STORAGE NAME: h0387a.hcs
DATE: March 8, 1999

HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE SERVICES
ANALYSIS

BILL #: HB 387

RELATING TO: Health Care Services

SPONSOR(S): Representative Crow & others

COMPANION BILL(S): SB 216 (s)

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) HEALTH CARE SERVICES
(2) JUDICIARY
(3) INSURANCE
(4) GENERAL GOVERNMENT APPROPRIATIONS
(5)

I. SUMMARY:

HB 387 provides for a civil cause of action against a health maintenance organization (HMO) for violations of section 641.3903(5)(a), (b), (c)1.-7., (10), or (12), F.S., or for the HMO's failure to provide a covered service when in good faith the HMO should have provided the service and the service is medically necessary. In addition, the bill:

- creates conditions and duties pertaining to civil actions against HMOs;
- establishes notice requirements;
- provides for attorney's fees under certain circumstances;
- establishes that certain actions by HMOs dealing with refusal to cover an individual due to specified characteristics and the cancellation or nonrenewal of a health maintenance contract will be considered illegal dealings;
- establishes HMO liability for the plaintiff's damages, court costs, and attorney's fees upon adverse adjudication;
- requires certain conditions for punitive damages awards; and
- provides that damages must be a reasonably foreseeable result of a specified violation by the HMO and may include an award or judgment in an amount that exceeds contract limits.

The bill specifies that the provisions do not authorize a class action suit against an HMO or a civil action against agencies, nor do the provisions in the bill preempt any other remedy, create a cause of action for medical malpractice, or apply to provisions of medical care, treatment or attendance pursuant to chapter 440, F.S., relating to workers' compensation. In addition, the bill states that the Legislature has determined that the act fulfills an important state interest.

The fiscal impact of this bill will include the costs state agencies incur by receiving, processing, and investigating notice requirements. At this time, the exact costs to agencies is not known.

The bill provides for an appropriation of $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. According to the Department of Insurance, this act will require three additional full-time positions at an annual cost of $137,621, and an additional $24,357 for the first year to cover Operating Capital Outlay and other expenses.

II. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

Health maintenance organizations (HMOs) have grown rapidly since the late 1980s and have often been credited with helping to lower the cost of health care. Over 70 million Americans are enrolled in an HMO. In Florida, HMO enrollment exceeds 4.5 million. In the early 1990s, enrollment in HMOs grew at a rate of close to 20 percent per year, reflecting general consumer satisfaction with the care provided by, and the costs associated with, health maintenance organizations. In 1997, HMO enrollment increased by only 7 percent, indicating a slowdown in HMO enrollment growth for the latter part of the decade.

Critics charge that HMOs limit physician and patient options and may compromise quality of care in efforts to control costs. These critics argue that managed care plans may have a potential to deny services to subscribers over the recommendation of the treating physician. On the other hand, managed care groups argue that their ability to decide what services are provided allows them to control over-utilization and unnecessary treatments while traditional fee-for-service and indemnity plans cannot.

HMOs are regulated by parts I and III of chapter 641, F.S., and are exempt from all other provisions of the Florida Insurance Code. Part I of chapter 641, F.S., authorizes the Department of Insurance to regulate finances, contracting, and marketing activities of HMOs, and part III of chapter 641, F.S., authorizes the Agency for Health Care Administration (AHCA) to regulate the quality of care provided by HMOs. Provisions in part III of chapter 641, F.S., allow for AHCA to: (1) require all HMOs to obtain and maintain accreditation with a nationally recognized accreditation organization having expertise in HMO quality of care issues; (2) conduct follow-up examinations in those instances when the external accreditation reviews indicate that the HMO is out of compliance with accreditation standards; (3) have full access to medical records of HMOs; and (4) levy administrative fines in cases of continued non-compliance.

HMOs also have internal grievance procedures for subscribers to protest a denial of services or payment for services. A growing number of HMO subscribers, however, have expressed substantial dissatisfaction with the current grievance procedures. Under s. 408.7056, F.S., subscribers have a right to appeal any unresolved grievance to the Statewide Provider and Subscriber Assistance Panel, which was created to review enrollment/disenrollment, financial, contractual, and quality of care complaints against HMOs. The panel may review and consider subscriber and provider grievances and make recommendations to AHCA and the Department of Insurance as to any action that should be taken concerning such grievances.

