**STORAGE NAME:** h0283.sgc.doc
**DATE:** December 12, 2001

**HOUSE OF REPRESENTATIVES**
**SMARTER GOVERNMENT COUNCIL**
**ANALYSIS**

**BILL #:** HB 283 (PCB SA 02-07)

**RELATING TO:** Public Records & Meetings Exemptions

**SPONSOR(S):** Committee on State Administration and Representative(s) Brummer

**TIED BILL(S):**

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

(1) COMMITTEE ON STATE ADMINISTRATION YEAS 3 NAYS 0
(2) SMARTER GOVERNMENT COUNCIL YEAS 11 NAYS 0
(3)
(4)
(5)

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I. SUMMARY:

The Open Government Sunset Review Act of 1995 provides that an exemption from the requirements of the public records or public meetings laws may be created or maintained only if it serves an identifiable public purpose and may be no broader than is necessary to meet the public purpose it serves.

The Act, in pertinent part, sets forth a review process which requires that on October 2nd in the fifth year after enactment of a new exemption, the exemption is to repeal, unless the Legislature reenacts the exemption. By June, of the year before the repeal of an exemption, the Division of Statutory Revision of the Office of Legislative Services must certify, to the President of the Senate and the Speaker of the House of Representatives, the language that will repeal and the statutory citation for each exemption scheduled for repeal.

Sections 641.67 and 641.68, F.S., were certified by the Division of Statutory Revision and will repeal on October 2, 2002, unless otherwise reenacted by the Legislature. Section 641.67, F.S., provides that patient records and certain identifying information held by statewide or district managed care ombudsman committees are confidential and exempt from public records requirements. Section 641.68, F.S., provides that the portion of a meeting conducted by the statewide or district managed care ombudsman committee where patient records and identifying information are discussed is exempt from public meetings requirements. The statewide and district ombudsman committees are volunteer organizations that provide an informal process for subscribers to file complaints about managed care programs. The statewide committee has held no closed meetings since its inception, and at the two open meetings held by such committee over the past year, only two members were present.

The Statewide Subscriber and Provider Assistance Program is the formal process through which subscribers and providers file complaints with the Agency for Health Care Administration relating to managed care.

**This bill reenacts the public records and meetings exemptions found in ss. 641.67 and 641.68, F.S., with respect to the district managed care ombudsman committees, and repeals the public records and meetings exemptions for the statewide managed care ombudsman committee**. In addition, this bill removes the public necessity statements found in ss. 641.67 and 641.68, F.S., because public necessity statements are not to be codified in the Florida Statutes, although they remain in the Laws of Florida.

This bill does not appear to have a fiscal impact on state or local governments.

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:

**Public Records and Public Meetings Laws**

Florida Constitution

Article I, s. 24(a), Florida Constitution, expresses Florida's public policy regarding access to government records as follows:

> Every person has the right to inspect or copy any public records made or received in connection with the official business of any public body, officer, or employee of the state, or persons acting on their behalf, except with respect to records exempted pursuant to this section or specifically made confidential by this Constitution. This section specifically includes the legislative, executive, and judicial branches of government and each agency or department created thereunder; counties, municipalities, and districts; and each constitutional officer, board, and commission, or entity created pursuant to law or this Constitution.

In regard to public meetings, Article I, s. 24(b), Florida Constitution, provides that

> [a]ll meetings of any collegial public body of the executive branch of state government or of any collegial public body of a county, municipality, school district, or special district, at which official acts are to be taken or at which public business of such body is to be transacted or discussed, shall be open and noticed to the public . . . .

Article I, s. 24(c), Florida Constitution, does, however, permit the Legislature to provide by general law for the exemption of records and meetings from the requirements of s. 24. The general law must state with specificity the public necessity justifying the exemption and must be no broader than necessary to accomplish its purpose.

Article 1, s. 24, Florida Constitution, does not set forth any repeal or review requirements.

Florida Statutes

Public policy regarding access to government records is also addressed in the Florida Statutes. Section 119.07(1)(a), F.S., provides:

> Every person who has custody of a public record shall permit the record to be inspected and examined by any person desiring to do so, at a reasonable time, under reasonable conditions, and under supervision by the custodian of the public record or the custodian's designee.

