SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/CS/SB 1066

SPONSOR: Banking and Insurance Committee, Health, Aging, and Long-Term Care Committee and Senator Saunders

SUBJECT: Health Maintenance Organizations

DATE: January 21, 2004 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Harkey	Wilson	HC	Favorable/CS
2.	Emrich	Deffenbaugh	BI	Favorable/CS
3.			AHS	
4.			AP	
5.				
6.				

I. Summary:

Committee Substitute for Committee Substitute for Senate Bill 1066 changes the name of the Statewide Provider and Subscriber Assistance Program to the Subscriber Assistance Program. The bill specifies that, when the Agency for Health Care Administration is investigating a grievance between a subscriber and a managed care entity under the Subscriber Assistance Program, the managed care entity or health care provider is required to submit grievance-related records, in addition to the current requirement for "medical records." The bill adopts federal claims procedures established under the Employee Retirement Income Security Act as the minimum standards for grievance procedures for claims for benefits for certain organizations that administer small and large group health plans.

This bill amends the following sections of the Florida Statutes: 408.7056, 641.3154, 641.511, and 641.58.

II. Present Situation:

Statewide Provider and Subscriber Assistance Program

Section 408.7056, F.S., requires the Agency for Health Care Administration (AHCA) to implement the Statewide Provider and Subscriber Assistance Program to assist subscribers of managed care entities with grievances that have not been satisfactorily resolved through the managed care entity's internal grievance process. The program can hear grievances of subscribers of health maintenance organizations, prepaid health clinics and exclusive provider organizations. According to AHCA, the program title, "The Statewide Provider and Subscriber Assistance Program," is misleading and causes confusion to a large number of contracted and non-contracted managed health care providers who believe, incorrectly, that the panel can

resolve their billing problems. Section 408.7057, F.S., establishes the Statewide Provider and Health Plan Claim Dispute Resolution Program in AHCA for the purpose of resolving billing problems.

Currently, managed health care entities and health care providers are required to submit medical records to the program upon request when the program is investigating a grievance between a subscriber and a managed care entity. Failure to provide medical records within 10 days of the request may subject the entity or provider to fines.

Employee Retirement Income Security Act of 1974

The Employee Retirement Income Security Act of 1974 (ERISA or law) is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans. The law was enacted to protect private employee pension plans from fraud and mismanagement. It also provides a single national standard for health insurance provided by private companies that have employees in multiple states. The law preempts state laws in so far as they relate to an employee benefit plan. However, the preemption provisions of ERISA contain an exception which permits states to regulate "the business of insurance", i.e., how insurers conduct traditional insurance business.

The Employee Retirement Income Security Act requires plans to provide participants with information including plan features and funding; it outlines the fiduciary responsibilities for those who manage and control plan assets; it requires plans to establish a grievance and appeals process for participants to get benefits from their plans; and it gives participants the right to sue for benefits and breaches of fiduciary duty. This law is part of the federal tax code.

In general, ERISA does not cover group health plans established or maintained by governmental entities, churches for their employees, or plans which are maintained solely to comply with applicable workers compensation, unemployment, or disability laws. The law also does not cover plans maintained outside the United States primarily for the benefit of nonresident aliens or unfunded excess benefit plans.

State and Federal Claims Procedures

State and federal claims procedures for health maintenance organizations (HMOs) differ significantly, and the federal procedures may preempt the current state statutes that are less restrictive. Under current Florida law, s. 641.511(5), F.S., HMOs must resolve subscriber grievances within 60 days after receipt of the grievance, or within a maximum of 90 days if the grievance involves the collection of information outside the service area.

The federal regulations, 29 C.F.R. 2560.503-1, effective to all ERISA-covered HMOs by January 1, 2002, are more restrictive and break down grievance procedures into two distinct categories, pre-service and post-service claims. Pre-service claims must be processed and a decision provided by the health plan within 15 days of receipt, plus a 15-day extension when a plan member receives a bona fide reason for extension. Post-service claims must be processed within 30 days with an additional 15-day authorized extension when the health plan has justified the extension in writing and notified the member.

A United States Department of Labor interpretive guideline addresses the "federal preemption" language of the final federal regulation and says, "States may impose non-conflicting standards for internal processes." (Paragraph 29, C.F.R. 2560.503-1(k)(1)). Under this interpretive guideline, states having less restrictive claims/grievance procedures for small and large group health plans may be in conflict with the federal standards and thereby preempted by federal law. Florida's grievance resolution time lines are less restrictive than the federal regulation and may be preempted.

III. Effect of Proposed Changes:

Section 1 Amends s. 408.7056, F.S., to change the program title from "Statewide Provider and Subscriber Assistance Program" to "Subscriber Assistance Program." The bill further defines the records that a health care provider must provide to Agency for Health Care Administration (AHCA) upon receiving a patient authorization along with a properly filed grievance. Records are "medical records, communication logs associated with the grievance both to and from the subscriber, contracts, and any other contents of the internal grievance file associated with the complaint filed with the Subscriber Assistance Program."

The Agency for Health Care Administration officials anticipate that clarifying the documents and records needed will speed up the review process. This change would incorporate grievance files and other requested records with the medical records, and more importantly, would permit fines to be applied when records other than medical records are not supplied as requested. Such records would include telephone logs, correspondence, grievance hearing records, billing statements, premium/rate change notices, formulary lists, contracts, etc. In FY 2002-2003, 46 percent of all submissions of records other than medical records to the program were in excess of the 10 days permitted for the filing of medical records. According to representatives with AHCA, this significantly slows down the review process.

The bill provides greater flexibility in the composition of the Subscriber Assistance Panel by permitting *at least* two members employed by AHCA, *at least* two members employed by the Department of Financial Services, a physician appointed by the Governor, and *if necessary*, physicians who have expertise relevant to the case to be heard. The current authorization for the panel to contract with a medical director and a primary care physician to provide additional medical expertise is modified to authorize *a medical director, a primary care physician, or both*, and the bill specifies that they must not be voting members of the panel.

The bill defines a quorum as a majority of the required membership and requires the presence of a quorum before the panel can hear a grievance. The maximum size of the panel will be 11 members.

Section 2 Amends s. 641.3154, F.S., to change the program name to Subscriber Assistance Program.

Section 3 Amends s. 641.511, F.S., to change the program name to Subscriber Assistance Program. In addition, subsection (5) of this section is amended to adopt federal claims procedures established under the Employee Retirement Income Security Act (ERISA), in 29

C.F.R. 2560.503-1, as the minimum standards for grievance procedures for claims for benefits for small and large group plans that are subject to 29 C.F.R. 2560.503-1. Incorporating the federal standards in this statute would give the regulating departments, AHCA and the Department of Financial Services, administrative authority over organizations that violated the ERISA standards.

Section 4 Amends subsection (4) of s. 641.58, F.S., to change the program name to Subscriber Assistance Program.

Section 5 Provides that the bill will take effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Art. I, s. 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The Agency for Health Care Administration does not anticipate a cost to the agency for the implementation of this bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

This bill adopts federal ERISA requirements for grievance processes for claims for benefits under 29 C.F.R. 2560.503-1, as applicable to all commercial organizations that administer small and large group health plans that are subject to s. 641.511, F.S. It is important to note that the reference would be to the federal law in effect on the date this bill becomes law. Changes in the federal law would have to be incorporated into this statute by subsequent legislatures if they were to apply under this statute.

VIII. Amendments:

None.