Health Innovation Subcommittee

Wednesday, March 13, 2013
9:00 AM - 11:00 AM
306 HOB

Will Weatherford
Speaker

John Wood
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health Innovation Subcommittee

Start Date and Time:	Wednesday, March 13, 2013 09:00 am
End Date and Time:	Wednesday, March 13, 2013 11:00 am
Location:	306 HOB
Duration:	2.00 hrs

Consideration of the following bill(s):

HB 125 Program of All-inclusive Care for the Elderly by Smith
HB 581 Dentists by Renuart
HB 709 Health Care Clinics by Diaz, J.

Consideration of the following proposed committee substitute(s):

PCS for HB 301 -- Cancer Treatment

Pursuant to rule 7.12, the deadline for amendments to bills on the agenda by non-appointed members is 6:00 p.m., Tuesday, March 12, 2013.

By request of the chair, all committee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Tuesday, March 12, 2013.

NOTICE FINALIZED on 03/11/2013 16:19 by Iseminger.Bobbye

HB 125

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 125 Program of All-inclusive Care for the Elderly
SPONSOR(S): Smith
TIED BILLS: **IDEN./SIM. BILLS:** SB 440

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		Entress	Shaw
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The Program of All-inclusive Care for the Elderly (PACE) is a federal program, which integrates Medicaid and Medicare programs, and is available to qualified Floridians in need of nursing home level of care. PACE offers a continuum of services to individuals in the community with the goal of delaying nursing home entry. There are currently four PACE providers operating in Florida, serving clients in six counties.

The bill creates two PACE centers to serve Citrus, Hernando, and Pasco Counties. One PACE centers must be a not-for-profit organization with more than 30 years' experience as a licensed hospice and currently be a licensed hospice serving individuals and families in Citrus, Hernando, and Pasco counties. The other PACE center must be a private health care organization, the sole member of which is a private, not-for-profit corporation that owns and manages health care organizations licensed in Citrus, Hernando and Pasco counties.

The bill exempts the two PACE centers from the state requirements of health care service programs and from the state requirements of contracts for long-term care services within community diversion pilot project areas.

The bill requires the Agency for Health Care Administration (AHCA), in consultation with the Department of Elder Affairs (DOEA) to approve up to 150 initial enrollees for each PACE center.

The bill specifies that the requirements for each PACE site are subject to federal approval of the application to be a PACE site.

Funding for the new PACE centers is subject to an appropriation.

The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

The Program for All-Inclusive Care for the Elderly (PACE) is a federal program, which integrates Medicare and Medicaid programs to provide an array of preventive, primary, acute, home and community-based, and long-term care services, with the goal of delaying nursing home admission.[1] The PACE model was tested through CMS demonstration projects that began in the mid-1980s and was established as a permanent Medicare program by the Balancing Budget Act of 1997.[2] A PACE organization is a non-profit private or public entity primarily engaged in providing PACE health care services.[3] As of June 3, 2011, there were approximately 20,000 PACE participants and 80 operational PACE organizations throughout 30 states.[4]

Payment

PACE providers receive both Medicare and Medicaid capitated payments and are responsible for providing the full continuum of medical and long-term care services.[5] In addition, PACE sites receive an enhanced capitation payment from Medicare, beyond that of a traditional Medicare health maintenance organization.[6] In exchange, PACE organizations assume full financial risk for all enrollee care, including nursing home care.[7] The rate is specified in the PACE agreement, set up between CMS, AHCA, and the PACE providers.[8]

PACE covers a variety of services, including, but not limited to:

- Adult day care;
- Transportation;
- Prescription drugs;
- Meals;
- Hospital care;
- Primary care; and
- Physical therapy.[9]

Florida PACE

[1] OPPAGA Analysis of Rates for Florida's Program for All-Inclusive Care for the Elderly, OPPAGA research memorandum (January 4, 2013).
[2] Pub. 100-11 Programs of All-Inclusive Care for the Elderly (PACE) Manual, CMS Manual System, page 2, accessible at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Program-of-All-Inclusive-Care-for-the-Elderly-PACE/Program-of-All-Inclusive-Care-for-the-Elderly-PACE.html.
[3] PACE benefits, Medicaid.gov, accessible at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Program-of-All-Inclusive-Care-for-the-Elderly-PACE/PACE-Benefits.html.
[4] Pub. 100-11 Programs of All-Inclusive Care for the Elderly (PACE) Manual, CMS Manual System, page 2, accessible at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Program-of-All-Inclusive-Care-for-the-Elderly-PACE/Program-of-All-Inclusive-Care-for-the-Elderly-PACE.html.
[5] Program for All-Inclusive Care for the Elderly, Florida Department of Elder Affairs, accessible at: http://elderaffairs.state.fl.us/doea/pace.php.
[6] *Id.*
[7] OPPAGA Analysis of Rates for Florida's Program for All-Inclusive Care for the Elderly, OPPAGA research memorandum (January 4, 2013).
[8] *Id.*
[9] Quick Fact about Programs of All-inclusive Care for the Elderly, Centers for Medicare & Medicaid Services, accessible at: http://www.bing.com/search?q=cms+quick+facts+about+pace&src=IE-SearchBox&FORM=IE8SRC.

The Florida PACE project is one project among many that provide alternative, long-term care options for elders who qualify for Medicare and the state Medicaid program. The PACE project was initially authorized in chapter 98-327, Laws of Florida, and is codified in s. 430.707(2), F.S. The PACE model targets individuals who would otherwise qualify for Medicaid nursing home placement and provides them with a comprehensive array of home and community based services at a cost less than the cost of nursing home care.[10] The PACE project is administered by DOEA in consultation with AHCA.[11] There are currently four PACE providers in Florida, serving clients in Hillsborough, Miami-Dade, Collier, Lee, Charlotte, and Pinellas counties.[12] As of February 2013, there were 807 individuals in Florida using PACE services.[13]

To receive PACE, an individual must meet the following qualifications:

- Be 55 years old or older;
- Live in a service area of a PACE organization;
- Meet the need for nursing home level of care (as determined by the Department of Elder Affairs)[14];
- Be able to live safely in the community with the help of PACE services;[15] and
- Be eligible for Medicare or Medicaid.[16]

Florida PACE programs are subject to funding provided in the General Appropriation Act[17] The capitated rate is negotiated between the Agency for Health Care Administration (AHCA) and the provider and must meet Center for Medicaid and Medicare Services (CMS) guidelines.[18]

PACE providers may contract with AHCA to participate in the Long-Term Care Managed Care Program. PACE providers are not subject to the procurement requirements or the regional plan number limits of the Long Term Care Managed Care Program.

Approval of PACE Sites

To become a PACE provider, an organization must submit an application to CMS, along with a letter from AHCA stating that AHCA considers the entity to be qualified to be a PACE organization and that AHCA is willing to enter into a PACE program agreement with the entity.[19] CMS must inform the applicant of approval or disapproval within 90 days of receiving all required information.[20]

PACE organizations must:

- Have a governing board that includes community representation;
- Have a physical site to provide adult day services;
- Have a defined service area;
- Be able to provide the complete service package regardless of frequency or duration of services;

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[10] Program for All-Inclusive Care for the Elderly, Florida Department of Elder Affairs, accessible at: http://elderaffairs.state.fl.us/doea/pace.php.

[11] *Id.*

[12] *Id.*

[13] PACE Enrollments Self Reported by Health Plan, Florida Department of Elder Affairs, accessible at: www.PACE_Monthly_Enrollment_Report[1].pdf.

[14] Capitation Rate Development for PACE program, Milliman, accessible at: http://elderaffairs.state.fl.us/doea/diversion/Capitation_Rates_2012_2013.pdf (September 2012-August 2013).

[15] Quick Fact about Programs of All-inclusive Care for the Elderly, Centers for Medicare & Medicaid Services, accessible at: http://www.bing.com/search?q=cms+quick+facts+about+pace&src=IE-SearchBox&FORM=IE8SRC.

[16] Program for All-Inclusive Care for the Elderly, Florida Department of Elder Affairs, accessible.at: http://elderaffairs.state.fl.us/doea/pace.php.

[17] S. 409.981(4), F.S.

[18] *Id.*

[19] 42 CFR 460.12.

[20] 42 CFR 460.20.

- Have safeguards against conflict of interest; and
- Be able to demonstrate fiscal soundness.[21]

A PACE organization must employ or contract with a program director who is responsible for oversight and administration of the entity and a medical director who is responsible for the delivery of participant care, for clinical outcomes, and for the implementation, as well as oversight, of the quality assessment and performance improvement program.[22] Among other requirements, the PACE organization must have an organizational chart,[23] have an insolvency plan,[24] and have a program agreement between the provider, CMS, and AHCA.[25] This process typically takes at least one year to complete.[26]

In addition, in order for two PACE providers to operate in the same geographic area, the providers are responsible for identifying that there is a need and enough potential participants for each PACE provider to be viable.[27] Documentation must be submitted to AHCA that will insure that neither provider will have to compete for the same recipients.[28]

The following sections of law approved or amended PACE sites in Florida:

- Section 3, chapter 2006-25, L.O.F., included proviso language in the 2006-2007 GAA to authorize 150 additional clients for the existing PACE project in Miami-Dade County and funding for the development of PACE projects to serve 200 clients in Martin and St. Lucie counties, and 200 clients in Lee County.
- Section 3, chapter 2008-152, L.O.F., included proviso language in the 2008-09 GAA to reallocate 150 unused PACE slots to Miami-Dade, Lee and Pinellas Counties. Each site received 50 slots.
- Section 20, chapter 2009-55, L.O.F., directed the AHCA, upon federal approval of an application to be a site for PACE, to contract with one private, not-for-profit hospice organization located in Hillsborough County, which provides comprehensive services, including hospice care for frail and elderly persons. This section also authorized the AHCA, in consultation with DOEA and subject to an appropriation, to approve up to 100 slots for the program.
- Section 14, chapter 2010-156, L.O.F., directed the AHCA to contract with a private health care organization to provide comprehensive services to frail and elderly persons residing in Polk, Highlands, Hardee, and Hillsborough Counties. This section also authorized 150 initial slots for the program.
- Section 15, chapter 2010-156, L.O.F., directed AHCA to contract for a new PACE site in Southwest Miami-Dade County and approved 50 initial slots for the program.
- Section 17, chapter 2011-61, L.O.F., directed AHCA to contract for a new PACE site in Palm Beach County and authorized up to 150 initial enrollee slots.
- Section 19, chapter 2012-33, L.O.F., directed AHCA to contract for new PACE sites in Broward County and in Manatee, Sarasota, and DeSoto counties; and approved up to 150 initial enrollees for each site, subject to a specific appropriation.

