STORAGE NAME: h0337s1z.hcs ****FINAL ACTION****
DATE: June 9, 1999 ****SEE FINAL ACTION STATUS SECTION****

HOUSE OF REPRESENTATIVES
AS REVISED BY THE COMMITTEE ON
HEALTH CARE SERVICES
FINAL ANALYSIS

BILL #: CS/HB 337 (Passed as CS/SB 232)

RELATING TO: Health Care

SPONSOR(S): Committee on Health Care Services, Rep. Goode and others

COMPANION BILL(S): SB 232 (s), SB 800 (c), SB 1238 (c), and HB 1415 (c)

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) HEALTH CARE SERVICES YEAS 16 NAYS 0
(2) HEALTH AND HUMAN SERVICES APPROPRIATIONS YEAS 8 NAYS 0
(3)
(4)
(5)

I. FINAL ACTION STATUS:

06/08/99 Approved by Governor; Chapter No. 99-264

II. SUMMARY:

CS/HB 337 was commonly referred to throughout the session as the HMO “due process” bill.

The bill adds as a prohibited unfair method of competition and unfair or deceptive act or practice by an HMO any retaliatory action by an HMO against a contracted provider, including, but not limited to, termination of a contract with a 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. (This is commonly referred to as the “gag clause.”)

The bill stipulates that an HMO or a health care provider may not terminate a contract with a health care provider or an HMO unless the party terminating the contract provides the terminated party with a written reason for contract termination, which may include termination for business reasons of the terminating party. The stated reason for termination or any other information relating to the reason for the termination does not create any new administrative or civil action and may not be used as substantive evidence in any action, but may be used for impeachment purposes. The term “health care provider” is defined as a physician licensed under ch. 458, 459, 460, or 461, F.S., or a dentist licensed under ch. 466, F.S.

The bill also specifies coverage continuation requirements in those instances involving termination of a contract between an HMO and a treating physician for any reason other than cause. Specifically addressed are provisions relating to: coverage and care continuation, including prenatal care; circumstances under which a provider may refuse to continue to provide care to a subscriber; and contract applicability. The bill amends the state group insurance program provision to stipulate the same requirements relating to the termination of a contract between a treating provider and the state-contracted health maintenance organization as are specified above for HMOs generally.

Effective July 1, 1999, and applicable to policies and contracts issued or renewed on or after that date, HMO rates and rating methodologies are subject to the same requirements as are applicable to indemnity health insurance policies. Specifically, these provisions relate to: inconsistent, indeterminate, ambiguous, misrepresented, or misunderstood rating methodology; prior filing with the Department of Insurance; and rate filing approval process and time frames.

The effective date of this bill is upon becoming a law, and the provisions apply only to contracts entered into after the effective date.

The bill has no direct fiscal impact on the state.

III. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

HMO Contract Termination

In general, current Florida law does not restrict the authority of a health maintenance organization (HMO) from terminating the contract of a health care provider. The allowable reasons for termination of the contract by either party are subject to the terms of the contract itself. However, 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.)

Unfair Methods of Competition and Unfair or Deceptive Acts or Practices as Part of HMO Contracts

Section 641.3903, F.S., defines several unfair methods of competition and unfair or deceptive acts or practices as part of health maintenance contracts. Specifically included are: misrepresentation and false advertising; false information and advertising generally; defamation; false statements and entries; unfair claim settlement practices; failure to maintain complaint-handling procedures; operation without a subsisting certificate of authority; misrepresentation in applications; illegal dealings in premiums; excess or reduced charges for coverage; false claims; obtaining or retaining money dishonestly; discriminatory practices; and misrepresentation as to availability of providers.

HMO Continuity of Care

HMO legislation enacted in 1997 requires HMOs 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. (ch. 97-159, L.O.F.; s. 641.51(7), F.S.)

Continuity of Care for State-Contracted HMO Enrollees

Section 110.123, F.S., provides for the state group insurance program, which is "the package of insurance plans offered to state officers and employees, retired state officers and employees, and surviving spouses of deceased state officers and employees pursuant to this section, including the state group health insurance plan, health maintenance organization plans, and other plans required or authorized by this section."

