By Senators Brown-Waite and Peaden

10-235-02

A bill to be entitled

An act relating to health care; creating s. 408.7058, F.S.; providing for a statewide provider-qualification dispute-resolution program to be established by the Agency for Health Care Administration; providing definitions; authorizing the agency to adopt rules; providing for adoption of final orders; providing for payment of costs; amending s. 627.6474, F.S.; providing terms and conditions of contracts between a health insurer and a health care provider; providing conditions for terminating contracts; providing for waiver or nullification of such conditions by contract of the parties; amending s. 641.315, F.S.; eliminating the requirement for a 60 days' written notice of cancellation without cause of a contract between a health maintenance organization and a health care provider; eliminating certain discretionary reasons for terminating such contracts; prescribing new procedures for terminating such contracts; providing notice requirements; specifying that terms and conditions to be met by health care providers must be stated in the contract with the health maintenance organization; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 408.7058, Florida Statutes, is created to read:

408.7058 Statewide provider-qualification dispute-resolution program.--

(1) As used in this section, the term:

(a) "Health care provider" means any hospital licensed under chapter 395 or any health care practitioner as defined by s. 456.001.

(b) "Health maintenance organization" or "organization" means an organization certified under part I of chapter 641.

(c) "Health insurer" means an entity licensed under chapter 627.

(d) "Qualification dispute" means any dispute between a health maintenance organization and a health care provider, or a health insurer and a health care provider, as to whether the provider meets the entity's written terms and conditions provided to the health care provider pursuant to s. 627.6474 or s. 641.315(10).

(e) "Resolution organization" means a qualified independent third-party claim-dispute-resolution entity selected by and contract with the Agency for Health Care Administration.

(2)(a) The Agency for Health Care Administration shall establish a program by January 1, 2003, to provide assistance to contracted and noncontracted health care providers for resolution of qualification disputes that are not resolved by the provider and the health maintenance organization or health insurer. The agency shall contract with a resolution organization to timely review and consider qualification

disputes submitted by providers and recommend to the agency an appropriate resolution of those disputes.

(b) The resolution organization shall review qualification disputes filed by contracted and noncontracted providers unless the dispute is the basis for an action pending in state or federal court.

(3) The agency shall adopt rules to establish a process to be used by the resolution organization in considering qualification disputes submitted by a health care provider which must include the issuance by the resolution organization of a written recommendation, supported by findings of fact, to the agency within 60 days after receipt of the dispute submission. The written recommendation may include a recommendation that the health care provider not be terminated from the health maintenance organization or health insurer.

(4) Within 30 days after receipt of the recommendation of the resolution organization, the agency shall adopt the recommendation as a final order.

(5) The entity that does not prevail in the agency's order must pay a review cost to the review organization, as determined by agency rule. If the nonprevailing party fails to pay the ordered review cost within 35 days after the agency's order, the nonpaying party is subject to a penalty of not more than $500 per day until the penalty is paid.

(6) The Agency for Health Care Administration may adopt rules to administer this section.

Section 2. Section 627.6474, Florida Statutes, is amended to read:

627.6474 Provider contracts.--

(1) A health insurer shall not require a contracted health care practitioner as defined in s. 456.001(4) to accept the terms of other health care practitioner contracts with the insurer or any other insurer, or health maintenance organization, under common management and control with the insurer, including Medicare and Medicaid practitioner contracts and those authorized by s. 627.6471, s. 627.6472, or s. 641.315, except for a practitioner in a group practice as defined in s. 456.053 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 subsection ~~section~~ is void. A violation of this subsection ~~section~~ is not subject to the criminal penalty specified in s. 624.15.

(2) Each contract between a health insurer and a health care provider must contain the organization's terms and conditions that must be met by health care providers contracting with the health insurer. The insurer's terms and conditions for contracting with the health care provider may not be modified or amended in any way by the health insurer during the term of the contract between the health insurer and the health care provider.

(3) A health insurer that has a market share of over 25 percent in a county in any of its plans may not refuse to enter into or renew a contact in such plan with any licensed health care provider that is willing to meet the terms and conditions established by the insurer under subsection (2), that practices within the geographic area served by the insurer, and whose credentials are verified and examined by the insurer's system for verification and examination of the credentials of each of its providers.

