STORAGE NAME: h1021s1a.hhs
DATE: April 22, 1997

HOUSE OF REPRESENTATIVES
AS REVISED BY THE COMMITTEE ON
HEALTH AND HUMAN SERVICES APPROPRIATIONS
BILL ANALYSIS & ECONOMIC IMPACT STATEMENT

BILL #: CS/HB 1021

RELATING TO: Health Care Practitioners/Discrimination

SPONSOR(S): Committee on Health Care Standards & Regulatory Reform and Representative Bloom

STATUTE(S) AFFECTED: Amends sections 408.706, 627.6471, 627.6472, 641.21, 641.315, 641.405, and creates 641.3923, F.S.

COMPANION BILL(S): SB 1070(I)

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) HEALTH CARE STANDARDS & REGULATORY REFORM YEAS 4 NAYS 1
(2) HEALTH AND HUMAN SERVICES APPROPRIATIONS YEAS 11 NAYS 0
(3)
(4)
(5)

I. SUMMARY:

The bill prohibits health maintenance organizations (HMOs), accountable health partnerships, preferred provider contracts, exclusive provider organizations, prepaid health clinics, and other persons or entities from discriminating against “health care practitioners”, licensed pursuant to chapters 458, 459, 460, 463, 464, part III of 468, 486, or 490, F.S., based on the category of license they hold.

It includes provisions for a complaint procedure, investigation, and a hearing to determine the validity of the complaint by the Agency for Health Care Administration (AHCA).

If AHCA determines that a HMO or other managed care plan has discriminated against a health care practitioner based solely on the their category of licensure, AHCA is authorized to issue a cease and desist order. If the discrimination continues, AHCA is authorized to take action against the HMO’s or plan’s certificate of authority to operate.

According to AHCA, the bill will not have a fiscal impact on state government, local government, and the private sector in general. There is an indeterminate fiscal impact on HMOs and other managed care plans.

II. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

Most health maintenance organizations (HMOs) and other managed health care plans provide an approved list or "provider panel" of health care practitioners for their members or subscribers to use when in need of medical assistance. HMOs or other plans usually have signed agreements providing for the terms of any service provided to a member of subscriber of the respective plans. In many instances, the approved list or "provider panel" does not include all of the professions currently covered by the definition of "health care practitioners", as defined in s. 455.01, F.S.

Section 381.0406, F.S., currently provides for rural health networks, by law, to take any willing provider; regardless of the category of licensure.

Section 455.01, F.S., includes: medical, osteopathic, chiropractic, optometric, and podiatric physicians, physician assistants, dentists, nurses, advanced registered nurse practitioners (ARNPs), nurse anesthetists, respiratory, occupational and physical therapists, and mental health counselors, to mention a majority of the professions included in the definition.

As noted above, all of the health care practitioners defined in s. 455.01, F.S., are not on the approved list or "provider panels" of many HMOs or other managed care plans. Under current law, the decision as to which type practitioners to include is the responsibility of the HMOs or various plans. IF the HMOs or other plans decide to not include certain practitioners as approved providers, there is no recourse for these practitioners to appeal.

It has been claimed by a number of health care practitioners that in a number of instances, they have been excluded from the approved list or "provider panel" based solely on the category of licensure. Without an appeals process, there is not currently any method to combat this so called practitioner discrimination. Many of these groups have expressed support for managed care non-discrimination legislation. Supposedly, this legislation would provide an appeals process for instances of discrimination based solely on the category of licensure.

B. EFFECT OF PROPOSED CHANGES:

The bill prohibits HMOs, accountable health partnerships, preferred provider contracts, exclusive provider organizations, prepaid health clinics, and other persons or entities from discriminating against "health care practitioners", licensed pursuant to chapters 458, 459, 460, 463, 464, part III of 468, 486, or 490, F.S., based on the category of license they hold.

It includes provision for a complaint procedure, investigation, and a hearing to determine the validity of the complaint by AHCA.

If AHCA determines that a HMO or other managed care plan has discriminated against a health care practitioner based solely on the their category of licensure, AHCA is

authorized to issue a cease and desist order. If the discrimination continues, AHCA is authorized to take action against the HMO's or plan's certificate of authority to operate.

C. APPLICATION OF PRINCIPLES:

1. Less Government:

a. Does the bill create, increase or reduce, either directly or indirectly:

(1) any authority to make rules or adjudicate disputes?

