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HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE SERVICES
ANALYSIS

BILL #: HB 337

RELATING TO: Health Care Provider Contracts

SPONSOR(S): Rep. Goode and others

COMPANION BILL(S): None

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) HEALTH CARE SERVICES
(2) HEALTH & HUMAN SERVICES APPROPRIATIONS
(3)
(4)
(5)

I. SUMMARY:

HB 337 prohibits a managed care plan from terminating or nonrenewing a health care provider contract without a hearing, if requested by the health care provider, except in cases involving imminent harm to patient health or a final disciplinary action by the provider's licensing board which impairs the provider's ability to practice. The hearing must be before a panel of at least three persons appointed by the managed care plan, one of whom (or one-third) must be a clinical peer in the same discipline and specialty as the provider being terminated. Time periods for notice of termination or nonrenewal of not less than 30 days must be given within which the provider may request a hearing. A managed care plan's governing body is not bound by the recommendations of the hearing panel. Prior to termination or nonrenewal, a provider must be given at least 90 days' notice.

Enactment of this legislation may result in higher costs for employee health benefits provided by state and local governments through managed care plans.

II. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

In general, current Florida law does not restrict the authority of a health maintenance organization (HMO) from terminating the contract of a health care provider. The allowable reasons for termination of the contract by either party are subject to the terms of the contract itself. However, the current law requires that HMOs provide at least 60 days' written notice prior to canceling a contract with a health care provider, without cause, except in a case in which a patient's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action by the Board of Medicine or other governmental agency. The law also requires the health care provider to give the HMO at least 60 days' notice prior to canceling the contract, but allows the HMO and the provider to agree to terminate the contract in less than 60 days if the HMO is not financially impaired or insolvent. (s. 641.315, F.S.)

HMO legislation enacted in 1997 requires HMOs to allow subscribers to continue care for 60 days with a terminated treating provider when medically necessary, provided the subscriber has a life-threatening condition or a disabling and degenerative condition. Each HMO must allow a subscriber who is in the third trimester of pregnancy to continue care with a terminated treating provider until completion of postpartum care. The HMO and the provider must continue to be bound by the terms of the contract for such continued care. However, these requirements do not apply to a provider who has been terminated for cause. (ch. 97-159, L.O.F.; s. 641.51(7), F.S.)

B. EFFECT OF PROPOSED CHANGES:

Managed care plans will be prohibited from terminating or nonrenewing a contract with a health care provider without a hearing (if the provider requests a hearing). However, the managed care plan appoints the members of the hearing panel, and the plan is not bound by the recommendations of the panel. If a panel decides to terminate or nonrenew a provider's contract, the provider must be given at least 90 days' notice of this decision.

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 gives either the Department of Insurance or the Agency for Health Care Administration, depending on where this language is placed in the statutes, additional authority to regulate contracts between managed care plans and health care providers.

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

Yes, managed care plans will have additional obligations regarding provider contracts.

(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?

No.

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

No.

4. Individual Freedom:

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

No.

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

Yes, the bill creates new requirements relating to contracts between managed care plans and health care providers.

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?

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?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. STATUTE(S) AFFECTED:

None.

E. SECTION-BY-SECTION ANALYSIS:

Section 1. Creates an unnumbered statute that prohibits a managed care plan from terminating or failing to renew a contract with a health care provider unless the plan provides the provider a written explanation of the reasons for the termination or nonrenewal. The provider must be given an opportunity for a review or hearing unless there is a threat of imminent harm to patient health or a final disciplinary action by the provider's licensing board which impairs the provider's ability to practice. Contained within this newly created section of law are the following subsections:

Subsection (1). Specifies that the notice of the proposed contract termination or nonrenewal must include: the reasons for the proposed action; notice that the provider has the right to request a hearing or review, at the provider's discretion, before a panel appointed by the managed care plan; a time limit of not less than 30 days within which the provider may request a hearing; and a time limit for a hearing, which must be held not less than 30 days nor more than 60 days after the date of receipt of the request for a hearing.

Subsection (2). Specifies that if the provider requests a hearing, he or she must be provided written notice which states: the time, place and date of the hearing; and the names of any witnesses which are expected to testify on behalf of the plan.

Subsection (3). Requires the hearing be conducted by a panel composed of three persons appointed by the plan. At least one person on the panel must be a clinical peer in the same discipline and the same or similar specialty as the provider under review. The panel may consist of more than 3 persons if the clinical peers constitute at least one-third of the panel.

Subsection (4). Requires the hearing panel to render a decision in a timely (but unspecified) manner. The decision must include the panel's recommendations in the following form. The panel recommends the provider contract should be: reinstated or renewed; provisionally reinstated or renewed subject to specified conditions; terminated; or not renewed.

Subsection (5). Specifies the governing body of the plan, after considering the decision and recommendation of the panel, must render its decision within 30 days after the issuance of the panel's recommendation. Requires the governing body's decision to include: reinstatement or renewal; provisional reinstatement or renewal subject to specified conditions; termination; or nonrenewal of the contract.

Subsection (6). Prohibits a plan from terminating or nonrenewing a contract with a provider earlier than 30 days after the health care provider is informed of the decision to terminate; or earlier than 90 days after the provider receives the notice of the termination or nonrenewal.

Section 2. Provides an effective date of October 1, 1999.

III. <u>FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT</u>:

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:

   Managed care plans will experience additional costs related to terminating or nonrenewing health care provider contracts.

2. Direct Private Sector Benefits:

   Health care providers will benefit by additional protections from termination or nonrenewal of contracts with managed care organizations.

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

   This legislation will alter the balance in contract negotiations between health care providers and managed care plans.

D. FISCAL COMMENTS:

Enactment of this legislation may result in increased costs associated with providing health benefits to state and local government employees. This increase may occur in two forms: increased costs associated with the termination or nonrenewal process, which will require the appointment of a hearing panel; and potential reductions in the bargaining power of the managed care plan in the negotiation process. However, the amount of increase is not possible to estimate.

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.

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:

Several terms are used in this legislation which are not defined. The act uses the term “managed care plan” and “health care provider” and fails to define either term. Therefore, it is unclear which types of entities would be impacted by this bill. A managed care plan might include a health maintenance organization, a preferred provider organization, an exclusive provider organization, or a prepaid limited health services organization. The term health care provider might include physicians, dentists, optometrists, hospitals, home health agencies, durable medical equipment suppliers, or others. It is recommended these terms be defined.

Assigning the created provisions to a designated section of statute would further clarify the applicability of these new requirements.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

N/A

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

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