Section 430.707, F.S. governs contracts for long-term care services within community diversion pilot project areas and requires DOEA to contract with managed care organizations and other qualified providers for long-term care within community diversion pilot project areas. These long term-care

[21] PACE benefits, Medicaid.gov, accessible at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Program-of-All-Inclusive-Care-for-the-Elderly-PACE/PACE-Benefits.html.
[22] 42 CFR 460.60.
[23] *Id.*
[24] 42 CFR 460.80(b).
[25] 42 CFR 460.30.
[26] Agency for Health Care Administration analysis of HB 125, on file with Health Innovation Subcommittee staff. (3/9/13).
[27] Agency for Health Care Administration analysis of HB 125, on file with Health Innovation Subcommittee staff. (3/9/13).
[28] Agency for Health Care Administration analysis of HB 125, on file with Health Innovation Subcommittee staff. (3/9/13).

providers can be PACE programs.[29] Health care service program requirements are specified in ch. 641, F.S. However, the PACE program is exempt from the program requirements of ch. 641, F.S. if the entity is a private, nonprofit, superior-rated nursing home, and if at least fifty percent of its residents are eligible for Medicaid.[30] The PACE centers which either were created or were expanded between 2009 and 2012 were exempt from requirements under 641 and s. 430.707, F.S.

The state is in the process of implementing the statutorily required Statewide Medicaid Managed Care Long-term Care Managed Care (SMMC LTC) program, which serves the PACE-eligible population, provides a similar set of Medicaid services as PACE, and which incorporates strong quality measurement and monitoring. PACE is a competing model to LTC SMMC in the delivery of long-term care services.[31]

Effect of the Bill

The bill creates two new PACE centers in Citrus, Hernando and Pasco counties.

The bill requires the AHCA to contract with one not-for-profit organization to provide PACE services to frail elders who reside in Citrus, Hernando, and Pasco counties. The not-for-profit organization must have more than 30 years of experience as a licensed hospice and currently be licensed as a hospice serving individuals and families in Citrus, Hernando, and Pasco Counties.

The bill also requires AHCA to contract with one private health care organization. The health care organization, the sole member of which is a private, not-for-profit corporation that owns and manages health care organizations licensed in Citrus, Hernando and Pasco counties which provide comprehensive services to frail elders who reside in those counties, including hospice and palliative care.

The bill requires AHCA, in consultation with DOEA, to approve up to 150 initial enrollees in each newly created PACE organization. This number of enrollees is consistent with the number approved in past legislation for new PACE providers, which varied from 50 to 150 slots for new enrollees.

Before either PACE center can operate, the center must be approved by AHCA. Since the bill allows two PACE centers in one area, the PACE centers must identify that there is a need and enough potential participants for each PACE provider to be viable and submit documentation to AHCA that will insure that neither provider will have to compete for the same recipients.

Normally, s. 430.707, F.S. governs contracts for long-term care services within community diversion pilot project areas. The bill exempts s. 430.707, F.S. from application to both the PACE providers. The bill also exempts the PACE providers from the requirements of health care service programs, which are specified in ch. 641, F.S. These exemptions are also consistent with the previous legislation to approve new PACE providers.

The bill is subject to federal approval of the applications to be a PACE site.

B. SECTION DIRECTORY:

Section 1: Creates an unnumbered section of law, relating to the Program of All-inclusive Care for the Elderly.

Section 2: Creates an unnumbered section of law, relating to the Program of All-inclusive Care for the Elderly.

Section 3: Provides for an effective date.

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[29] S. 430.707, F.S.

[30] *Id.*

[31] Agency for Health Care Administration analysis of HB 125, on file with Health Innovation Subcommittee staff. (3/9/13).

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   AHCA estimates the fiscal impact to AHCA for administration of the PACE application process would be $72,128 for Fiscal Year 2013-2014.The estimate includes salary for one FTE and human resource costs.[32] The recurring impact is estimated to be $67,135.[33]

   Funding for the new PACE centers is subject to an appropriation.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

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[32] Agency for Health Care Administration analysis of HB 125, on file with Health Innovation Subcommittee staff. (3/9/13).

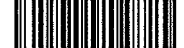
[33] Agency for Health Care Administration analysis of HB 125, on file with Health Innovation Subcommittee staff. (3/9/13).

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to the Program of All-inclusive Care
3 for the Elderly; authorizing the Agency for Health
4 Care Administration to contract with certain
5 organizations to provide services under the federal
6 Program of All-inclusive Care for the Elderly in
7 Citrus, Hernando, and Pasco Counties; providing an
8 exemption from ch. 641, F.S., for the organizations;
9 authorizing, subject to appropriation, enrollment
10 slots for the program in such counties; providing an
11 effective date.
12
13 Be It Enacted by the Legislature of the State of Florida:
14
15 Section 1. Notwithstanding s. 430.707, Florida Statutes,
16 and subject to federal approval of the application to be a site
17 for the Program of All-inclusive Care for the Elderly (PACE),
18 the Agency for Health Care Administration shall contract with
19 one not-for-profit organization that has more than 30 years'
20 experience as a licensed hospice and is currently a licensed
21 hospice serving individuals and families in Citrus, Hernando,
22 and Pasco Counties. This not-for-profit organization shall
23 provide PACE services to frail elders who reside in Citrus,
24 Hernando, and Pasco Counties. The organization shall be exempt
25 from the requirements of chapter 641, Florida Statutes. The
26 agency, in consultation with the Department of Elderly Affairs
27 and subject to an appropriation, shall approve up to 150 initial
28 enrollees in the Program of All-inclusive Care for the Elderly

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

29 established by this organization to serve frail elders who
30 reside in Citrus, Hernando, and Pasco Counties.
31 Section 2. Notwithstanding s. 430.707, Florida Statutes,
32 and subject to federal approval of the application to be a site
33 for the Program of All-inclusive Care for the Elderly (PACE),
34 the Agency for Health Care Administration shall contract with
35 one private health care organization, the sole member of which
36 is a private, not-for-profit corporation that owns and manages
37 health care organizations licensed in Citrus, Hernando, and
38 Pasco Counties which provide comprehensive services, including
39 hospice and palliative care, to frail elders who reside in those
40 counties. The organization shall be exempt from the requirements
41 of chapter 641, Florida Statutes. The agency, in consultation
42 with the Department of Elderly Affairs and subject to an
43 appropriation, shall approve up to 150 initial enrollees in the
44 Program of All-inclusive Care for the Elderly established by
45 this organization to serve frail elders who reside in Citrus,
46 Hernando, and Pasco Counties.
47 Section 3. This act shall take effect July 1, 2013.



Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED ____ (Y/N)

ADOPTED AS AMENDED ____ (Y/N)

ADOPTED W/O OBJECTION ____ (Y/N)

FAILED TO ADOPT ____ (Y/N)

WITHDRAWN ____ (Y/N)

OTHER

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1 Committee/Subcommittee hearing bill: Health Innovation
2 Subcommittee
3 Representative Smith offered the following:
4
5 **Amendment (with title amendment)**
6 Remove everything after the enacting clause and insert:
7 Section 1. Notwithstanding s. 430.707, Florida Statutes,
8 and subject to federal approval of the application to be a site
9 for the Program of All-inclusive Care for the Elderly (PACE),
10 the Agency for Health Care Administration shall contract with
11 one not-for-profit organization that has more than 30 years'
12 experience as a licensed hospice and is currently a licensed
13 hospice serving individuals and families in Hernando and Pasco
14 Counties. This not-for-profit organization shall provide PACE
15 services to frail elders who reside in Hernando and Pasco
16 Counties. The organization shall be exempt from the requirements
17 of chapter 641, Florida Statutes. The agency, in consultation
18 with the Department of Elderly Affairs and subject to an
19 appropriation, shall approve up to 150 initial enrollees in the

20 Program of All-inclusive Care for the Elderly established by
21 this organization to serve frail elders who reside in Hernando
22 and Pasco Counties.
23 Section 2. Notwithstanding s. 430.707, Florida Statutes,
24 and subject to federal approval of the application to be a site
25 for the Program of All-inclusive Care for the Elderly (PACE),
26 the Agency for Health Care Administration shall contract with
27 one private health care organization, the sole member of which
28 is a private, not-for-profit corporation that owns and manages
29 health care organizations licensed in Hernando and Pasco
30 Counties which provide comprehensive services, including hospice
31 and palliative care, to frail elders who reside in those
32 counties. The organization shall be exempt from the requirements
33 of chapter 641, Florida Statutes. The agency, in consultation
34 with the Department of Elderly Affairs and subject to an
35 appropriation, shall approve up to 150 initial enrollees in the
36 Program of All-inclusive Care for the Elderly established by
37 this organization to serve frail elders who reside in Hernando
38 and Pasco Counties.
39 Section 3. This act shall take effect July 1, 2013.
40
41 ---
42 **T I T L E A M E N D M E N T**
43 Remove everything before the enacting clause and insert:
44 A bill to be entitled
45 An act relating to the Program of All-inclusive Care
46 for the Elderly; authorizing the Agency for Health
47 Care Administration to contract with certain

48 organizations to provide services under the federal
49 Program of All-inclusive Care for the Elderly in
50 Hernando and Pasco Counties; providing an exemption
51 from ch. 641, F.S., for the organizations;
52 authorizing, subject to appropriation, enrollment
53 slots for the program in such counties; providing an
54 effective date.