With regard to public meetings, section 286.011, F.S., provides that

> [a]ll meetings of any board or commission of any state agency or authority or of any agency or authority or any county, municipal corporation, or political subdivision, except as otherwise provided in the Constitution at which official acts are to be taken are declared to be public meetings open to the public at all times, and no resolution, rule, or formal action shall be considered binding except as taken or made at such meeting. The board or commission must provide reasonable notice of all such meetings.

Open Government Sunset Review Act of 1995

Section 119.15, F.S., the Open Government Sunset Review Act of 1995, provides that an exemption may be created or maintained only if it serves an identifiable public purpose and may be no broader than is necessary to meet the public purpose it serves. An identifiable public purpose is served if the exemption meets one of the following purposes, and the Legislature finds that the purpose is sufficiently compelling to override the strong public policy of open government and cannot be accomplished without the exemption:

> 1. Allows the state or its political subdivisions to effectively and efficiently administer a governmental program, which administration would be significantly impaired without the exemption;
>
> 2. Protects information of a sensitive personal nature concerning individuals, the release of which information would be defamatory to such individuals or cause unwarranted damage to the good name or reputation of such individuals or would jeopardize the safety of such individuals. However, in exemptions under this subparagraph, only information that would identify the individuals may be exempted; or
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> 3. Protects information of a confidential nature concerning entities, including, but not limited to, a formula, pattern, device, combination of devices, or compilation of information which is used to protect or further a business advantage over those who do not know or use it, the disclosure of which information would injure the affected entity in the marketplace.

Section 119.15, F.S., sets forth a review process which requires that on October 2nd in the fifth year after enactment of a new exemption or "substantial amendment" [1]of an existing exemption, the exemption is to repeal, unless the Legislature reenacts the exemption. By June, of the year before the repeal of an exemption, the Division of Statutory Revision of the Office of Legislative Services must certify, to the President of the Senate and the Speaker of the House of Representatives, the

[1] An exemption is "substantially amended" if the amendment expands the scope of the exemption to include more records or information or to include meetings as well as records. An exemption is not substantially amended if the amendment narrows the scope of the exemption. s. 119.15(3)(b), F.S.

language that will repeal and the statutory citation for each exemption scheduled for repeal. s. 119.15(3)(d), F.S.

Sections 641.70 and 641.78, F.S., were certified by the Division of Statutory Revision and will repeal on October 2, 2002, unless otherwise reenacted by the Legislature.

**Analytical Framework**

The Florida Constitution does not require the repeal, review, or reenactment of exemptions; the Open Government Sunset Review Act of 1995 (s. 119.15, F.S.) does. However, the Open Government Sunset Review Act of 1995 is a Florida statutory provision created by the Legislature. Accordingly, because one Legislature cannot bind another, the requirements of s. 119.15, F.S., do not have to be met. Nonetheless, because the certified exemptions as found in the Florida Statutes actually contain language that repeal the exemption as of October 2nd, 2002, these exemptions *will* repeal unless the legislature reenacts the exemption. However, allowing the exemption to repeal by its own terms, without affirmatively repealing the exemption through legislation leads to confusion, because the exemption, albeit technically repealed, remains in statute. Affirmatively removing the exemption from statute provides a clear directive regarding the status of the exemption.

**Statewide Provider and Subscriber Assistance Program**

Section 408.7056, F.S., provides for the Statewide Provider and Subscriber Assistance Program. This section requires the Agency for Health Care Administration (AHCA) to adopt and implement a program to provide assistance to both subscribers and providers of managed care. This program consists of one or more panels that meet as often as necessary to timely review, consider, and hear grievances and recommend to AHCA or the Department of Insurance (DOI) any actions that should be taken concerning individual cases. The panel hears every type of grievance filed by subscribers and providers with several exceptions.[2]

AHCA is responsible for reviewing the grievances and deciding whether they will be heard by the assistance panel. If a grievance is to be heard, the hearing must be conducted within 120 days after the grievance is filed. The panel is permitted to take testimony under oath and to collect any documentation or information that will assist the panel is making a finding of fact and issuing a recommendation. The panel must issue its recommendation within 15 working days after hearing the grievance. Any grievances that AHCA considers pose an immediate threat to any subscriber's health must be given first priority by the panel.[3]

