STORAGE NAME: h0337s1a.hhs
DATE: April 16, 1999

HOUSE OF REPRESENTATIVES
AS REVISED BY THE COMMITTEE ON
HEALTH AND HUMAN SERVICES APPROPRIATIONS
ANALYSIS

BILL #: CS/HB 337

RELATING TO: Health Care Provider Contracts

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

COMPANION BILL(S): None

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. SUMMARY:

CS/HB 337 defines as an untoward act the following actions by an HMO against a contracted provider: termination of a contract with a provider; refusal to compensate the provider for health care services provided to subscribers; or any retaliatory action against the provider.

The bill also 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 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 any physician or group of physicians licensed under chapters 458, 459, 460, 461, or 466, F.S.

Finally, the bill specifies 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. This provision also allows 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 preclude a provider from refusing to continue to provide care to a particular subscriber for reasons unrelated to his termination of his contract with the HMO. For care continued under this subsection, the HMO and the provider shall continue to be bound by the terms of the last contract mutually agreed to.

The bill has no direct fiscal impact on the state.

II. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

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.)

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 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.)

B. EFFECT OF PROPOSED CHANGES:

The bill will define the following actions by an HMO as an untoward act against a contracted provider: termination of a contract with a provider; refusal to compensate the provider for health care services provided to subscribers; or any retaliatory action against the provider.

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 any physician or group of physicians licensed under chapters 458, 459, 460, 461, or 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.

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?

No.

(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 641.315, 641.3903, and 641.51, 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 specifically define as an untoward act the following actions by an HMO against 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: termination of a contract with a provider; refusal to compensate the provider for health care services provided to subscribers; or any retaliatory action against the provider.

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 reasons provided in the notice required in this section or any other information relating to the reason for termination may not be used 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. For purposes of this subsection, the term "health care provider" shall mean any physician or group of physicians licensed under chapters 458, 459, 460, 461, or 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 shall not preclude a provider from refusing to continue to provide care to a particular subscriber for reasons unrelated to his termination of his contract with the HMO. For care continued under this subsection, the HMO and the provider shall continue to be bound by the terms of the last contract mutually agreed to.

Section 4. Provides for the bill to take effect immediately upon becoming law, and to apply to contracts entered into after the effective date.

III. 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.

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 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.

V. COMMENTS:

New subsection (14) of s. 641.3903, F.S., is unclear with regard to the adversity relating to an HMO's refusal to compensate a provider for "health care services" provided to subscribers. Does this apply to *any* health care services, or only to *contracted* or *covered* health care services?

The revised continuity of care provisions in s. 641.51(7), F.S., refer to at least two terms that could be subject to differing interpretations: "subscribers for whom treatment was *active*" and "continue coverage and care *when medically necessary*."

This latter amended subsection also appears to enable a provider to terminate a relationship with a subscriber at will. It is unclear in this context what continuity of care provisions would apply to a subscriber so situated.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On March 11, 1999, the **Committee on Care Services** adopted a "strike everything" amendment to this bill 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 providing technical changes and adding a provision requiring both parties to agree to changes made within thirty days before termination of the contract.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by: Phil E. Williams

Staff Director: Phil E. Williams

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

Prepared by:	Staff Director:
Tom Weaver	Lynn Dixon