HB 581

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 581 Dentists
SPONSOR(S): Renuart and others
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		Poche	Shaw
2) Insurance & Banking Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

House Bill 581 prohibits health insurance provider contracts from containing provisions requiring dentists to provide services at a fee set by the health insurer, prepaid limited health service organization or health maintenance organization unless the services are covered under the subscriber agreement. The bill defines "covered services" and requires the insurer or organization to set fees for covered services in good faith. Fees may not be nominal or de minimis in an effort to circumvent the provisions of the bill. Lastly, the bill prohibits an insurer or an organization from requiring, as a term of its contract with a dentist, that the dentist participate in a discount medical plan.

The bill also adds PLHSO provider arrangement contracts to the list of insurers which may not require a health care practitioner to accept the terms of other health care practitioner contracts with an insurer, PLHSO, or HMO as a condition of continuing or renewing a contract.

The bill does not appear to have a fiscal impact on state or local government.

The bill provides an effective date of July 1, 2013, and applies to contracts entered into or renewed on or after that date.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Regulation of Health Insurers and Health Maintenance Organizations (HMOs)

The Office of Insurance Regulation (OIR) regulates health insurance policies and rates under Part VI of Chapter 627, F.S. OIR also regulates HMO contracts and rates under Part I of Chapter 641, F.S. The Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under Part III of Chapter 641, F.S.

Health Care Practitioners

Health care practitioners, as defined in s. 456.001(4), F.S., include, but are not limited to, physicians, osteopathic physicians, chiropractors, podiatrists, nurses, pharmacists, dentists, midwives, optometrists, speech pathologists, occupational therapists, orthotic providers, massage therapists, clinical laboratory personnel, and psychologists.

Health Insurer Provider Arrangements

Health insurer provider contracts are regulated by the OIR. Current Florida law does not prohibit provider contracts between health insurers and dentists from containing provisions that require the dentist to provide services to the subscribers to a health insurance plan or policy at a fee set by the health insurer, regardless of whether or not the services are covered under the health insurance plan or policy.

Section 627.6474, F.S., provides that a health insurer cannot require a contracted health care practitioner to accept the terms of other health care practitioner contracts with the insurer, or any other insurer or HMO under common management and control with the insurer, including Medicare and Medicaid practitioner contracts, preferred provider, exclusive provider organizations, or provider contracts, except for a practitioner in a group practice who must accept the terms of a contract negotiated for the practitioner by the group, as a condition of continuation or renewal of the contract. Any contract provision that violates this provision is considered void.

Prepaid Limited Health Service Organization (PLHSO) Provider Arrangements

PLHSOs are authorized in s. 636.003, F.S. This statute defines "limited health service" to include the following:

- ambulance services;
- dental care services;
- vision care services;
- mental health services;
- substance abuse services;
- chiropractic services;
- podiatric care services; and
- pharmaceutical services.

AHCA currently has two types of PLHSOs- a prepaid dental health plan (PDHP), as authorized in s. 409.912(43), F.S., and a prepaid mental health plan (PMHP), as authorized in s. 409.912(4)(b), F.S.

These prepaid limited health service organizations are administered under contract with AHCA and reimbursed on a capitated basis.

As of March 2013, approximately 1,385,862 beneficiaries are enrolled in the PDHP program and 632,150 beneficiaries are enrolled in the PMHP program.

Provider arrangements for PLHSOs are authorized in s. 636.035, F.S. Current law does not prohibit provider contracts between PLHSOs and dentists from containing provisions that require dentists to provide non-covered services to the PLHSO subscribers at a fee set by the PLHSO.

HMO Provider Contracts

Section 641.315, F.S., specifies requirements for the HMO provider contracts with "health care practitioners" as defined in s. 456.001(4), F.S. Section 641.315, F.S., does not currently prohibit provider contracts between health maintenance organizations and dentists from containing provisions that require the practitioner to provide services to the HMO subscribers at a fee set by the HMO unless the services are covered services under the applicable subscriber agreement.

Effect of Proposed Changes

The bill amends s. 627.6474, F.S., to add PLHSO provider arrangement contracts, authorized under s. 636.035, F.S., to the list of insurers which may not require a health care practitioner to accept the terms of other health care practitioner contracts with an insurer, PLHSO, or HMO.

The bill also amends ss. 627.6474, 636.035, and 641.315, F.S., to prohibit a contract between a health insurer, a PLHSO, or an HMO and a dentist from containing provisions that require the dentist to provide a service to the insured or subscriber at a fee set by the insurer, PLHSO, or HMO, unless the service is a covered service under the applicable policy or subscriber agreement. The bill defines a "covered service" as a service listed as a benefit to which the insured or subscriber is entitled under the contract with the insurer, PHLSO, or HMO. The bill requires the insurer to set reimbursement rates for covered services in good faith, prohibiting de minimis or nominal payments for covered services as a means to avoid the requirement of the bill

The bill prohibits an insurer, PHLSO, or HMO from including in its contract with a dentist a requirement that the dentist participate in a discount medical plan.

The bill defines "covered services" as those services that are reimbursable under an applicable contract, subject to contractual limitations on benefits. The bill specifically exempts from the definition of "covered services" any dental services provided by a dentist to a covered individual who has met or exceeded the periodic maximum amount of benefits allowed by the individual's health insurance plan or policy. Also, services that are not listed in an individual's health insurance plan or policy as a benefit to which the individual is entitled under the plan or policy are not considered covered services.

The bill applies to all contracts entered into or renewed on or after July 1, 2013.

B. SECTION DIRECTORY:

Section 1: Amends s. 627.6474, F.S., relating to provider contracts.
Section 2: Amends s. 636.035, F.S., relating to provider arrangements.
Section 3: Amends s. 641.315, F.S., relating to provider contracts.
Section 4: Provides an effective date of July 1, 2013, and applies to contracts entered into or renewed on or after that date.

II. 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:

The bill may allow dentists to charge higher fees to patients for services that are not considered "covered services" under a contract with a PLHSO, HMO, or health insurer.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The title of the bill, an act relating to dentists, is narrower than the substance of the bill. For instance, section 1 of the bill concerns provider contracts between health insurers and health care providers. Because the bill, in part, applies to health care providers other than dentists, it is recommended that the title of the bill be amended to a more general "act relating to" clause. An appropriate title is, "An act relating to health care provider contracts."

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to dentists; amending s. 627.6474,
3 F.S.; prohibiting a contract between a health insurer
4 and a dentist from requiring the dentist to provide
5 services at a fee set by the insurer under certain
6 circumstances; providing that covered services are
7 those services listed as a benefit that the insured is
8 entitled to receive under a contract; prohibiting an
9 insurer from providing merely de minimis reimbursement
10 or coverage; requiring that fees for covered services
11 be set in good faith and not be nominal; prohibiting a
12 health insurer from requiring as a condition of a
13 contract that a dentist participate in a discount
14 medical plan; amending s. 636.035, F.S.; prohibiting a
15 contract between a prepaid limited health service
16 organization and a dentist from requiring the dentist
17 to provide services at a fee set by the organization
18 under certain circumstances; providing that covered
19 services are those services listed as a benefit that a
20 subscriber of a prepaid limited health service
21 organization is entitled to receive under a contract;
22 prohibiting a prepaid limited health service
23 organization from providing merely de minimis
24 reimbursement or coverage; requiring that fees for
25 covered services be set in good faith and not be
26 nominal; prohibiting the prepaid limited health
27 service organization from requiring as a condition of
28 a contract that a dentist participate in a discount

29 medical plan; amending s. 641.315, F.S.; prohibiting a
30 contract between a health maintenance organization and
31 a dentist from requiring the dentist to provide
32 services at a fee set by the organization under
33 certain circumstances; providing that covered services
34 are those services listed as a benefit that a
35 subscriber of a health maintenance organization is
36 entitled to receive under a contract; prohibiting a
37 health maintenance organization from providing merely
38 de minimis reimbursement or coverage; requiring that
39 fees for covered services be set in good faith and not
40 be nominal; prohibiting the health maintenance
41 organization from requiring as a condition of a
42 contract that a dentist participate in a discount
43 medical plan; providing for applicability; providing
44 an effective date.
45
46 Be It Enacted by the Legislature of the State of Florida:
47
48 Section 1. Section 627.6474, Florida Statutes, is amended
49 to read:
50 627.6474 Provider contracts.—
51 (1) A health insurer may ~~shall~~ not require a contracted
52 health care practitioner as defined in s. 456.001(4) to accept
53 the terms of other health care practitioner contracts with the
54 insurer or any other insurer, or health maintenance
55 organization, under common management and control with the
56 insurer, including Medicare and Medicaid practitioner contracts

57 and those authorized by s. 627.6471, s. 627.6472, s. 636.035, or
58 s. 641.315, except for a practitioner in a group practice as
59 defined in s. 456.053 who must accept the terms of a contract
60 negotiated for the practitioner by the group, as a condition of
61 continuation or renewal of the contract. Any contract provision
62 that violates this section is void. A violation of this
63 subsection ~~section~~ is not subject to the criminal penalty
64 specified in s. 624.15.
65 (2)(a) A contract between a health insurer and a dentist
66 licensed under chapter 466 for the provision of services to an
67 insured may not contain any provision that requires the dentist
68 to provide services to the insured at a fee set by the health
69 insurer unless such services are covered services under the
70 applicable contract.
71 (b) Covered services are those services that are listed as
72 a benefit that the insured is entitled to receive under the
73 contract. An insurer may not provide merely de minimis
74 reimbursement or coverage in order to avoid the requirements of
75 this section. Fees for covered services shall be set in good
76 faith and must not be nominal.
77 (c) A health insurer may not require as a condition of the
78 contract that the dentist participate in a discount medical plan
79 under part II of chapter 636.
80 Section 2. Subsection (13) is added to section 636.035,
81 Florida Statutes, to read:
82 636.035 Provider arrangements.—
83 (13)(a) A contract between a prepaid limited health
84 service organization and a dentist licensed under chapter 466

85 for the provision of services to a subscriber of the prepaid
86 limited health service organization may not contain any
87 provision that requires the dentist to provide services to the
88 subscriber of the prepaid limited health service organization at
89 a fee set by the prepaid limited health service organization
90 unless such services are covered services under the applicable
91 contract.
92 (b) Covered services are those services that are listed as
93 a benefit that the subscriber is entitled to receive under the
94 contract. A prepaid limited health service organization may not
95 provide merely de minimis reimbursement or coverage in order to
96 avoid the requirements of this subsection. Fees for covered
97 services shall be set in good faith and must not be nominal.
98 (c) A prepaid limited health service organization may not
99 require as a condition of the contract that the dentist
100 participate in a discount medical plan under part II of this
101 chapter.
102 Section 3. Subsection (11) is added to section 641.315,
103 Florida Statutes, to read:
104 641.315 Provider contracts.—
105 (11)(a) A contract between a health maintenance
106 organization and a dentist licensed under chapter 466 for the
107 provision of services to a subscriber of the health maintenance
108 organization may not contain any provision that requires the
109 dentist to provide services to the subscriber of the health
110 maintenance organization at a fee set by the health maintenance
111 organization unless such services are covered services under the
112 applicable contract.