Any recommendation issued by the panel may include specific actions the managed care entity must take to comply with state laws or rules regulating managed care entities. A managed care entity, provider, or subscriber may furnish written evidence in opposition of the panel's

[2] The panel does not hear grievances if the grievance: relates to a managed care entity's refusal to accept a provider into its network of providers; 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; is related to a health plan not regulated by the state; is related to appeals by in-plan suppliers and providers, unless related to quality of care provided by the plan; is part of a Medicaid fair hearing; is the basis for an action pending in state or federal court; is related to an appeal by nonparticipating providers; was filed before the subscriber or provider completed the entire internal grievance procedure of the managed care entity; has been resolved to the satisfaction of the subscriber or provider who filed the grievance; is limited to seeking damages for pain and suffering, lost wages, or other incidental expenses; 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; or is withdrawn by the subscriber or provider.

[3] Section 408.7056, F.S.

recommendation. In response to the panel's recommendation, AHCA or DOI may issue fines and sanctions against the managed care entity, as well as reject all or part of the recommendation.

The panel consists of members employed by AHCA and DOI, chosen by their respective agencies. The panel also includes 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. AHCA may contract with a medical director and a primary care physician if additional technical expertise is needed on the panel for a particular grievance.[4]

Meetings of the statewide provider and subscriber assistance panel are open to the public unless

- the provider or subscriber whose grievance will be heard requests a closed meeting;
- AHCA or DOI determines that information of a sensitive personal nature which discloses the subscriber's medical treatment or history will be discussed;
- information is discussed which constitutes a trade secret; or
- information relating to internal risk management programs may be revealed at the panel meeting.

According to AHCA, the Statewide Provider and Subscriber Assistance Program is the formal process through which subscribers and providers file complaints relating to managed care.[5]

There is also an informal process for subscribers to file complaints against managed care programs with statewide and district managed care ombudsman committees.

**Statewide and District Managed Care Ombudsman Committees**

Section 641.60, F.S., creates the Statewide Managed Care Ombudsman Committee within the Agency for Health Care Administration (AHCA). This statewide committee is designed to act as a consumer protection and advocacy organization on behalf of all health care consumers receiving services through managed care programs in the state. The statewide committee consists of the chairpersons of the district committees established in s. 641.65, F.S.[6] The members of the statewide committee receive no compensation for their duties, but are reimbursed for travel expenses. These travel expenses are funded from the Health Care Trust Fund created by s. 408.16, F.S.[7]

According to s. 641.60(6), F.S., the Statewide Managed Care Ombudsman Committee is designed to serve as a volunteer organization to protect the rights of all enrollees participating in managed care programs in the state. This committee receives complaints from AHCA regarding the quality of care provided by managed care programs, and may assist AHCA with the investigation and resolution of such complaints. The committee may conduct site visits with AHCA, review existing and new or revised managed care quality assurance programs of AHCA, and make

[4] Section 408.7056(11), F.S.
[5] Pursuant to telephone conversation with AHCA's Office of Legislative Affairs and AHCA's Bureau of Consumer Protection, July 30, 2001.
[6] According to AHCA representatives, there are 11 district committees. Pursuant to telephone conversation with the Chief of the Bureau of Consumer Protection, August 6, 2001.
[7] Section 408.16, F.S., states: "There is created in the State Treasury a special fund to be designated as the Health Care Trust Fund, which shall be used in the operation of the Agency for Health Care Administration in the performance of the various functions and duties required of it by law. "

recommendations as to how the rights of managed care enrollees are affected by such programs. Additionally, the statewide committee may submit a report to the Legislature concerning specific recommendations and complaints. The committee is required to conduct meetings at least two times a year, adopt agency guidelines to carry out its purposes and responsibilities and those of the district committees, monitor the district committees, and provide technical assistance to district committee members.[8] In the one-year period from June 2000 to June 2001, the statewide managed care ombudsman committee met two times, with only two members participating.[9]