Yes. It authorizes AHCA to adjudicate disputes between a health care provider and a HMO or other managed care plans.

(2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

HMO's and other managed health plans must provide a plan of operation to ensure the entity is not discriminating against a health care practitioner based solely on type of licensure.

(3) any entitlement to a government service or benefit?

Only as noted above.

b. If an agency or program is eliminated or reduced:

(1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

Not Applicable.

(2) what is the cost of such responsibility at the new level/agency?

Not Applicable.

(3) how is the new agency accountable to the people governed?

Not Applicable.

2. Lower Taxes:

   a. Does the bill increase anyone's taxes?

      No.

   b. Does the bill require or authorize an increase in any fees?

      No.

   c. Does the bill reduce total taxes, both rates and revenues?

      No.

   d. Does the bill reduce total fees, both rates and revenues?

      No.

   e. Does the bill authorize any fee or tax increase by any local government?

      No.

3. Personal Responsibility:

   a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

      No.

   b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

      Not Applicable.

4. Individual Freedom:

   a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs?

      Not Applicable.

   b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

      It would prohibit HMO's from refusing to contract with certain types of providers based solely on their type of license.

5. Family Empowerment:

   a. If the bill purports to provide services to families or children:

      (1) Who evaluates the family's needs?

          Not Applicable.

      (2) Who makes the decisions?

          Not Applicable.

      (3) Are private alternatives permitted?

          Not Applicable.

      (4) Are families required to participate in a program?

          Not Applicable.

      (5) Are families penalized for not participating in a program?

          Not Applicable.

   b. Does the bill directly affect the legal rights and obligations between family members?

      No.

   c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

      (1) parents and guardians?

          Not Applicable.

      (2) service providers?

          Not Applicable.

      (3) government employees/agencies?

          Not Applicable.

D. SECTION-BY-SECTION ANALYSIS:

<u>Section 1.</u> Creates a new s. 408.706(12), F.S., relating to community health purchasing alliances (CHPAs). It provides that an accountable health partnership in acting on a provider application for participation in its provider network, shall not deny the application of an otherwise qualified practitioner licensed pursuant to chapters 458, 459, 460, 463, 464, part III of 468, 486, or 490, F.S., who provides services within the practitioner's scope of practice, based solely on the practitioner's category of licensure.

An accountable health partnership is required to demonstrate and ensure that it does not discriminate against, or exclude such health care practitioners. Compliance with this section shall be enforced by filing a complaint with AHCA against such discriminating partnership network. Complaints may be filed by AHCA, health care practitioners, subscribers, CHPAs, or any other interested party.

Upon the filing of a complaint, the accountable health partnership that is the subject of the complaint is required to demonstrate compliance with the nondiscrimination prohibition. If compliance can not be demonstrated, AHCA shall issue a cease and desist order to the offending party. Failure to comply with the cease and desist order will result in the revocation of the designation of the accountable health partnership.

<u>Section 2.</u> Amends s. 627.6471, F.S., relating to contracts for reduced rates of payment, etc., by adding a new paragraph (1)(d) that provides "reasonable access" means the insurer does not discriminate against practitioners licensed pursuant to chapters 458, 459, 460, 463, 464, part III of 468, 486, or 490, F.S., who provide services within the scope of their practice, based solely on the category of licensure.

<u>Section 3.</u> Amends s. 627.6472, F.S., relating to exclusive provider organizations, by adding a new paragraph (1)(g) that provides "reasonable access" means the insurer does not discriminate against practitioners licensed pursuant to chapters 458, 459, 460, 463, 464, part III of 468, 486, or 490, F.S., who provide services within the scope of their practice, based solely on the category of licensure. It further adds a new paragraph (5)(f) that provides each proposed plan of operation must include written information to demonstrate the insurer does not discriminate against, or exclude from participation health care practitioners listed above, who provide services within the scope of their practice, based solely on the category of licensure.

<u>Section 4.</u> Amends s. 641.21, F.S., relating to application for certificate, by adding a new paragraph (1)(j), that provides each application shall include a proposed

plan of operation to demonstrate the HMO does not discriminate against, or exclude from participation health care practitioners licensed pursuant to chapters 458, 459, 460, 463, 464, part III of 468, 486, or 490, F.S., who

provide services within the scope of their practice, based solely on the category of licensure.