113 (b) Covered services are those services that are listed as
114 a benefit that the subscriber is entitled to receive under the
115 contract. A health maintenance organization may not provide
116 merely de minimis reimbursement or coverage in order to avoid
117 the requirements of this subsection. Fees for covered services
118 shall be set in good faith and must not be nominal.
119 (c) A health maintenance organization may not require as a
120 condition of the contract that the dentist participate in a
121 discount medical plan under part II of chapter 636.
122 Section 4. This act shall take effect July 1, 2013, and
123 applies to contracts entered into or renewed on or after that
124 date.

HB 709

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 709 Health Care Clinics
SPONSOR(S): Diaz
TIED BILLS: **IDEN./SIM. BILLS:** SB 594

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		Poche	Shaw
2) Insurance & Banking Subcommittee			
3) Health Care Appropriations Subcommittee			
4) Health & Human Services Committee			

SUMMARY ANALYSIS

Prior to 2012, clinics, rehabilitation agencies, and public health agencies, certified by Medicare under 42 C.F.R. part 485, subpart H, providing physical therapy and speech-language pathology services under Personal Injury Protection (PIP) insurance coverage were exempt from a licensing requirement in the Health Care Clinic Act. In 2012, the PIP insurance and Florida Motor Vehicle No-Fault Law were significantly amended under House Bill 119. The bill, which was passed by the Legislature and signed by the Governor, removed the exemption and required entities certified by Medicare under 42 C.F.R. part 485, subpart H to be licensed as a clinic in order to be reimbursed under the law.

House Bill 709 replaces the exemption that existed prior to the 2012 law change for clinics, rehabilitation agencies, and public health agencies, certified by Medicare pursuant to 42 C.F.R. part 485, subpart H, that are providing physical therapy and speech-language pathology services from licensing requirements under the Health Care Clinic Act. The bill extends the exemption to facilities, also certified by Medicare under the applicable regulation, commonly owned by an entity that receives the original exemption before June 30, 2014.

The bill does not appear to have a fiscal impact on state or local government.

The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Regulation of Health Care Clinics

Health care clinics are regulated under part X of ch. 400, F.S., the Health Care Clinic Act (Act). This act was passed in 2003 to reduce fraud and abuse in the personal injury protection (PIP) insurance system. Florida's Motor Vehicle No-Fault Law[1] requires motor vehicle owners to maintain $10,000 of PIP insurance. PIP benefits are available for certain express damages sustained in a motor vehicle accident, regardless of fault.

Pursuant to the Act, the Agency for Health Care Administration (AHCA) licenses entities that meet the definition of a "clinic"- an entity at which health care services are provided to individuals and which tenders charges for reimbursement for such services, including a mobile clinic and a portable equipment provider.[2] The biennial health care clinic license fee is $2,000.00.[3]

The statute creates a number of exemptions from the health care clinic licensure requirements, including, but not limited to:

- Entities licensed or registered by the state under chapter 395;[4]
- Clinical facilities affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows;[5]
- Orthotic or prosthetic clinical facilities that are a publicly traded corporation or that are wholly owned, directly or indirectly, by a publicly traded corporation;[6] and
- Entities that employ 50 or more licensed health care practitioners licensed under chapter 458 or chapter 459 where the billing for medical services is under a single tax identification number.[7]

An entity exempt from the licensing requirements of the Act may submit an Application for Certificate of Exemption from Licensure as a Health Care Clinic to AHCA.[8] The certificate, however, is not required to be exempt from licensure.[9]

Applicants must provide proof of compliance with applicable rules and financial ability to operate. As an alternative to submitting certain detailed financial projections, an applicant may submit a surety bond, payable to AHCA, in the amount of $500,000.00.[10] A level two background screening is required of each applicant for clinic licensure, and certain criminal offenses bar licensure.[11] Each clinic must have a medical director or clinic director[12] who agrees in writing to accept legal responsibility pursuant to s. 400.9935, F.S., for the following activities on behalf of the clinic:

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[1] Sections 627.730-627.7405, F.S., the Florida Motor Vehicle No-Fault Law, were repealed on October 1, 2007 pursuant to s. 19, ch. 2003-411 L.O.F. The No-Fault Law was revived and reenacted effective January 1, 2008 pursuant to ch. 2007-324 L.O.F.
[2] S. 400.9905(4), F.S.
[3] Rule 59A-33.002(1)(a), F.A.C.
[4] S. 400.9905(4)(a), F.S.
[5] S. 400.9905(4)(h), F.S.
[6] S. 400.9905(4)(l), F.S.
[7] S. 400.9905(4)(n), F.S.
[8] Rule 59A-33.006(1), F.A.C.; The Certificate of Exemption from Licensure as a Health Care Clinic carries a $100 fee. Rule 59A-33.006(7), F.A.C.
[9] Id.
[10] Rule 59A-33.002(1)(d), F.A.C.
[11] Rule 59A-33.002(1)(e), F.A.C.
[12] Rule 59A-33.008, F.A.C., contains additional details regarding the role and responsibilities of the medical director or clinic director.

- Ensuring that all practitioners providing health care services or supplies to patients maintain a current, active, and unencumbered Florida license;
- Reviewing patient referral contracts or agreements made by the clinic;
- Ensuring that all health care practitioners at the clinic have active appropriate certification or licensure for the level of care being provided;
- Serving as the clinic records owner;
- Ensuring compliance with the recordkeeping, office surgery, and adverse incident reporting requirements of chapter 456, F.S., the respective practice acts, and rules adopted under the Health Care Clinic Act; and
- Conducting systematic reviews of clinic billings to ensure billings are not fraudulent or unlawful. If an unlawful charge is discovered, immediate corrective action must be taken.

AHCA may deny, revoke, or suspend a health care clinic license and impose administrative fines of up to $5,000 per violation pursuant to s. 400.995, F.S.

As of March 2013, AHCA has issued 2,084 Health Care Clinic Licenses and 9,121 Certificates of Exemption.[13] Rehabilitation agencies, clinics, and public health agencies providing outpatient physical therapy and speech-language pathology services certified under Medicare pursuant to 42 C.F.R. part 485, subpart H are exempted from licensure under the Act.[14] AHCA reports 770 exempt rehabilitation agencies in the state, with nearly two thirds of those agencies located in the following counties:[15]

- Pinellas (82)
- Miami-Dade (68)
- Indian River (64)
- Broward (54)
- Palm Beach (52)
- Lee (44)
- Duval (38)
- Orange (37)
- Hillsborough (35)

2012 Changes to Florida Motor Vehicle No-Fault Law and Personal Injury Protection (PIP) Insurance

In 2012, House Bill 119, making significant changes to PIP law and the Florida Motor Vehicle No-Fault Law, was passed by the Legislature and approved by the Governor.[16] The bill made certain changes to the Act:

- Required previously exempt entities to be licensed under the Act in order to receive reimbursement for services provided under PIP;[17]
- Provided exceptions to the licensing requirement for reimbursement for services provided under PIP; and
- Revised the definition of "clinic", clarifying that a license is required for reimbursement under PIP, regardless of the location where services are actually provided.

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[13] E-Mail correspondence from AHCA staff to Health Innovation subcommittee staff, March 11, 2013 (on file with Health Innovation subcommittee staff); staff also notes that there is no requirement that a Certificate of Exemption be updated or that a clinic advise AHCA when it goes out of business. Staff suspects that the number of Certificates of Exemption is inflated and may be much lower.
[14] S. 400.9905(4)(a) through (d), F.S.
[15] Agency for Health Care Administration, *2013 Bill Analysis & Economic Impact Statement- HB 709*, paged 1-2 (on file with Health Innovation subcommittee staff).
[16] Ch. 2012-197, L.O.F.
[17] S. 400.9905(4), F.S.

In order to receive reimbursement under the Motor Vehicle No-Fault Law for providing reasonable medical, rehabilitative, and other appropriate services, House Bill 119 required clinics, rehabilitation agencies, and public health agencies providing outpatient physical therapy and speech-language pathology services and certified under Medicare in 42 C.F.R. part 485, subpart H to be licensed under the Act. The entities retained their general exemption from licensure under the Act.

Effect of Proposed Changes

The bill removes the requirement that an entity providing services under the Motor Vehicle No-Fault Law be licensed under the Act for the following entities, which are exempted from general licensing requirements under the Act:

- A clinic, rehabilitation agency, or public health agency certified by Medicare as a provider of outpatient physical therapy services under 42 U.S.C. part 485, subpart H.
- A clinic, rehabilitation agency, or public health agency certified by Medicare as a provider of speech-language pathology services under 42 U.S.C. part 485, subpart H.

