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: SB 436

SPONSOR: Senator Campbell

SUBJECT: Health Care Services

DATE: April 18, 2003 REVISED: 04/21/03

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Emrich	Deffenbaugh	BI	Fav/2 amendments
2.	Harkey	Wilson	HC	Fav/1 amendment
3.			JU	
4.			AHS	
5.			AP	
6.				

I. Summary:

Senate Bill 436 changes the law in Florida regarding the contractual relationship between health care plans and providers. This legislation, known as the "any willing provider" provision, mandates that health plans contract with any health care provider willing to meet the plan's terms and conditions as to qualifications and contracting, even if the plan's network already includes enough providers to meet patient needs. Specifically, the bill does the following:

- Requires managed care organizations (MCOs) to allow any health care provider to participate as a service provider under a health plan offered by the MCO, if the provider agrees to:
  - accept reimbursement rates negotiated by the MCO with other health care providers that provide the same service under the health plan; and
  - comply with all guidelines relating to quality of care and utilization criteria which must be met by other employee or nonemployee providers.
- Provides civil fines of up to $25,000 (per violation) for MCOs that violate the above provisions; and, up to $100,000 (per violation) if the MCOs engages in a pattern of violations (as determined by the Director of the Agency for Health Care Administration).
- Defines MCOs to include health maintenance organizations (HMOs), prepaid health clinics, exclusive provider organizations, and preferred provider organizations.
- Mandates that health insurance policies, plans, or other contracts providing for payment for medical benefits allow any provider to participate as a service provider under a health plan

offered by the health insurance policy, health care services plans, or other contracts, if the provider agrees to the provisions described above. Similar penalties apply to providers.

This bill amends s. 627.419, F.S., and creates two undesignated sections of law.

II. Present Situation:

Managed Care

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, 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 (MCOs) 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., or an exclusive provider organization certified under s. 627.6472, F.S. What these 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

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).[1] Under existing statutes relating to HMOs, the Agency for Health Care Administration (AHCA) is responsible for the enforcement of ch. 641, part III, while DFS is responsible for enforcing the provisions in ch. 641, part I.

Exclusive Provider Organizations and Prepaid Health Clinics

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 ch. 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.

Preferred Provider Organizations

In addition to these entities, a health insurer that sells a preferred provider contract may be considered to be a "managed care" plan.[2] 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. The PPO law limits the amount of the difference between the network and non-network deductible and coinsurance that the insurer may impose.

Construction of Insurance Policies

Section 627.419, F.S, provides that every insurance contract must be construed according to the entirety of its terms and conditions. This section sets forth various provisions applying to health care contracts relating to optometrists, chiropractics, disability income or credit disability

[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 2002 act"). CS/CS/SB 1712 makes changes to the Insurance Code to conform to the 2002 act.
[2] S. 627.6471, F.S.

insurance, registered nurse first assistants or employers of physician assistants, surgical procedures, and dental services.

Any Willing Provider Provisions

Any willing provider (AWP) laws have been enacted in more than twenty states, but only those in Idaho, Illinois, Indiana, Kentucky, Minnesota, and Wyoming cover a number of health care professions.[3] Nineteen states are limited, generally covering only pharmacy. The AWP laws in Kentucky have been challenged and on April 2, 2003, the United States Supreme Court issued its opinion in the case of *Kentucky Association of Health Plans v. Miller* upholding the Kentucky provisions. The issue involves the legality of the AWP law which requires managed care plans to reimburse providers willing to provide services to the plans' members and meet plans' conditions for participation, regardless of whether the plan has included the provider in its network. The Kentucky law covers physicians, pharmacists, and other licensed health professionals. (See discussion below under Constitutional Issues, Section IV.)

Proponents for enacting AWP laws assert that these provisions were passed by numerous states across the country in the mid-nineties in response to claims that HMOs were excessively restricting patients' choice. These laws came about as a way to stop managed care organizations from excluding physicians, pharmacists or others, thereby hurting their ability to practice. Proponents argue that the bill will promote greater freedom of provider choice for patients (subscribers) and may make it easier for patients to change plans. According to the sponsor, patients want to be able to see their favorite physicians even if they are not in their health plan network.

