SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based only on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/SB 2554

SPONSOR: Banking and Insurance Committee and Senator King

SUBJECT: Health Maintenance Organizations/Health Care Providers

DATE: April 19, 1999 REVISED:

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

I. Summary:

Committee Substitute for Senate Bill 2554 requires that payments by a fiscal intermediary to a health care provider, pursuant to contracts with health maintenance organizations (HMOs), include the following information:

For a "*noncapitated*" health care provider, an explanation of services being reimbursed which includes the patient's name, date of service, procedure code, amount of reimbursement and plan identification.
For a "*capitated*" health care provider, a statement of services which includes the number of patients covered by the contract, rate per patient, total amount of payment, and the identification of the plan on whose behalf the payment is made.

The bill allows HMOs to increase the copayment for any benefit, or amend benefits to which a subscriber is untitled under a group contract, subject to written notice to the contract holder at least 45 days in advance of the time of coverage renewal. Such notice must identify deletions, limitations, or amendments to any benefits provided in the group contract which will be included in the group contract upon renewal.

The bill further requires that HMO contracts providing for massage must also cover the services of persons licensed to practice massage under certain circumstances. Such massage services are subject to the same terms, conditions, and limitations as other providers. Finally, a contract between a HMO and health care provider may not contain provisions which prohibit:

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

This committee substitute amends the following sections of the Florida Statutes: 626.883, 641.31, 641.315, and 641.316.

II. Present Situation:

Health Maintenance Organizations and Provider Contracts

Current law requires a health maintenance organization (HMO) to reimburse all claims or any portion thereof made by a contract provider for services or goods provided under a contract within 35 days after receipt of the claim by the HMO (ch. 98-79, L.O.F.; s. 641.3155, F.S., 1998 Supplement). If such claim is contested by the HMO, the HMO is required to formally notify the contract provider within 35 days after receipt of the claim by the HMO. If the HMO requests additional information, the provider must offer the information within 35 days of the receipt of such request. Upon receipt of the additional information, the HMO must pay or deny the contested claim within 45 days after receipt of the information. In any event, an insurer must pay or deny any claim no later than 120 days after receiving the claim. An overdue payment of a claim bears simple interest at the rate of 10 percent per year.

Similarly, s. 627.613, F.S., requires group, blanket, and franchise health insurers (pursuant to s. 627.662, F.S.) to adhere to certain parameters in paying claims, although the particular time frame is 45 days as opposed to the 35-day requirement for paying uncontested claims under the HMO provision. However, there are currently no requirements for third party administrators (TPAs) to timely pay claims under the Insurance Administrator Law (Part VII, ss. 626.88-626.899, F.S.) nor are their such requirements for fiscal intermediary services organizations (s. 641.316, F.S.). Insurance administrators are licensed by the Department of Insurance to effect coverage, collect charges, and adjust or settle claims in connection with indemnity insurers and HMOs. Similarly, fiscal intermediary services organizations perform fiscal services, e.g., manage and administer the business affairs, to health care providers who contract with health maintenance organizations.

According to proponents of the bill, there are currently no requirements for fiscal intermediaries to delineate specific patient service information when they submit payments to health care providers. This practice by fiscal intermediaries has caused confusion as providers attempt to reconcile their records as to which claims have or have not been paid.

Pursuant to law, HMOs must adhere to certain requirements when contracting with subscribers or members and particular coverage provisions must be included in the contract (s. 641.31, F.S.). According to representatives with the Department of Insurance, HMOs may amend their contracts to change benefits, rates or co-payment provisions *only* at the time of coverage renewal (ss. 641.31074(4) and 627.6425(4), F.S., and Rule 4-191.033(1)(a)(b), Florida Administrative Code) and the subscriber must be given 30 days' advance written notice of any rate change. Additionally, a HMO may revise its prescription drug formulary (which limits the providers choice of a drug), so long as the HMO continues to provide the drugs necessary to treat the subscribers medical condition.

In general, current Florida law does not restrict the authority of a HMO from terminating the contract of a health care provider. The allowable reasons for termination of the contract by either party would be subject to the terms of the contract itself. It is a long established rule in Florida for private employment contracts that employees may be discharged at any time, with or without cause. This provision is known as the employment-at-will rule and Florida courts have long held

firm to this rule. However, exceptions to the employment-at-will provision may be made by the Legislature. For example, the current law requires that HMOs provide at least 60 days' written notice prior to canceling a contract with a health care provider, without cause, 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. The law also requires the health care provider to give the HMO at least 60 days' notice prior to canceling the contract, but allows the HMO and the provider to agree to terminate the contract in less than 60 days if the HMO is not financially impaired or insolvent. (s. 641.315, F.S.)

