HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 187 Managed Health Care/Health Care Equity Act
SPONSOR(S): Galvano
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 154 (s)

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Services (Sub)		Chavis	Collins
2) Health Care			
3) Health Access & Financing (Sub)			
4) Insurance			
5) Health Appropriations (Sub)			
6) Appropriations			

SUMMARY ANALYSIS

HB 187 creates the “Health Care Equity Act.” The bill revises the contractual requirements of managed care plans by prohibiting the inclusion of various provisions in provider contracts that are issued, amended, or renewed on or after January 1, 2004. The bill prohibits managed care plans from changing a material term of the contract unless: the provider agrees; 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.

Current law requires an HMO or provider to give a 60-day notice to the affected party and the department prior to the “without cause” termination of a contract. The bill requires that changes made by amending a manual, policy, or procedure document that is referenced in the contract must meet a 45-day notice requirement and; if a provider and managed care plan are unable to agree to the change, the provider may terminate the contract prior to the implementation of the change. Current law provides that such changes require a 30-day notice.

The bill specifies new grounds for disciplinary action by the Agency for Health Care Administration (agency) against a managed care organization for violation of certain provisions. The Secretary of the agency is authorized to prohibit any person from serving as an officer, director, employer, associate, or provider of a managed care plan under certain circumstances. In addition, the bill provides that “acts and omissions” that constitute grounds for agency action consists of any violation of chapter 641, F.S., and that grounds for disciplinary action can be that the 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.” This appears to give the agency the authority to take action against an HMO in regulatory areas and with regulatory authority that is otherwise exercised by the Department of Financial Services, formerly the Department of Insurance.

The bill appears to conflict with the patient protection requirement of s. 641.51(8), F.S., which specifies that when a contract between a managed care organization and a treating provider is “terminated for any reason other than cause,” both the organization and the treating provider must allow “subscribers for whom treatment was active to continue coverage and care when medically necessary, or during the next open enrollment period, whichever is longer, but not longer than 6 months after the termination of the contact.” This subsection also requires that “a subscriber who has initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care and coverage until completion of postpartum care.”

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.”

The bill takes effect July 1, 2003.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. DOES THE BILL:

1. Reduce government?	Yes[]	No[x]	N/A[]
2. Lower taxes?	Yes[]	No[x]	N/A[]
3. Expand individual freedom?	Yes[]	No[]	N/A[x]
4. Increase personal responsibility?	Yes[]	No[]	N/A[x]
5. Empower families?	Yes[]	No[]	N/A[x]

For any principle that received a "no" above, please explain:

The bill expands the authority of the Agency for Health Care Administration to regulate contracts between providers and managed care organizations, including health maintenance organizations, exclusive provider organizations, prepaid health clinics, and prepaid health plans. In addition, the bill expands the agency's authority to regulate preferred provider organization contracts with providers. Such contracts are currently regulated by the Department of Financial Services.

The bill is without statutory "location", and may possibly apply to Medicaid managed care organizations and result in increasing costs to the Medicaid managed care program. Typically, organizations with established provider networks can encourage their providers to add Medicaid membership to the scope of their existing contracts. These addenda can be executed in short timeframes. This capability is generally advantageous in geographic areas that have very limited specialty providers.

B. EFFECT OF PROPOSED CHANGES:

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, integrated 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 typically 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 (agency) and a certificate of authority by the Department of Financial Services (department). Under existing statutes relating to HMOs, the agency is responsible for enforcement of Chapter 641, Part III, F.S., while the department is responsible for enforcing the provisions in Chapter 641, Part I. 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 the department, must have its

plan of operation approved by the agency 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 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. 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 department, 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 department.

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. HB 187 is drafted without statutory "location" and, therefore, may apply to Medicaid managed care plans.

HB 187 expands the rights of providers under contract with a MCO. Specifically, the bill provides that a MCO cannot 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. In addition, the bill requires a MCO to provide at least 45 business days' notice of its intent to change a material term, unless state, federal, or accreditation requirements require a shorter timeframe. Moreover, the bill specifies that if a change is made by amending a manual, policy, or procedure document that is referenced in the contract, the MCO 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.

The bill further provides that if a provider and a managed care plan provides benefits to enrollees or subscribers through a preferred provider arrangement, the contract may contain provisions permitting 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. Moreover, a contract cannot require a provider to accept more patients than specified in the contract. However, if a contract does not include a specific number, the health care provider may limit the number of patients accepted based on his/her professional judgment.

