HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 899 Managed Care
SPONSOR(S): Troutman
TIED BILLS: **IDEN./SIM. BILLS:** SB 2182

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Health Innovation	6 Y, 2 N	Ciccone	Calamas
2) Healthcare Council			
3) Policy & Budget Council			
4)			
5)			

SUMMARY ANALYSIS

House Bill 899 amends several statutory sections regarding health maintenance organizations (HMOs), provider service networks (PSNs) and minority physician networks (MPNs), regarding the provider application process, minimum financial surplus and solvency requirements. and Medicaid recipient provider assignments.

The bill:

- Amends s. 409.912(3), F.S., to require that HMO applicants for Medicaid contracts demonstrate, as a condition of the HMO application approval, a three-year record of success in: providing comprehensive health insurance coverage in Florida; or prepaid capitated comprehensive Medicaid services in any state; or prepaid comprehensive services to Medicare or Title XXI members. This provision would affect HMO applicants who apply for Medicaid contracts after July 1, 2007.

- Amends s. 641.225, F.S., to increase the minimum surplus from $1.5 million to $5 million that HMOs or their guarantors, must maintain. This provision would affect HMOs receiving a certificate of authority after July 1, 2007.

- Amends ss. 409.912(4)(d), 409.91211(3)(e), and 641.2261, F.S., to require prepaid and fee-for-service PSNs not operated by a hospital to meet the surplus, solvency and other financial requirements that HMOs must meet under Part I of chapter 641, F.S. The bill provides that new PSNs must comply with these new requirements by July 1, 2007 and current PSNs must comply by July 1, 2010. These amendments apply to non-reform PSNs.

- Amends s. 409.912(49), F.S., to require current MPNs to meet the proposed surplus, solvency and other financial requirements that HMOs must meet under part I of chapter 641, F.S., by July 1, 2010. New MPNs must comply prior to state approval of MPNs.

- Creates s. 409.912(53), F.S., to prohibit the Agency for Health Care Administration (agency) from contracting with managed care plans that are eligible to receive Medicaid recipients under certain circumstances—when the managed care contract would cause the county to have fewer than 35,000 recipients subject to mandatory Medicaid managed care enrollment for each plan eligible to receive assignments. Certain entities are exempt from this provision, including Children's Medical Services Network.

The bill appears to have no fiscal impact on the Medicaid program, and provides an effective date of July 1, 2007.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government – The bill provides increased regulatory requirements on health maintenance organizations, certain provider service networks and minority physician networks.

B. EFFECT OF PROPOSED CHANGES:

House Bill 899 provides several new solvency, financial, and other regulatory requirements on HMOs, non-hospital based PSNs, and MPNs in an effort to establish parody among these providers. The increases regarding financial surplus requirements for HMOs may not negatively affect some of the larger HMOs; however the provision may have a significant impact on smaller or newer HMOs, non-hospital PSNs and MPNs. The effect of these increased regulations may limit competition in the Medicaid insurance market by placing significantly greater financial requirements on these managed care plans.

The bill restricts the agency from contracting with non-hospital based PSNs and MPNs that do not meet these new solvency and financial requirements. The PSNs and MPNs currently operating in the state are reimbursed on a fee-for-service basis and the MPNs are not responsible for comprehensive care. The fee-for-service PSNs' risk is limited to repayment of a portion of administrative fees. Even with the phasing in of these new requirements on current MPNs and non-hospital based PSNs, applying the solvency requirements specified in the bill to MPNs and PSNs is likely to limit these entities' ability to participate as Medicaid health plans and managed care organizations. The bill only applies the higher solvency requirement to PSNs not operated by hospitals, resulting in comparatively lower surplus requirements for hospital-based PSNs. While there are no capitated PSNs currently in the state, the contract requirements currently treat all PSNs, hospital based or non-hospital based the same.

The bill may prevent new entities from entering the Medicaid marketplace and may cause smaller existing managed care providers to withdraw. This may in turn reduce or curtail the managed care plan choices available to Medicaid recipients, especially in rural areas. In particular, the bill may prevent the development of provider service networks specializing in certain diagnoses.

The bill also requires HMO applicants to demonstrate a three-year "record of success" in providing some type of comprehensive insurance coverage – either in Florida or another state. This provision imposes a new requirement and may prevent new HMOs from entering the Medicaid marketplace.

