STORAGE NAME: H0325.hcr
DATE: March 17, 1997

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

BILL #: HB 325

RELATING TO: Health Maintenance Organizations

SPONSOR(S): Representative Maygarden

STATUTE(S) AFFECTED: ss. 641.315, 641.495, 641.51, 641.511, and 641.54, F.S.

COMPANION BILL(S): HB 297(i) and SB 348(c)

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) HEALTH CARE STANDARDS & REGULATORY REFORM
(2)
(3)
(4)
(5)

I. SUMMARY:

This bill amends Chapter 641, F.S., relating to health maintenance organizations (HMOs) to change a number of issues to make them more consumer friendly.

It prohibits "gag" clauses in contracts between HMOs and providers and requires that HMO medical directors be licensed in Florida; it also requires that HMOs: provide out-of-network referrals if an appropriately trained and experienced provider is not available in the existing network of providers; have written policies and procedures to provide for standing referrals to specialists for those with chronic and disabling conditions; allow subscribers with life threatening, disabling and degenerative conditions to continue care (for up to 60 days) with a terminated provider when medically appropriate or necessary to ensure continuity of care; allow pregnant women in their third trimester to continue receiving care from a terminated provider through post partum care; release access and quality indicator data to the Agency for Health Care Administration (AHCA) for formatting and publication to the public; the agency to develop a uniform customer satisfaction survey to be used by all HMOs; adopt a 90 percent compliance goal for preventive pediatric care; have an expedited grievance procedure; make available to their subscribers a variety of information regarding descriptions of processes used for authorization/referral to services, determining medical necessity, approval or denial of experimental or investigational treatments, provider credentialing, and included or excluded formulary drugs; and make available to subscribers descriptions of the quality assurance program, procedures to protect confidentiality of patient records, and policies and procedures used to address the needs of non-English speaking subscribers.

The bill will have no fiscal impact on state and local government, and the fiscal impact, if any, on the private sector is indeterminate at this time.

II. SUBSTANTIVE ANALYSIS:

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.

Power and authority of HMO medical directors. This issue involves defining and regulating the medical decision-making parameters of out-of-state, non-Florida licensed medical directors of managed care organizations.

Consumer awareness/protection. An informed consumer is the cornerstone of any competitive marketplace model. Consumers, however, may lack essential information about providers in some managed care plans. For example, data regarding quality of care, referral patterns and policies, capitation methods, and coverage limitations may not be available in certain instances.

B. EFFECT OF PROPOSED CHANGES:

HMO subscribers will have expanded access to information about their HMO, including more open dialogue with their treating physicians, procedures for referrals to specialists, quality indicator data, customer satisfaction surveys, procedures for determining medical necessity and for approval or denial of experimental treatments or excluded formulary drugs, and quality assurance programs and procedures to protect confidentially of

patient records. In addition, if an HMO subscriber's treating physician leaves the HMO, pregnant women in their third trimester of pregnancy or patients with life threatening, disabling and degenerative conditions may continue treatment with the physician for a period of time. Finally, subscribers will have access to an expedited grievance review process for an emergency condition.

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, the agency will be authorized to make rules to implement portions of this legislation.

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

Yes, HMOs will incur additional obligations to provide information to their subscribers and to the agency.

(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?

      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?

      N/A

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

      Yes, subscribers will likely be required to pay slightly increased premiums to cover any additional costs HMOs realize through enactment of this bill.

4. Individual Freedom:

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

      The bill will result in HMO subscribers having access to additional information about their HMO and require HMOs to provide that additional information.

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

The bill does impose additional requirements on HMOs.

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. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 641.315, F.S., relating to HMO provider contracts, to add a new subsection (8) to require that no contract between an HMO and a provider shall contain any provision restricting the provider's ability to communicate information to the provider's patients regarding medical care or treatment options for the patient when the provider deems knowledge of such information by the patient to be in the patient's best interest.

Section 2. Amends s. 641.495, F.S., relating to requirements for issuance and maintenance of a certificate, to add a new subsection (11) to require all HMOs to designate a medical director who is a Florida licensed physician.

Section 3. Amends s. 641.51, F.S., relating to quality assurance programs and second medical opinions, to add new subsections (5) through (10) to require HMOs to:

(5) Provide subscribers with an out of network referral if the organization has not contracted with or employed an appropriately trained and experienced specialist to provide medically necessary health care services to a subscriber.

(6) Develop and maintain written policies and procedures for the provision of standing referrals to subscribers with chronic and disabling conditions which require ongoing specialty care.

(7) Allow subscribers with life threatening, disabling and degenerative conditions to continue care, for up to 60 days, with a terminated provider when medically appropriate or necessary to ensure continuity of care. The HMO is required to allow pregnant women in their third trimester to continue receiving care from a terminated provider through post partum care.

(8) Release access and quality indicator data to the agency for formatting and publication to the public within specified time frames. The agency is required to develop rules specifying reporting requirements for these indicators.

(9) Conduct a standardized customer satisfaction survey of its membership periodically. The agency is required to develop a uniform survey instrument.

(10) Adopt a 90 percent compliance goal for preventive pediatric health care.

Section 4. Amends s. 641.511, F.S., relating to subscriber grievance reporting and resolution requirements, to add a new subsection (6) to require all HMOs to maintain an expedited grievance procedure for reviewing denials of ungently needed health care services. A procedure for classifying grievances must be developed and must include time frames for resolving grievances which shall not exceed seven days.

Section 5. Amends s. 641.54, F.S., relating to hospital and physician information disclosure, to amend the catch line striking the words"hospital and physician" and to add new subsections (3) through (5) to require each HMO to make available to its subscribers a description of:

(3) The process used to determine authorization and referral criteria for health care services.

(4) The process used to determine whether health care services are "medically necessary".

(5) Its quality assurance program; policies and procedures of its prescription drug benefit to include the disclosure of any included and excluded drugs and the use of any formulary; policies and procedures to protect the subscribers' medical records; the decision making process used for approval or denial of experimental or investigational medical treatments; policies and procedures for addressing the needs of non-English speaking subscribers; and the process used to examine qualifications of and the credentialing of all providers with the organization.

Section 6. Provides an effective date of July 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:

   None.

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:

   Enactment of this proposal will result in some increased costs to HMOs in the form of additional out-of-network referrals, additional in-network referrals to specialists, and increased reporting and data requirements. Any increased costs will likely be passed on to HMO subscribers in the form of higher premiums.

2. Direct Private Sector Benefits:

   If the additional information made available to potential HMO subscribers (as required by this proposal) makes these potential subscribers more comfortable with managed care, the number of HMO subscribers may increase.

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

   The availability of additional information for consumers should heighten competition by enabling consumers to make more informed decisions. The publishing of “report cards” should allow the consumer to compare health plans using uniform criteria.

D. FISCAL COMMENTS:

The agency’s fiscal analysis reflected no additional costs to the agency from passage of this bill..

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

A. APPLICABILITY OF THE MANDATES PROVISION:

This legislation does not impose any mandates on local governments.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This legislation does not reduce the revenue raising authority of local governments.

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

This legislation does not reduce state taxes shared with local governments.

V. COMMENTS:

None.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

None.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE STANDARDS & REGULATORY REFORM:

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