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HOUSE OF REPRESENTATIVES
COMMITTEE ON
INSURANCE
ANALYSIS

BILL #: HB 1571

RELATING TO: Subscriber Assistance Program

SPONSOR(S): Representative Attkisson

TIED BILL(S): None

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

(1) INSURANCE YEAS 11 NAYS 0
(2) FISCAL POLICY & RESOURCES
(3) COUNCIL FOR COMPETITIVE COMMERCE
(4)
(5)

I. SUMMARY:

The Agency for Health Care Administration is required to establish the Statewide Provider and Subscriber Assistance Program (program) to resolve grievances between managed care subscribers and providers. The grievance is submitted to a panel or panels created for this purpose.

According to Interim Project Report 2001-138, by the Senate Health, Aging and Long-Term Care Committee, September 2001, Florida is the only state to give subscribers the opportunity to deliver a personal presentation before a panel of this type. The Senate report identifies a number of procedural and substantive shortcomings. The bill would implement the majority of the Senate report recommendations, including the following:

- Provide for the closure of the record after allowing the parties to supply additional information;
- Create a method to resolve ties among panel members;
- Allow the declaration of a deadlock;
- Require, rather than permit, the imposition of a $500 per day penalty against a managed care entity for failure to produce a requested medical record;
- Mandate, rather than permit, the issuance of a proposed final order or emergency order;
- Allow additional investigations following the panel's recommendation;
- Permit modification of the finding of facts and specify the basis for modification or rejection of the findings of fact;
- Require panel members to be trained in panel procedures and precedent; and
- Require notification of those with urgent grievances of their right to submit written grievances to the program upon conclusion of a managed care entity's internal grievance proceeding.

The Agency for Health Care Administration indicates that the bill would have no fiscal impact on state government expenditures and would increase state revenue to the extent that managed care providers would be subject to penalties that would be mandatory under the bill for failure to provide medical records within the required time period.

On February 25, 2002, the Committee on Insurance reported the bill favorably with one amendment that is traveling with the bill. Please see Section VI., Amendments or Committee Substitute Changes.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1. Less Government Yes [] No [x] N/A []

The bill would require additional procedures within the Statewide Provider and Subscriber Assistance Program, require additional notification of grievance rights by managed care entities, and require the levy of a currently permissive penalty.

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]

B. PRESENT SITUATION:

Statewide Provider and Subscriber Assistance Program

The Agency for Health Care Administration (Agency) is required to establish the Statewide Provider and Subscriber Assistance Program (program) to resolve grievances between managed care subscribers and providers.[1] Grievances are submitted to a panel or panels created for this purpose. This program is available to subscribers of health maintenance organizations, prepaid health clinics, prepaid health plans, and exclusive provider organizations. The program also is available to "providers."[2]

The panel consists of three members employed by the Agency, three members employed by the Department of Insurance (Department), a consumer selected by the Governor, and physicians with relevant expertise, on a rotating basis. To make additional expertise available to the panel, the agency may contract with a medical director selected from a health maintenance organization operating under a current Florida certificate of authority, and a primary care physician.[3] Panel meetings must be public; although, certain personally-identifying information contained in reports obtained by the Agency or Department is an exempt public record.[4]

The panel is required to hear every subscriber and provider grievance, unless it falls within a specified exception.[5] The Agency is required to decide whether a hearing will be held within 60

[1] Section 409.7056, F.S.
[2] "Provider" means a state-licensed or state-authorized facility, a facility principally supported by a local government or by funds from a charitable organization that holds a current exemption from federal income tax under s. 501(c)(3) of the Internal Revenue Code, a licensed practitioner, a county health department established under part I of chapter 154, a prescribed pediatric extended care center defined in s. 400.902, a federally supported primary care program such as a migrant health center or a community health center authorized under s. 329 or s. 330 of the United States Public Health Services Act that delivers health care services to individuals, or a community facility that receives funds from the state under the Community Alcohol, Drug Abuse, and Mental Health Services Act and provides mental health services to individuals. Section 408.7056(1)(d), F.S.
[3] Section 408.7056(11), F.S.
[4] Section 408.7056(13) and (15), F.S.
[5] These exceptions are: the refusal of a managed care entity to accept a provider into the network; internal grievances within a Medicare managed care entity or reconsideration appeal through the Medicare appeals process and does not involve a quality of care

days after the grievance is filed. If a hearing is granted, then the panel must hold the hearing within 120 days after the grievance is filed.

