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 1088

SPONSOR: Senator Cowin

SUBJECT: HMO/Provider Contracts/Heath Care

DATE: January 19, 2004 REVISED: _____ _____ _____ _____

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

I. Summary:

This bill requires a health maintenance organization (HMO) that has a contract with a health care provider to disclose to the provider the schedule of fees for which the health maintenance organization and the provider of health care services have contracted, including any additional deviations from the contracted schedule of fees requested by the health maintenance organization and agreed upon by the provider of the health care services.

This bill amends s. 641.315, F.S.

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 and then a certificate of authority by the Department of Financial Services (DFS). 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.

Section. 641.315, F.S., establishes requirements for HMO contracts with health care providers. Each contract between an HMO and a provider of health care services must be in writing and must contain a provision that the subscriber is not liable to the provider for any services for which the HMO is liable as specified in s. 641.3154, F.S.

All provider contracts must require the provider to give 60 days' advance written notice to the HMO and the Office of Insurance Regulation before canceling the contract with the HMO for any reason. The contract must also provide that nonpayment for goods or services rendered by the provider to the HMO is not a valid reason for avoiding the 60-day advance notice of cancellation.

The HMO must provide 60 days' advance written notice to the provider and the Office of Insurance Regulation before canceling, without cause, the contract with the provider, except in a case in which a patient's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action by the Board of Medicine or other governmental agency. Upon receipt by the HMO of a 60-day cancellation notice, the HMO may, if requested by the provider, terminate the contract in less than 60 days if the HMO is not financially impaired or insolvent.

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

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

A health maintenance organization 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.

A contract between an HMO and a provider of health care services must not contain any provision restricting the provider's ability to communicate information to the provider's patient regarding medical care or treatment options for the patient when the provider deems knowledge of such information by the patient to be in the best interest of the health of the patient.

A contract between an HMO and a provider of health care services may not contain any provision that in any way prohibits or restricts:

- The health care provider from entering into a commercial contract with any other HMO; or
- The HMO from entering into a commercial contract with any other health care provider.

An HMO or health care provider (for this requirement, health care provider is defined to include a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461, F.S., or a dentist licensed under chapter 466, F.S.) may not terminate a contract with a health care provider or HMO unless the party terminating the contract provides the terminated party with a written reason for the contract termination, which may include termination for business reasons of the terminating party. The reason provided in the notice or any other information relating to the reason for termination does not create any new administrative or civil action and may not be used as substantive evidence in any such action, but may be used for impeachment purposes.

The HMO must establish written procedures for a contract provider to request, and the HMO to grant, authorization for utilization of health care services. The HMO must give written notice to the contract provider prior to any change in these procedures.

A contract between an HMO and a contracted primary care or admitting physician may not contain any provision that prohibits such physician from providing inpatient services in a contracted hospital to a subscriber if such services are determined by the organization to be medically necessary and covered services under the organization's contract with the contract holder.

An HMO must not require a contracted health care practitioner as defined in s. 456.001(4), F.S., to accept the terms of other health care practitioner contracts with the HMO or any insurer, or other HMO, under common management and control with the HMO, including Medicare and Medicaid practitioner contracts and those authorized by s. 627.6471, s. 627.6472, or s. 641.315, F.S., except for a practitioner in a group practice as defined in s. 456.053, F.S., who must accept the terms of a contract negotiated for the practitioner by the group, as a condition of continuation or renewal of the contract. Any contract provision that violates s. 641.315, F.S., is void. A violation of this section is not subject to the criminal penalty specified in s. 624.15, F.S.

III. Effect of Proposed Changes:

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 schedule of fees for which the health maintenance organization and the provider of health care services have contracted, including any additional 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 upon becoming a law.

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:

HMOs would incur the cost of disclosing fee schedules and any changes to fee schedules to their contract providers and securing the providers' agreement to the changes.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The provisions of the bill would be applicable to contracts entered into or renewed after the effective date of the bill.

The bill requires an HMO to disclose to the provider "any additional deviation from the contracted schedule of fees" which implies that there would have been prior deviations from the contracted schedule. However the bill does not address deviations from the fee schedule that would have preceded the "additional" ones.

VIII. Amendments:

None.