Section 440.11, F.S., provides for employer liability requirements for medical treatment and compensation for disability and death. This liability is exclusive and in place of all other liability to any third-party tortfeasor and the employee or his or her representatives. Under this section, an employer's workers' compensation carriers are not liable as third-party tortfeasors for assisting the employer in carrying out the employer's rights and responsibilities. The liability of a carrier to an employee is limited to the provisions in s. 440.11, F.S., except as provided in the Insurance Code, s. 624.155, F.S.

Section 624.155, F.S., authorizes actions against insurance companies for not attempting to settle a claim in good faith, as well as for unfair settlement practices, illegal dealing in premiums, unjustified refusals to insure, coercing debtors, and discrimination. Notice must be provided to the Department of Insurance when an action is taken against an insurance company. The courts have construed recoverable damages under this section to include "those damages which are the natural, proximate, probable, or direct consequence of the insurer's bad faith actions...." McLeod v. Continental Ins. Co., 591 So. 2d 621 (Fla. 1992).

Section 641.28, F.S., allows an HMO subscriber to sue an HMO when the HMO refuses to pay for a necessary course of treatment. The subscriber can sue to force the HMO to provide the treatment or the subscriber can sue to recover expense incurred for denied treatment. A subscriber who prevails in such a suit can also recover attorney's fees. Such actions appear to be the only civil remedy available against an HMO. Although s. 641.3903, F.S, provides for rules against unfair or deceptive trade practices, and s. 641.3108, F.S., deals with wrongful cancellation, current case law indicates that there have been no private actions taken to enforce these sections.

Recently, the issue of HMO liability has become a popular and controversial subject throughout the country. Many states have considered legislation addressing HMO liability and a consumer's right to sue a health plan. Two states, Missouri and Texas, have passed legislation to hold plans accountable for wrongful denials or delays of health care services, but Texas is the only state to pass a law creating a cause of action so individuals can sue their health plans. The 1997 Texas law, which holds HMOs liable for denying medically necessary care and allows consumers to sue if they believe their HMO denied them quality care, was upheld in a federal district court decision last September. It is believed that this ruling, decided by U.S. District Judge Vanessa Gilmore, will encourage other states to enact similar HMO liability laws. In her decision, Judge Gilmore also invalidated the Texas independent review process for HMOs. Corp. Health Ins.v. Tex. Dept. of Ins., No. 97-2072 (S. D. Tex. Sept. 18, 1998). Nineteen other states have established similar external appeals processes for HMOs, but it is not clear what effect this recent decision will have on these laws.

In October 1998, a Pennsylvania appeals court assigned HMOs the state's malpractice standards for hospitals and remanded the case for trial. If the ruling stands, HMOs in Pennsylvania will face greater liability and may be susceptible to malpractice suits.

According to chapter 766, F.S., to be sued for medical malpractice, an entity must be a "health care provider," but it is not clear whether an HMO is a "health care provider" under that chapter. Florida courts have not determined 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. HMOs may argue that subscribers are not denied medical services when the HMO refuses to pay for the services for reasons specified in contract because the subscribers can still obtain the treatment if they pay for it themselves.

B. EFFECT OF PROPOSED CHANGES:

The rights of HMO subscribers to sue their HMO in cases where the HMO denies a medical treatment or service to the subscriber will be significantly expanded. An HMO subscriber will be able to sue the HMO for compensatory damages and attorney's fees if the subscriber can show that the HMO failed to provide a covered service when in good faith the HMO should have provided the service and the service is medically necessary. Punitive damages will be awarded if violations are proven to indicate a general business practice and are willful, wanton, and malicious or show reckless disregard.

Certain actions by HMOs dealing with refusal to cover an individual due to specified characteristics and the cancellation or nonrenewal of a health maintenance contract will be considered illegal actions.

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?

The Department of Insurance will be required to receive, process, and investigate notices of civil actions against an HMO.

(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?

An HMO subscriber will be able to pursue a civil cause of action against the HMO when certain damages are suffered.

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

No.

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 440.11, 641.28, 641.3903, and 641.3917, F.S.

E. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 440.11, F.S., relating to employer liability for purposes of workers' compensation, to clarify the cause of action set out in this bill does not affect the exclusiveness of liability under workers' compensation law.

Section 2. Amends s. 641.28, F.S., relating to HMO civil remedies, to provide 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, F.S., or a notice pursuant to s. 641.3917, F.S., the prevailing party is entitled to reasonable attorney's fees and court costs. If 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.

Section 3. Creates s. 641.3903(10)(c), F.S., to provide that canceling or terminating any HMO contract 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 is an illegal dealing.