Representatives with managed care plans assert that such plans depend on their ability to control costs by negotiating discounts with network providers in return for an increased volume of patients from a plans' members, and these savings are passed on to consumers in the form of lower premiums. Negotiating with providers and thereby reducing health insurance costs is at the heart of the managed health care concept. By allowing any provider to declare themselves a part of the network undermines the plan's ability to reduce health insurance costs.[4]

Opponents argue that AWP laws effectively eliminate a health plan's ability to reduce utilization of services and to obtain price discounts from providers. These discounts help keep health insurance more affordable, which results in more people being able to be insured. Opponents state that AWP laws make it more difficult for plans to exclude or terminate providers who do not practice cost effective medicine or who do not meet the plans' quality standards. Further, such laws make it more difficult to implement cost containment programs, which are most effective when the network of providers is limited. Also, AWP laws could reduce a plan's ability to negotiate price discounts with providers. Since such laws would result in a greater number of providers in each network, plans could not always assure each provider a sufficient increase in volume to justify the discount. Finally, such laws increase administrative costs for plans. These

[3] Health Insurance Association of America.

[4] Health care costs have skyrocketed in Florida according to a recent health insurance survey of 4,000 employers by the Florida Chamber of Commerce (December 2002). The survey found that employers were not only concerned about increasing health care costs, but also the shrinking availability and restricted access to health care services, and that many employers were considering eliminating this coverage for their employees.

costs are associated with having a greater number of providers in the network, incurring additional patient billing and utilization review costs, and costs associated with credentialing and documenting the disenrollment of providers.

Employee Retirement Income Security Act of 1974

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans. ERISA requires the following: that plans provide participants with information including plan features and funding; it outlines the fiduciary responsibilities for those who manage and control plan assets; it requires plans to establish a grievance and appeals process for participants to get benefits from their plans; and gives participants the right to sue for benefits and breaches of fiduciary duty. This law is part of the federal tax code.

There have been a number of amendments to ERISA, expanding the protections available to health benefit plan participants and beneficiaries, including the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), the Newborns' and Mothers' Health Protection Act, the Mental Health Parity Act, and the Women's Health, the Pregnancy Discrimination Act, and Cancer Rights Act.

In general, ERISA does not cover group health plans established or maintained by governmental entities, churches for their employees, or plans which are maintained solely to comply with applicable workers compensation, unemployment, or disability laws. ERISA also does not cover plans maintained outside the United States primarily for the benefit of nonresident aliens or unfunded excess benefit plans.

It is unclear whether this bill's provisions apply to health plans subject to ERISA. As noted below, Kentucky enacted an AWP law that is similar to the proposed bill and it has recently been upheld by the United States Supreme Court (See Section IV below, under Constitutional Issues).

III. Effect of Proposed Changes:

Section 1. This section does not amend or create a section of law under the Florida Statutes. It mandates that a managed care organization allow any health care provider to participate as a service provider under a health plan offered by the managed care organization (MCO), if the provider agrees to:

- Accept reimbursement rates negotiated by the MCO with other health care providers that provide the same service under the health plan; and

- Comply with all guidelines relating to quality of care and utilization criteria which must be met by other employee or nonemployee providers.

The bill defines the term "managed care organization" to mean an HMO or prepaid health clinic certified under ch. 641, F.S., a health insurer that issues an exclusive provider organization policy under s. 627.6472, F.S., or s. 627.662(9), F.S., or a health insurer that issues a preferred

provider organization policy under s. 627.6472, F.S., or s. 627.662(8), F.S. It provides that an MCO that violates the above provisions is subject to a civil fine in the amount of:

- Up to $25,000 for each violation; or
- If the Director of the Health Care Administration determines that the entity has engaged in a pattern of violations of the above, up to $100,000 for each violation.

Section 2. Amends s. 627.419, F.S., which applies to construction of insurance policies, to provide that any health insurance policy, health care services plan, or other contract that provides for payment for medical expense benefits or procedures must allow any health care provider to participate as a service provider under a health plan offered by the health insurance policy, health care services plan, or other contract that provides for payment for medical expense benefits or procedures, if the health care provider agrees to:

- Accept reimbursement rates negotiated by the health care policy, services plan, or other contract that provides for payment for medical expense benefits or procedures with other health care providers that provide the same service under the health plan; and
- Comply with all guidelines relating to quality of care and utilization criteria which must be met by other providers with whom the health insurance policy, services plan, or other contract that provides for payment for medical expense benefits or procedures and has contractual arrangements for those services.

The provider of any health insurance policy, health care services plan, or other contract that violates the above provisions is subject to a civil fine in the amount of:

- Up to $25,000 for each violation; or
- If the Insurance Commissioner[5] determines that the provider has engaged in a pattern of violations of the above, up to $100,000 for each violation.

Section 3. Provides that sections 1 and 2 of this act do not apply to any health insurance policy that is in force before the effective date of this act, but do apply to such policies at the next renewal period immediately following October 1, 2003.

Section 4. Provides that the act will take effect October 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.

