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HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE STANDARDS AND REGULATORY REFORM
BILL RESEARCH & ECONOMIC IMPACT STATEMENT

BILL #: CS/HB 1087

RELATING TO: Health Care/Provider Contracts

SPONSOR(S): Committee on Health Care Standards and Regulatory Reform and Representatives Goode, Fasano, and Culp

COMPANION BILL(S): HB 1547(c), SB 490(c), and SB 2080(s)

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) HEALTH CARE STANDARDS AND REGULATORY REFORM YEAS 8 NAYS 0
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I. SUMMARY:

CS/HB 1087 provides revised procedures for health care provider terminations or nonrenewal of health care contracts.

It provides that all health care provider contracts entered after the effective date of this act must provide for a probationary period of up to one year in which a contract may be terminated without cause by either party. After the probationary period, the contract will be for two years, or such other period mutually agreed to by both parties.

After the probationary period has expired without action on the part of either party, such contracts may be terminated only for cause or mutual consent. Each contract shall include such conditions or terms that would constitute cause for termination. For purposes of this section, a health care provider is defined as practitioners licensed under chapters 458, 459, 460, and 461, and facilities licensed under chapter 395.

There is no fiscal impact on the State, local government, or private sector in general. Managed care groups, such as, health maintenance organizations, may incur additional costs related to the process established by the bill. These costs could be passed on to their subscribers.

II. SUBSTANTIVE RESEARCH:

A. PRESENT SITUATION:

Managed care features systems or plans which utilize agreements with providers for the appropriate and cost-effective provision of health care. Among others, managed care plans in Florida include HMOs, preferred provider organizations, exclusive provider organizations, Medicaid prepaid health plans, and the MediPass program.

As of March 1996, Florida HMO enrollment was 3.7 million persons. This total includes Medicare beneficiaries, Medicaid recipients, and commercial subscribers. The number of HMO participants has steadily increased in recent years, reflecting general consumer satisfaction with the care provided by, and the costs associated with, HMOs. However, the growth of HMOs has also generated several concerns.

Complaints against HMOs in Florida began in the 1980s. Most complaints were related to questionable enrollment practices and inadequate quality of care in HMOs that held Medicare contracts with the federal government.

In 1987, the Legislature created Part III of Chapter 641, F.S., to ensure that HMOs delivered high quality health care to their subscribers. Part III requires an HMO to receive from the Agency for Health Care Administration a Health Care Provider Certificate, which confirms the HMO is in compliance with the provisions of Part III, before it obtains from the Department of Insurance a Certificate of Authority to operate as an HMO in the state.

In the 1991 Session, a sunset review of Part III, Chapter 641, F.S., was conducted resulting in a number of changes which strengthened the Agency for Health Care Administration's ability to ensure the quality of care in HMOs. These changes include: (1) requiring all HMOs to obtain and maintain accreditation with a nationally recognized accreditation organization having expertise in HMO quality of care issues; (2) directing the agency to conduct follow-up examinations in those instances when the external accreditation reviews indicate that the HMO is out of compliance with accreditation standards; (3) providing the agency with full access to medical records in HMOs; (4) and providing the agency with the authority to levy administrative fines in cases of continued noncompliance, including those identified by the Statewide Subscriber Assistance Panel.
Since the enactment of Ch. 91-282, Laws of Florida, the agency has worked with the industry and with three national accreditation organizations in the development of rules to implement the provisions in the law. The agency has established a consumer hotline which responds to quality of care complaints.

Despite these efforts, quality of care issues continued to surface especially with regards to HMOs which serve Medicaid recipients. A series of articles appearing in the Fort Lauderdale *Sun Sentinel* highlighted numerous abuses in Medicaid HMOs and prompted the Legislature to enact reform measures during the 1996 Session.

However, a number of managed care issues continue to generate controversy. While managed care organizations continue to enjoy increased member enrollments and expanded market shares, government may be less willing to grant them special protections. Moreover, providers and consumers are more vocal about their concerns.

Providers realize that "managed care" means not only managing the care that patients receive, but also managing the providers who render that care. Consumers want lower health care costs, but they also balk at lack of access to specialized care and at perceived quality of care problems. Some of the more controversial issues are:

Gag clauses. Recently, gag or confidentiality clauses in HMO/provider contracts have surfaced as areas of concern to physicians. Physician organizations define these clauses as provisions which prevent a physician from saying anything that would undermine the patient's confidence in the plan's policies and coverage. They contend that such provisions eviscerate physician/patient relationships by undercutting communication, trust and treatment. They interpret gag clauses to prohibit physicians from recommending treatment options not covered by the HMO, even if they are the most appropriate and safest options available. Also, gag clause opponents argue that physicians cannot tell patients about expensive treatments, or refer patients to the best specialists or facilities for a certain treatment, if such specialists do not participate in the plan. HMOs counter that gag clauses as defined by physician advocates either do not exist or do not have the effect purported by HMO opponents. HMOs concede that open physician/patient communication is essential and contractual provisions should not limit matters specifically related to covered services and approved treatments. However, they argue that a business has both a right and a need to protect against actions which would undermine the business/consumer relationship. Accordingly, HMOs contend that clauses preventing a physician from criticizing a plan are appropriate.

