SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/SB 154

SPONSOR: Committee on Health, Aging, and Long-Term Care and Senator Campbell

SUBJECT: Managed Health Care

DATE: April 22, 2003 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Harkey	Wilson	HC	Favorable/CS
2.	Emrich	Deffenbaugh	BI	Favorable
3.			AHS	
4.			AP	
5.				
6.				

I. Summary:

This bill creates the Health Care Providers' Bill of Rights. The bill revises the contractual requirements of managed care plans by prohibiting the inclusion of various provisions in health care provider contracts that are issued, amended, or revised on or after January 1, 2004. The bill prohibits managed care plans from changing a material term of the contract unless the provider agrees; unless the change is necessary to comply with state or federal laws; or the change is necessary to comply with accreditation standards of a private accreditation organization. If the provider does not agree to the change, the provider may terminate the contract prior to the implementation of the change.

The bill specifies new grounds for disciplinary action by the Agency for Heath Care Administration (AHCA) against managed care plans for violation of certain provisions. The bill authorizes the Secretary of AHCA to prohibit any person from serving as an officer, director, employer, associate, or provider of a managed care plan under certain circumstances. The bill also provides that specified acts and omissions constitute grounds for disciplinary action by AHCA including "any violation" of ch. 641, F.S. This appears to give AHCA the authority to take action against an HMO in regulatory areas that are currently under the jurisdiction of the Office of Insurance Regulation.[1]

According the Agency for Health Care Administration, "(I)t is unclear whether the proposed bill would impact Medicaid contracts since the bill contains no statutory citations."

[1]. Effective January 7, 2003, the Department of Insurance was transferred to the Department of Financial Services and to the Office of Insurance Regulation (ch. 2002-404, L.O.F.). The Office of Insurance Regulation (OIR) is responsible for regulating specified financial and other activities concerning Health Maintenance Organizations under part I of ch. 641, F.S. and prepaid health clinics under part II of ch. 641, F.S. This session, CS/CS/SB 1712 makes conforming changes to the Florida Statutes.

This bill creates two unnumbered sections of law.

II. Present Situation:

Managed care refers to a variety of methods of financing and organizing the delivery of comprehensive health care in which an attempt is made to control costs and improve quality by controlling the provision of services. Managed care, in varying degrees, integrates the financing and delivery of medical care through contracts with selected physicians, hospitals, and other health care providers that provide comprehensive health services to enrolled members for a predetermined monthly premium.

Typically, a managed care organization (MCO) or health maintenance organization (HMO) contracts with individuals, employers, unions, and other purchasers to provide comprehensive health care services to people who enroll in the plan. This contract is known as the "plan," "contract," or "agreement." The purchaser pays the MCO or HMO a fixed fee each month per individual or family. The enrolled individuals who become known as "members," "subscribers," or "enrollees" may be responsible for paying all or a portion of the fixed fee, depending on whether they have purchased the health care coverage themselves or whether it is offered by their employer or union as part of an employee benefits package. Based on employment or contractual arrangements with health care professionals, the MCO or HMO delivers or arranges for the delivery of health care services using various policies, procedures, and utilization review processes to control the cost and use of health care services.

Under current law, HMOs are issued a health care provider certificate from the Agency for Health Care Administration (AHCA) and a certificate of authority from the Office of Insurance Regulation (OIR). The Agency for Health Care Administration regulates the quality of care by HMOs under part III, of ch. 641, F.S., while the OIR is responsible for enforcing primarily financial and contractual activities of HMOs under the provisions in part I of ch. 641, F.S. In addition, exclusive provider organizations (EPOs) are authorized health insurers that limit coverage to services or treatment from network providers, very similar to an HMO. The EPO, in addition to obtaining a certificate of authority as a health insurer from OIR, must have its plan of operation approved by AHCA to determine the adequacy of the provider network and assurance of quality of care.

The term, managed care organization, or managed care plan, is not a licensure category under Florida law; however, the term managed care is used in the statutes for limited purposes. For example, s. 408.7056, F.S., provides for a statewide panel to resolve grievances against a managed care entity. For this purpose, managed care entity is defined to mean: a health maintenance organization or a prepaid health clinic certified under ch. 641, F.S.; a prepaid health plan authorized under s. 409.912, F.S.; or an exclusive provider organization certified under s. 627.6472, F.S. These entities serve a very limited market in Florida. In addition to these entities, a health insurer that sells a preferred provider contract may also be considered a "managed care" plan if the policy provides greater benefits to an insured who obtains services from a network provider, and lesser benefits (greater deductibles and coinsurance) from a non-network provider. The insurer must have these policies approved by the OIR, but not the agency. Such plans are often referred to as preferred provider organizations (PPOs) and are regulated under s. 627.6471, F.S., by the OIR.