(4)(a) A health insurer or health care provider may not terminate a contract with a health care provider or health insurer unless the party terminating the contract provides the terminated party with a written reason for the proposed contract termination.

(b) A health insurer may terminate a contract with a health care provider only if the provider fails to comply with the organization's written term and conditions that have been provided to the health care provider under subsection (2). If a health insurer proposes to terminate a contract with a health care provider, the health insurer must provide the health care provider with 60 days' advance written notice of its intent to terminate the provider's contract. This paragraph does not apply in cased involving imminent harm to patient health or a final disciplinary action by the provider's licensing board or other governmental agency which impairs the health care provider's ability to practice within the jurisdiction.

(c) If a health insurer proposes to terminate a contract of a health care provider, the health insurer may not notify the provider's patients of the proposed termination until the effective date of the termination or the conclusion of the review or hearing provided in this section, whichever occurs later. If a provider's contract is terminated for reasons related to imminent harm to patient health or a final disciplinary action by the provider's licensing board or other governmental agency which impairs the health care provider's ability to practice within the jurisdiction, the health insurer may notify the provider's patients immediately.

(d) The notice of the proposed contract termination provided by the health insurer to the health care provider must include:

1. The specific term and condition established by the health insurer which the insurer alleges has been breached by the health care provider and which serves as the reason for the proposed termination.

2. Notice that the health care provider has the right to request a review before the statewide provider and health insurer qualification dispute-resolution program created under s. 408.7058.

3. A time period of not less than 30 days within which a health care provider may request a review.

(e) If the health care provider requests a review, the health care provider must be given a written notice that states the names of the witnesses, if any, expected to testify at the hearing on behalf of the health insurer.

(5) The provisions of this section apply to contracts entered into under ss. 627.6471 and 627.6472.

(6) The provisions of this section may not be waived, voided, or nullified by contract.

Section 3. Section 641.315, Florida Statutes, is amended to read:

641.315 Provider contracts.--

(1) Each contract between a health maintenance organization and a provider of health care services must be in writing and must contain a provision that the subscriber is not liable to the provider for any services for which the health maintenance organization is liable as specified in s. 641.3154.

(2)~~(a) For all~~ Provider contracts ~~executed after October 1, 1991, and within 180 days after October 1, 1991, for contracts in existence as of October 1, 1991~~:

(a)~~1. The contracts~~ Must require the provider to give 60 days' advance written notice to the health maintenance organization and the department before canceling the contract with the health maintenance organization for any reason; and

(b)~~2. The contract~~ Must also provide that nonpayment for goods or services rendered by the provider to the health maintenance organization is not a valid reason for avoiding the 60-day advance notice of cancellation.

~~(b) All provider contracts must provide that the health maintenance organization will provide 60 days' advance written notice to the provider and the department before canceling, without cause, the contract with the provider, 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.~~

~~(3) Upon receipt by the health maintenance organization of a 60-day cancellation notice, the health maintenance organization may, if requested by the provider, terminate the contract in less than 60 days if the health maintenance organization is not financially impaired or insolvent.~~

(3)~~(4)~~ Whenever a contract exists between a health maintenance organization and a provider, the health maintenance organization shall disclose to the provider:

(a) The mailing address or electronic address where claims should be sent for processing;

(b) The telephone number that a provider may call to have questions and concerns regarding claims addressed; and

(c) The address of any separate claims-processing centers for specific types of services.

A health maintenance organization shall provide to its contracted providers no less than 30 calendar days' prior written notice of any changes in the information required in this subsection.

(4)~~(5)~~ A contract between a health maintenance organization and a provider of health care services shall not contain any provision restricting the provider's ability to communicate information to the provider's patient regarding medical care or treatment options for the patient when the provider deems knowledge of such information by the patient to be in the best interest of the health of the patient.

(5)~~(6)~~ A contract between a health maintenance organization and a provider of health care services may not contain any provision that in any way prohibits or restricts:

(a) The health care provider from entering into a commercial contract with any other health maintenance organization; or

(b) The health maintenance organization from entering into a commercial contract with any other health care provider.

