**The Florida Senate**

# PROFESSIONAL STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

Prepared By: Governmental Operations Committee

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| BILL: | SB 590 |
| INTRODUCER: | Senators Saunders and Atwater |
| SUBJECT: | HMO Contract/New Subscriber's Rights |
| DATE: | March 9, 2007 REVISED: |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Peacock | Deffenbaugh | BI | **Fav/1 amendment** |
| 2. | Wilson | Wilson | GO | **Favorable** |
| 3. | | | HR | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |

**Please see last section for Summary of Amendments**

- [ ] Technical amendments were recommended
- [x] Amendments were recommended
- [ ] Significant amendments were recommended

## I. Summary:

Senate Bill 590 expands the right of a person (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. The bill deletes the current requirement that the HMO primary care physician make a determination that such care is in the best interests of the subscriber. Instead, the bill requires that such referral be requested by the subscriber and agreed to by the facility. The bill further requires that HMOs provide in writing a disclosure of such rights to new subscribers who reside at a continuing care facility or retirement facility, including the right to use a specified grievance process in the event their request to be referred to the skilled nursing unit or assisted living facility at their place of residence is not honored.

This bill substantially amends section 641.31 of the Florida Statutes.

## II. Present Situation:

**Health Maintenance Organizations (HMOs)**

The Office of Insurance Regulation (OIR) regulates health maintenance organization solvency, contracts, rates, and marketing activities under part I of chapter 641, F.S., while the Agency for

Health Care Administration (AHCA) regulates the quality of care provided by HMOs 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, as provided in s. 408.7056, F.S., which is administered by the Agency for Health Care Administration.

**Continuing Care Retirement Communities (CCRCs)**

One of many retirement options that exist in Florida is a Continuing Care Retirement Community (CCRC). A CCRC allow 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: independent living, assisted living facilities, and skilled nursing facilities. At each community the three levels are located on the same campus. Other services are provided, such as one or more hot meals a day and a variety of social, educational, physical education, and spiritual activities.

There are two kinds of residents in a CCRC: contract (most residents) and rental (only a few). Both have access to all services offered. However, contract residents have a lifetime contract. They make a substantial investment to prepay for their potential care and they pay monthly operational fees as well. They are guaranteed living space suitable for their needs for the rest of their lives. CCRCs and their lifetime contracts are subject to licensure and regulation by the Office of Insurance Regulation under ch. 651, F.S. In addition, nursing home care and assisted living care may be subject to regulation by the Agency for Health Care Administration under chs. 400 or 409, F.S., respectively.[2] A total of 69 licensed CCRCs exist within the State of Florida. These communities are home to approximately 24,000 Florida seniors. The average age of residents is 83 years old.[3]

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

Current law, in s. 651.31(25), F.S., provides that if a person ("subscriber") covered under an HMO contract is a resident of a continuing care facility or a retirement facility consisting of a nursing home, 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. Two requirements exist for this referral, the first being that the facility agrees to be

[1] Chapter 641.31 (4), F.S.
[2] See, ss. 400.141, 400.235, 429.04, and 651.118, F.S.
[3] Letter, dated March 01, 2007, from Bennett Napier, Executive Director of the Florida Life Care Residents Association (FLiCRA).

reimbursed at the HMOs contract rate negotiated with similar providers for the same services and supplies. 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 for the same services and supplies.

## III. Effect of Proposed Changes:

**Section 1** amends section 641.31, F.S., to expand the right of a subscriber under an 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. The bill deletes the current requirement that the primary care physician under the HMO contract make a determination that such care is in the best interests of the subscriber. Instead, the bill requires that such referral be requested by the subscriber and agreed to by the facility. (See, Related Issues, below.) The bill also applies this requirement to an assisted living facility, as well as a nursing home, that is part of a continuing care facility or retirement facility. The bill further requires HMOs to provide in writing a disclosure of such rights to new subscribers who reside at a continuing care facility or retirement facility, including the right to use the grievance process specified in s. 641.511, F.S., if their request to be referred to the skilled nursing unit or assisted living facility that is part of the subscriber's place of residence is not honored.

**Section 2** provides that the act shall take effect July 1, 2007.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

## V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The private sector impact is indeterminate. If it is not the intent of the legislation to expand coverage for care that is not medically necessary (see Related Issues, below), the costs should be minimal. 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.

C. Government Sector Impact:

None.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

By deleting the current requirement that the HMO primary care physician must make a determination that it is in the best interest of the subscriber to refer him or her to the nursing home (or assisted living facility) of the subscriber's continuing care or retirement facility, the bill may be interpreted as eliminating the need for any determination by the primary care physician of the medical necessity for such care.

# VIII. Summary of Amendments:

**Barcode 864150 by Banking and Insurance:**
This amendment clarifies that the HMO primary care physician must make a determination that the referral for nursing care or assisted living care is medically necessary. Once this determination is made, the insured subscriber has the right to have that care provided at his or her own facility.