The panel may administer oaths, collect information and perform investigations in pursuit of making findings of fact and a recommendation concerning the grievance. The panel must provide the parties and either the Agency or the Department with a written recommendation and findings of fact within 15 days of the hearing. However, if the panel requests additional documents at the hearing, the time period is tolled (e.g., stopped) until the information is received. The recommendation may include requiring the managed care entity to take specific actions. These proceedings are exempt from the requirements of the Administrative Procedure Act.[6]

A managed care entity is subject to a $500 per day penalty for failure to provide properly requested medical records.[7]

This section also provides for expedited resolution of urgent and emergency grievances. In urgent cases, where the grievance involves an immediate and serious threat to the health of the subscriber, the grievance receives priority over other grievances and must be heard within 45 days of filing. Where the Agency determines that the life of the subscriber is in imminent and emergent danger, the panel may meet within 24 hours of notice to the managed care entity and the subscriber. Completion of the required internal grievance procedure is waived.

At the conclusion of the emergency hearing, the panel must issue an emergency recommendation and findings of fact to the parties, and Agency or Department. Within 24 hours, the Agency or Department may issue an emergency order, which remains in effect until the grievance is resolved by the managed care entity, medical intervention is no longer necessary, or the completion of a full hearing resulting in a recommended order acted upon by the Agency or Department.

Within 10 days, or 72 hours in the case of an expedited grievance, the parties may submit written evidence opposing the recommendation or findings of fact. In 30 days or less, or 10 days or less for expedited grievances, the Agency or Department may adopt the recommended order and findings of fact as a proposed order or emergency order under the Administrative Procedure Act. The Agency or Department may reject all or part of the recommended order. The Agency's or Department's proposed or emergency order may impose fines or sanctions, including administrative penalties of up to $2,500 per violation ($25,000 in the aggregate) for non-willful violations, or up to $20,000 per violation ($250,000 in the aggregate) for knowing and willful violations that would be grounds for revocation of the managed care entity's certificate of authority.[8]

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issue; the health plan is not regulated by the State; those related to appeals by in-plan suppliers and providers, unless there is a quality of care issue; those part of a Medicare fair hearing; ones that form the basis of a pending court action; any related to a non-participating subscriber, unless there is a quality of care issue and the provider is caring for the subscriber; ones filed before the completion of the internal grievance process, which has complied with time line requirements, and it is not subject to an emergency hearing under the section; those resolved to the subscriber's satisfaction, unless the initial action was egregious and indicative a pattern of inappropriate behavior; ones limited to a claim for punitive or economic damages and costs; any limited to conduct issues, not indicating a pattern of inappropriate behavior, subject to discipline by a licensing board, which have been reported to the applicable board; and those withdrawn (non-attendance constitutes withdrawal). Section 408.7056(2)(a)-(l), F.S.

[6] Chapter 120, F.S.

[7] A properly requested medical record is one that is the subject of a properly filed grievance and a proper patient authorization. Section 408.7056(4), F.S.

[8] Among the factors to be considered in determining applicable fines or sanctions are: the severity of the non-compliance, including the probability of death or harm to the subscriber; remedial actions by the managed care entity; previous non-compliance; and other factors the Agency or Department deem relevant and appropriate. Section 408.7056(10), F.S.

Every managed care entity must submit quarterly reports of internal grievances not resolved to the satisfaction of the aggrieved party. The Agency is required to notify these persons of their right to file a grievance with the panel.

Senate Interim Project Report 2001-138

According to Interim Project Report 2001-138, by the Senate Health, Aging and Long-Term Care Committee, September 2001, Florida is the only state to give subscribers the opportunity to deliver a personal presentation before a panel of this type.