In order to provide services under No-Fault Law without being licensed under the Act, the specified entity must be exempted from licensing requirements by June 30, 2014.

The bill extends the exemption beyond June 30, 2014 to other entities, also certified by Medicare under 42 U.S.C. part 485, subpart H, owned by the single legal entity which owns the entity originally exempted from licensing requirements under the act prior to June 30, 2014.

B. SECTION DIRECTORY:

Section 1: Amends s. 400.9905, F.S., relating to definitions.
Section 2: Provides an effective date of July 1, 2013.

II. 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:

Entities certified by Medicare under 42 C.F.R. part 485, subpart H will not have to pay the biennial license fee of $2,000 in order to be reimbursed under the Florida Motor Vehicle No-Fault Law.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The Agency for Health Care Administration has appropriate rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to health care clinics; amending s.
3 400.9905, F.S.; providing that a specified federal
4 certification exempts a health care clinic from
5 certain state licensure requirements; providing a
6 timeframe within which a clinic must qualify for the
7 exemption; providing an exception from the timeframe
8 for clinics owned by a single legal entity under
9 certain circumstances; providing an effective date.
10
11 Be It Enacted by the Legislature of the State of Florida:
12
13 Section 1. Subsection (4) of section 400.9905, Florida
14 Statutes, is amended to read:
15 400.9905 Definitions.—
16 (4) "Clinic" means an entity where health care services
17 are provided to individuals and which tenders charges for
18 reimbursement for such services, including a mobile clinic and a
19 portable equipment provider. As used in this part, the term does
20 not include and the licensure requirements of this part do not
21 apply to:
22 (a) Entities licensed or registered by the state under
23 chapter 395; entities licensed or registered by the state and
24 providing only health care services within the scope of services
25 authorized under their respective licenses under ss. 383.30-
26 383.335, chapter 390, chapter 394, chapter 397, this chapter
27 except part X, chapter 429, chapter 463, chapter 465, chapter
28 466, chapter 478, part I of chapter 483, chapter 484, or chapter

29 651; end-stage renal disease providers authorized under 42
30 C.F.R. part 405, subpart U; providers certified under 42 C.F.R.
31 part 485, subpart B or subpart H; or any entity that provides
32 neonatal or pediatric hospital-based health care services or
33 other health care services by licensed practitioners solely
34 within a hospital licensed under chapter 395.
35 (b) Entities that own, directly or indirectly, entities
36 licensed or registered by the state pursuant to chapter 395;
37 entities that own, directly or indirectly, entities licensed or
38 registered by the state and providing only health care services
39 within the scope of services authorized pursuant to their
40 respective licenses under ss. 383.30-383.335, chapter 390,
41 chapter 394, chapter 397, this chapter except part X, chapter
42 429, chapter 463, chapter 465, chapter 466, chapter 478, part I
43 of chapter 483, chapter 484, or chapter 651; end-stage renal
44 disease providers authorized under 42 C.F.R. part 405, subpart
45 U; providers certified under 42 C.F.R. part 485, subpart B or
46 subpart H; or any entity that provides neonatal or pediatric
47 hospital-based health care services by licensed practitioners
48 solely within a hospital licensed under chapter 395.
49 (c) Entities that are owned, directly or indirectly, by an
50 entity licensed or registered by the state pursuant to chapter
51 395; entities that are owned, directly or indirectly, by an
52 entity licensed or registered by the state and providing only
53 health care services within the scope of services authorized
54 pursuant to their respective licenses under ss. 383.30-383.335,
55 chapter 390, chapter 394, chapter 397, this chapter except part
56 X, chapter 429, chapter 463, chapter 465, chapter 466, chapter

57 478, part I of chapter 483, chapter 484, or chapter 651; end-
58 stage renal disease providers authorized under 42 C.F.R. part
59 405, subpart U; providers certified under 42 C.F.R. part 485,
60 subpart B or subpart H; or any entity that provides neonatal or
61 pediatric hospital-based health care services by licensed
62 practitioners solely within a hospital under chapter 395.
63 (d) Entities that are under common ownership, directly or
64 indirectly, with an entity licensed or registered by the state
65 pursuant to chapter 395; entities that are under common
66 ownership, directly or indirectly, with an entity licensed or
67 registered by the state and providing only health care services
68 within the scope of services authorized pursuant to their
69 respective licenses under ss. 383.30-383.335, chapter 390,
70 chapter 394, chapter 397, this chapter except part X, chapter
71 429, chapter 463, chapter 465, chapter 466, chapter 478, part I
72 of chapter 483, chapter 484, or chapter 651; end-stage renal
73 disease providers authorized under 42 C.F.R. part 405, subpart
74 U; providers certified under 42 C.F.R. part 485, subpart B or
75 subpart H; or any entity that provides neonatal or pediatric
76 hospital-based health care services by licensed practitioners
77 solely within a hospital licensed under chapter 395.
78 (e) An entity that is exempt from federal taxation under
79 26 U.S.C. s. 501(c)(3) or (4), an employee stock ownership plan
80 under 26 U.S.C. s. 409 that has a board of trustees at least
81 two-thirds of which are Florida-licensed health care
82 practitioners and provides only physical therapy services under
83 physician orders, any community college or university clinic,
84 and any entity owned or operated by the federal or state

85 government, including agencies, subdivisions, or municipalities
86 thereof.
87 (f) A sole proprietorship, group practice, partnership, or
88 corporation that provides health care services by physicians
89 covered by s. 627.419, that is directly supervised by one or
90 more of such physicians, and that is wholly owned by one or more
91 of those physicians or by a physician and the spouse, parent,
92 child, or sibling of that physician.
93 (g) A sole proprietorship, group practice, partnership, or
94 corporation that provides health care services by licensed
95 health care practitioners under chapter 457, chapter 458,
96 chapter 459, chapter 460, chapter 461, chapter 462, chapter 463,
97 chapter 466, chapter 467, chapter 480, chapter 484, chapter 486,
98 chapter 490, chapter 491, or part I, part III, part X, part
99 XIII, or part XIV of chapter 468, or s. 464.012, and that is
100 wholly owned by one or more licensed health care practitioners,
101 or the licensed health care practitioners set forth in this
102 paragraph and the spouse, parent, child, or sibling of a
103 licensed health care practitioner if one of the owners who is a
104 licensed health care practitioner is supervising the business
105 activities and is legally responsible for the entity's
106 compliance with all federal and state laws. However, a health
107 care practitioner may not supervise services beyond the scope of
108 the practitioner's license, except that, for the purposes of
109 this part, a clinic owned by a licensee in s. 456.053(3)(b)
110 which provides only services authorized pursuant to s.
111 456.053(3)(b) may be supervised by a licensee specified in s.
112 456.053(3)(b).

113 (h) Clinical facilities affiliated with an accredited
114 medical school at which training is provided for medical
115 students, residents, or fellows.
116 (i) Entities that provide only oncology or radiation
117 therapy services by physicians licensed under chapter 458 or
118 chapter 459 or entities that provide oncology or radiation
119 therapy services by physicians licensed under chapter 458 or
120 chapter 459 which are owned by a corporation whose shares are
121 publicly traded on a recognized stock exchange.
122 (j) Clinical facilities affiliated with a college of
123 chiropractic accredited by the Council on Chiropractic Education
124 at which training is provided for chiropractic students.
125 (k) Entities that provide licensed practitioners to staff
126 emergency departments or to deliver anesthesia services in
127 facilities licensed under chapter 395 and that derive at least
128 90 percent of their gross annual revenues from the provision of
129 such services. Entities claiming an exemption from licensure
130 under this paragraph must provide documentation demonstrating
131 compliance.
132 (l) Orthotic or prosthetic clinical facilities that are a
133 publicly traded corporation or that are wholly owned, directly
134 or indirectly, by a publicly traded corporation. As used in this
135 paragraph, a publicly traded corporation is a corporation that
136 issues securities traded on an exchange registered with the
137 United States Securities and Exchange Commission as a national
138 securities exchange.
139 (m) Entities that are owned by a corporation that has $250
140 million or more in total annual sales of health care services

141 provided by licensed health care practitioners where one or more
142 of the owners is a health care practitioner who is licensed in
143 this state and who is responsible for supervising the business
144 activities of the entity and is legally responsible for the
145 entity's compliance with state law for purposes of this part.
146 (n) Entities that employ 50 or more licensed health care
147 practitioners licensed under chapter 458 or chapter 459 where
148 the billing for medical services is under a single tax
149 identification number. The application for exemption under this
150 subsection shall contain information that includes: the name,
151 residence, and business address and phone number of the entity
152 that owns the practice; a complete list of the names and contact
153 information of all the officers and directors of the
154 corporation; the name, residence address, business address, and
155 medical license number of each licensed Florida health care
156 practitioner employed by the entity; the corporate tax
157 identification number of the entity seeking an exemption; a
158 listing of health care services to be provided by the entity at
159 the health care clinics owned or operated by the entity and a
160 certified statement prepared by an independent certified public
161 accountant which states that the entity and the health care
162 clinics owned or operated by the entity have not received
163 payment for health care services under personal injury
164 protection insurance coverage for the preceding year. If the
165 agency determines that an entity which is exempt under this
166 subsection has received payments for medical services under
167 personal injury protection insurance coverage, the agency may
168 deny or revoke the exemption from licensure under this

169 subsection.
170
171 Notwithstanding this subsection, an entity shall be deemed a
172 clinic and must be licensed under this part in order to receive
173 reimbursement under the Florida Motor Vehicle No-Fault Law, ss.
174 627.730-627.7405, unless exempted under s. 627.736(5)(h) or
175 exempted under this subsection before June 30, 2014, as a
176 provider certified pursuant to subpart H of 42 C.F.R. part 485;
177 however, if a single legal entity owns a clinic certified
178 pursuant to subpart H of 42 C.F.R. part 485 which is exempted
179 under this subsection before June 30, 2014, the exemption
180 extends beyond that date to other clinics owned by that entity
181 which are certified pursuant to subpart H of 42 C.F.R. part 485.
182 Section 2. This act shall take effect July 1, 2013.