According to s. 110.123(3)(c), F.S., "it is the intent of the Legislature to offer a comprehensive package of health insurance benefits for state employees which are provided in a cost-efficient and prudent manner, and to allow state employees the option to choose benefit plans which best suit their individual needs." Section 110.123(3)(c), F.S., further provides that the state group insurance program may include "the state group health insurance plan, health maintenance organization plans, group life insurance plans, group accidental death and dismemberment plans, and group disability insurance plans."

The state group insurance program is administered by the Division of State Group Insurance within the Department of Management Services and is headed by a director who is appointed by the Governor. Section 110.123(3)(a), F.S., provides that "the division shall be a separate budget entity, and the director shall be its agency head for all purposes."

According to the Division of State Group Insurance, the State Employees' PPO Plan has a standard operating procedure that addresses cases where it would be medically necessary for the original treating provider to continue care. Cases which routinely qualify for continued or transition of care include: second trimester pregnancies through birth, including postpartum care; scheduled surgery up to 30 days; end stage renal disease, up to 30 days; outpatient rehabilitation services, up to 30 days; and chemotherapy and radiation therapy, up to 90 days. Other cases may be considered for transition of care benefits upon appeal to Blue Cross and Blue Shield of Florida and the Division of State Group Insurance.

All HMOs contracted with the state employees' insurance program are subject to the provisions of s. 641.51(7), F.S., which requires that HMOs and providers must allow 60 days of continued care when the treating provider is terminated, or terminates, from the HMO. Continued care must be medically necessary and the patient must have a life-threatening, disabling, or degenerative disease or condition, or must be in the third trimester of pregnancy. In accordance with this section, HMOs and providers are bound to the same terms and conditions of the contract for the continued care.

In February of 1999, a Tallahassee-based HMO "was forced to drop some providers to improve its bargaining position with others after significant financial losses last year." [Pensacola News Journal, Friday, March 5, 1999, at 1A, 6A (quoting the chief operating officer of the HMO)] As a result, many of the HMO's members were required to switch providers. About half of the affected members were state employees covered under the state group insurance program.

HMO Rate Filings and Rating Methodologies

Currently, s. 641.31(3)(a), F.S., provides that health maintenance organizations (HMOs) may change rates that are charged for an HMO contract immediately upon filing the rate change with the Department of Insurance, subject to disapproval by the department. Following receipt of notice of disapproval or withdrawal of approval, the HMO may not use the rate. This procedure for rate changes is part of, and identical to, the procedures the HMO must follow for changes to its forms or contracts.

Any change in an HMO's rates 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 HMO to have the employer provide the required notice to the individual members of the group (s. 641.31(3)(a), F.S.).

Subject to the above procedures, the department may disapprove rates charged by an HMO that are excessive, inadequate, or unfairly discriminatory. The department, in accordance with generally accepted actuarial practice as applied by HMOs, 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 such requirements (s. 641.31(2), F.S.).

The department may also disapprove a rate if the rating methodology followed by the HMO 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 HMO 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 HMO (s. 641.31(3)(b)6., F.S.).

According to information provided by the department, HMOs will typically wait for department approval prior to implementing a rate change, even though the HMOs are legally entitled to use the rate immediately upon filing with the department. During 1998, only one HMO implemented a rate increase without department approval. This rate filing affected about 10,000 subscribers and the average premium before the rate increase was $1,925, and after the increase was $2,496, for an average increase of $571 per subscriber. The filing was disapproved by the department and the case is pending at the Division of Administrative Hearings. The department estimates that this HMO collected about $3 million in additional premiums in 1998 as a result of implementing this rate increase.

Further information provided by the department reflects all HMO rate increases as filed and as approved in 1998. According to this information, 109 rate filings were made by 29 different HMOs. Of these 109 rate filings, 83 rate filings by 24 different HMOs were approved as filed. The other 26 rate filings by 13 different HMOs were ultimately approved at a rate lower than the rate filed by the HMO. The department estimates that had these 26 filed rate increases been implemented, the 13 HMOs, in aggregate, would have collected in excess of $22 million more than the ultimately approved rates.

