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: February 19, 2003 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Harkey	Wilson	HC	Favorable/CS
2.			BI	
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 or unless the change is necessary to comply with state or federal laws or accreditation standards. Providers can terminate a contract under certain conditions without advance notice.

Additionally, 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 Heath Care Administration to prohibit any person from serving as an officer, director, employer, associate, or provider of a managed care plan under certain circumstances.

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.

All forms of managed care represent attempts to control costs by modifying the behavior of physicians and other health care providers who prescribe treatment, although they do so in different ways. Most forms also restrict the access of their insured populations to physicians and other health care providers who are not affiliated with a particular plan. Primary care physicians assume broader roles in these systems. Once plans contract with a physician or other health care provider, they use two basic mechanisms to influence the provider's practice patterns – clinical rules and incentives. Clinical rules take a variety of forms: quality-assurance procedures, treatment protocols or algorithms, regulations, administrative constraints, practice guidelines, and utilization review. Incentives are related to a health care provider's financial return for professional services.

Managed care organizations affect access to, and control payment for, health care services through the use of one or more of the following techniques: prior, concurrent, and retrospective review of the medical necessity and appropriateness of services or site of services; contracts with selected health care providers; financial incentives or disincentives related to the use of specific providers, services, or service sites; controlled access to and coordination of services by a case manager; and disease management programs.

A key cost containment feature for many contracts between health maintenance organizations and health care providers is a fixed, per patient fee, regardless of the services provided, referred to as a per capita fee arrangement. This provides an economic incentive to a provider to limit services to those that are medically necessary.

The term, managed care organization, or managed care plan, is not a licensure category under Florida law, but the term managed care is used in the statutes for limited purposes. For example, in s. 408.7056, F.S., the law 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 chapter 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. What these four organizations, summarized below, have in common is that they provide services or compensation only if the insured or subscriber obtains services or treatment from an identified list of providers, referred to as contract providers (or network or panel providers), subject to legal requirements to compensate non-contract providers under certain circumstances.

Health maintenance organizations (HMOs), which might be considered the prototype managed care organization, are entities that are issued a health care provider certificate from the Agency for Health Care Administration and then a certificate of authority by the Department of Financial Services (DFS). Under existing statutes relating to HMOs, AHCA is responsible for the enforcement of Chapter 641, Part III, while DFS is responsible for enforcing the provisions in Chapter 641, Part I.

Exclusive provider organizations (EPOs), are authorized health insurers that limit coverage to services or treatment from network providers, very similar to an HMO. In addition to obtaining a certificate of authority as a health insurer from the Department of Financial Services, the insurer must have its plan of operation approved by the Agency for Health Care Administration to

determine the adequacy of the provider network and assurance of quality of care, also similar to an HMO.

Prepaid health clinics, licensed under parts II and III of chapter 641, F.S., are entities that limit their services to physician care from network physicians, but not including hospital inpatient services. These entities serve a very limited market in Florida.

Prepaid health plans are entities that contract with the Agency for Health Care Administration to serve Medicaid recipients, pursuant to statutory criteria in s. 409.912, similar to an HMO.

In addition to these entities, a health insurer that sells a preferred provider contract may be considered to be a "managed care" plan. This is a health insurance policy that provides greater benefits if an insured obtains services from a network provider, and lesser benefits (greater deductibles and coinsurance) if the insured obtains services from a non-network provider. The insurer must have these policies approved by the Department of Financial Services, but not the Agency for Health Care Administration. There is not a separate license or certificate that is issued to a health insurer for this purpose. Such plans are often referred to as preferred provider organizations, or PPOs. There is one statute that regulates such contracts, s. 627.6471, F.S., which, among other requirements, limits the amount of the difference between the network and non-network deductible and coinsurance that the insurer may impose.

The Financial Services Commission is an independent agency housed within DFS. The Commission consists of the Governor and Cabinet. Two offices are created under the commission: the Office of Insurance Regulation and the Office of Financial Institutions and Securities Regulation. The Office of Insurance Regulation is responsible for regulation of insurance companies and other risk bearing entities, including licensing, rates, policy forms, solvency, claims, adjusters, market conduct, viatical settlements, and premium financing, and administrative supervision of insurers, as provided under the Insurance Code or chapter 636, F.S.

III. Effect of Proposed Changes:

The bill creates the Health Care Providers' Bill of Rights. A contract between a managed care 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.

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 chapter 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 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 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 chapter 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.

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 chapter 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 chapter 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 chapter 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 chapter 120, F.S.

The bill takes effect July 1, 2003.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Art. I, s. 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

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:

The exact fiscal impact on AHCA cannot be determined based on the bill in its current format. Some of the responsibilities assigned to AHCA would be duplicative of functions carried out by DFS; other responsibilities assigned to the Agency are duplicative of existing provisions.

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 addend 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 in chapter 641, F.S., but the bill does not amend that statute.

The bill assigns oversight of selected managed care plan contract provisions that are under the jurisdiction of the Department of Financial Services (DFS), formerly the Department of Insurance, to AHCA without amending existing statutory provisions.

VIII. Amendments:

None.