The Senate Report pointed out what it considered to be several shortcomings. The Agency has not adopted procedural rules for use in the program; there are no panel quorum requirements; there is no procedure to resolve ties or declare a deadlock; the statute refers to a panel chair but provides no means for designating the chair; there is no limitation on presentation time before the panel; the statute lacks a standard to guide the Agency or Department in modifying or rejecting the recommendation; there is no provision for remand of grievances requiring further consideration by the panel; and there is a lack of timely notice to those with urgent grievances of their right to submit their grievance to the panel.

C. EFFECT OF PROPOSED CHANGES:

This bill would implement the majority of the recommendations included within the September 2001 Interim Project Report 2002-138, by the Senate Committee on Health, Aging and Long-Term Care.

The bill would:

- Allow the parties 5 days following the hearing to supplement the record of the proceeding;
- Provide for the closure of the record of the proceedings;
- Require the panel's written recommendation within 10 days of the closure of the record, rather than within 15 days of the hearing;
- Create a method to resolve ties among the panel;
- Allow the declaration of a deadlock, which would result in a "no-action" recommendation to the Agency or Department;
- Identify certain records as being a medical record, which the panel may request from the managed care entity;
- Require, rather than permit, the imposition of a $500 per day penalty against a managed care entity for failure to produce a requested medical record;
- Allow written exceptions, rather than written evidence, in opposition to the panel's recommendation or findings of fact;
- Mandate, rather than permit, the issuance of a proposed final order or emergency order by the Agency or Department;
- Allow additional investigation by the Agency or Department following the panel's recommendation;
- Permit the modification of the finding of facts, in addition to the current power of the Agency or Department to reject the findings of fact;
- Specify the basis for modification or rejection of the findings of fact;
- Require panel members to be trained in procedures and precedent;
- Require notification of those with urgent grievances of their right to submit written grievances to the program upon conclusion of a managed care entity's internal grievance proceeding;

- Rename the Statewide Provider and Subscriber Assistance Program the Subscriber Assistance Program; and
- Make certain technical drafting changes.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 408.7056, F.S., to rename the program and implement the recommendations in the Senate Interim Project Report 2001-138.

Sections 2 and 4. Amends s. 641.3154(4) and 641.58(4), F.S., to conform other sections referencing the name of the program.

Section 3. Amends s. 641.511, F.S., to make technical drafting type changes, conform references to the name of the program, and require managed care organizations to notify those with an urgent grievance of their right to file a written grievance with the program upon the conclusion to the managed care entity's internal grievance process.

Section 5. Makes the bill effective on July 1, 2002.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

Indeterminate. See Section III.D., Fiscal Comments.

2. Expenditures:

Indeterminate. See Section III.D., Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None

2. Expenditures:

None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Since the $500 per day penalty for failure to produce medical records would now be mandatory, managed care entities could experience increased penalties to the extent that managed care entities fail to produce requested medical records and the Agency levies penalties that previously would have been waived. According to the Agency, for the 2001 calendar year, medical records were received late (i.e., in more than the required 10 days) in 90 of 239 cases, or 37.6 percent of cases.

D. FISCAL COMMENTS:

The Agency would see increased revenues of an indeterminate amount to the extent that managed care entities fail to produce medical records within 10 days of request requiring the Agency to impose a $500 per day penalty. The Agency indicates that the receipt of late medical records from managed care entities is common. According to the Agency, for the 2001 calendar year, medical records were received late (i.e., in more than the required 10 days) in 90 of 239 cases, or 37.6 percent of cases. Similar data has been provided for the current fiscal year, to date. They also indicate that they have never imposed the authorized penalty.

The Agency indicates that the bill would have no fiscal impact on state government.

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 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:

On February 25, 2002, the Committee on Insurance reported the bill favorably with one amendment that is traveling with the bill.

Amendment 1 by the Committee on Insurance (page 6, line 15): The amendment would allow an exception to the mandatory $500, per day, penalty proposed by the bill in circumstances beyond the party's control.

VII. SIGNATURES:

COMMITTEE ON INSURANCE:

Prepared by:	Staff Director:
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