STORAGE NAME: h1547.cjcl
DATE: April 14, 1997

HOUSE OF REPRESENTATIVES
COMMITTEE ON
Judiciary
BILL RESEARCH & ECONOMIC IMPACT STATEMENT

BILL #: HB 1547

RELATING TO: Health Care/Civil Actions

SPONSOR(S): Representatives Crow and Flanagan

STATUTE(S) AFFECTED: Chapters 440 and 641, Florida Statutes

COMPANION BILL(S): SB 1168, CS/CB 834, CS/SB 2066

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) Civil Justice & Claims
(2) General Government Appropriations
(3)
(4)
(5)

I. SUMMARY:

HB 1547 contains substantially the same provisions as CS/HB 1853 (1996) which was passed by the 1996 Legislature, but vetoed by the Governor.

HB 1547 creates a civil cause of action against a health maintenance organization for certain violations of s. 641.3903, F.S., relating to unfair or deceptive practices, and also for the HMO's failure to provide covered service when in good faith the HMO should have provided the service and the service is medically necessary.

The bill also provides for the recovery of attorneys fees, and for punitive damages for wanton, willful, malicious or reckless acts.

The bill specifies pre-suit notice and discovery procedures.

The bill does not create causes of action against DOI, AHCA, or affect workers' compensation. The bill does not create a cause of action for medical malpractice against an HMO.

The Governor's veto message expressed a primary concern with the substantial impact civil actions would have on the delivery of health care by HMOs in Florida . The veto message also suggested that the Statewide Subscriber-Provider Assistance Panel grievance system should be utilized to address the concerns raised by this bill.

The bill does have a fiscal impact.

II. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

Managed care plans in Florida include health maintenance organizations, preferred provider organizations, exclusive provider organizations, Medicaid prepaid health plans and the MediPass program. Approximately three million Floridians receive health care through health maintenance organizations and prepaid health plans. Health Maintenance Organizations (hereinafter HMOs) are currently regulated by the Department of Insurance and the Agency for Health Care Administration. Prepaid health plans are authorized by s. 409.912, F.S., to provide for cost effective purchasing of health care. Prepaid health plans are regulated only by the Agency for Health Care Administration. Prepaid health plans are not HMOs and consequently are not subject, statutorily, to any licensure requirements. Consumer complaints against HMOs relate mainly to questionable enrollment practices and inadequate quality of care.

Administratively, HMOs are regulated only by chapter 641, Florida Statutes (1995). Health maintenance organizations are "exempt from all other provisions of the Florida Insurance Code." Id. Chapter 641, Florida Statutes, requires HMOs to obtain a Care Provider Certificate, which confirms the HMO is in compliance with Part II before it obtains from the Department of Insurance a Certificate of Authority to operate as an HMO in the state. In 1991, a sunset review of Part II, Chapter 641, Florida Statutes, was conducted resulting in a strengthening of the Agency's ability to assure the quality of care of HMOs. Additionally, Part III of chapter 641, Florida Statutes, now: (1) requires all HMOs to obtain and maintain accreditation with a nationally recognized accreditation organization having expertise in HMO quality of care issued; (2) directs the Agency for Health Care Administration to conduct follow-up examinations in those instances when the external accreditation reviews indicate that the HMO is out of compliance with accreditation standards; (3) provides the agency with full access to medical records of HMOs; and (4) provides the agency with the authority to levy administrative fines in cases of continued non-compliance.

HMOs also have internal grievance procedures for subscribers to protest a denial of payment. Many subscribers to HMOs, however, have expressed substantial dissatisfaction with the current grievance procedures.

Section 624.155, Florida Statutes (1995), authorizes actions against insurance companies for not attempting to settle claims in good faith. See e.g. Boston Colony Insurance Co. v. Gutierrez, 386 So. 2d 783 (Fla. 1983)(concerning duties to settle); Robinson v. State Farm Fire and Casualty, 583 So. 2d 1063 (Fla. 5th DCA 1991)(concerning unjustly denying coverage); Campbell v. Government Employees Insurance Co., 306 So. 2d 525 (Fla. 1974)(concerning insurer negligence); Liberty Mutual Insurance Co. v. Dowls, 412 F. 2d 475 (5th Cir. 1957)(concerning failure to negotiate). Additionally, the section allows persons to sue for unfair settlement practices, illegal dealings in premiums, unjustified refusals to insure, coercing debtors, illegal dealings, and discrimination on the basis of sickle cell traits. Section 625.155 (1)(a), Florida Statutes (1995). This section provides that notice must be provided to the Department of Insurance before a suit may be maintained. In McLeod v. Continental Ins. Co., 591 So. 2d 621 (Fla. 1992), the court, construing s. 624.155, F.S., held that the damages recoverable in a first party action under the section "are those damages which are the natural, proximate, probable, or direct consequence of the insurer's bad faith

actions. . . ." There has been extensive litigation on the scope, authorized remedies, damages, proper plaintiffs, obligations and meaning of s. 624.155, F.S. See Fla. Jur. 2d *Insurance* § 3774 (1995).