[5] Note, see Section VIII, Amendment provisions below.

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.

D. Other Constitutional Issues:

On April 2, 2003, the United States Supreme Court upheld Kentucky's AWP laws in the case of *Kentucky Association of Health Plans v. Miller.*[6] The issue before the high court involved two AWP laws which prohibited health insurers from discriminating against any provider who is willing to meet the terms and conditions for participation established by the insurer, and required a health benefit plan that included chiropractic benefits to permit any licensed chiropractor who agrees to abide by the terms and conditions of the plan to serve as a participating primary chiropractic provider. The managed care industry argued that the law prevents managed care operators from keeping costs down and that it is pre-empted by the 1974 Employee Retirement Income Security Act (ERISA), which forbids states from regulating employee benefit plans. Counsel for Kentucky countered that ERISA allows states to regulate insurance and that the any willing provider law falls under their insurance statute.

The high court ruled unanimously that Kentucky's law did not violate the ERISA provisions and that states like Kentucky can force managed care plans to open up their provider networks. Writing for the court, Justice Antonin Scalia said that "by expanding the number of providers from whom an insured may receive health services, AWP laws alter the scope of permissible bargains between insurers and insureds in a manner similar to the mandated-benefit laws we upheld" before. He stated further that "no longer may Kentucky insureds seek insurance from a closed network of health care providers in exchange for a lower premium."

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

[6] The Sixth Circuit Court of Appeals upheld Kentucky's AWP law by ruling that the law was an insurance regulation and that such regulations fall under a "saving clause" under ERISA, and therefore ERISA did not preempt the Kentucky provision. (K*entucky Association of Health Plans, Inc. v. Nichols,* 227 F.3d 352 (6th Cir. 2000)). The Kentucky case represents the fourth time a federal appellate court has ruled on the issue of whether ERISA supersedes state AWP provisions. The decisions now are evenly split. In 1993, the U.S. Court of Appeals for the Fourth Circuit (covering the Carolinas, Maryland and West Virginia) ruled ERISA did not supersede any willing provider laws. However, in separate rulings over the past 3 years, the U.S. Court of Appeals for the Fifth Circuit ruled ERISA took precedence over any willing provider laws enacted by Arkansas and Louisiana.

B. Private Sector Impact:

Health plan members would have direct access to an increased number of service providers under the bill, and providers who are not currently in health plans could participate in plan networks, so long as they met specified conditions. However, premiums may increase for health plan members, and higher health care costs could occur under the bills' provisions because managed care entities will not be allowed to limit their provider networks.

Managed care organizations and providers are subject to penalties of up to $25,000 for each violation committed under the bill and up to $100,000 if either AHCA or the Office of Insurance Regulation determines the entity or provider has engaged in a pattern of violations.

C. Government Sector Impact:

According to AHCA, the bill is likely to increase the cost of operating managed care plans because it will significantly impact the ability of such plans to negotiate discounted fees from providers who currently can be promised a higher volume of patients when the number of providers is limited. Assuming that the increased costs will be shifted to consumers, including employers and government entities that pay for some or all of the health insurance costs, the bill would increase managed care premiums for individuals and governmental entities, including Medicaid, according to AHCA. However, AHCA cannot determine the exact fiscal impact of this legislation.

Over 600,000 Florida Medicaid beneficiaries are currently served by managed care organizations at some point. Under current law, Medicaid managed care organizations are paid a percentage of the projected fee-for-service costs based on the assumption that they are better able to control costs. If the managed care organizations lost some of their leverage in controlling costs, according to AHCA, then they would be less likely to provide services to Medicaid beneficiaries at the established discounted rate. Also, Medicaid managed care entities may discontinue services or require AHCA to raise capitation rates under this bill.

According to the Office of Insurance Regulation, if this legislation results in increased payments to providers as an overall component of claims costs, those costs would be passed through to health plan members in the form of increased premiums.

VI. Technical Deficiencies:

On page 2, line 3, "627.6472" should be changed to "627.6471."

On page 2, line 7, "Director" should be changed to "Secretary."

On page 3, line 7, "Insurance Commissioner" should be changed to "Office of Insurance Regulation."

VII. Related Issues:

None.

VIII. Amendments:

#1 by Banking and Insurance:
Removes the term "Director of Health Care Administration" and inserts the "Secretary of the Agency for Health Care Administration."

#2 by Banking and Insurance:
Removes the term "Insurance Commissioner" and inserts the "Office of Insurance Regulation."

#1 by Health, Aging, and Long-Term Care:
Corrects a statutory reference by changing "627.6472" to "627.6471."