The development of Medicaid alternative service arrangements attempts to restructure the Medicaid Program through initiatives which will reduce costs, increase efficiencies and improve the delivery of health care services. To the extent possible, all Medicaid clients in Florida must enroll in a managed care program.

Proponents of this bill assert that providers should have notice and the opportunity to negotiate and agree to material changes in their managed care contracts. If these providers can not agree to the change, then they should have the right to terminate the contract prior to the implementation of the change.

Opponents argue that the bill imposes further costs on the managed care plans, forcing them to increase premiums to policyholders and that such increases would place pressure on individuals and business to drop their current insurance, increasing the already unacceptable large number of citizens who are uninsured. Further, representatives with the plans state that they have three overall concerns with this legislation: the bill includes no statutory citations, and it is unclear if it would impact Medicaid and thereby cause significant budgetary implications; the bill materially restricts a plans utilization review and quality control efforts which are designed to insure that care is medically necessary and appropriate;[2] and portions of the bill are redundant as they are addressed in existing provisions of the law.

III. Effect of Proposed Changes:

Section 1. The bill does not contain any statutory reference. It creates the "Health Care Providers' Bill of Rights" and provides that a contract between a managed care plan (plan) and a health care provider that is issued, amended, or renewed on or after January 1, 2004, must adhere to the following provisions:

1. A managed care plan may not change material terms of the contract unless the provider agrees to the changes or the changes are the result of state, federal, or accreditation requirements. A managed care plan must give a provider at least 45 business days' notice of its intent to change a material term, unless state, federal, or accreditation requirements require a shorter timeframe. The bill specifies that if a change is made by amending a manual, policy, or procedure manual that is referenced in the contract, the managed care plan has to give providers 45 days' prior notice of any changes, and if the provider does not agree to the changes to the manual, policy, or procedure documents, the provider can terminate the contract prior to the implementation of the changes. The 45 business days' notice requirement may be waived if both parties agree.

2. The bill further provides that if a provider and a managed care plan provide benefits to enrollees or subscribers through a preferred provider arrangement, the contract may contain provisions permitting a material change to the contract if the plan provides at least 45 business days' notice to the provider of the change and if the provider has the right to terminate the contract prior to the implementation of the change.

[2] These representatives state that provider contracts are "evergreen," meaning that they have no express expiration. And since the bill relates to changes which occur in mid-term, that provision would prevent health plans from imposing new utilization review or quality review standards or procedures at any time during the contractual relationship between the plan and the provider (unless the provider agreed to such standards or procedures).

3. A contract cannot require a provider to accept more patients than specified in the contract. If the contract does not include a specific number, the health care provider may limit the number of patients accepted based on his/her professional judgment.

4. A contract may not contain a requirement to comply with quality of care improvement programs, unless the requirements are disclosed 15 days prior to the execution of the contract, or unless the change is necessary to comply with state, federal, or accreditation requirements.

5. Contracts may not contain any provisions that waive or conflict with the requirements of ch. 641, F.S.

6. Contracts may not have a requirement to permit access to patient information in violation of federal or state laws concerning the confidentiality of patient information.

Any contract provision that violates these requirements is void, unlawful, and unenforceable.

The bill defines *health care provider* as any physician, hospital, or other institution, organization, or person that furnishes health care services and is licensed or otherwise authorized to practice health care services in this state. *Material* is defined as a provision in a contract to which a reasonable person would attach importance in determining the action to be taken upon the provision.

The bill provides grounds for disciplinary action against managed care plans and gives the Secretary of AHCA the authority, after appropriate notice and opportunity for a hearing, to suspend or revoke a license or issue a fine for the following violations:

1. The managed care plan is operating at variance with the basic organizational documents filed and approved by AHCA and its licensure requirements.

2. The managed care plan issued or uses evidence of coverage or a schedule of charges for health care services inconsistent with "evidence of coverage" approved by AHCA.