By way of comparison, rate (and form) changes for *health insurance* policies must be made not less than *30 days in advance of use*. At the expiration of this 30-day period, the rate is deemed approved unless prior to such time the rate has been affirmatively approved or disapproved by order of the department. The department may extend by not more than an additional 15 days the period within which it may affirmatively approve or disapprove the rate, by giving notice of the extension before expiration of the initial 30-day period. At the expiration of this maximum 45-day period, the rate is deemed approved in the absence of prior affirmative approval or disapproval. In general, the grounds for disapproval of a health insurance rate change are similar to the grounds for disapproval of an HMO rate change, in that the rate may not be excessive, inadequate, or unfairly discriminatory (ss. 627.410 and 627.411, F.S.).

B. EFFECT OF PROPOSED CHANGES:

The bill will specify that certain actions by an HMO against a provider based on the provider's communication of certain information to a patient of the provider are unfair and deceptive practices.

The bill will stipulate that an HMO or a health care provider may not terminate a contract with a health care provider or an HMO unless the party terminating the contract provides the terminated party with a written explanation of the reasons for contract termination, which may include termination for business reasons of the terminating party. The stated reasons for termination are excluded as substantive evidence but may be used for impeachment purposes in any administrative or civil action initiated by the terminated party against the other party. The term "health care provider" is defined as a physician licensed under ch. 458, 459, 460, or 461, or a dentist licensed under ch. 466, F.S.

The bill will provide for continuity of care in those instances involving termination of a contract between an HMO and a treating physician for any reason other than cause. Such care continuation cannot exceed 6 months, or through postpartum care in cases of pregnancy. Similar provisions will also be in place specific to state-contracted HMOs.

The bill will require HMOs to meet rate filing and rating methodology requirements comparable to those currently required for indemnity health insurance products.

C. APPLICATION OF PRINCIPLES:

1. <u>Less Government:</u>

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

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

Yes. The Department of Insurance is required to adopt additional rule provisions relating to HMO rate filings and rating methodologies.

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

Yes. Managed care plans will have additional obligations regarding provider contracts.

(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?

N/A

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

N/A

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

N/A

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?

No.

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

No.

4. Individual Freedom:

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

      No.

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

      Yes, the bill creates new requirements relating to contracts between managed care plans and health care providers.

5. Family Empowerment:

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

      (1) Who evaluates the family's needs?

          N/A

      (2) Who makes the decisions?

          N/A

      (3) Are private alternatives permitted?

          N/A

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

          N/A

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

          N/A

   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?

          N/A

      (2) service providers?

          N/A

(3) government employees/agencies?

N/A

D. STATUTE(S) AFFECTED:

Sections 110.123(3)(h), 641.315, 641.3903, 641.31(2) and (3), and 641.51(7), F.S.

E. SECTION-BY-SECTION ANALYSIS:

Section 1. Adds a new subsection (14) to section 641.3903, F.S., relating to unfair methods of competition and unfair or deceptive acts or practices as part of health maintenance contracts, to add to such prohibited acts any retaliatory action by an HMO against a contracted provider, including, but not limited to, termination of a contract with a 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. (This is commonly referred to as the "gag clause.")

Section 2. Adds a new subsection (9) to s. 641.315, F.S., relating to health maintenance provider contracts, to stipulate that an HMO or a health care provider 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 explanation of the reasons for contract termination, which may include termination for business reasons of the terminating party. The stated reason for termination or any other information relating to the reason for the termination does not create any new administrative or civil action and may not be used as substantive evidence in any action, but may be used for impeachment purposes. For purposes of this subsection, the term "health care provider" means a physician licensed under ch. 458, 459, 460, or 461, or a dentist licensed under ch. 466, F.S.

Section 3. Amends subsection (7) of s. 641.51, F.S., relating to continuity of care in instances of provider termination under health maintenance contracts, to specify that, in termination of a contract between an HMO and a treating physician for any reason other than cause, each party to the contract 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 HMO, whichever is longer, but no longer than 6 months after termination of the contract. Each party to the terminated contract shall allow a subscriber who has initiated a course of prenatal care, irrespective of the trimester in which care is initiated, to continue care and coverage until completion of postpartum care.

These provisions do 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 these circumstances, the organization and the provider will continue to be bound by the terms of the terminated contract. Changes made within 30 days before termination of a contract will be effective only if agreed to by both parties.