Apparently, the only successful civil remedy that can be brought against an HMO or prepaid health plan is an action to enforce the terms of the contract provided pursuant to s. 641.28, F.S. (1995). Section 641.28, Florida Statutes, also provides for a "prevailing party" attorney fees award in any action brought against HMOs. Also, s. 641.31, F.S. (1995), provides for requirements in HMO contracts. Section 641.3903, Florida Statutes, provides for rules against unfair or deceptive trade practices. Current case law, however, indicates there has never been a private action to enforce these sections. These sections are enforced by the Department of Insurance and the Agency for Health Care Administration. Further, there is no court decision reported on a private enforcement action under s. 641.3108, F.S., dealing with wrongful cancellation.

Seemingly, there is not a recognized common law cause of action for "bad faith" denials of payment for medical services against HMOs. No appellate case can be found addressing that issue in Florida. Additionally, no appellate cases could be found where a plaintiff had recovered against an HMO for medical malpractice under s. 766, F.S. (1995).

Whether an HMO is liable for medical malpractice is an open question because it is unclear whether an HMO is a "health care provider" under Ch. 766, F.S. (1995). To be sued for medical malpractice, an entity must be a "health care provider." Section 768.50, Florida Statutes (1985), which defined "health care provider" was repealed by Ch. 86-160, L.O.F. Another unanswered question in a medical malpractice action against an HMO, assuming one lies, is whether the denial of payment for a health care service by an HMO is a negligent act which causes damage under s. 766.102, F.S., which defines medical malpractice. The courts have not decided whether an HMO's denial of payment for a medical service is covered by medical malpractice law. Currently, an HMO cannot "negligently" deny payment for medical services. The patient is not "denied" a medical service by an HMO or prepaid health plan because the HMO merely refuses to pay for it for reasons specified in the contract. Ostensibly, the reasoning is that the HMO is not negligent because the subscriber can still obtain treatment they want. The subscriber must, however, pay for it themselves.

Accordingly, the only civil action that seems to lie for a person against an HMO is an action in contract for breach of payment responsibilities. See e.g. Riera v. Finaly Medical Centers HMO Corp., 543 So. 2d 372 (Fla. 3d DCA 1989). Consequently, no punitive or pain and suffering damages have ever been awarded in Florida to a subscriber whose HMO denies payment requested for medical services.

B. EFFECT OF PROPOSED CHANGES:

CS/HB 1853 provides that a contract between an HMO and a health care provider cannot restrict 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 patient.

CS/HB 1853 creates a civil cause of action against HMOs by any person to whom a duty is owed when the person suffers damages as a result of:

--a violation of s. 641.3903(5)(a), (b), (c)1.-7., (10) or (12), F.S., by the HMO (these subsections relate to unfair methods of competition and unfair or deceptive acts or practices); or

--the failure by the HMO to provide a covered service when in good faith the HMO should have done so had it acted fairly and honestly toward its subscriber or enrollee and with due regard for his interests and, in the independent medical judgment of a contract treating physician or other physician authorized by the HMO, the service is medically necessary.

A person pursuing a civil action under this section does not have to prove the acts were committed or performed with such frequency as to indicate a general business practice unless the person is seeking punitive damages.

The bill provides for a 60-day notice of intent to to the HMO and the Department of Insurance. Attorneys fees are tied to compliance with the notice provision.

The bill clarifies contractual provisions between HMOs and a provider of health care services. The bill provides further provisions which will be considered illegal dealings in premiums and/or excess or reduced charges for HMO coverage. As well, the bill provides additional provisions relating to the refusal to cover, or refusal to continue to cover any individual due to specified characteristics.

C. APPLICATION OF PRINCIPLES:

1. Less Government:

a. Does the bill create, increase or reduce, either directly or indirectly:

(1) any authority to make rules or adjudicate disputes?

This bill provides for judicial remedies for adjudicating disputes between subscribers and HMOs.

