians to render adverse determinations because of the smaller availability of physicians in their pool. All HMOs may incur expense in locating new, Florida licensed, active, specialists in areas that were primarily served by out of state specialists either by incurring costs related to contracting with or identifying the specialist or by employing a physician to, or adding to a current physician's work load the duty to, approve out of state determinations. Florida physicians may see an increase in demand for their services as they become necessary to the operation of a Florida HMO's adverse determination process.

D. FISCAL COMMENTS:

N/A

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

A. APPLICABILITY OF THE MANDATES PROVISION:

There are no mandates to county or municipal governments in this bill.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

There is no effect on county or municipal revenue raising authority by this bill.

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

There are no reductions in state tax shared with counties or municipalities in this bill.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

None.

B. RULE-MAKING AUTHORITY:

None.

C. OTHER COMMENTS:

None.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On March 7, 2001, the Committee on Insurance adopted without objection one amendment as amended, changing the effective date of the bill from “upon becoming law” to “January 1, 2002” to address HMO concern about available time to comply.

Amendment 1, as drafted by Representative Wiles (page 2, lines 6 & 7) changed the effective date from “upon becoming law” to July 1, 2001.

Amendment 1 to Amendment 1, offered by Representative Melvin removed the date July 1, 2001 from Amendment 1 and inserted the date January 1, 2002.

VII. SIGNATURES:

COMMITTEE ON INSURANCE:

Prepared by:	Staff Director:
Warren A. "Drew" Crawford	Stephen T. Hogge