PCS for HB 301

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 301 Cancer Treatment
SPONSOR(S): Health Innovation Subcommittee; Mayfield
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health Innovation Subcommittee		Poche	Shaw

SUMMARY ANALYSIS

Although Florida law does not require health plans and health maintenance organizations (HMOs) to cover intravenous, injectable, or oral cancer treatment medications, health plans and HMOs routinely cover these treatments.

PCS for HB 301 requires health insurance policies and contracts and HMO contracts that provide cancer treatment medication coverage to also provide coverage for oral cancer treatment medications. Out-of-pocket costs to the insured or member are often higher for oral cancer treatment medications that for other forms of cancer treatment. The PCS requires policies and contracts to apply cost-sharing requirements for oral cancer treatment medications that are no less favorable than the cost-sharing requirements for other cancer treatment medications, such as intravenous and injectable medications. Grandfathered health plans, as that term is defined by the Patient Protection and Affordable Care Act (PPACA) and detailed in applicable regulations, are exempted from the oral cancer treatment medications coverage and cost-sharing parity requirements.

The PCS prohibits insurers, HMOs, and certain other entities from taking specific actions in an effort to avoid compliance with the coverage and cost-sharing parity requirements. Prohibited actions include, but are not limited to, varying the terms of the policy in effect on the effective date of the PCS and penalizing a health care provider for recommending or providing services that comply with the provisions of the PCS.

The PCS may have an indeterminate negative fiscal impact on state government and local government.

The PCS provides an effective date of January 1, 2015, and applies to policies and contracts issued or renewed on or after that date.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

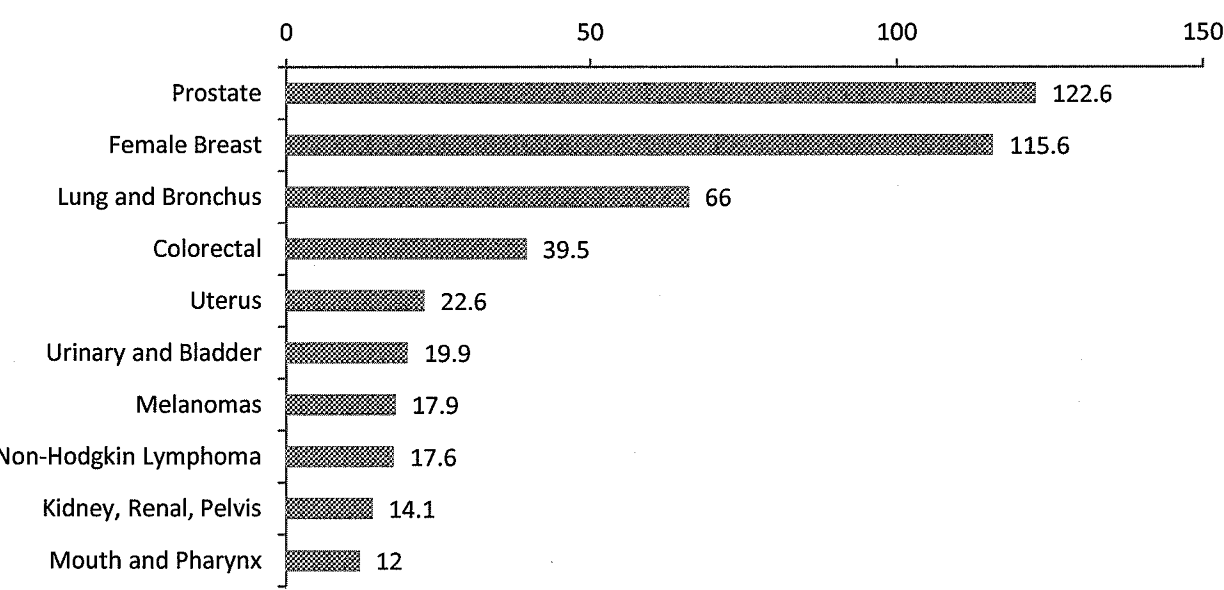
A. EFFECT OF PROPOSED CHANGES:

Background

Cancer

Cancer is a group of diseases which cause the growth of abnormal cells in the body, resulting in severe sickness and death. It can be caused by external factors, such as tobacco use and exposure to certain chemicals, and internal factors, like genetics, hormones, and immune conditions. These factors may work together or separately to promote the development of cancer. Common treatments for cancer include surgery, radiation, and chemotherapy.

Cancer is the second leading cause of death in the U.S., killing 573,313 people in 2011, a decrease of 2.4% over the number of deaths in 2010.[1] It is the leading cause of death of people between the ages of 45 and 64, accounting for 161,072 of the total cancer deaths in 2011.[2] In 2010, Florida had 173,791 total deaths, of which 41,467 were caused by cancer, accounting for nearly 24 percent of all deaths in the state.[3] The following chart shows the top ten cancer sites for men and women in Florida in 2009, the last year for which complete data is available[4]:



[1] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics Report, *Deaths: Preliminary Data for 2011*, page 4, Vol. 61, No. 6 (October 10, 2012) (available at www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_06.pdf).

[2] Id. at page 30.

[3] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics Report, *Deaths: Final Data for 2010*, page 112, Vol. 61, No. 4 (available at www.cdc.gov/nchs/data/dvs/deaths_2010_release.pdf).

[4] Chart created using information from U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Program of Cancer Registries, *United States Cancer Statistics-2009 Top Ten Cancers-Florida* (available at http://apps.nccd.cdc.gov/uscs/toptencancers.aspx) (last viewed March 11, 2013).

Approximately 1,660,290 new cases of cancer are expected to be diagnosed in the U.S. in 2013.[5] Of those new cases, 118,320 cases are expected to be diagnosed in Florida.[6] From 2005 to 2009, Florida averaged 101,744 incidences of cancer each year.[7]

Cancer care expenditures have been increasing nationwide. In 2008, the National Institutes of Health estimated the direct costs of cancer, including all health care expenditures, were $77.4 billion.[8] In 2010, total costs of cancer care were $124.6 billion[9] In 2020, estimates of cancer care costs in the U.S. range from $158 billion to $207 billion.[10] It should be noted that these are estimates of direct costs of care for the treatment of cancer and do not incorporate additional types of costs related to treatment.[11]

The National Cancer Institute estimates that there were 13.7 million cancer survivors alive in the U.S. on January 1, 2012.[12] By 2020, it is estimated that there will be 18.1 million cancer survivors in the U.S., an increase of 30% over 2010.[13]

Oral Cancer Treatment Medications

The trend in the treatment of cancer has been towards the development of oral chemotherapy medications. Experts estimate that more than 25 percent of the 400 chemotherapy drugs in the development pipeline are planned as oral medications.[14]

There are a more than two dozen oral cancer treatment medications that do not have an intravenous or injectable equivalent, including tamoxifen, used to treat breast cancer, Gleevec, used to treat chronic myeloid leukemia, and anastrozole, used to treat prostate cancer.

There is a significant cost disparity to the patient between intravenous or injectable cancer treatment medications and oral cancer treatment medications. In most cases, intravenous or injectable cancer treatment medications are covered in the medical benefits portion of a health insurance plan. Due to the nature of the delivery system of the medication, a patient is required to go to the hospital, a clinic, or her doctor's office in order to have an intravenous line inserted and the medication dose administered or to have the medication injected. Because this form of treatment is covered under the medical benefits portion of insurance, the out-of-pocket expenses to the patient are limited to the office co-payment amount, which is normally a very reasonable cost, or have a cap on annual or lifetime out-of-pocket payments.

Oral cancer treatment medications, however, are covered under the pharmacy benefits portion of health insurance coverage. Many pharmacy benefit designs assign medications into tiers based on cost. Each tier carries a co-payment amount, which significantly increases as the tier, and associated drug cost, increases. Also, pharmacy benefit designs may have unlimited out-of-pocket cost-sharing requirements, meaning can be required to pay significant co-payments for as long as the patient is

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[5] American Cancer Society, *Cancer Facts & Figures 2013*, page 1.
[6] Id., *Estimated Number of New Cases for Selected Cancers by State, US, 2013*, page 5.
[7] U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute, *State Cancer Profiles-Florida, Incidence Rate Tables, Incidence Rate Report for Florida by County-All Races (includes Hispanic), Both Sexes, All Cancer Sites, All Ages Sorted by Rate* (available at http://statecancerprofiles.cancer.gov/cgi-bin/quickprofiles/profile.pl?12&001).
[8] See supra, FN 4 at page 3.
[9] U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute, *The Cost of Cancer*, table 1 (January 2011)(available at www.cancer.gov/aboutnci/servingpeople/cancer-statistics/costofcancer) (last viewed on March 11, 2013).
[10] Id.; $158 billion is estimated based on 2010 dollars; $173 billion is estimated assuming a 2% increase in costs over time; and $207 billion is estimated based on a 5% increase in costs over time;
[11] Id.
[12] See supra, FN 4.
[13] U.S. Department of Health and Human Service, National Institutes of Health, National Cancer Institute, *Cancer Prevalence and Cost of Care Projections- Key Facts* (available at http://costprojections.cancer.gov) (last viewed on March 11, 2013).
[14] Weingart, S.N., Bach, P.B., et al., *NCCN task force report: oral chemotherapy*, Journal of the National Comprehensive Cancer Network, 2008;6: S1-S17.

required to take a certain medications. Oral cancer treatment medications can run into the thousands of dollars per month in out-of-pocket costs to the patient.

The following chart illustrates the cost of medications for serious illness, including oral oncology medications:[15]

Average Monthly Patient Out-of-Pocket Cost Per Prescription, 2011			
	Rheumatoid Arthritis	Multiple Sclerosis	Oral Oncology
Actual Out-of-Pocket (OOP) Cost	**$235**	**$227**	**$470**
Estimated OOP Cost (by Coinsurance Level)			
33% cost sharing	**$653**	**$1,100**	**$1,920**
25% cost sharing	**$495**	**$833**	**$1,454**
5% cost sharing	**$99**	**$167**	**$291**

Out-of-pocket costs for oral cancer medication treatments averaged $2,942 in 2009, which is a 17 percent increase over the costs in 2008.

