SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based only on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/SB 1900

SPONSOR: Banking and Insurance Committee and Senator Brown-Waite

SUBJECT: Health maintenance organizations

DATE: April 12, 2000 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Deffenbaugh	Deffenbaugh	BI	Favorable/CS
2.			HC	
3.				
4.				
5.				

I. Summary:

CS/SB 1900 creates the "Managed Care Organization's Patient's Bill of Rights." The bill creates a statutory cause of action for a subscriber against a health maintenance organization (HMO) for actual damages, punitive damages, and attorney's fees, caused by a violation of any of 20 specified subscriber rights. The "rights" are in a list of selected *current statutory requirements* that apply to HMOs including, among others, requirements that HMOs: (1) ensure that health care services are rendered under reasonable standards of quality of care consistent with the prevailing standards of medical practice in the community; (2) not modify the professional judgment of a physician unless the course of treatment is inconsistent with the prevailing standards of medical practice in the community; (3) not restrict a provider's ability to communicate information regarding medical care options that are in the best interest of the subscriber; (4) provide for standing referrals to specialists for subscribers with chronic and disabling conditions; (5) allow a female subscriber to have direct access to visit an obstetrician/gynecologist; (6) not limit coverage for the length of a stay in a hospital for a maternity or newborn stay, or for a mastectomy, to a time period less than that determined to be medically necessary by the treating physician; (7) not exclude coverage for drugs on the ground that the drug is not approved by the U.S. Food and Drug Administration; (8) not exclude coverage for bone marrow transplant procedures determined by the Agency for Health Care Administration to not be experimental; (9) give the subscriber the right to a second medical opinion; (10) allow subscribers to continue treatment from a provider after the provider's contract with the organization has been terminated; and (11) establish a procedure for resolving subscriber grievances, including the right to an independent external review by a statewide subscriber and provider assistance panel; and (12) provide emergency services and care without prior authorization.

Each of these "rights" is referenced by the applicable current statute, and the bill expresses that the summarized list of rights does not alter the current statutory requirements.

The bill also lists *responsibilities* of HMO subscribers, but does not specify the consequences for the failure of a subscriber to meet his or her responsibilities. All HMOs would be required to provide subscribers with a copy of their rights and responsibilities as set forth in the bill and must operate in accordance with those rights.

However, section 2 of the bill has legislative findings and intent that the act creates substantive rights and provides remedies for persons harmed by the failure of a *managed care organization* to meet appropriate standards for quality health care, and that such organizations have a *fiduciary duty* to provide such care. *Managed care organization* is defined to include health insurance carriers, health service plans, other managed care entities, and entities providing health care benefits regulated under chapters 624 through 631, and chapter 641, F.S. Yet, the only specific rights in the bill that would clearly authorize a right of action are limited to HMOs and limited to a violation of one of 20 current statutory requirements, as described above. Section 4 states that it creates a cause of action against managed care organizations, but the action is limited to a person whose rights in newly created s. 641.275, F.S., are violated, which applies only to HMOs. The intent language may provide legislative support for lawsuits against other managed care organizations and lawsuits based on broader grounds than the specific violations listed.

The bill creates section 641.275 and three as yet unnumbered sections of the Florida Statutes.

II. Present Situation:

Background

As an increasing number of persons receive health care through managed care plans, public attention has been focused on some of the problems consumers have with such plans. Although surveys reflect that a majority of consumers are satisfied with their plans, some express concern that the plans' methods of managing care and controlling costs limit access to needed services. Some of these concerns, reflected by common features of legislative proposals under consideration or adopted during the past few years, include: (1) increased access to specialists; (2) requirements for the organizations to establish internal and external appeals processes; (3) empowering subscribers to sue the organizations for failure to provide necessary services; (4) elimination of barriers to emergency room access; (5) prohibiting managed care organizations from interfering with the discussion of health care alternatives by prohibiting inclusion of so-called "gag clauses" in the plan contract; and (6) establishing certain due process protections for providers whose contracts are terminated.