In 1996, the Legislature passed, as part of CS/HB 1853 dealing with HMO and civil remedies, an amendment to s. 641.315, F.S., dealing with HMO contracts. This provision prohibited any contract between an HMO and a health care provider from containing any provision that would restrict the provider's ability to communicate information to the provider's patient regarding medical care or treatment options for the patient when the provider believes providing the information is in the patient's best interest. The Governor vetoed CS/HB 1853, focusing on the civil remedies portion of the bill.

However, the 1997 Legislature passed CS/CS/HBs 297 & 325 which contained a number of modifications to HMO contracts and other requirements. One provision specifically prohibits HMO provider contracts from restricting the provider's ability to communicate medical care or treatment information to a patient when such information is deemed by the provider to be in the patient's best interest (see s. 641.315(8), F.S.).

Another area of concern by health care providers relate to termination or nonrenewal of provider contracts by the various managed care entities. Existing law requires 60 days notice of a termination, but it does not provide for the reason for such termination or for the failure to renew an existing contract when it expires.

B. EFFECT OF PROPOSED CHANGES:

It provides revised language on health care provider terminations or nonrenewal of health care contracts.

It provides that all health care provider contracts entered after the effective date of this act must provide for a probationary period of up to one year in which a contract may be terminated without cause by either party. After the probationary period, the contract will be for two years, or such other period mutually agreed to by both parties. After the probationary period has expired without action on the part of either party, such contracts may be terminated only for cause or mutual consent. Each contract shall include such conditions or terms that would constitute cause for termination. For purposes of this section, a health care provider is defined as practitioners licensed under chapters 458, 459, 460, and 461, and facilities licensed under chapter 395.

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?

No.

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

No.

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

No.

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?

N/A

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

N/A

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

N/A

2. Lower Taxes:

a. Does the bill increase anyone's taxes?

N/A

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

N/A

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

N/A

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

N/A

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

N/A

3. Personal Responsibility:

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

N/A

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

No. The beneficiaries of the legislation are the health care providers. Additional costs, if any, will likely be paid by the membership (subscribers) of the managed health plan.

4. Individual Freedom:

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

      Yes. It creates managed health care provider appeal rights prior to termination or nonrenewal of their contract with an HMO. Also, it requires managed health care plans to provide a written explanation of the reasons for the proposed termination or nonrenewal of a provider contract.

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

      No.

5. Family Empowerment:

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

      (1) Who evaluates the family's needs?

          N/A

      (2) Who makes the decisions?

          N/A

      (3) Are private alternatives permitted?

          N/A

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

          N/A

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

          N/A

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

      N/A

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?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. STATUTE(S) AFFECTED:

Amends no specific statutes.

E. SECTION-BY-SECTION RESEARCH:

Section 1. It provides language on health care provider terminations or nonrenewal of a health care contract.

It provides for a probationary period of up to one year in which a contract may be terminated without cause by either party. After the probationary period, the contract will be for two years, or any other period mutually agreed to by both parties. For purposes of this section, a health care provider is defined as practitioners licensed under chapters 458, 459, 460, and 461, and facilities licensed under chapter 395.

Section 2. Provides an effective date of October 1 of the year in which enacted.

FISCAL RESEARCH & ECONOMIC IMPACT STATEMENT:

F. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

None.

2. Recurring Effects:

   None.

3. Long Run Effects Other Than Normal Growth:

   None.

4. Total Revenues and Expenditures:

   None.

G. 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.

H. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

   There are no direct private sector costs. Health maintenance organizations may or may not incur additional costs related to the contracting process for health care providers. Additional costs, if any, incurred by HMOs will likely be passed on to subscribers.

2. Direct Private Sector Benefits:

   There are no direct private sector benefits. Health care providers could benefit from the fact that after the probationary period, provider contracts will be for two year periods or any other period mutually agreed to by both parties.

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

   There are no direct effects on competition or employment markets. However, health maintenance organizations may be more careful in their initial selection process for providers realizing that termination of a provider after the probationary period may potentially be more difficult.

I. FISCAL COMMENTS:

The Agency for Health Care Administration stated that this bill would have no fiscal impact on the State or local government. However, health maintenance organizations may incur additional costs related to the revised process or retaining health care providers that would otherwise have been terminated. Any additional costs incurred by HMOs will likely be passed on to subscribers.

III. 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 counties and municipalities 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.

IV. COMMENTS:

None.

V. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

There were three amendments adopted. However, amendment three was a strike everything amendment that eliminated the first two amendments. It provided new language on health care provider terminations or nonrenewal of a health care contract.

The original bill set up a process for appealing either a termination or nonrenewal of a health care contract. The amendment eliminated the appeals process. It provided for a probationary period of up to one year in which a contract could be terminated without cause by either party. After the probationary period, the contract would be for two years, or any other period mutually agreed to by both parties. For purposes of this section, a health care provider is defined as practitioners licensed under chapters 458, 459, 460, and 461, and facilities licensed under chapter 395. The committee voted to make a committee substitute out of the bill.

VI. SIGNATURES:

COMMITTEE ON HEALTH CARE STANDARDS AND REGULATORY REFORM:

Prepared by:	Legislative Research Director:
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