A bill to be entitled

An act relating to health care; amending s. 641.3903, F.S.; providing that certain actions by a health maintenance organization against a provider based on the provider's communication of certain information to a patient are unfair or deceptive practices; amending s. 641.315, F.S.; requiring certain written notice in order to terminate certain provider contracts; providing limitations on the use of such notice; amending s. 641.51, F.S.; providing for continued care of subscribers when certain provider contracts are terminated; amending s. 110.123, F.S.; requiring the state-contracted health maintenance organization to provide an enrollee with continued access to a treating health care provider who loses provider status under the program; providing limitations; providing applicability; amending s. 641.31, F.S.; revising the procedures and standards for rate changes made by an organization; deleting current provisions that allow rate changes to be implemented immediately upon filing with the Department of Insurance, subject to disapproval; requiring rate changes to be filed with the department a specified time period prior to use; providing that a filing is deemed approved after a certain time period absent affirmative approval or disapproval by the department; making conforming changes;

providing for applicability of the act;
providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (14) is added to section 641.3903, Florida Statutes, to read:

641.3903 Unfair methods of competition and unfair or deceptive acts or practices defined.--The following are defined as unfair methods of competition and unfair or deceptive acts or practices:

(14) ADVERSE ACTION AGAINST A PROVIDER.--Any retaliatory action by a health maintenance organization against a contracted provider, including, but not limited to, termination of a contract with the provider, on the basis that the provider communicated 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.

Section 2. Subsection (9) is added to section 641.315, Florida Statutes, to read:

641.315 Provider contracts.--

(9) A health maintenance organization or health care provider may not terminate a contract with a health care provider or health maintenance organization 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 required in this section 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. As used in this subsection, the term "health care provider" means a physician licensed under ch. 458, ch. 459, ch. 460, or ch. 461, or a dentist licensed under chapter 466.

Section 3. Subsection (7) of section 641.51, Florida Statutes, is amended to read:

641.51 Quality assurance program; second medical opinion requirement.--

(7) When a contract between an organization and a treating provider is terminated for any reason other than for cause, each party ~~Each organization~~ shall allow subscribers for whom treatment was active to continue coverage and care when medically necessary, through completion of treatment of a condition for which the subscriber was receiving care at the time of the termination, until the subscriber selects another treating provider, or during the next open enrollment period offered by the organization, whichever is longer, but not longer than 6 months after termination of the contract.~~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 party to the terminated contract ~~organization~~ shall allow a subscriber who has initiated a course of prenatal care, regardless of ~~is in~~ the ~~third~~ trimester in which care was initiated,~~of pregnancy~~ to continue care and coverage ~~with a terminated treating provider~~ until completion of postpartum care. This does not prevent a provider from refusing to continue to provide care to a subscriber who is abusive, noncompliant, or in arrears in payments for services provided. For care continued under this subsection,the organization and

the provider shall continue to be bound by the terms of the terminated contract ~~for such continued care. This subsection shall not apply to treating providers who have been terminated by the organization for cause~~. Changes made within 30 days before termination of a contract are effective only if agreed to by both parties.

Section 4. Paragraph (h) of subsection (3) of section 110.123, Florida Statutes, 1998 Supplement, is amended to read:

110.123 State group insurance program.--

(3) STATE GROUP INSURANCE PROGRAM.--

(h)1. A person eligible to participate in the state group health insurance plan may be authorized by rules adopted by the division, in lieu of participating in the state group health insurance plan, to exercise an option to elect membership in a health maintenance organization plan which is under contract with the state in accordance with criteria established by this section and by said rules. The offer of optional membership in a health maintenance organization plan permitted by this paragraph may be limited or conditioned by rule as may be necessary to meet the requirements of state and federal laws.

2. The division shall contract with health maintenance organizations to participate in the state group insurance program through a request for proposal based upon a premium and a minimum benefit package as follows:

a. A minimum benefit package to be provided by a participating HMO shall include: physician services; inpatient and outpatient hospital services; emergency medical services, including out-of-area emergency coverage; diagnostic laboratory and diagnostic and therapeutic radiologic services;

mental health, alcohol, and chemical dependency treatment services meeting the minimum requirements of state and federal law; skilled nursing facilities and services; prescription drugs; and other benefits as may be required by the division. Additional services may be provided subject to the contract between the division and the HMO.

b. A uniform schedule for deductibles and copayments may be established for all participating HMOs.

c. Based upon the minimum benefit package and copayments and deductibles contained in sub-subparagraphs a. and b., the division shall issue a request for proposal for all HMOs which are interested in participating in the state group insurance program. Upon receipt of all proposals, the division may, as it deems appropriate, enter into contract negotiations with HMOs submitting bids. As part of the request for proposal process, the division may require detailed financial data from each HMO which participates in the bidding process for the purpose of determining the financial stability of the HMO.