3. The managed care plan does not provide basic health care services as set forth in the evidence of coverage.

4. The continued operation of a managed care plan that constitutes a risk to subscribers.

5. The managed care plan has violated any provisions of ch. 641, F.S., or any related rules.

6. The managed care plan has engaged in unfair methods of competition or unfair or deceptive trade practices under s. 641.3903, F.S.

7. The managed care plan has aided or abetted any violation by a contractor which would provide grounds for discipline against the contractor.

8. The managed care plan has permitted, aided, or abetted the commission of any illegal act.

9. The managed care plan has engaged the services of an officer, director, employee, associate, or provider of the plan in violation of an order issued by the Secretary.

10. The managed care plan has engaged a solicitor or supervisor of solicitation contrary to the provisions of an order issued by the Secretary.

11. The managed care plan, its management company, or any other affiliate of the plan, or any controlling person, officer, director, or other person occupying a principal management or supervisory position has been convicted of, or has pled nolo contendere to, a crime or committed any act involving dishonesty, fraud, or deceit, which crime or act is substantially related to the qualifications, functions, or duties of a person engaged in business in accordance with ch. 641, F.S.

12. The managed care plan has been subject to a final disciplinary action taken by this state, another state, an agency of the federal government, or another country for any act or omission that would constitute a violation of ch. 641, F.S.

13. The managed care plan has violated any law requiring that medical information be kept confidential.

The Secretary of AHCA may also prohibit any person from serving as an officer in a plan if the prohibition is in the public interest and the person has participated in an act that was a violation of ch. 641, F.S., or the person was an officer, director, employee, associate, or provider whose license was suspended or revoked and the person had knowledge of any of the acts for which the license was suspended or revoked.

A proceeding under this section requires notice to, and the opportunity for a hearing with regard to, the person affected in accordance with ch. 120, F.S.

Section 2. The bill takes effect July 1, 2003.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

If a managed care plan incurred administrative costs from legal negotiations with providers, the managed care plan could be expected to recoup those costs in increased premiums charged to subscribers.

C. Government Sector Impact:

According to the Agency for Health Care Administration, the exact fiscal impact on AHCA cannot be determined based on the language in the bill. Some of the responsibilities assigned to AHCA would be duplicative of functions currently carried out by the Office of Insurance Regulation (OIR); while other responsibilities assigned to AHCA are duplicative of existing provisions.

According to AHCA representatives, many geographic areas of the state have limited choice for Medicaid beneficiaries' managed care. In an effort to reduce costs in these areas by as much as 8 percent, the state is developing pilot programs and trying to encourage existing contractors to build Medicaid provider networks and initiate operation as managed care or alternative service arrangements in counties with no such existing arrangement.

Organizations do occasionally amend subcontracts with their network providers to add the Medicaid population. This capability is generally advantageous in geographic areas that have limited specialty providers. If organizations are not able to establish adequate Medicaid provider networks or if the organizations are forced to pay higher rates for specialists, they will be reluctant to initiate operations in these areas. Therefore, many Medicaid beneficiaries will not have many choices for their managed care plans. Furthermore, the state will not have the opportunity to save up to eight percent of the Medicaid costs in those counties.

VI. Technical Deficiencies:

None.

VII. Related Issues:

This bill creates provisions that would appear to replace provisions currently in ch. 641, F.S., but the bill does not amend or repeal those provisions in the statute. The bill assigns oversight of selected managed care plan contract provisions that are currently under the jurisdiction of the Office of Insurance Regulation (OIR) to AHCA without amending or repealing existing statutory provisions.

The bill prohibits contractual provisions which waive or conflict with the requirements of ch. 641, F.S.; however, the bill itself appears to conflict with the patient protection provision of s. 641.51(8), F.S., which requires that, in the event of a termination of a contract, for any reason other than "for cause," each party shall allow subscribers to continue treatment, when medically necessary, for subscribers who were receiving active treatment, until the subscriber selects another treating provider, or during the next open enrollment period offered by the organization, whichever is longer, but not longer than 6 months after the termination of the contract. In addition, subsection (8) provides that for a subscriber who has initiated a course of prenatal care, regardless of the trimester in which the care was initiated, the contract must allow the subscriber to continue care and coverage (with the provider) until completion of postpartum care. Moreover, current law already requires compliance with the provisions of ch. 641, F.S., unless the law specifically allows for waiving of the requirement.

VIII. Amendments:

None.