What is "Managed Care?"

Managed care refers to a variety of methods of financing and organizing the delivery of comprehensive health care in which an attempt is made to control costs and improve quality by controlling the provision of services. All forms of managed care represent attempts to control costs by modifying the behavior of health care providers, although they do so in different ways. Most forms also restrict the access of insureds to providers who are not affiliated with a particular plan. Primary care physicians assume broader roles in these systems to direct health care and to refer to other providers. Methods for controlling access to, and costs of care include prior, concurrent, and retrospective review of the medical necessity and appropriateness of services or

site of services; contracts with selected health care providers; financial incentives or disincentives related to the use of specific providers, services, or service sites; controlled access to and coordination of services by a case manager; and disease management programs. Contracts between health maintenance organizations and health care providers will typically provide for a fixed, per patient fee, regardless of the services provided, referred to as a per capita fee arrangement. This provides an economic incentive to a provider to limit services to those that are medically necessary.

The term, *managed care organization* is not a licensure category under Florida law. One statute defines the term *managed care entity* for the purpose of the statewide panel that is created to help resolve grievances against such entities. This law, s. 408.7056, F.S., defines *managed care entity* to mean the following four organizations, each of which provide services or compensation *only* if the insured or subscriber obtains services or treatment from an exclusive list of providers (referred to as contract providers), subject to certain exceptions: (1) *health maintenance organizations (HMOs)*, certified under parts I and III of chapter 641; (2) *prepaid health clinics* certified under parts II and III of chapter 641, F.S., which limit services to physician care, but not including hospital inpatient services (and which serve a very limited market in Florida); (3) *prepaid health plans* authorized under s. 409.912, F.S., which are entities that contract with the Agency for Health Care Administration (AHCA) to serve Medicaid recipients, pursuant to statutory criteria similar to an HMO; and (4) *exclusive provider organizations* (EPOs), which are authorized health insurers which limit coverage to services or treatment from network providers, very similar to an HMO. In addition to obtaining a certificate of authority as a health insurer from the Department of Insurance, the EPO insurer must have its plan of operation approved by the AHCA to determine the adequacy of the provider network and assurance of quality of care, also similar to an HMO.

In addition to these four entities, a health insurer that sells a *preferred provider contract* may be considered to be a "managed care" plan. This is a health insurance policy that provides greater benefits if an insured obtains services from a network provider, and lesser benefits (greater deductibles and coinsurance) if the insured obtains services from a non-network provider. The insurer must have these policies approved by the Department of Insurance, but not AHCA. There is not a separate license that is issued to a health insurer for this purpose, but such plans are referred to as preferred provider organizations, or PPOs. There is one statute that regulates PPO contracts, s. 627.6471, F.S., which limits the amount of the difference between the network and non-network deductible and coinsurance that the insurer may impose, and other requirements.

Generally, an *indemnity* health insurance policy that provides the same reimbursement for health care expenses, regardless of the provider chosen, is not considered a managed care plan. Yet, even these insurers may use cost containment measures such as utilization review and fee schedules that could be categorized as managed care techniques.

Health Maintenance Organizations

In Florida, HMOs are regulated under parts I and III of chapter 641, F.S., by the Department of Insurance (DOI) and the Agency for Health Care Administration (AHCA). Generally, DOI regulates contractual, financial, and other operational requirements relating to HMOs under part I, while AHCA regulates HMOs' quality-of-care practices under part III. Quality requirements for

HMOs include, among others: an internal quality assurance program; accreditation; and demonstration of the HMO's capability to provide health care services of a quality consistent with the prevailing standards of medical practice in the community.