Section 641.65, F.S, creates a district managed care ombudsman committee in each district of AHCA that has staff assigned for the regulation of managed care programs.[10] Each district committee must have at least 9 members and no more than 16 members.[11] The first three members are chosen by the director of AHCA, and the remaining members are selected by the initial three appointees. Each district committee receives complaints from AHCA regarding the quality of care provided by managed care programs. A complaint may be referred by AHCA to the committees regarding whether an enrollee's managed care program may have inappropriately denied the enrollee a covered medical service, may be inappropriately delaying the provision of a covered medical service to the enrollees, or is providing substandard covered medical services. The district committees are responsible for establishing and following uniform criteria in reviewing information and receiving complaints. The district committees must submit an annual report to the statewide committee. Meetings are held by the district committees as required by the committees' chairperson, the director of AHCA, the statewide committee, or by written request of a majority of the district committee members.[12]

Members of the district committees do not receive any reimbursement, including charges resulting from travel or phone use.[13]

**Sections 641.67 and 641.68, F.S.**

In 1997, SB 1634 created a public records and public meetings exemption for statewide or district managed care ombudsman committees. Section 641.67, F.S., provides that patient records and certain identifying information held by statewide or district managed care ombudsman committees are confidential and exempt from s. 119.07(1), F.S., and s. 24(a), Art. I of the State Constitution. The law specifically exempts the following identifying information:

> The name or identify of a complainant who files a complaint with the statewide or a district managed care ombudsman committee, including any problem identified by the ombudsman committee as a result of an investigation, unless the complainant provides written consent that authorizes the release of his or her name or unless a court of competent jurisdiction orders that the name or identity of a complainant be disclosed.[14]

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[8] Section 641.60(6), F.S.
[9] AHCA states that if the statewide committee reaches full membership of 11 members, there are not enough funds to cover the travel expenses of the entire committee.
[10] According to AHCA, the agency no longer has staff assigned to particular districts for the regulation of managed care programs. Pursuant to telephone conversation with AHCA's Bureau of Consumer Protection, August 6, 2001.
[11] District managed care ombudsman committees must consist of the following members: a licensed general physician, a physician licensed in osteopathic medicine, a physician licensed in chiropractic medicine, a physician licensed in podiatric medicine, a psychologist, a registered nurse, a clinical social worker, an attorney, and a consumer.
[12] Section 641.65, F.S.
[13] However, if members of the district committee utilize AHCA's telephones, these charges are covered by AHCA. Pursuant to telephone conversation with AHCA's Chief of the Bureau of Consumer Protection, August 6, 2001.
[14] Section 641.67(1)(b), F.S.

The Legislature found it was a public necessity to maintain the confidentiality of such records and identifying information for the following reasons:

- The citizens of Florida benefit from the thorough investigation of complaints regarding the quality of care provided by managed care programs, and to investigate these complaints often requires careful review of a patient's medical record;
- These records are often personal and private;
- The disclosure to the public of such record or a complainant's identity would discourage the filing of complaints, therefore affecting the quality of care provided; and
- The harm to the individual and the public in disclosing patient records and identifying information substantially outweighs the public benefits in allowing such disclosure.[15]

Section 641.68, F.S., provides that the portion of a meeting conducted by the statewide or district managed care ombudsman committee where patient records and identifying information are discussed is exempt from s. 286.011, F.S. and s. 24(b), Art. I of the State Constitution. The Legislature found it was a public necessity to provide an exemption to the public meetings requirements for the following reasons:

- In order to maintain consistency in the law relating to the management and handling of sensitive and personal information;
- Ombudsman committee members must be able to discuss personal information in order to provide an accurate evaluation;
- Improper dissemination to the public of information about managed care programs would have a "chilling effect" on the willingness of persons to report complaints;
- The evaluations of the committee may require certain remedial actions of health maintenance organizations which serve to enhance overall quality of care of potentially the entire managed care industry; and
- The confidentiality of this information will allow AHCA to carry out its duties in protecting the public.[16]

**The Open Government Sunset Review Questionnaire**

The Committee on State Administration sent out an Open Government Sunset Review Questionnaire in June 2001 to AHCA regarding the public meetings and public records exemptions found in ss. 641.67 and 641.68, F.S.