(6)(a)~~(7)~~ A health maintenance organization or health care provider may not terminate a contract with a health care provider or health maintenance organization unless the party terminating the contract provides the terminated party with a written reason for the proposed contract termination~~, which may include termination for business reasons of the~~

~~terminating party. The reason provided in the notice required in this section or any other information relating to the reason for termination does not create any new administrative or civil action and may not be used as substantive evidence in any such action, but may be used for impeachment purposes. As used in this subsection, the term "health care provider" means a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461, or a dentist licensed under chapter 466~~.

(b) A health maintenance organization may terminate a contract with a health care provider only if the provider fails to comply with the organization's written terms and conditions that have been provided the health care provider under subsection (10). If a health maintenance organization proposes to terminate a contract with a health care provider, the health maintenance organization shall give the health care provider 60 days' advance written notice of its intent to terminate the provider's contract. This paragraph does not apply in cases involving imminent harm to patient health or a final disciplinary action by the provider's licensing board or other governmental agency which impairs the health care provider's ability to practice within the jurisdiction.

(c) If a health maintenance organization proposes to terminate a contract of a health care provider under this section, the health maintenance organization may not notify the provider's patients of the proposed termination until the effective date of the termination or the conclusion of the review or hearing provided in this section, whichever occurs later. If a provider's contract is terminated for reasons related to imminent harm to patient health or a final disciplinary action by the provider's licensing board or other governmental agency which impairs the health care provider's

ability to practice within the jurisdiction, the health maintenance organization may notify the provider's patients immediately.

(d) The notice of the proposed contract termination provided by the health maintenance organization to the health care provider must include:

1. The specific term and condition established by the health maintenance organization which the organization alleges has been breached by the health care provider and which serve as the reason for the proposed termination.

2. Notice that the health care provider has the right to request a review before the statewide provider and health maintenance organization qualification dispute-resolution program created under s. 408.7058.

3. A time period of not less than 30 days within which a health care provider may request a review.

(c) If the health care provider requests a review, the health care provider must be provided a written notice that states the names of the witnesses, if any, expected to testify at the hearing on behalf of the health maintenance organization.

(7)~~(8)~~ The health maintenance organization must establish written procedures for a contract provider to request and the health maintenance organization to grant authorization for utilization of health care services. The health maintenance organization must give written notice to the contract provider prior to any change in these procedures.

(8)~~(9)~~ A contract between a health maintenance organization and a contracted primary care or admitting physician may not contain any provision that prohibits such physician from providing inpatient services in a contracted

hospital to a subscriber if such services are determined by the organization to be medically necessary and covered services under the organization's contract with the contract holder.

(9)~~(10)~~ A health maintenance organization shall not require a contracted health care practitioner as defined in s. 456.001(4) to accept the terms of other health care practitioner contracts with the health maintenance organization or any insurer, or other health maintenance organization, under common management and control with the health maintenance organization, including Medicare and Medicaid practitioner contracts and those authorized by s. 627.6471, s. 627.6472, or s. 641.315, except for a practitioner in a group practice as defined in s. 456.053 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 section is void. A violation of this section is not subject to the criminal penalty specified in s. 624.15.

(10) Each contract between a health maintenance organization and a health care provider must contain the organization's terms and conditions that must be met by health care providers contracting with the health maintenance organization. The organization's terms and conditions for contracting with the health maintenance organization may not be modified or amended in any way by the health maintenance organization during the term of the contract between the health maintenance organization and the health care provider. The provisions of this subsection may not be waived, voided, or nullified by contract.

(11) A health maintenance organization that has a market share of over 25 percent in a county in any of its health maintenance organization plans may not refuse to enter into or renew a contract in such plan with any licensed health care provider who is willing to meet the terms and conditions established by the organization under subsection (10), who practices within the geographic area served by the organization, and whose credentials are verified and examined by the organization under s. 641.495(6).

Section 4. This act shall take effect July 1, 2002.

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SENATE SUMMARY

Provides for the establishment by the Agency for Health Care Administration of a statewide provider-qualification dispute-resolution program. Provides the agency with rulemaking authority. Provides for adoption of final orders and payment of costs. Provides terms and conditions to be included in contracts between health insurers and health care providers. Prescribes conditions for terminating such contracts and for waiver of such conditions. Prescribes new procedures for terminating contracts between a health maintenance organization and a health care provider. Specifies that terms and conditions to be met by a health care provider must be stated in its contract with the HMO.