HMOs are required to allow subscribers to continue care for 60 days with a terminated treating provider when medically necessary, provided the subscriber has a life-threatening condition or a disabling and degenerative condition. Each HMO must allow a subscriber who is in the third trimester of pregnancy to continue care with a terminated treating provider until completion of postpartum care. The HMO and the provider must continue to be bound by the terms of the contract for such continued care. However, these requirements do not apply to a provider who has been terminated for cause (s. 641.51(7), F.S.).

Additionally, a contract between a HMO and a provider may not contain any provision restricting the provider's ability to communicate information to the provider's patient regarding medical care or treatment options. Currently, there is no statutory provision that would prohibit the contracting HMO and the health care provider from contracting with any other HMO or health care provider.

Proponents of the committee substitute assert that many HMOs present physicians and other providers with a contract containing a provision that would restrict the health care provider from contracting with a different HMO for the provision of the same or different services. They state that such provisions stifle patient choice and unduly restrain competition. As to the issue of an HMO amending its contract, proponents state that fundamental fairness dictates that contract holders have sufficient notice of contract changes before their contract is renewed.

Representatives with the larger HMOs in Florida assert that while some HMOs do not have exclusive provider provisions in their contracts, the ones that do have such a provision do so because they can reduce their overall costs. Such a provision, which is also commonly used by hospitals when they contract with physicians, enables HMOs to manage quality of care and the cost of medical services which contributes to the savings that a managed care plan can achieve. Additionally, HMOs note that since they can't change their benefit provisions during the contract period, the committee substitute's requirement that HMOs notify group contract holders in a managed care plan of a contract change is unnecessarily burdensome.

III. Effect of Proposed Changes:

Section 1. Amends s. 626.883, F.S., relating to insurance administrators, to require that payments by a fiscal intermediary to a health care provider include the following information:

For a "*noncapitated*" health care provider, an explanation of services being reimbursed which includes specific information such as the patient's name, date of service, procedure code, amount of reimbursement and plan identification.

For a "*capitated*" health care provider, a statement of services which must include the number of patients covered by the contract, the rate per patient, the total amount of payment, and the identification of the plan on whose behalf the payment is made.

Neither the bill nor the current law defines the terms "capitated" or "noncapitated" health care provider. A "capitated" provider is one who performs services for a specified dollar amount on a per patient basis for a specific period of time, regardless of the services provided. A "noncapitated" provider is paid on a fee for service basis. A "fiscal intermediary" is a person or entity which performs various financial services to health care professionals who contract with HMOs (s. 641.316, F.S.).

Section 2. Amends s. 641.31, F.S., relating to health maintenance organization contracts, to allow a HMO to increase the copayment for any benefit, or delete, limit, or amend any of the benefits to which a subscriber is untitled under a group contract, upon written notice to the contract holder at least 45 days in advance of the time of coverage renewal. The HMO may amend the contract with the contract holder, with such amendment effective at the time of renewal. Such notice must identify deletions, limitations, or amendments to any benefits provided in the group contract which will be included in the group contract upon renewal. This provision does not apply to increases in benefits provided by the HMO.

Additionally, the committee substitute requires that HMO contracts providing for massage must also cover the services of persons licensed to practice massage pursuant to chapter 480 (regulates massage practice), if the massage is prescribed by a licensed physician as medically necessary and the prescription specifies the number of treatments. The reference to physicians are those licensed under certain provisions of Florida law which are the following: chapter 458-practice of medicine, chapter 459-practice of osteopathic medicine, chapter 460-practice of chiropractic, and chapter 461-practice of podiatric medicine. Such massage services are subject to the same terms, conditions, and limitations as other providers.

Section 3. Amends s. 641.315, F.S., relating to HMO and health care provider contracts, to provide that a contract between a HMO and a provider of health care services shall not contain any provision which prohibits or restricts:

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

Section 4. Amends s. 641.316, F.S., relating to fiscal intermediary services, to provide that payments by a fiscal intermediary to a health care provider include specific information for "noncapitated" and "capitated" providers. This provision contains the same requirements as section 1, above.

Section 5. Provides for an effective date of July 1, 1999, and shall apply to contracts renewed or entered into 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:

Group contract holders will benefit from the provision which requires their HMO to provide advance notice of specific contract changes prior to contract renewal. Likewise, persons licensed to practice massage therapy will benefit because their services will be specifically covered by HMOs if such services are prescribed by physicians as medically necessary.

Health maintenance organizations will experience increased costs due to the notification requirements to contract holders as well as the provision prohibiting exclusive contracts with health care providers. However, the fiscal impact on such HMOs is indeterminate.

Health care providers will benefit by being able to contract with multiple managed care plans. Additionally, requiring fiscal intermediaries to provide explicit information when paying health care providers will reduce the amount of confusion providers currently experience as they attempt to reconcile patient records and keep track of claims.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.

This Senate staff analysis does not reflect the intent or official position of the bill's sponsor or the Florida Senate.