d. In determining which HMOs to contract with, the division shall, at a minimum, consider: each proposed contractor's previous experience and expertise in providing prepaid health benefits; each proposed contractor's historical experience in enrolling and providing health care services to participants in the state group insurance program; the cost of the premiums; the plan's ability to adequately provide service coverage and administrative support services as determined by the division; plan benefits in addition to the minimum benefit package; accessibility to providers; and the financial solvency of the plan. Nothing shall preclude the division from negotiating regional or statewide contracts with health

maintenance organization plans when this is cost-effective and when the division determines the plan has the best overall benefit package for the service areas involved. However, no HMO shall be eligible for a contract if the HMO's retiree Medicare premium exceeds the retiree rate as set by the division for the state group health insurance plan.

e. The division may limit the number of HMOs that it contracts with in each service area based on the nature of the bids the division receives, the number of state employees in the service area, and any unique geographical characteristics of the service area. The division shall establish by rule service areas throughout the state.

f. All persons participating in the state group insurance program who are required to contribute towards a total state group health premium shall be subject to the same dollar contribution regardless of whether the enrollee enrolls in the state group health insurance plan or in an HMO plan.

3. The division is authorized to negotiate and to contract with specialty psychiatric hospitals for mental health benefits, on a regional basis, for alcohol, drug abuse, and mental and nervous disorders. The division may establish, subject to the approval of the Legislature pursuant to subsection (5), any such regional plan upon completion of an actuarial study to determine any impact on plan benefits and premiums.

4. In addition to contracting pursuant to subparagraph 2., the division shall enter into contract with any HMO to participate in the state group insurance program which:

a. Serves greater than 5,000 recipients on a prepaid basis under the Medicaid program;

b. Does not currently meet the 25 percent non-Medicare/non-Medicaid enrollment composition requirement established by the Department of Health and Human Services excluding participants enrolled in the state group insurance program;

c. Meets the minimum benefit package and copayments and deductibles contained in sub-subparagraphs 2.a. and b.;

d. Is willing to participate in the state group insurance program at a cost of premiums that is not greater than 95 percent of the cost of HMO premiums accepted by the division in each service area; and

e. Meets the minimum surplus requirements of s. 641.225.

The division is authorized to contract with HMOs that meet the requirements of sub-subparagraphs a. through d. prior to the open enrollment period for state employees. The division is not required to renew the contract with the HMOs as set forth in this paragraph more than twice. Thereafter, the HMOs shall be eligible to participate in the state group insurance program only through the request for proposal process described in subparagraph 2.

5. All enrollees in the state group health insurance plan or any health maintenance organization plan shall have the option of changing to any other health plan which is offered by the state within any open enrollment period designated by the division. Open enrollment shall be held at least once each calendar year.

6. When a contract between a treating provider and the state-contracted health maintenance organization is terminated for any reason other than for cause, each party shall allow

any enrollee for whom treatment was active to continue coverage and care when medically necessary, through completion of treatment of a condition for which the enrollee was receiving care at the time of the termination, until the enrollee selects another treating provider, or until the next open enrollment period offered, whichever is longer, but no longer than 9 months after termination of the contract. Each party to the terminated contract shall allow an enrollee who has initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care and coverage until completion of postpartum care. This does not prevent a provider from refusing to continue to provide care to an enrollee who is abusive, noncompliant, or in arrears in payments for services provided. For care continued under this subparagraph, the program and the provider shall continue to be bound by the terms of the terminated contract. Changes made within 30 days before termination of a contract are effective only if agreed to by both parties.

7.~~6.~~ Any HMO participating in the state group insurance program shall, upon the request of the division, submit to the division standardized data for the purpose of comparison of the appropriateness, quality, and efficiency of care provided by the HMO. Such standardized data shall include: membership profiles; inpatient and outpatient utilization by age and sex, type of service, provider type, and facility; and emergency care experience. Requirements and timetables for submission of such standardized data and such other data as the division deems necessary to evaluate the performance of participating HMOs shall be adopted by rule.

8.~~7.~~ The division shall, after consultation with representatives from each of the unions representing state and

university employees, establish a comprehensive package of insurance benefits including, but not limited to, supplemental health and life coverage, dental care, long-term care, and vision care to allow state employees the option to choose the benefit plans which best suit their individual needs.

a. Based upon a desired benefit package, the division shall issue a request for proposal for health insurance providers interested in participating in the state group insurance program, and the division shall issue a request for proposal for insurance providers interested in participating in the non-health-related components of the state group insurance program. Upon receipt of all proposals, the division may enter into contract negotiations with insurance providers submitting bids or negotiate a specially designed benefit package. Insurance providers offering or providing supplemental coverage as of May 30, 1991, which qualify for pretax benefit treatment pursuant to s. 125 of the Internal Revenue Code of 1986, with 5,500 or more state employees currently enrolled may be included by the division in the supplemental insurance benefit plan established by the division without participating in a request for proposal, submitting bids, negotiating contracts, or negotiating a specially designed benefit package. These contracts shall provide state employees with the most cost-effective and comprehensive coverage available; however, no state or agency funds shall be contributed toward the cost of any part of the premium of such supplemental benefit plans.