Oral Cancer Treatment Parity

Between 2008 and January 2013, twenty-one states and the District of Columbia have enacted oral chemotherapy parity laws that require the same cost-sharing requirements for oral cancer treatment medications and intravenous or injectable cancer treatment medications.[16] It is anticipated that 16 states, including Florida, will have similar legislation introduced in 2013.[17]

In 2009, Milliman, Inc., in a study commissioned by GlaxoSmithKline, examined the average increase in insurance costs resulting from oral cancer treatment medication parity legislation. Such legislation requires state-regulated payers to cover oral cancer treatment medication with the same cost-sharing requirements as intravenous or injectable cancer treatment medications. Milliman found that, for most benefit plans, parity will increase plan costs less than $0.50 per member per month (PMPM).[18] Parity for some benefit plans that carry very high cost-sharing requirements for oral specialty drugs and low medical benefits may see a cost of $1.00 PMPM or more.[19] Other benefit plans that have a low cost-sharing requirement in general could see parity costs of $0.05 to $0.10 PMPM.[20]

Patient Protection and Affordable Care Act

In March 2010, the Congress passed and the President signed the Patient Protection and Affordable Care Act (PPACA).[21] Under PPACA, qualified health plans (QHP) would be available from the state or federal Exchange beginning January 1, 2014. PPACA required the Secretary of Health and Human Services to establish for those QHP's a minimum package of essential health benefits (EHB).[22] The EHB package must cover benefits across ten general categories, including, but not limited to preventive services, maternity care, hospital services and prescription drugs.[23]

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[15] Pharmaceutical Executive, *Who Pays for Specialty Medicines?* (citing Healthcare Analytics 2011, Amundsen Group Analysis)(available at http://license.icopyright.net/user/viewFreeUse.act?fuid=MTY5MTg4MiA%3D).
[16] *Oral Chemotherapy Parity Legislative Landscape- January 2013* (on file with Health Innovation Subcommittee staff).
[17] Id.
[18] Milliman, Client Report, Fitch, K., Iwasaki, K., Pyenson, B., *Parity for Oral and Intravenous/Injected Cancer Drugs*, page 1 (December 15, 2009).
[19] Id.
[20] Id.
[21] Pub. Law No. 111-148, H.R. 3590, 111th Cong. (Mar. 23, 2010).
[22] Id.
[23] Center for Consumer Information and Insurance Oversight, *Essential Health Benefits Coverage Bulletin*, (1), Dec. 16, 2011, available at: http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf (last viewed March 11, 2013).

Section 1311(d)(3)(B) of PPACA allows a state to require QHPs to cover additional benefits above those required under the EHB; however, the law also directs the state to offset the costs of those supplemental benefits to the enrollee.[24] Under the final rule released on February 25, 2013, a distinction in the proposed rule's preamble is made between changes in benefits versus changes in cost sharing. The final rule limits the offset requirement only to "care, treatment and services," thereby excluding a state's obligations to defray costs relating to changes relating to provider types, cost-sharing or reimbursement.[25]

In addition to these provisions, certain plans under PPACA received "grandfather status." A grandfathered health plan is a plan that existed on March 23, 2010, the date that PPACA was enacted, and that at least one person had been continuously covered for one year.[26] Some consumer protection elements do not apply to grandfathered plans that were part of PPACA but others are applicable, regardless of the type of plan.[27]

Providing the essential health benefits are also not required of grandfathered health plans.[28] A grandfathered plan can lose its status if significant changes to benefits or cost sharing changes are made to the plan since attaining its grandfathered status.[29] Grandfathered plans are required to disclose their status to their enrollees every time plan materials are distributed and to identify the consumer protections that are not available as a grandfathered plan.[30] Even though exempt from the EHB, a grandfathered plan could still be required to meet a new a requirement under state law if otherwise required under state requirements.[31]

The PPACA's provisions include annual limitations on cost sharing in section 1302(c)(1) and an annual limitation on deductibles in section 1302(c)(2) of the Affordable Care Act effective January 1, 2014. The type of plan an individual is enrolled in and the level of benefits selected or "medal plan," will determine the amount of out of pocket costs that an individual may incur.

The federal law further prohibits the imposition of annual and lifetime benefit limits, except for certain grandfathered plans, effective January 1, 2014. These protections went into effect for children earlier, September 23, 2010, and apply to grandfathered group health insurance plans. These restrictions would impact any out of pocket costs applied to prescription drug coverage whether delivered as an oral or an injectable medication.

Health Insurance Mandates and Mandated Offerings

A health insurance mandate is a legal requirement that an insurance company or health plan cover services by particular health care providers, specific benefits, or specific patient groups.
Mandated offerings, on the other hand, do not mandate that certain benefits be provided. Rather, a mandated offering law can require that insurers offer an option for coverage for a particular benefit or specific patient groups, which may require a higher premium and which the insured is free to accept or reject. A mandated offering law in the context of mental health can require that insurers offer an option

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[24] 78 Fed. Reg. 12,837, 12,837-12,838 (February 25, 2013).
[25] Id.
[26] Healthcare.gov, *Grandfathered Health Plans*, available at http://www.healthcare.gov/law/features/rights/grandfathered-plans/index.html (last viewed March 11, 2013).
[27] Healthcare.gov., *Factsheet,* available at http://www.healthcare.gov/news/factsheets/2012/11/ehb11202012a.html (last viewed March 11, 2013).
[28] Barr, S., *FAQ: Grandfathered Health Plans*, December 2012, available at http://www.kaiserhealthnews.org/stories/2012/december/17/grandfathered-plans-faq.aspx (last viewed March 11, 2013).
[29] Healthcare.gov, *Keeping the Health Plan You Have: The Affordable Care Act and "Grandfathered Health Plans*, June 14, 2010, available at http://www.healthcare.gov/news/factsheets/2010/06/keeping-the-health-plan-you-have-grandfathered.html (last viewed March 11, 2013).
[30] Id.
[31] 75 Fed. Reg. 34, 538, 34,540 (June 17, 2010).

of coverage for mental illness, which may require a higher premium and which the insured is free to accept or reject or require that, if insurers offer mental illness coverage, the benefits must be equivalent to other types of benefits.

Florida currently has at least 59 mandates.[32] The Council for Affordable Health Insurance estimates that mandated benefits currently increase the cost of basic health coverage by a little less than 20 percent, but possibly higher depending on the number of mandates, the benefit design and the cost of the initial premium.[33] Each mandate adds to the cost of a plan's premiums, in a range of less than 1 percent to 10 percent, depending on the mandate.[34] Higher costs resulting from mandates are most likely to be experienced in the small group market since these are the plans that are subject to state regulations. The national average cost of insurance for a family of four is $15,745.[35]

Health Insurance Mandate Report

Section 624.215, F.S., was enacted in 1987 to aid the Legislature in assessing the impact of health insurance mandates and mandated offerings on insurance policy premiums when considering proposed health insurance mandates. The statute requires that any proposal for legislation that mandates health benefit coverage or mandatorily offered health coverage must be submitted with a report to Agency for Health Care Administration and to the legislative committees having jurisdiction over the issue. The report must assess the social and financial impact of the proposed coverage to the extent information is available, and shall include:

- To what extent is the treatment or service generally used by a significant portion of the population.[36]
- To what extent is the insurance coverage generally available.[37]
- If the insurance coverage is not generally available, to what extent does the lack of coverage result in persons avoiding necessary health care treatment.[38]
- If the coverage is not generally available, to what extent does the lack of coverage result in unreasonable financial hardship.[39]
- The level of public demand for the treatment or service.[40]
- The level of public demand for insurance coverage of the treatment or service.[41]
- The level of interest of collective bargaining agents in negotiating for the inclusion of this coverage in group contracts.[42]
- To what extent will the coverage increase or decrease the cost of the treatment or service.[43]
- To what extent will the coverage increase the appropriate uses of the treatment or service.[44]
- To what extent will the mandated treatment or service be a substitute for a more expensive treatment or service.[45]

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[32] Florida House of Representatives, Health and Human Services Quality Subcommittee, *Meeting Packet for November 15, 2011*, pages 7-9; see also Council for Affordable Health Insurance , *Health Insurance Mandates in the States 2010- Table 1: Total Mandates by State*, page 3 (on file with Health Innovation Subcommittee staff).
[33] Id. at page 7.
[34] Id. at pages 4-6.
[35] The Henry J. Kaiser Family Foundation, Employer Health Benefits 2012 Annual Survey- Summary of Findings, page 1 (available at http://ehbs.kff.org/pdf/2012/8345.pdf) (last viewed March 11, 2013).
[36] S. 624.215(2)(a), F.S.
[37] S. 624.215(2)(b), F.S.
[38] S. 624.215(2)(c), F.S.
[39] S. 624.215(2)(d), F.S.
[40] S. 624.215(2)(e), F.S.
[41] S. 624.215(2)(f), F.S.
[42] S. 624.215(2)(g), F.S.
[43] S. 624.215(2)(h), F.S.
[44] S. 624.215(2)(i), F.S.

- To what extent will the coverage increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.[46]
- The impact of this coverage on the total cost of health care.[47]

The International Myeloma Foundation (Foundation) delivered a report to the Senate Health Policy Committee on February 21, 2013, assessing SB 422 and HB 301 against the criteria of s. 624.215, F.S., while specifically not admitting that the bill's directives mandate any specific health coverage.[48] According to the Foundation, insurance coverage of oral cancer medications is not the precise issue. The issue is the out of pocket cost differential to patients between intravenous or injectables and oral treatments as most insurance plans already cover the medication.[49]

Effect of Proposed Changes

The PCS requires an individual or group insurance policy or contract or a health maintenance organization (HMO) contract that provides coverage for cancer treatment medications (intravenous or injectable cancer treatment medications) must also provide coverage for oral cancer treatment medications. In addition, the PCS prohibits a policy or contract from applying cost-sharing requirements to coverage for oral cancer treatment medications that are less favorable than the cost-sharing requirements for intravenous or injectable cancer treatment medications. The PCS requires that all cancer treatment medications be covered and be treated the same by health insurance policies and contracts. The PCS exempts grandfathered health plans from the oral cancer treatment medication coverage and cost-sharing parity.