(2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

The bill provides that HMOs shall meet established standards.

(3) any entitlement to a government service or benefit?

NO

b. If an agency or program is eliminated or reduced:

(1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

NA.

(2) what is the cost of such responsibility at the new level/agency?

NA.

(3) how is the new agency accountable to the people governed?

NA.

2. Lower Taxes:

a. Does the bill increase anyone's taxes?

No

b. Does the bill require or authorize an increase in any fees?

No

c. Does the bill reduce total taxes, both rates and revenues?

No

d. Does the bill reduce total fees, both rates and revenues?

No

e. Does the bill authorize any fee or tax increase by any local government?

No

3. Personal Responsibility:

a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

NA.

b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

NA.

4. Individual Freedom:

a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs?

NA.

b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

NA.

5. Family Empowerment:

a. If the bill purports to provide services to families or children:

(1) Who evaluates the family's needs?

NA.

(2) Who makes the decisions?

NA.

(3) Are private alternatives permitted?

NA.

(4) Are families required to participate in a program?

NA.

(5) Are families penalized for not participating in a program?

NA.

b. Does the bill directly affect the legal rights and obligations between family members?

No.

c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

(1) parents and guardians?

NA.

(2) service providers?

NA.

(3) government employees/agencies?

NA.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. This section clarifies that this cause of action does not affect the exclusiveness of liability under workers' compensation law pursuant to ch. 440, F.S.

Section 2. Provides that if a civil action is filed against an HMO before or within 60 days after the subscriber or enrollee filed a notice of intent to sue with the statewide provider and subscriber assistance program (pursuant to s. 408.7056), or a notice pursuant to s. 641.3917, F.S., the prevailing party is entitled to reasonable attorney's fees and court costs.

If, however, the civil action is filed more than 60 days after the subscriber or enrollee filed a notice pursuant to s. 408.7056, F.S., or s. 641.3917, F.S., and the subscriber or enrollee prevails against the HMO, the court must award the subscriber or enrollee reasonable attorney's fees and court costs.

Provides that the section does not authorize a civil action against the department, employees, Insurance Commissioner, or the Agency for Health Care Administration.

Section 3. Amends s. 641.315, F.S., to preclude contractual provisions, in contracts between HMOs and a provider of health care services, that would restrict the provider's ability to communicate information to the provider's patient regarding medical care or treatment options for the patient when the provider believes providing the information is in the best interest of the patient.

Section 4. This section creates three new paragraphs prohibiting unfair methods of competition and unfair or deceptive acts or practices. The new paragraphs relate specifically to illegal dealings in premiums and excess or reduced charges for HMO coverage as follows:

Section 5. Amends s. 641.3917, F.S., to create a civil cause of action against HMOs. Any person to whom a duty is owed may bring a civil action against an HMO when the person suffers damages as a result of:

--a violation of s. 641.3903(5)(a), (b), (c)1.-7., (10) or (12), F.S., by the HMO; or

--the failure by the HMO to provide a covered service when in good faith the HMO should have done so had it acted fairly and honestly toward its subscriber or enrollee and with due regard for his interests and, in the independent medical judgment of a contract treating physician or other physician authorized by the HMO, the service is medically necessary.

A person pursuing a civil action under this section does not have to prove the acts were committed or performed with such frequency as to indicate a general business practice.

The bill creates the following conditions and duties pertaining to suits brought under this section:

--Section 641.3917(2)(a), F.S., creates as a condition precedent to bringing an action. The plaintiff must give 60-days written notice of the violation to the HMO and to the Department. The Department can return the notice for lack of specificity.

--Section 641.3917(2)(b), F.S., requires the Department to prepare a form for notice that includes, but is not limited to, the following information:

1. The provision and language of the law the HMO allegedly violated.
2. The facts and circumstances giving rise to the violation.
3. The name of any individual involved in the violation.
4. A reference to the specific contract language that is relevant to the violation.
5. A statement that the notice is given to perfect the right to pursue the civil remedy.

--Section 741.3917(2)(c), F.S., provides that within 20 days after receipt of the notice, the department may return the notice if it does not provide the information listed above. When the department returns the notice, it must indicate the specific deficiencies contained in the notice. Chapter 120, F.S. (1995), does not apply to this section.

--Section 741.3917(2)(d), F.S., provides that if the damages alleged are paid or the circumstances giving rise to the situation are corrected within 60 days of the notice, the cause of action shall be extinguished.

--Section 741.3917(2)(e), F.S., provides that the HMO is required to notify the department on any disposition of an alleged violation.