Section 641.19(13), F.S., provides the following definition of health maintenance organization:

> (13) "Health maintenance organization" means any organization authorized under this part which:
>
> (a) Provides emergency care, inpatient hospital services, physician care including care provided by physicians licensed under chapters 458, 459, 460, and 461, ambulatory diagnostic treatment, and preventive health care services;
>
> (b) Provides, either directly or through arrangements with other persons, health care services to persons enrolled with such organization, on a prepaid per capita or prepaid aggregate fixed-sum basis;
>
> (c) Provides, either directly or through arrangements with other persons, comprehensive health care services which subscribers are entitled to receive pursuant to a contract;
>
> (d) Provides physician services, by physicians licensed under chapters 458, 459, 460, and 461, directly through physicians who are either employees or partners of such organization or under arrangements with a physician or any group of physicians; and
>
> (e) If offering services through a managed care system, then the managed care system must be a system in which a primary physician licensed under chapter 458 or chapter 459 and chapters 460 and 461 are designated for each subscriber upon request of a subscriber requesting service by a physician licensed under any of those chapters, and is responsible for coordinating the health care of the subscriber of the respectively requested service and for referring the subscriber to other providers of the same discipline when necessary. Each female subscriber may select as her primary physician an obstetrician/gynecologist who has agreed to serve as a primary physician and is in the health maintenance organization's provider network.

Under part III of ch. 641, F.S., an HMO is required, as a condition of doing business in Florida, to be accredited within 1 year of receiving its certificate of authority from DOI. Accreditation must be maintained as a condition of doing business in the state. HMOs must undergo an accreditation assessment at least every 2 years, or more frequently if AHCA deems additional assessments are necessary. According to AHCA, as of February 14, 2000, there were 30 HMOs in Florida. Of that number, 15 are using the National Committee for Quality Assurance (NCQA) for accreditation, 13 are using the Accreditation Association for Ambulatory Health Care (AAAHC), 1 is using the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and 1 HMO is due for initial accreditation and will be using NCQA.

Specific Requirements for Health Maintenance Organizations

The current Florida law includes the following requirements for HMOs, among many others. Note that the following is a summary only and that the referenced statutes provides the specific requirements and limitations. Such provisions require HMOs to:

1) ensure that health cares services provided to subscribers are rendered under reasonable standards of quality of care consistent with the prevailing standards of medical practice in the community, as required by s. 641.51, F.S.;

2) have a quality assurance program for health care services, as required by s. 641.51, F.S.;

3) not modify the professional judgment of a physician unless the course of treatment is inconsistent with the prevailing standards of medical practice in the community, as required by s. 641.51, F.S.;

4) not restrict a provider's ability to communicate information to the subscriber/patient regarding medical care options that are in the best interest of the subscriber/patient, as required by s. 641.315(8), F.S.;

5) provide for standing referrals to specialists for subscribers with chronic and disabling conditions, as required by s. 641.51, F.S.;

6) allow a female subscriber to select an obstetrician/gynecologist as her primary care physician, as required by s. 641.19(13)(e), F.S.;

7) provide direct access, without prior authorization, for a female subscriber to visit a obstetrician/gynecologist, as required by s. 641.51(10), F.S.;

8) provide direct access, without prior authorization, to a dermatologist, as required by s. 641.31(33), F.S.;

9) not limit coverage for the length of a stay in a hospital for a mastectomy to any time period that is less than that determined to be medically necessary by the treating physician, as required by s. 641.31(31), F.S.;

10) not limit coverage for the length of a maternity or newborn stay in a hospital or for follow-up care outside the hospital to any time period less than that determined to be medically necessary by the treating provider, as required by s. 641.31(18);

11) not exclude coverage for bone marrow transplant procedures determined by the Agency for Health Care Administration to not be experimental, as required by s. 627.4236, F.S.;

12) not exclude coverage for drugs on the ground that the drug is not approved by the U.S. Food and Drug Administration, as required by s. 627.4239, F.S.;

13) give the subscriber the right to a second medical opinion as required by s. 641.51(4), F.S.;