The PCS permits a policy or contract with cost-sharing requirements for intravenous or injectable cancer medications less than $50 to apply cost-sharing requirements up to $50 to prescribed oral cancer treatment medications.

The PCS prohibits the following actions by insurers, HMOs, and other specific entities designed to avoid the parity requirements of the bill:

- Varying the terms of the policy in effect on the effective date of the PCS.
- Providing any incentive to a covered person to accept coverage that includes anything less than parity.
- Penalizing a provider for recommending or providing oral cancer treatment medications.
- Providing any incentive to a provider to not comply with the parity provisions.
- Changing cost-sharing requirements or classification of intravenous or injectable cancer treatment medications in effect on the effective date of the PCS.

The bill provides an effective date of January 1, 2015, and applies to policies or contracts issued or renewed after that date.

B. SECTION DIRECTORY:

Section 1: Provides that the act maybe cited as the "Cancer Treatment Fairness Act."
Section 2: Creates s. 627.42391, F.S., relating to insurance policies; cancer treatment parity; orally administered cancer treatment medications.
Section 3: Creates s. 641.313, F.S., relating to health maintenance contracts; cancer treatment parity; orally administered cancer treatment medications.

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[45] S. 624.215(2)(j), F.S.
[46] S. 624.215(2)(k), F.S.
[47] S. 624.215(2)(l), F.S.
[48] International Myeloma Foundation, *Health Insurance Mandate Report, Parity for Oral and Intravenous Cancer Medications*, page 1, February 2013 (on file with the Health Innovation Subcommittee).
[49] Id. at page 2.

Section 4: Provides direction to the Division of Law Revision and Information.
Section 5: Provides an effective date of January 1, 2015.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The Department of Management Services has estimated that HB 301 would have an indeterminate negative fiscal impact on the State Group Insurance Program. The PCS has not been reviewed by the Department.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   Local governments may have a negative fiscal impact if health premiums increase as a result of the PCS.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Health insurers and HMOs may raise premiums to address the impact of oral cancer medication treatment coverage and cost-sharing parity under the PCS. As a result, policyholders and contract holders for health care coverage may see an increase in monthly premiums for the same coverage for policies and contracts issued or renewed after the effective date of the PCS.

Also, patients receiving oral cancer treatment medications may realize less out-of-pocket expenses to obtain their medications.

D. FISCAL COMMENTS:

PPACA allows a state to require QHPs to cover additional benefits above those required under the EHB. The law also directs the state to offset the costs of those supplemental benefits to the enrollee. The PCS creates a new coverage and parity requirement for oral cancer treatment medications. While PPACA requires the state to be responsible for offsetting the cost of this additional coverage and parity requirement, there are no guidelines addressing how the total cost will be determined, how it will be paid by the state, and to whom the payments will be made. As a result, the PCS presents a potential indeterminate negative fiscal impact to the state.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to require counties or municipalities to spend funds or take action requiring the expenditures of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Not applicable. Rule-making authority is not required by the PCS.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to cancer treatment; providing a short
3 title; creating ss. 627.42391 and 641.313, F.S.;
4 providing definitions; requiring that an individual or
5 group insurance policy or contract or a health
6 maintenance contract that provides coverage for cancer
7 treatment medications provide coverage for orally
8 administered cancer treatment medications; requiring
9 that an individual or group insurance policy or
10 contract or a health maintenance contract provide
11 coverage for orally administered cancer treatment
12 medications on a basis no less favorable than that
13 required by the policy or contract for intravenously
14 administered or injected cancer treatment medications;
15 excluding grandfathered health plans from coverage and
16 cost-sharing requirements; prohibiting insurers,
17 health maintenance organizations, and certain other
18 entities from engaging in specified actions to avoid
19 compliance with this act; providing limits on certain
20 cost-sharing requirements; providing an effective
21 date.
22
23 Be It Enacted by the Legislature of the State of Florida:
24 Section 1. This act may be cited as the "Cancer Treatment
25 Fairness Act."
26 Section 2. Section 627.42391, Florida Statutes, is created
27 to read:
28 627.42391 Insurance policies; cancer treatment parity;

29 orally administered cancer treatment medications.—
30 (1) As used in this section, the term:
31 (a) "Cancer treatment medication" means medication
32 prescribed by a treating physician who determines that the
33 medication is medically necessary to kill or slow the growth of
34 cancerous cells in a manner consistent with nationally accepted
35 standards of practice.
36 (b) "Cost sharing" includes copayments, coinsurance,
37 dollar limits, and deductibles imposed on the covered person.
38 (c) "Grandfathered health plan" has the same meaning as
39 that term is defined in 42 U.S.C. s. 18011 and subject to the
40 conditions for maintaining status as a grandfathered health plan
41 specified in 45 C.F.R. s. 147.140.
42 (2) An individual or group insurance policy delivered,
43 issued for delivery, renewed, amended, or continued in this
44 state that provides medical, major medical, or similar
45 comprehensive coverage and includes coverage for cancer
46 treatment medications must also cover prescribed, orally
47 administered cancer treatment medications and may not apply
48 cost-sharing requirements for orally administered cancer
49 treatment medications that are less favorable to the covered
50 person than cost-sharing requirements for intravenous or
51 injected cancer treatment medications covered under the policy
52 or contract.
53 (3) An insurer providing a policy or contract described in
54 subsection (2) and any participating entity through which the
55 insurer offers health services may not:
56 (a) Vary the terms of the policy in effect on the

CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

57 effective date of this act to avoid compliance with this
58 section.
59 (b) Provide any incentive, including, but not limited to,
60 a monetary incentive, or impose treatment limitations to
61 encourage a covered person to accept less than the minimum
62 protections available under this section.
63 (c) Penalize a health care practitioner or reduce or limit
64 the compensation of a health care practitioner for recommending
65 or providing services or care to a covered person as required
66 under this section.
67 (d) Provide any incentive, including, but not limited to,
68 a monetary incentive, to induce a health care practitioner to
69 provide care or services that do not comply with this section.
70 (e) Change the classification of any intravenous or
71 injected cancer treatment medication or increase the amount of
72 cost sharing applicable to any intravenous or injected cancer
73 treatment medication in effect on the effective date of this
74 section in order to achieve compliance with this section.
75 (4) This section does not apply to grandfathered health
76 plans.
77
78 Notwithstanding this section, if the cost-sharing requirements
79 for intravenous or injected cancer treatment medications under
80 the policy or contract are less than $50 per month, then the
81 cost-sharing requirements for orally administered cancer
82 treatment medications may be up to $50 per month.
83 Section 3. Section 641.313, Florida Statutes, is created
84 to read:

85 641.313 Health maintenance contracts; cancer treatment
86 parity; orally administered cancer treatment medications.—
87 (1) As used in this section, the term:
88 (a) "Cancer treatment medication" means medication
89 prescribed by a treating physician who determines that the
90 medication is medically necessary to kill or slow the growth of
91 cancerous cells in a manner consistent with nationally accepted
92 standards of practice.
93 (b) "Cost sharing" includes copayments, coinsurance,
94 dollar limits, and deductibles imposed on the covered person.
95 (c) "Grandfathered health plan" has the same meaning as
96 that term is defined in 42 U.S.C. s. 18011 and subject to the
97 conditions for maintaining status as a grandfathered health plan
98 specified in 45 C.F.R. s. 147.140.
99 (2) A health maintenance contract delivered, issued for
100 delivery, renewed, amended, or continued in this state that
101 provides medical, major medical, or similar comprehensive
102 coverage and includes coverage for cancer treatment medications
103 must also cover prescribed, orally administered cancer treatment
104 medications and may not apply cost-sharing requirements for
105 orally administered cancer treatment medications that are less
106 favorable to the covered person than cost-sharing requirements
107 for intravenous or injected cancer treatment medications covered
108 under the contract.
109 (3) A health maintenance organization providing a contract
110 described in subsection (2) and any participating entity through
111 which the health maintenance organization offers health services
112 may not:

113 (a) Vary the terms of the policy in effect on the
114 effective date of this act to avoid compliance with this
115 section.
116 (b) Provide any incentive, including, but not limited to,
117 a monetary incentive, or impose treatment limitations to
118 encourage a covered person to accept less than the minimum
119 protections available under this section.
120 (c) Penalize a health care practitioner or reduce or limit
121 the compensation of a health care practitioner for recommending
122 or providing services or care to a covered person as required
123 under this section.
124 (d) Provide any incentive, including, but not limited to,
125 a monetary incentive, to induce a health care practitioner to
126 provide care or services that do not comply with this section.
127 (e) Change the classification of any intravenous or
128 injected cancer treatment medication or increase the amount of
129 cost sharing applicable to any intravenous or injected cancer
130 treatment medication in effect on the effective date of this
131 section in order to achieve compliance with this section.
132 (4) This section does not apply to grandfathered health
133 plans.
134
135 Notwithstanding this section, if the cost-sharing requirements
136 for intravenous or injected cancer treatment medications under
137 the contract are less than $50 per month, then the cost-sharing
138 requirements for orally administered cancer treatment
139 medications may be up to $50 per month.
140 Section 4. The Division of Law Revision and Information is

141 directed to replace the phrase "the effective date of this act"
142 wherever it occurs in this act with the date this act takes
143 effect.
144 Section 5. This act shall take effect on January 1, 2015,
145 and applies to policies and contracts issued or renewed on or
146 after that date.
147