HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1235 w/CS Provider Contracts for Health Care Services
SPONSOR(S): Representative Homan & others
TIED BILLS: None **IDEN./SIM. BILLS:** CS/SB 1088

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Access & Finance (Sub)	8 Y, 0 N	Callaway	Cooper
2) Insurance	20 Y, 0 N w/CS	Callaway	Cooper
3) Health Care	18 Y, 0 N	Rawlins	Collins
4) Appropriations			
5)			

SUMMARY ANALYSIS

According to health care provider representatives, physicians and hospitals contracting with a managed care organizations for services are sometimes not provided with the basic fee schedule. Additionally, some providers have complained they are not provided a complete fee schedule at all during their contract period with the health maintenance organization (HMO).

As a result of a national class action lawsuit, two HMOs, Aetna and Cigna, agreed to allow participating physicians to receive their fee schedule via email. Additionally, both companies agreed to update their fee schedules annually and not to reduce their fee schedules more often than once annually.

HMO representatives emphasize 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. In addition, HMOs need to update their fee schedules for physician services to add payment rates for newly adopted Physician's Current Procedural Terminology (CPT) codes, for new technologies, and for new uses of established technologies.

This bill requires an HMO that has a contract with a provider to disclose to the provider, in an electronic or written format, the complete schedule of reimbursement for which the HMO and the health care provider have contracted, including any deviations from the contracted schedule of reimbursement requested by the HMO and agreed upon by the provider. The HMO must provide a 30-day written notice before changes to the provider fee schedule can be made. The bill also defines a "schedule of reimbursement."

This bill is not anticipated to have a significant fiscal impact on state government, local government, or the private sector.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. DOES THE BILL:

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

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

B. EFFECT OF PROPOSED CHANGES:

Background

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. Most forms also restrict the access of their insured populations to physicians and other health care providers who are not affiliated with a particular managed care plan. Primary care physicians assume broader roles in managed care systems. Once a managed care plan contracts with a physician or other health care provider, it uses two basic mechanisms to influence the health care 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 (HMOs) 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

HMOs, 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 chapter 641, part III, while DFS is responsible for enforcing the provisions in chapter 641, part I.

Section 641.315, F.S., establishes requirements for HMO contracts with health care providers.[1] This section mandates a number of provisions for HMO contracts with health care providers, including requirements that: each contract be in writing,[2] contain notice and cancellation provisions,[3] contain procedures for granting authorization for utilization of health care services,[4] and contain no restrictions on specified communications.[5]

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

- The mailing or 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 mailing or electronic address for claims processing, the telephone number relating to claims questions, or the address of separate claims-processing centers.[6]

Schedule of Fees

According to health care provider representatives, physicians and hospitals contracting with a managed care organizations for services are sometimes not provided with the basic fee schedule. Additionallly, some providers have complained they are not provided a complete fee schedule at all during their contract period with the HMO.

As a result of a national class action lawsuit, two large HMOs, Aetna and Cigna, agreed to allow participating physicians to receive their fee schedule via email. Additionally, both companies agreed to update their fee schedules annually and not to reduce their fee schedules more often than once annually.

Representatives with managed care entities allege fee schedules are often voluminous and worry HMOs would have to list every Physician's Current Procedural Terminology (CPT) code in a provider contact and provide a fee schedule listing all CPT codes, because the schedule of fees is not defined in the proposed legislation. This type of listing could involve volumes of data and may increase administrative costs. Managed care representatives assert only CPT codes pertaining to a provider's specialty should be provided to the health care provider. This would limit the volume of information provided, but would provide the pertinent data.

HMO representatives emphasize the need for the HMO 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. In addition, HMOs need to update their fee schedules for physician services to add payment rates for newly adopted CPT codes, for new technologies, and for new uses of established technologies.

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[1] Health care provider is defined as "physician, hospital, or other institution, organization, or person that furnishes health care services and is licensed or otherwise authorized to practice in the state." s. 641.19(14), F.S.

[2] s. 641.315(1), F.S. (2003)

[3] s. 641.315(2), (3), F.S. (2003)

[4] s. 641.315 (8), F.S. (2003)

[5] s. 641.315(5), F.S. (2003)

[6] s. 641.315(4), F.S. (2003)

Effect of Proposed Bill

This bill requires HMOs to disclose to providers the complete schedule of all reimbursements contracted between the HMO and the provider. The HMO must also disclose any agreed-upon deviations from the contracted fee. The schedule of reimbursement disclosures required by the bill can be by electronic means or by written means. The provider must request a written copy of the schedule of reimbursement in order to obtain it in a written format. The disclosure of the schedule of reimbursement is subject to the confidentiality provisions in the contract between the provider and the HMO. The schedule of reimbursement disclosure provision applies to medical doctors, osteopathic doctors, chiropractors, podiatrists, and dentists. “Schedule of reimbursement” is defined in the bill.

The schedule of reimbursement is not currently required to be disclosed by HMOs. Currently, HMOs only have to disclose the mailing or 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 bill also requires the HMO to provide at least a 30-day written notice to the provider before changes in the contracted schedule of reimbursement can be made. This imposes a new requirement on HMOs and HMO representatives are concerned this requirement will preclude HMO flexibility in changing their reimbursement schedule and will be administratively difficult and costly.

C. SECTION DIRECTORY:

Section 1. The bill adds a new subsection (16) to s. 641.14, F.S., providing a definition of “schedule of reimbursements.”

Section 2. The bill amends subsection (4) of s. 641.315, F.S., requiring disclosure of all contracted fees and agreed-upon deviations in fees by an HMO to a provider.

Section 3. The bill takes effect January 1, 2005.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Health care providers should benefit under the provisions of this bill, because they will have access to their specific reimbursement schedule and changes to it.

HMOs could incur additional costs relating to disclosing reimbursement schedules and changes to their contract providers. The 30-day notice requirement for changes to the reimbursement schedule could limit the flexibility HMOs have to change their reimbursement schedule payment rates to reflect changes in market prices or reflect changes in new technologies.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds. The bill does not reduce the percentage of a 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:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On March 30, 2004, the Subcommittee on Health Access & Financing recommended a strike-everything amendment by Rep. Homan that made the following changes to the bill:

- Provided an HMO can provide its contracted fee schedule or changes to it to the provider in an electronic format, unless the provider requests a written format.
- Provided for confidentiality of the fee schedule by the provider.
- Delineated what types of providers are covered by the fee schedule disclosure provisions.
- Defined “schedule of reimbursements.”

On April 1, 2004, the Committee on Insurance adopted the strike-everything amendment recommended by the Subcommittee on Health Access & Financing and reported the bill favorably as a committee substitute.