A contractual requirement of providers to comply with quality of care improvement programs is prohibited by the bill, 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. In addition, the bill prohibits contracts from having a requirement to permit access to patient information in violation of federal or state laws concerning the confidentiality of patient information.

Currently, non-Medicaid HMO contracts are regulated by s. 641.315, F.S., which provides, in part, that an HMO or provider can terminate a contract "without cause" by giving a 60-day written notice to the affected party and the department. Typically, the HMO and/or provider use this time to notify HMO subscribers of the provider of the contract termination and inform the subscribers of their options and rights.

The bill prohibits contractual provisions which waive or conflict with the requirements of chapter 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," continued* 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 until completion of postpartum care.* ***Moreover, current law already requires compliance with the provisions of chapter 641, F.S., unless the law specifically allows for waiving of the requirement.***

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 the Agency for Health Care Administration the authority, after appropriate notice and opportunity for a hearing, to suspend or revoke a license or issue a fine for the following violations:

- The managed care plan is operating at variance with the basic organizational documents filed and approved by the agency and its licensure requirements. [Note: many of these documents are filed with the department and not with the agency.]
- The managed care plan issued or used evidence of coverage or a schedule of charges for services inconsistent with "evidence of coverage" approved by the agency.
- The managed care plan does not provide basic health care services as set forth in the evidence of coverage.
- The continued operation of a managed care plan constitutes a risk to subscribers.
- The managed care plan has violated any provisions of chapter 641, F.S., or any related rules or orders. [Note: This paragraph is worded broadly to authorize an agency action for a violation of the department's regulatory authority.]
- The managed care plan has engaged in unfair methods of competition or unfair or deceptive trade practices.
- The managed care plan has permitted, aided or abetted any violation by a contractor which would provide grounds for discipline against the contractor.
- The managed care plan has permitted, aided, or abetted the commission of any illegal act. [Note: There is no definition of "permitted." It is unclear whether a managed care plan would need to terminate the contract of a provider convicted of jaywalking or speeding.]
- The managed care plan has engaged in services of an officer, director, employee, associate, or provider of the plan in violation of an order issued by the secretary.
- 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 to chapter 641., F.S.
- 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.
- The managed care plan has violated any law requiring that medical information be kept confidential.

The bill also authorizes the Secretary of the agency to 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. Any proceeding under this section requires notice to, and an opportunity for a hearing with regard to, the person affected in accordance with chapter 120, F.S., relating to the Administrative Procedure Act.

C. SECTION DIRECTORY:

Section 1. Creates the "Health Care Equity Act," and provides the following:

- Prohibits a contract between a MCO and a health care provider from containing provisions allowing the managed care plan to change a material term of the contract and provides certain exceptions;
- Requires a MCO plan to notify a provider within a specified period of time of its intent to change a material term of the contract and provides certain exceptions;
- Prohibits a provision in a contract which requires a health care provider to accept additional patients or comply with certain programs or procedures without prior disclosure and provides certain exceptions; and
- Prohibits certain other contract provisions that conflict with state law or federal confidentiality requirements.

Section 2. Specifies acts and omissions which constitute grounds for disciplinary action by the Secretary of the Agency for Health Care Administration against a managed care plan; and requires that proceedings under the act comply with the requirements for notice and hearing provided in ch. 120, F.S., relating to the Administrative Procedure Act.

Section 3. Provides an effective date of July 1, 2003.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments Section.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

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.

D. FISCAL COMMENTS:

According to the Agency for Health Care Administration, the exact fiscal impact on the agency cannot be determined based on the proposed bill. Some of the responsibilities assigned to the agency would be duplicative of functions currently carried out by the department; while 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 8 percent of the Medicaid costs in those counties.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to take an action requiring the expenditure of funds. This bill does not reduce the percentage of state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenues.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Section 2. Paragraph (2)(d) provides for the disciplinary action by the Secretary of the Agency for Health Care Administration when the "continued operation of the managed care plan will constitute a substantial risk to its subscribers and enrollees"; however, the bill provides no criteria for what

constitutes a “substantial risk,” nor does the bill provide authority for the agency to promulgate a rule to make such a determination.

The bill creates provisions that would appear to replace provisions in chapter 641, F.S.; however, the bill does not amend that statute.

The bill assigns oversight of selected managed care plan contract provisions to the Agency for Health Care Administration without amending existing statutory provisions. These responsibilities are presently under the jurisdiction of the Department of Financial Services. The appropriate statutory changes were not included to reflect the transfer of authority.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES