HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1001 Health Maintenance Contracts
SPONSOR(S): Evers
TIED BILLS: **IDEN./SIM. BILLS:** SB 590

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Healthy Seniors	7 Y, 0 N	Walsh	Schoolfield
2) Healthcare Council		Walsh	Gormley
3)			
4)			
5)			

SUMMARY ANALYSIS

House Bill 1001 expands the right of a subscriber covered under a health maintenance organization (HMO) contract who is a resident of a continuing care facility or a retirement facility, to be referred to that facility's skilled nursing unit or assisted living facility upon the subscriber's request and with the agreement of the facility. The bill requires that the HMO provide a written disclosure of these rights to new subscribers who live in these facilities, including the right to use a specified grievance process if their request to be referred is not honored.

The act is effective July 1, 2007.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Safeguard Individual Liberty --- The bill preserves the arrangements of those seniors who are HMO subscribers to receive their lifetime care in the facilities of their chosen continuing care or retirement facility, by allowing them to request that medically necessary rehabilitative care be delivered in their home communities.

B. EFFECT OF PROPOSED CHANGES:

Background

Health Maintenance Organizations (HMO)

The Office of Insurance Regulation (OIR) regulates HMO under Part I of Chapter 641, F.S., while the Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMO under Part III of Chapter 641, F.S. Before receiving a certificate of authority from OIR, an HMO must receive a Health Care Provider Certificate from AHCA. Any entity that is issued a certificate of authority and that is otherwise in compliance with the licensure provisions under Part I may enter into contracts in Florida to provide an agreed-upon set of comprehensive health care services to subscribers.

Generally, health maintenance contracts, certificates, or member handbooks are required to clearly state all of the services to which a subscriber is entitled under the contract and must include a clear and understandable statement of any limitations on the services or kinds of services to be provided.[1] Every HMO is required to have a grievance procedure available to its subscribers, as required by s. 641.511, F.S. If the HMO's internal review process does not resolve the grievance, the subscriber may submit a grievance to the Subscriber Assistance Program administered by AHCA, as provided in s. 408.7056, F.S.

Continuing Care Retirement Communities (CCRC) and Retirement Facilities

A Continuing Care Retirement Community (CCRC) allows seniors flexible accommodations that are designed to meet their health and housing needs as these needs change over time. This type of facility offers three levels of care on one campus: independent living, assisted living facilities, and skilled nursing facilities.

Contract residents of a CCRC have a commitment for lifetime care. They make a substantial investment to prepay for their potential care and are guaranteed living space suitable for their needs for the rest of their lives. CCRC are licensed and regulated by OIR under Chapter 651, F.S. In addition, their skilled nursing and assisted living components are subject to regulation by AHCA.[2] There are a total of 69 licensed CCRC in Florida. These communities are home to approximately 24,000 Florida seniors.

Retirement facilities consisting of residential apartments and a nursing home or assisted living facility or both also provide their residents flexibility in accommodations over time; however, they operate without the prepaid contracts of the CCRC model.

[1] Section 641.31 (4), F.S.
[2] *See*, ss. 400.141, 400.235, 429.04, and 651.118, F.S.

Referral of HMO Subscribers for Nursing Care at CCRC or Retirement Facility

Section 641.31(25), F.S., provides that if a person covered under an HMO contract ("subscriber") is a resident of a continuing care facility or of a retirement facility consisting of a nursing home and residential apartments, the HMO primary care physician **must** refer the subscriber to that facility's skilled nursing care unit if the primary care physician finds it is in the best interest of the subscriber to do so; and if the facility agrees to be reimbursed at the HMO contract rate negotiated with similar providers. In addition, the facility must meet all guidelines established by the HMO related to quality of care, utilization, referral authorization, risk assumption, use of the HMOs network, and other criteria applicable to providers under contract.

It has been reported that HMO physicians have not always referred their subscribers to the skilled nursing facilities associated with their home CCRC or retirement facility campuses for rehabilitation after hospitalization. This can result in the subscriber being physically isolated from his or her spouse, friends, and other caregivers at a time when such support is most important. Placements away from their home campuses also thwart the careful retirement planning these individuals engaged in and serve to discourage others from such planning.

Effect of Proposed Bill

HB 1001 expands the right of a subscriber covered under an HMO contract who is a resident of a CCRC or a retirement facility to be referred to that facility's skilled nursing unit or assisted living facility upon the subscriber's request and with the agreement of the facility.[3] The bill specifies the physicians who may make the referral.

The bill requires that the HMO provide a written disclosure of these rights to new subscribers living in CCRC or retirement facilities, including the right to use the grievance process in s. 641.511, F. S., if their request to be referred is not honored.

HB 1001 is effective July 1, 2007.

C. SECTION DIRECTORY:

Section 1: Amends s. 641.31(25), F. S.; provides additional criteria for referral; specifies physicians who can make referral; requires disclosure; specifies grievance process.

Section 2: Provides effective date of July 1, 2007.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

[3] The bill does not change the requirement that the subscriber's HMO primary care physician find such placement to be in the subscriber's best interest.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

If a subscriber elects to be referred to the nursing home or assisted living facility of his or her own facility, that facility must accept the contract rate negotiated by the HMO with similar providers for the same services, as well as being subject to all requirements of the HMO related to quality of care, utilization, referral authorization, and risk assumption.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Lines 24-26: The bill includes a list of physicians who may make the required finding of subscriber best interest. However, the definition of "Health Maintenance Organization" at s. 641.19(12)(e), F.S., provides that a primary physician is any physician licensed under Chapters 458, 459, 460, or 461, F.S. It is suggested that the bill be amended to remove the list as it is unnecessary.

D. STATEMENT OF THE SPONSOR:

No statement submitted.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

At its March 13, 2007, meeting, the Committee on Healthy Seniors adopted one amendment to HB 1001 as filed. The amendment conforms the House bill to its Senate companion and requires that the subscriber's primary care physician make a finding that the requested care is medically necessary, rather than in the subscriber's best interest. The amendment also removes the unnecessary list of physician The Committee reported the bill favorably with one amendment.