14) allow subscribers to continue treatment from a provider after the provider's contract with the organization has been terminated, as required by s. 641.51(7), F.S.;

15) establish a procedure for resolving subscriber grievances and expedited review of urgent subscriber grievances, as required by s. 641.511, F.S.;

16) notify subscribers of their right to a review of an unresolved grievance by the Statewide Provider and Subscriber Assistance Panel, as required by s. 408.7056, F.S.;

17) provide, without prior authorization, coverage for emergency services and care, as required by s. 641.513, F.S.;

18) not require or solicit genetic information or use genetic test results for any insurance purposes, as required by s. 627.4301, F.S.;

19) pay, contest, or deny claims within the time periods required by s. 641.3155, F.S.; and

20) provide information to subscribers regarding benefits, limitations, resolving grievances, emergency services and care, treatment by non-contract providers, list of contract providers, authorization and referral process, the process used to determine whether services are medically necessary, quality assurance program, prescription drug benefits and use of a drug formulary, confidentiality and disclosure of medical records, process of determining experimental or investigational medical treatments, and process used to examine qualifications of contract providers; as required by ss. 641.31, 641.495, and 641.54, F.S.

The enforcement of the above provisions depends on the particular requirement, but one or more of the following methods of enforcement apply to each of these requirements: (1) a condition of issuance or renewal of an HMO's certificate of authority issued by DOI; (2) a condition of issuance or renewal of an HMO's provider certificate issued by AHCA; (3) administrative penalties, including fines issued by DOI or AHCA; and (4) private actions in state or federal court to enforce the terms of the HMO contract.

Statewide Subscriber and Provider Assistance Program

Section 408.7056. F.S., requires the Agency for Health Care Administration (AHCA) to establish a program to provide assistance to subscribers and providers, including those whose grievances are not resolved by a managed care entity (see definition on page 3, above) to the satisfaction of the subscriber or provider. Grievances that are submitted to the program and determined by the agency to meet the criteria for consideration are heard by a 7-member panel. The panel consists of three members employed or contracted by the agency (the manager of the Managed Care Commercial Compliance Unit, a physician consultant employed by the Department of Health, and a senior management analyst); three members employed by the department (the DOI chief of staff, the deputy insurance commissioner, and the consumer advocate); and a consumer appointed by the Governor (but no consumer member currently sits on the panel). The physician member is appointed by the Governor. Additionally, physicians who have expertise relevant to the case under consideration, must be appointed on a rotating basis. The specialist physician member is chosen from a list of 45 physicians who have agreed to participate as needed. The agency may contract

with a medical director and a primary care physician to provide the program panel with technical expertise.

All panel hearings are conducted by video conference from the Department of Management Services (DMS) Center in Tallahassee to various DMS Centers located in the state. Hearings are held at least 3 days each month. Hearings are public, unless a closed hearing is requested by the subscriber or a portion of a hearing may be closed by the panel when deliberating information of a sensitive personal nature such as information from medical records.

Following its review, the panel must make a recommendation to AHCA or DOI. The recommendation may include specific actions the managed care entity must take to comply with state laws or rules regulating such entities. A managed care entity, subscriber, or a provider acting on behalf of a subscriber that is affected by the panel's recommendation may within 10 days (72 hours for expedited grievances) after receipt of the recommendation furnish AHCA or DOI, as appropriate, written evidence in opposition to the panel's recommendation or finding of fact. The agency or the department has the discretion to adopt all, part, or none of the panel's recommendation and must do so within 30 days after the panel issues the recommendation or findings of fact by issuing a proposed order or an emergency order, in accordance with the Administrative Procedure Act. Such an order may impose a fine or sanctions, as prescribed by state law, on the managed care entity against which the grievance was filed.

