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 1088

SPONSOR: Banking and Insurance Committee and Senator Cowin

SUBJECT: HMO/Provider Contracts/Heath Care

DATE: February 19, 2004 REVISED: _____ _____ _____ _____

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

I. Summary:

Committee Substitute for Senate Bill 1088 requires a health maintenance organization (HMO) that has a contract with a health care provider to disclose to the provider the complete schedule of all fees for which the health maintenance organization and the provider of health care services have contracted, including any deviations from the contracted schedule of fees requested by the health maintenance organization and agreed upon by the provider of the health care services. The bill would take effect January 1, 2005, and apply to contracts entered into or renewed on or after that date.

This bill amends section 641.315of the Florida Statutes.

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 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 health care provider to limit services to those that are medically necessary.

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 (AHCA) 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 ch. 641, part III, while DFS is responsible for enforcing the provisions in ch. 641, part I.

Section 641.315, F.S., establishes requirements for HMO contracts with health care providers. That section mandates a number of provisions including requirements that each contract be in writing; contain notice and cancellation provisions; nonpayment of services provisions; procedures for granting authorization for utilization of health care services; and prohibitions on restricting specified communications.

Under s. 641.315(4), F.S., the HMO must disclose to the provider with which it has a contract:

- The mailing electronic address where claims should be sent for processing;
- The telephone number that a provider may call to have questions regarding claims addressed; and
- The address of any separate claims-processing centers for specific types of services.

The HMO must provide to its contracted providers no less than 30 calendar days' prior written notice of any changes in the information required in this subsection.

Schedule of Fees

Representatives with the Florida Medical Association (FMA) and the Florida Orthopaedic Society (FOS) state that currently many physicians are not provided basic disclosure information of the fee schedule that they have contracted with managed care companies. While some physician contracts provide that their payment rate will be based on a percentage of the prevailing Medicare Allowable Amount, that reference is not necessarily accurate, according to these representatives. That is because HMOs have the ability to change their fees at random during the contract period. Other contracts that are not based on a percentage of Medicare rates, are based on the HMO's own reimbursement schedule, sometimes referred to as the "REF," meaning a reasonable and equitable fee schedule. The REF may also be modified by the HMO periodically. Other providers have complained that they are not provided a complete fee schedule at all during their contract period with the HMO.

These representatives point out that as a result of a national class action lawsuit, both Aetna and Cigna have agreed to allow participating physicians to receive their fee schedule via email.[1] Both companies have agreed to update their fee schedules annually and not reduce their fee schedules more often than once annually.

Representatives with managed care entities argue that fee schedules are often voluminous and that since the schedule of fees is not defined in the proposed legislation, HMOs would have to list every related CPT (Physicians' Current Procedural Terminology) code under a provider contact which could literally involve volumes of data and increase administrative costs. These representatives assert that only a limited number of procedure codes should be given to providers which pertain to their functional specialty or, alternatively, fee schedules be based on a percentage of Medicare, for example, for relative-value based services, with non-relative-value services listed separately.

Further, HMO officials acknowledge the need to have flexibility to increase or decrease their fee schedule payment rates periodically for vaccines, pharmaceuticals, durable medical supplies or other goods or non-physician services to reflect changes in market prices. Also, HMOs need to update their fee schedules for physician services to add payment rates for newly-adopted CPT codes and for new technologies, and new uses of established technologies. However, these changes will be very difficult to implement due to the current requirement in s. 641.315, F.S., that HMOs must provide to contracted providers no less than 30 calendar days' prior written notice of any changes in the information required in their contract. Under this provision and the wording of the current bill, an HMOs flexibility to change their fee schedule will be administratively difficult and costly, and could foster more HMO-provider plan re-contracting, according to HMO officials.

[1] The class action involved physicians and physician associations who had brought lawsuits against a number of managed care companies concerning their reimbursement policies and procedures. Aetna settled its suit and entered into a settlement agreement in May 2003, while Cigna agreed to its settlement in November 2003. In 2000, a Court of Appeals in Georgia ruled in favor of the Georgia Medical Association and required Blue Cross/Blue Shield of Georgia to provide a schedule of fees to participating physicians and the precise methodology it used to determine its usual, customary and reasonable fee for services (244 Ga. App. 801, 536 S.E.2d 184).

III. Effect of Proposed Changes:

Section 1. The bill amends subsection (4) of s. 641.315, F.S., to require an HMO that has a contract with a health care provider to disclose to the provider the complete schedule of all fees for which the health maintenance organization and the provider of health care services have contracted, including any deviations from the contracted schedule of fees requested by the health maintenance organization and agreed upon by the provider of the health care services.

Section 2. The bill would take effect January 1, 2005, and apply to contracts entered into or renewed on or after that date.

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:

Health care providers will benefit under the provisions of this bill because they will have access to their specific fee schedule.

Health maintenance organizations would incur the costs of disclosing fee schedules and any changes to fee schedules to their contract providers as well as securing the providers' agreement to the changes. HMOs may be limited in their flexibility to change their fee schedule payment rates to reflect changes in market prices or reflect changes in new technologies under the provisions of the bill.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.