Present Situation[1]

Currently, the prepaid and fee-for-service PSNs (Medicaid Reform and non-reform) are exempt from surplus, solvency, and other financial requirements of part I of chapter 641, F.S., except that prepaid PSNs must meet the solvency requirements of 42 CFR s. 422.350, subpart H, and the solvency requirements established in approved federal waivers. There is no differentiation in these requirements between hospital based PSNs and non-hospital based PSNs.

For non-reform PSNs, 42 CFR s. 422.350, subpart H, requires that PSNs must maintain a minimum surplus of an amount that is the greater of $1 million or 1.5 percent of projected annual premiums, and allows an exception for PSNs operated by public or state agencies and include separate solvency requirements for federally qualified health centers (basically Medicare plus Choice requirements).

[1] Agency for Health Care Administration-March 2007, on file with the Committee.

Medicaid Reform PSNs may contract with Medicaid to provide either comprehensive and catastrophic health care coverage or comprehensive health care coverage (non-catastrophic coverage) only. Non-reform PSNs are required to cover comprehensive and catastrophic health care coverage.

For Medicaid Reform prepaid PSNs that provide comprehensive health care coverage (non-catastrophic coverage) only, the Medicaid Reform 1115 waiver requires that the PSNs maintain a minimum surplus of an amount that is the greater of $1 million or 1.5 percent of projected annual premiums and allows an exception for PSNs operated by public or state agencies and include separate solvency requirements for federally qualified health centers.

For Medicaid Reform prepaid PSNs that provide comprehensive and catastrophic health care coverage, the Medicaid Reform 1115 waiver requires that the PSNs meet the more stringent financial standards consistent with licensed HMOs in chapter 641, F.S. Chapter 641 requires that an entity shall at all times maintain a minimum surplus in an amount that is greater of $1,500,000, or 10 percent of total liabilities, or 2 percent of total contract amount.

Medicaid Reform fee-for-service PSNs that operated under s. 409.91211(3)(e), F.S., and authorized in the approved 1115 Medicaid Reform Demonstration Waiver are required to convert to a prepaid reimbursement methodology at the end of the third year of operation.

Pursuant to chapter 641, F.S., HMOs are currently required to maintain a minimum surplus of $1.5 million, 10 percent of total liabilities, or 2 percent of total annualized premium, whichever is greatest. The HMOs' guarantors are required to have a surplus of $2 million or 2 times the minimum surplus requirements of the HMO, whichever is greater.

Pursuant to sections 409.912 and 409.9122, F.S., the agency is authorized to contract with managed care plans in any county, regardless of how many recipients are subject to the Medicaid managed care mandatory assignment process specified in s. 409.9122, F.S.

C. SECTION DIRECTORY:

Section 1. Amends s. 409.912(3) and (4)(d) and (49)(a), F.S.; relating to cost-effective purchasing of health care, and creates s. 409.912(53)(a), F.S.; relating to agency contracts with managed care plans.

Section 2. Amends s. 409.91211(3)(e), F.S., relating to Medicaid manage care pilot programs.

Section 3. Amends s. 641.225(1) and (2) and (6)(a), F.S., relating to surplus requirements.

Section 4. Amends s. 641.2261(2), F.S., relating to application of solvency requirements to provider-sponsored organizations and Medicaid provider service networks.

Section 5. Provides an effective date of July 1, 2007.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The bill has no direct fiscal impact on the Medicaid Program.

2. Expenditures:

   The bill has no direct fiscal impact on the Medicaid Program.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

HMOs, non-hospital based PSNs, and MPNs will be significantly impacted. The bill increases the minimum surplus HMOs, or their guarantors must maintain and imposes significant surplus, solvency, and other financial requirements non-hospital based PSNs and MPNs. Non-hospital based PSNs would be put in an economic disadvantage compared to hospital-based PSNs due to these new requirements.

The increased regulatory and fiscal requirements in the bill may prevent new managed care entities from entering the Medicaid market and may cause smaller current managed care plans to withdraw. The bill also restricts the agency's ability to contract with managed care plans in counties with small Medicaid populations, which would restrict the establishment of new managed care plans and reduce Medicaid recipients' managed care choices.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenues.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

D. STATEMENT OF THE SPONSOR

No statement provided.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

On March 20, 2007, the Health Innovation Committee adopted three amendments to the bill. These amendments:

- Clarified certain health maintenance organization qualifications necessary to serve Medicaid recipients.
- Directed the Office of Insurance Regulation to address managed care organization solvency through risk-based capital requirements.
- Clarified that the Agency for Health Care Administration can contract with at least two Medicaid managed care plans per county.

The bill was reported favorably with three amendments.