A managed care entity may appeal to the Division of Administrative Hearings (DOAH) a proposed or emergency order issued by AHCA or DOI against it when the order only requires the entity to take a specific action, unless all parties agree otherwise. The Division of Administrative Hearings must hold a summary hearing for consideration of such orders. If the managed care entity does not prevail in its appeal to DOAH, it must pay AHCA's or DOI's reasonable costs and attorney's fees incurred as a result of the proceeding. Subscribers are not permitted to appeal panel recommendations to DOAH.

The types of grievances filed by subscribers include (1) excluded benefits, (2) medical necessity, (3) unauthorized out-of-network provider, (4) formulary, (5) billing, (6) contract interpretation, and (7) enrollment/disenrollment. AHCA reports that it provided the following summary of cases for the state 1998-1999 fiscal year.

AHCA reports that 49 percent of cases have been found in favor of the subscriber since 1994, for cases heard through February 1999. More recently, AHCA reports that 38 percent of cases were found in favor of the subscriber in fiscal year 1998-99, and that 53 percent of cases were found in favor of the subscriber in the current 1999-00 fiscal year through the end of February 2000.

According to AHCA staff, managed care entities have appealed 11 orders, according to agency records. Of these 11 appealed orders, 2 cases were settled before trial in favor of the HMO; 5 cases were settled before trial in favor of the subscriber; 1 case was settled during the trial, in favor of the subscriber; 1 case was adjudicated in favor of the subscriber; and 2 cases were dismissed because the HMO was placed in receivership.

Current Liability of Managed Care Plans

Lawsuits filed against any person or organization seeking to hold that person liable for harmful conduct are typically based on common law theories of liability recognized by the courts. In addition, state and federal statutes create various causes of action that may not otherwise be recognized under common law. Lawsuits against managed care plans based on common law theories of liability face various legal obstacles, but an increasing number of cases throughout the country have been successful in overcoming such obstacles. A few states have enacted statutory causes of action against managed care plans.

In some states, managed care plans can avoid lawsuits under state laws that prohibit the "corporate practice of medicine," interpreted by many courts as barring suits against HMOs and other health plans on the ground that HMOs and other corporations cannot be sued for medical malpractice if they are prohibited from "practicing medicine."

In 1961, Florida authorized licensed health care professionals to practice under a corporate entity with the passage of the Professional Services Corporation Act codified in chapter 621, Florida Statutes. The Professional Services Corporation Act (s. 621.15, F.S., (1961)) provided that all laws in conflict with the act are repealed, and in effect, it repealed any statute which prohibited professions from practicing under a corporate entity. Under this chapter, a "professional service corporation" is defined to mean a corporation which is organized for the sole and specific purpose of rendering professional services and which has as its shareholders only other professional corporations, professional limited liability companies, or individuals who themselves are duly licensed or otherwise legally authorized to render the same professional service as the corporation. Under the Professional Services Corporation Act, all shareholders must be licensed members of the profession or otherwise legally authorized to render the same specific professional services as those for which the corporation was incorporated, but does not specifically require the officers or directors of corporations to members of the same profession.

In Florida there is no legal ban on the corporate practice of medicine. It is unclear whether a court at some future date, may interpret the medical practice act and the practice act of other health care professionals listed s. 641.51(3), F.S., to recognize a ban on the corporate practice of medicine.

Theories of liability that have been pursued against HMOs and managed care entities in other states, with varying degrees of success, include: (1) medical malpractice or other direct negligence liability for acts of the entity, particularly utilization review activities, (2) vicarious liability for acts of individuals, either through "respondeat superior" or ostensible agency, (3) direct corporate liability for a non-delegable duty, and (4) intentional misrepresentation or fraud. There has been no Florida appellate court decision that has held an HMO liable in a civil negligence or malpractice action, but cases from other jurisdictions have done so under various theories.