According to AHCA's survey response, only 4 of the 11 district managed care ombudsman committees are operational.[17] In subsequent documentation provided by AHCA, various reasons were cited for the nonexistence of 7 of the 11 district committees. The primary reason is that initial appointees to particular district committees are still searching for additional members. Potential candidates are expressing concern over the lack of reimbursement for travel or phone calls as well

[15] Section 641.67(2), F.S.
[16] Section 641.68, F.S.
[17] House Committee on State Administration – Open Government Sunset Review Questionnaire, Sections 641.67 and 641.68, F.S., completed by the Agency for Health Care Administration, prepared on June 12, 2001, question #3.

as over the fact that no additional staff are provided for the particular committees. Another reason cited is the failure of initial appointees to request additional members or training. A final reason cited is the failure of the initial appointees to receive approval of additional members due to a lack of diversity in the selection process.[18]

AHCA's survey response indicated that in the past 12 months, no **closed** meetings have been held by the statewide ombudsman committee. More specifically, the survey stated: "Case specific discussions have not, thus far, occurred at the two statewide committee meetings held since the inception of the statewide organization in 1999."[19] The survey also indicated that in the past 12 months, no **closed** meetings have been held by the district managed care ombudsman committees.

C. EFFECT OF PROPOSED CHANGES:

**This bill reenacts the public records and meetings exemptions found in ss. 641.67 and 641.68, F.S., with respect to the district managed care ombudsman committees. However, this bill repeals the public records and meetings exemptions for the statewide managed care ombudsman committee.**

Section 641.67, F.S., provides that patient records and certain identifying information held by statewide or district managed care ombudsman committees are confidential and exempt from s. 119.07(1), F.S., and s. 24(a), Art. I of the State Constitution. The law specifically exempts the following identifying information:

> The name or identity of a complainant who files a complaint with the statewide or a district managed care ombudsman committee, including any problem identified by the ombudsman committee as a result of an investigation, unless the complainant provides written consent that authorizes the release of his or her name or unless a court of competent jurisdiction orders that the name or identity of a complainant be disclosed.

Section 641.68, F.S., provides that the portion of a meeting conducted by the statewide or district managed care ombudsman committee where patient records and identifying information are discussed is exempt from s. 286.011, F.S. and s. 24(b), Art. I of the State Constitution.

These exemptions from public records and public meetings requirements for the statewide managed care ombudsman committee are unnecessary as no **closed** meetings have been held by the statewide committee since its inception in 1999. There were two open meetings held by the statewide committee in the past year, and only two members were present.

The repeal of the public records and public meetings exemptions for the statewide committee found in ss. 641.67 and 641.68, F.S., does not abolish the statewide managed care ombudsman committee. Rather, it removes unnecessary exemptions to Florida's public records and meetings laws, in that no closed meeting has been held by such committee. Furthermore, this repeal does not affect the formal process of filing complaints with the Statewide Subscriber and Assistance Program. This program maintains its own public records and meetings exemptions.

In addition, this bill removes the public necessity statements found in ss. 641.67 and 641.68, F.S. It has been the practice of the Legislature that public necessity statements are not codified in statute; they are found only in the Laws of Florida. The public necessity statements removed from ss. 641.67 and 641.68, F.S., can be found in Chapter 97-106, Laws of Florida.

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[18] Pursuant to documentation received by facsimile transmission from AHCA's Bureau of Consumer Protection on July 30, 2001.
[19] House Committee on State Administration – Open Government Sunset Review Questionnaire, Sections 641.67 and 641.68, F.S., completed by the Agency for Health Care Administration, prepared on June 12, 2001, question #2.

Lastly, this bill makes editorial changes to s. 641.67, F.S. It relocates the statement "including any problem identified by the ombudsman committee as a result of an investigation," to its own subsection in order to clarify its original intent.

D. SECTION-BY-SECTION ANALYSIS:

See "Effect of Proposed Changes."

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

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:

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:

None.

B. RULE-MAKING AUTHORITY:

None.

C. OTHER COMMENTS:

None.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

None.

VII. SIGNATURES:

COMMITTEE ON STATE ADMINISTRATION:

| Prepared by: | Staff Director: |
|---|---|
| Lauren Cyran, M.S. | J. Marleen Ahearn, Ph.D., J.D. |

AS REVISED BY THE SMARTER GOVERNMENT COUNCIL:

| Prepared by: | Staff Director: |
|---|---|
| Lauren Cyran, M.S. | Don Rubottom |