Section 4. Amends s. 110.123(3)(h), F.S., 1998 Supplement, relating to the State Group Insurance Program, to specify that 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 will be required to 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 6 months after termination of the contract. An enrollee who has initiated a course of prenatal care regardless of the trimester in which care is initiated, will be permitted to continue care and coverage until completion of postpartum care.

These provisions will 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 these circumstances, the program and the provider will continue to be bound by the terms of the terminated contract. Changes made within 30 days before termination of a contract will be effective only if agreed to by both parties.

Section 5. Effective July 1, 1999, and applicable to policies and contracts issued or renewed on or after that date, amends s. 641.31(2) and (3), F.S., relating to HMO contracts, to apply to HMOs the same rate filing procedures that apply to indemnity health insurers. This will require HMOs to file rates at least *30 days in advance of use*, rather than being allowed to implement rates immediately upon filing with the department as currently authorized. The department may approve or disapprove the rate during this 30-day period, or during an extended period of an additional 15 days if the department gives notice of the extension. If the department disapproves the rate during this period, the HMO may not use the rate but may pursue its administrative hearing rights if it challenges the department's findings. If, however, the department does not affirmatively approve or disapprove the rate during this 30 to 45 day time period, the rate is deemed approved. (These requirements are provided in new paragraph (d) of s. 641.31(3), F.S.)

The bill does not change the current law that allows HMOs to amend contract forms and other forms immediately upon filing with the department, subject to disapproval by the department. Necessary conforming changes are made in the bill to delete current rate approval provisions that are contained in the provisions of subsection (3) that relate to both the filing of forms and the filing of rates. The current provisions of s. 641.31(3)(b)6., F.S., that prohibit HMOs from using a rating methodology determined by the department to be "inconsistent, indeterminate, ambiguous, or encouraging misrepresentation or misunderstanding," are transferred to subsection (2), which addresses HMO rate standards.

Section 6. Provides for the bill to take effect immediately upon becoming law, and to apply to contracts entered into after the effective date.

IV. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

None.

2. Recurring Effects:

None.

3. Long Run Effects Other Than Normal Growth:

None.

4. Total Revenues and Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

None.

2. Recurring Effects:

None.

3. Long Run Effects Other Than Normal Growth:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

The fiscal impact is unknown. The costs or savings associated with this bill depend upon the terms of the contracts and whether the health maintenance organization (HMO) or health care provider is the terminating party or terminated party. For instance, if the HMO is the terminating party and is able to enter into a new contract with more favorable terms than contained in existing contract, then the requirement binding the parties to the terms of a terminated contract for up to six months may add costs to the HMO.

2. Direct Private Sector Benefits:

Health care providers will benefit by additional protections from termination or nonrenewal of contracts with managed care organizations.

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

Unknown.

D. FISCAL COMMENTS:

None.

V. 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 revenues.

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.

VI. COMMENTS:

None.

VII. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On March 11, 1999, the Committee on Care Services adopted a strike-everything amendment to HB 337 which addressed: adverse action against providers by HMOs; termination of contracts between HMOs and health care providers; and continuity of care issues in situations involving termination of health maintenance contracts. The committee voted unanimously to adopt these revisions as a committee substitute.

On April 16, 1999, the Committee on Health and Human Services Appropriations adopted a strike-everything amendment to CS/HB 337, providing technical changes and adding a provision requiring both parties to agree to changes made within thirty days before termination of the contract.

When the full Senate took up CS/SB 232 on April 22, 1999, two substantive amendments were adopted relating to: continuation of coverage requirements for state-contracted HMO enrollees (the substance of SB 800) and HMO rate filing and rating methodologies (the substance of CS/SB 1238).

On April 29, 1999, the full House took up CS/SB 232 in lieu of CS/HB 337 and unanimously passed the bill, with all the revisions indicated above..

VIII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:	Staff Director:
Phil E. Williams	Phil E. Williams

AS REVISED BY THE COMMITTEE ON HEALTH AND HUMAN SERVICES APPROPRIATIONS:

Prepared by:	Staff Director:
Tom Weaver	Lynn Dixon

FINAL ANALYSIS PREPARED BY THE COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:	Staff Director:
Phil E. Williams	Phil E. Williams