Creates s. 641.3903(10)(d), F.S., 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 is an illegal dealing.

Creates s. 641.3903(10)(e), F.S., to provide that canceling or issuing a nonrenewal notice on any HMO contract without complying with any applicable cancellation or nonrenewal provision required under the Florida Insurance Code is an illegal dealing.

Creates s. 641.3093(14), F.S., to preclude HMOs from refusing to cover, or continuing to cover individuals solely because of race, color, creed, marital status, sex, or national origin. HMOs are also precluded from denial of coverage on the bases of residence, age or lawful occupation of 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, and denial of coverage based on the fact that the enrollee or applicant had been previously refused insurance coverage or health maintenance organization coverage when the refusal to cover or continue coverage for this reason occurs with such frequency as to indicate a general business practice.

Section 4. Amends s. 641.3917, F.S., relating to HMO civil liability. The following new subsections of this section are created:

Subsection (1) provides that a person 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.; 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 the subscriber's 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.

Subsection (2) establishes conditions and duties pertaining to civil actions against HMOs. These conditions and duties provide that:

- the plaintiff must give 60-days written notice of the violation to the HMO and to the Department of Insurance, and the department can return the notice for lack of specificity;

- the department provide a form for notice that includes but is not limited to:

    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, and
    5. A statement that the notice is given to perfect the right to pursue the civil remedy;

- if the notice does not provide the required information, the department may return the notice within 20 days of receipt of the notice with indication of the specific deficiencies and such a return is exempt from the requirement of chapter 120, F.S.;
- 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;
- the HMO is required to notify the department on any disposition of an alleged violation; and
- mailing the proper notice tolls the applicable statute of limitations for a period of 65 days.

Subsection (3) establishes HMO liability for the plaintiff's damages, court costs, and attorney's fees upon adverse adjudication at trial or upon appeal.

Subsection (4) 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, and if no punitive damages are awarded, the costs are awarded to the HMO.

Subsection (5) 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 an HMO 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 s. 641.3917(1)(b), F.S.

Subsection (6) specifies that this section does not: preempt any other remedy; create a cause of action for medical malpractice; or apply to the provisions of medical care, treatment or attendance pursuant to chapter 440, F.S., relating to workers' compensation. 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 judgment 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 5. Provides that the Legislature finds that the provisions of this bill fulfill an important state interest.

Section 6. 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 7. Provides for an effective date of July 1, 1999.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

Insurance Commissioner's Regulatory Trust Fund (ICRTF)

	Year 1	Year 2
Expense	$ 2,787	
OCO	$21,570	
Total Impact to the Fund	$24,357	

2. Recurring Effects:

Insurance Commissioner's Regulatory Trust Fund (ICRTF)

	Year 1	Year 2
FTE	3.0	3.0
Salaries and Benefits	$123,008	$123,008
Expense	$ 14,613	$ 14,613
Total Impact to the Fund	$137,621	$137,621

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:

None.

2. Recurring Effects:

Costs to local government should be concentrated in the courts. The number of lawsuits are likely to increase causing an increase in the workload of judges and court clerks.

3. Long Run Effects Other Than Normal Growth:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

HMOs are likely to incur costs associated with this new cause of action.

2. Direct Private Sector Benefits:

Subscribers would have another recourse against HMOs.

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

Unknown.

D. FISCAL COMMENTS:

Costs to state agencies would include the requirement to receive, process and investigate notices. According to the Department of Insurance, there are approximately 4,750,994 HMO subscribers in Florida who would have the opportunity to pursue a claim remedy under this law. Under s. 624.155, F.S., close to 5000 notices are filed annually. An additional 1000 notices are returned to complainants for proper completion of the notice and 70 percent of the Division of Consumer Services' public record requests are related to s. 624.115, F.S, notices. This workload is managed by five full-time positions.

The Department of Insurance anticipates that due to the large number of HMO subscribers statewide and the popularity of filing notices pursuant to s. 624.155, F.S., the department will experience a 30 percent increase in notice filings. Because of the increased workload and the investigative

requirements of the statute, the department states that it will need three additional full-time Insurance Specialist positions. According to the department, annual costs for support of the increased workload are anticipated to be $137,621. The Operating Capital Outlay requested for these positions is based upon the standard amount approved for the Larson Building, which is in excess of the standard amount due to the need for workstations. The appropriation in this bill does not cover all these anticipated costs.

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:

None.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

None.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by: Staff Director:

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