Section 5. Amends 641.315, F.S., relating to provider contracts, by adding a new subsection (8), that provides a HMO shall not refuse to enter a provider contract with otherwise qualified health care practitioners licensed pursuant to chapters 458, 459, 460, 463, 464, part III of 468, 486, or 490, F.S., who provide services within the scope of their practice, based solely on the category of licensure.

Section 6. Creates s. 641.3923, F.S., prohibiting discrimination by health provider groups in acting upon applications(of health care practitioners) for provider participation in their provider panels. It provides that a person, entity or HMO in acting upon an application for participation in a provider panel, may not deny the application of an otherwise qualified health care practitioners licensed pursuant to chapters 458, 459, 460, 463, 464, part III of 468, 486, or 490, F.S., who provide services within the scope of their practice, based solely on the category of licensure.

Each HMO must demonstrate and ensure that it does not discriminate against, or exclude from participation health care practitioners as defined above, who provide services within the scope of their practice, based solely on the category of licensure.

Provision is included for a complaint procedure, investigation, and a hearing to determine the validity of the complaint by AHCA. If AHCA determines that a HMO or other managed care plan has discriminated against a health care practitioner based solely on their category of licensure, AHCA is authorized to issue a cease and desist order to the offending party. Failure to comply with the cease and desist order will result in the suspension or revocation of the HMO's certificate of authority to operate.

Section 7. Amends s. 641.405, F.S., relating to applications for certificate of authority to operate a prepaid clinic by adding a new paragraph (2)(h). It provides each application shall include a plan of operation to demonstrate or ensure that the applicant does not discriminate against, or exclude from participation health care practitioners licensed pursuant to chapters 458, 459, 460, 463, 464, part III of 468, 486, or 490, F.S., who provide services within the scope of their practice, based solely on the category of licensure.

Section 8. Provides an effective date of October 1, 1997.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

None.

2. Recurring Effects:

None.

3. Long Run Effects Other Than Normal Growth:

See Fiscal Comments.

4. Total Revenues and Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

None.

2. Recurring Effects:

None.

3. Long Run Effects Other Than Normal Growth:

None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

Indeterminate. According to the Agency for Health Care Administration bill analysis, the requirement that managed care entities contract with all licensure categories is expected to have an impact on the industry.

2. Direct Private Sector Benefits:

None.

3. Effects on Competition, Private Enterprise and Employment Markets:

   Indeterminate. The Agency indicates that it may expand opportunities for certain professionals to market their service.

D. FISCAL COMMENTS:

According to AHCA, the bill will not have a fiscal impact on the state. The state, however, contracts with HMO's to provide health care access for state employees and Medicaid beneficiaries. If the requirement to contract with all licensure categories increases HMO costs as AHCA predicts, this may eventually lead to higher costs to the state.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that municipalities or counties have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

None.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

One amendment was adopted by the Committee on Health Care Standards and Regulatory Reform. It deleted all health care practitioners as defined in 455.01, F.S., and inserted only health care practitioners licensed pursuant to chapters 458, 459, 460, 463, 464, part III of 468, 486, or 490, F.S. Also, s. 381.0406, F.S., which currently provides for rural health networks to take any willing provider, regardless of the category of licensure, was deleted from the bill. A committee substitute was made out of the bill.

On April 18, 1997, the Committee on Health and Human Services Appropriations reported the bill favorably with the following three amendments:

Amendment 1: Deletes a provision relating to compliance of health partnership networks and replaces the provision with language that states neither the insured member nor the

accountable health partnership may be charged any fee for a reviewing or supervising physician. The fee may only be based on the treating provider's services provided during the visit.

Amendment 2: Conforms to Amendment 1.

Amendment 3: Deletes a provision relating to compliance of health partnership networks and replaces the provision with language that states neither the insured member nor the accountable health partnership may be charged any fee for a reviewing or supervising physician. The fee may only be based on the treating provider's services provided during the visit.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE STANDARDS & REGULATORY REFORM:

Prepared by:	Legislative Research Director:
Robert W. Coggins	Robert W. Coggins

AS REVISED BY THE COMMITTEE ON HEALTH AND HUMAN SERVICES APPROPRIATIONS:

Prepared by:	Legislative Research Director:
James P. DeBeaugrine	Lynn S. Dixon