b. Pursuant to the applicable provisions of s. 110.161, and s. 125 of the Internal Revenue Code of 1986, the division shall enroll in the pretax benefit program those state employees who voluntarily elect coverage in any of the

supplemental insurance benefit plans as provided by sub-subparagraph a.

c. Nothing herein contained shall be construed to prohibit insurance providers from continuing to provide or offer supplemental benefit coverage to state employees as provided under existing agency plans.

Section 5. Effective July 1, 1999, and applicable to policies and contracts issued or renewed on or after that date, subsections (2) and (3) of section 641.31, Florida Statutes, are amended to read:

641.31 Health maintenance contracts.--

(2) The rates charged by any health maintenance organization to its subscribers shall not be excessive, inadequate, or unfairly discriminatory or follow a rating methodology that is inconsistent, indeterminate, or ambiguous or encourages misrepresentation or misunderstanding. The department, in accordance with generally accepted actuarial practice as applied to health maintenance organizations, may define by rule what constitutes excessive, inadequate, or unfairly discriminatory rates and may require whatever information it deems necessary to determine that a rate or proposed rate meets the requirements of this subsection.

(3)(a) If a health maintenance organization desires to amend any contract with its subscribers or any certificate or member handbook, or desires to ~~change any rate charged for the contract or to~~ change any basic health maintenance contract, certificate, grievance procedure, or member handbook form, or application form where written application is required and is to be made a part of the contract, or printed amendment, addendum, rider, or endorsement form or form of renewal certificate, it may do so, upon filing with the department the

proposed change or, amendment~~, or change in rates~~. Any proposed change shall be effective immediately, subject to disapproval by the department. Following receipt of notice of such disapproval or withdrawal of approval, no health maintenance organization shall issue or use any form ~~or rate~~ disapproved by the department or as to which the department has withdrawn approval.

(b) Any change in the rate is subject to paragraph (d) and requires at least 30 days' advance written notice to the subscriber. In the case of a group member, there may be a contractual agreement with the health maintenance organization to have the employer provide the required notice to the individual members of the group.

(c)~~(b)~~ The department shall disapprove any form filed under this subsection, or withdraw any previous approval thereof, if the form:

1. Is in any respect in violation of, or does not comply with, any provision of this part or rule adopted thereunder.

2. Contains or incorporates by reference, where such incorporation is otherwise permissible, any inconsistent, ambiguous, or misleading clauses or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract.

3. Has any title, heading, or other indication of its provisions which is misleading.

4. Is printed or otherwise reproduced in such a manner as to render any material provision of the form substantially illegible.

5. Contains provisions which are unfair, inequitable, or contrary to the public policy of this state or which encourage misrepresentation.

~~6. Charges rates that are determined by the department to be inadequate, excessive, or unfairly discriminatory, or the rating methodology followed by the health maintenance organization is determined by the department to be inconsistent, indeterminate, ambiguous, or encouraging misrepresentation or misunderstanding. Use of the rating methodology must be discontinued immediately upon disapproval unless the health maintenance organization seeks administrative relief. If a new rating methodology is filed with the department, the premiums determined by such newly filed rating methodology may apply prospectively only to new or renewal business written on or after the effective date of the responsive filing made by the health maintenance organization.~~

6.~~7.~~ Excludes coverage for human immunodeficiency virus infection or acquired immune deficiency syndrome or contains limitations in the benefits payable, or in the terms or conditions of such contract, for human immunodeficiency virus infection or acquired immune deficiency syndrome which are different than those which apply to any other sickness or medical condition.

(d) Any change in rates charged for the contract must be filed with the department not less than 30 days in advance of the effective date. At the expiration of such 30 days, the rate filing shall be deemed approved unless prior to such time the filing has been affirmatively approved or disapproved by order of the department. The approval of the filing by the department constitutes a waiver of any unexpired portion of

such waiting period. The department may extend by not more than an additional 15 days the period within which it may so affirmatively approve or disapprove any such filing, by giving notice of such extension before expiration of the initial 30-day period. At the expiration of any such period as so extended, and in the absence of such prior affirmative approval or disapproval, any such filing shall be deemed approved.

(e)~~(c)~~ It is not the intent of this subsection to restrict unduly the right to modify rates in the exercise of reasonable business judgment.

Section 6. This act shall take effect upon becoming a law and shall apply only to contracts entered into after the effective date.