By the Committee on Health, Aging, and Long-Term Care; and Senator Campbell

317-1833-03

A bill to be entitled

An act relating to managed health care; providing a short title; prohibiting the contract between a managed care plan and a health care provider from containing provisions allowing the managed care plan to change a material term of the contract; providing certain exceptions; requiring that a managed care plan notify a provider within a specified period of its intent to change a material term; providing certain exceptions; prohibiting additional provisions in the contract which require a provider to accept additional patients or comply with certain programs or procedures without prior disclosure; providing certain exceptions; prohibiting certain other contract provisions that conflict with state law or confidentiality requirements; providing definitions; specifying acts and omissions constituting grounds for which the Secretary of Health Care Administration may take disciplinary action against a managed care plan; requiring that a proceeding under the act comply with the requirements for notice and a hearing provided in ch. 120, F.S.; providing an effective date.

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

Section 1. <u>Health Care Providers' Bill of Rights.--</u>

(1) This section may be cited as the "Health Care Providers' Bill of Rights."

(2) A contract issued, amended, or renewed on or after January 1, 2004, between a managed care plan and a health care provider for the provision of health care services to a plan enrollee or subscriber may not contain any of the following terms:

(a)1. Authority for the managed care plan to change a material term of the contract, unless the change has first been negotiated and agreed to by the provider and the managed care plan or unless the change is necessary to comply with state or federal law or any accreditation requirements of a private accreditation organization. If a change is made by amending a manual, policy, or procedure document that is referenced in the contract, the managed care plan must provide 45 business days' notice to the provider and the provider has the right to negotiate and agree to the change. If the managed care plan and the provider cannot agree to the change to a manual, policy, or procedure document, the provider may terminate the contract prior to implementation of the change. In any event, the managed care plan must provide at least 45 business days' notice of its intent to change a material term, unless a change in state or federal law or any accreditation requirements of a private accreditation organization require a shorter timeframe for compliance. However, if the parties mutually agree, the requirement for 45 business days' notice may be waived. This subparagraph does not limit the ability of the parties to mutually agree to the proposed change at any time after the provider has received notice of the proposed change.

2. If a contract between a provider and a managed care plan provides benefits to enrollees or subscribers through a preferred provider arrangement, the contract may contain provisions permitting a material change to the contract by the managed care plan 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.

(b) A provision that requires a health care provider to accept additional patients beyond the contracted number or in the absence of a number if, in the reasonable professional judgment of the provider, accepting additional patients would endanger patients' access to, or continuity of, care.

(c) A requirement to comply with quality improvement or utilization management programs or procedures of a managed care plan, unless the requirement is fully disclosed to the health care provider at least 15 business days prior to the date the provider executes the contract. However, the managed care plan may make a change to the quality improvement or utilization management programs or procedures at any time if the change is necessary to comply with state or federal law or any accreditation requirements of a private accreditation organization. A change to the quality improvement or utilization management programs or procedures must be made pursuant to paragraph (a).

(d) A provision that waives or conflicts with any provision of chapter 641, Florida Statutes. A provision in the contract that allows the managed care plan to provide professional liability or other coverage or to assume the cost of defending the provider in an action relating to

professional liability or in any other action does not conflict with or violate this paragraph.

(e) A requirement to permit access to patient information in violation of federal or state law concerning the confidentiality of patient information.

(3) Any contract provision that violates subsection (2) is void, unlawful, and unenforceable.

(4) This section may not be construed or applied as setting the rate of payment to be included in contracts between managed care plans and health care providers.

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

(a) "Health care provider" means 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.

(b) "Material" means a provision in a contract to which a reasonable person would attach importance in determining the action to be taken upon the provision.

Section 2. Grounds for disciplinary action.--

(1) The Secretary of Health Care Administration may, after appropriate notice and opportunity for a hearing, by order suspend or revoke any license issued by the agency to a managed care plan or assess administrative penalties if the secretary finds that the licensee has committed any of the acts or omissions constituting grounds for disciplinary action.

(2) The following acts or omissions constitute grounds for disciplinary action by the secretary:

(a) The managed care plan is operating at variance with the basic organizational documents filed with the agency, or with its published plan, or the managed care plan is

operating in any manner contrary to that described in, and reasonably inferred from, its application for licensure and annual report, or any modification thereof, unless amendments allowing the variation have been submitted to, and approved by, the secretary.

(b) The managed care plan has issued or uses, or permits others to use, evidence of coverage or a schedule of charges for health care services which do not comply with those published in the latest evidence of coverage approved by the agency.

(c) The managed care plan does not provide basic health care services to its enrollees and subscribers as set forth in the evidence of coverage. This paragraph does not apply to a contract for specialized health care services.

(d) The continued operation of the managed care plan will constitute a substantial risk to its subscribers and enrollees.

(e) The managed care plan has violated, attempted to violate, or conspired to violate, directly or indirectly, or assisted in or abetted a violation of or conspiracy to violate any provision of chapter 641, Florida Statutes, any rule adopted by the agency under chapter 641, Florida Statutes, or any order issued by the agency under chapter 641, Florida Statutes.

(f) The managed care plan has engaged in any conduct that constitutes an unfair method of competition or unfair or deceptive act or practice, as defined in section 641.3903, Florida Statutes.

(g) The managed care plan has permitted, or aided or abetted, any violation by an employee or contractor who holds a certificate, license, permit, registration, or exemption

which would constitute grounds for discipline against the holder of the certificate, license, permit, registration, or exemption.

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

(i) 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.

(j) The managed care plan has engaged a solicitor or supervisor of solicitation contrary to the provisions of an order issued by the secretary.

(k) 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 in the managed care plan, management company, or affiliate, 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, Florida Statutes.

(l) 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, Florida Statutes.

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

(3)(a) The secretary may prohibit any person from serving as an officer, director, employee, associate, or

provider of any managed care plan, or of any management company of a managed care plan, if:

1. The prohibition is in the public interest and the person has committed, caused, participated in, or had knowledge of a violation of chapter 641, Florida Statutes, by a managed care plan or management company.

2. The person was an officer, director, employee, associate, or provider of a managed care plan, or of a management company, whose license has been suspended or revoked and the person had knowledge of, or participated in, any of the prohibited acts for which the license was suspended or revoked.

(b) A proceeding for issuing an order under this subsection may be included as a part of a proceeding against a managed care plan under this section or may constitute a separate proceeding, subject in either case to subsection (4).

(4) 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, Florida Statutes.

Section 3. This act shall take effect July 1, 2003.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN COMMITTEE SUBSTITUTE FOR SB 154

The committee substitute differs from SB 154 by providing a definition of health care provider that matches the definition of provider in ch. 641, F.S.