--Section 741.3917(2)(f), F.S., provides that mailing the proper notice tolls the applicable statute of limitations for a period of 65 days.

--Section 741.3917(3), F.S., creates HMO liability for the plaintiff's damages, court costs and attorney's fees upon adverse adjudication at trial or upon appeal.

--Section 741.3917(4), F.S., provides that punitive damages shall not be awarded unless the acts giving rise to a violation occur with such frequency as to indicate a

general business practice and are willful, wanton, and malicious or are in reckless disregard of the subscriber's rights. A person who sues for punitive damages must post, in advance, a sum for discovery costs. Thereafter, if no punitive damages are awarded, the costs are awarded to the HMO. This section is somewhat similar to s. 624.155 (4), F.S.

--Section 741.3917(5), F.S., clarifies that this section does not authorize a class action suit against an HMO or a civil action against the department, its employees, or the Insurance Commissioner, or against the Agency for Health Care Administration, its employees, or the director of the agency or to create a cause of action when a health maintenance organization or a prepaid health plan refuses to provide service on the grounds that the charge for a service was unreasonably high, unless otherwise provided in (1)(b).

--Section 741.3917(6)(a), F.S., specifies that the section does not preempt any other remedy. Any person may obtain a judgment under either the common law remedy of bad faith or the remedy provided in this section, but is not entitled to a judgement under both remedies. Damages must be a reasonably foreseeable result of a specified violation of this section by the HMO and may include an award or judgment in an amount that exceeds contract limits.

--Section 741.3917(6)(b), F.S., clarifies that this section does not create a cause of action for medical malpractice. In addition, s. 741.3917(6)(c), F.S., clarifies that this section does not apply to the provisions of medical care, treatment or attendance pursuant to Chapter 440 (workers' compensation).

--Section 641.3903(10)(c), F.S., is created to provide that canceling or terminating any HMO contract or coverage, or requiring execution of a consent to rate endorsement, during the contract term for the purpose of offering to issue, or issuing, a similar or identical contract to the same subscriber or enrollee with the same exposure at a higher premium rate or continuing an existing contract with the same exposure at an increased premium.

--Section 641.3903(10)(d), F.S., is created to provide that issuing a nonrenewal notice on any HMO contract or requiring execution of a consent to rate endorsement, for the purpose of offering to issue, or issuing, a similar or identical contract to the same subscriber or enrollee at a higher premium rate or continuing an existing contract at an increased premium without meeting any applicable notice requirements.

--Section 3903(10)(e), F.S., is created to provide cancelling or issuing a nonrenewal notice on any HMO contract without complying with any applicable cancellation or nonrenewal provision required under the Florida Insurance Code.

A new **s. 641.3093(12), F.S.,** is added relating to refusal to cover. This section precludes HMOs from refusing to cover, or continue to cover individuals solely because of race, color, creed, marital status, sex, or national origin. It also precludes denial of coverage on the bases of residence, age or lawful occupation f the individual, unless there is a reasonable relationship between the residence, age, or lawful occupation of the individual and the coverage issued or to be issued; or the fact that the enrollee or applicant had been previously refused insurance coverage or health maintenance

organization when the refusal to cover or continue coverage for this reason occurs with such frequency as to indicate a general business practice.

Section 6. Statement of important state interest.

Section 7. Provides for three positions and $112,000 from the Insurance Commissioners' Regulatory Trust Fund to the Department of Insurance for the purposes of carrying out the provisions of this act.

Section 8. Provides for an effective date of July 1, 1997.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

Indeterminable

2. Recurring Effects:

AHCA indicates that the CS has no fiscal impact on that agency. AHCA notes, however, the Department of Insurance will incur costs associated with processing notices.

The Legislature appropriated $112,000 to fund three positions with the Department of Insurance.

3. Long Run Effects Other Than Normal Growth:

Indeterminable

4. Total Revenues and Expenditures:

Indeterminable

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

Unknown

2. Recurring Effects:

Unknown

3. Long Run Effects Other Than Normal Growth:

   Unknown

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

   HMOs and their insurers would likely incur additional costs associated with this new cause of action.

2. Direct Private Sector Benefits:

   Private plaintiffs would have another recourse against HMOs.

3. Effects on Competition, Private Enterprise and Employment Markets:

   Unknown

D. FISCAL COMMENTS:

None

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that municipalities or counties have to raise revenue in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

VII. FINAL ACTION:

IATURES:

COMMITTEE ON CIVIL JUSTICE & CLAIMS:

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