The states of Texas, California, and Georgia have enacted statutes creating specific causes of action against HMOs and other health plans. Texas was the first state to enact such a law, in 1997, followed by California and Georgia in 1999. These laws give individuals the right to sue health insurance carriers, HMOs, and managed care entities if their failure to exercise ordinary care results in patient injury. Such health plans are liable for damages for harm to an insured or enrollee proximately caused by the entity's failure to exercise ordinary care. Additionally, the

entity is liable for damages for harm proximately caused by the health care treatment decisions made by its employees, agents, ostensible agents, or representatives who are acting on its behalf.

The current Florida law, s. 624.155, F.S., provides a statutory civil remedy cause of action against *insurers*, enacted in 1982 ("civil remedy statute"). This section authorizes any person to bring a civil action against an insurer for violation of specified practices, most of which are prohibited practices listed in the Unfair Insurance Trade Practices section of the Insurance Code, plus other acts specified in the section. One of the acts which give rise to a civil action against an insurer is the following:

> *Not attempting in good faith to settle claims when, under all the circumstances, it could and should have done so, had it acted fairly and honestly toward its insured and with due regard for her or his interests*; [s. 624.155(1)(b)1., F.S.]

An insurer found in a suit under the civil remedy statute to be in violation of any of the specified acts is liable for damages, court costs, and reasonable attorney's fees incurred by the plaintiff. 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). The statute provides that punitive damages may not be awarded unless the acts giving rise to the violation occur with such frequency as to indicate a general business practice and are willful, wanton and malicious, or in reckless disregard for the rights of any insured. The statute requires that 60 days written notice be provided to the insurer and that no action shall lie if the damages are paid or the circumstances giving rise to the violation are corrected within this 60-day period.

However, with regard to health plan liability under the Florida civil remedy statute, two important restrictions apply. First, the statute has *no applicability to HMOs*, since it applies only to acts against an "insurer" (and s. 641.201, F.S., exempts HMOs from Insurance Code provisions outside of chapter 641). Secondly, even as to health insurers, an important exemption applies:

> *This section shall not be construed . . . to create a cause of action when a health insurer refuses to pay a claim for reimbursement on the ground that the charge for a service was unreasonably high or <u>that the service provided was not medically necessary</u>.* [s. 624.155(5), F.S., (underscoring added)]

In 1996, the Florida Legislature passed CS/HB 1853 which created a statutory cause of action against HMOs, similar to the civil remedy statute applicable to insurers, discussed above. This bill was vetoed by Governor Chiles on May 28, 1996. The Governor's veto message stated that one of his top priorities was to bring spiraling health care costs under control and that much of the success for achieving modest health care cost increases during the previous 2 years was due to the expansion of managed care and its cost discipline principles. Governor Chiles acknowledged that an expanded remedy may be needed, but questioned "whether opening up the issue to resolution through the tort system through suits for compensatory and punitive damages is in the best interest of the consumer and is best for Florida's health care system as whole. . . . I believe that it is not." The Governor recommended that instead, the Statewide Subscriber Assistance Panel be strengthened to handle grievances more quickly and to penalize HMOs which do not provide

services as ordered by the Panel. In 1998, legislation was enacted towards this goal. (See "Statewide Provider and Assistance Panel," above.)

Policy Issues Raised by Managed Care Liability Laws

The groups supporting the passage of the liability laws seek to achieve several objectives: (1) *Health plan accountability.* Supporters assert that managed care plan's decisions to deny or delay coverage influence physicians' willingness to provide treatment and when these decisions injure plan participants, plans should be held accountable. (2) *Equitable treatment*. Supporters see no justification for treating managed care plans differently from other businesses, which can be held responsible for conduct that injures customers. (3) *Injury prevention as well as compensation*. Supporters hope that the threat of litigation can encourage more appropriate managed care decisions about what is "medically necessary."

The groups opposing passage of managed care liability law raise the following concerns: (1) *Cost impact.* Opponents argue that managed care plan premiums would increase substantially because the threat of liability would force plans to cover inappropriate care and because of the potential that juries might make large financial awards because they view managed care plans as having "deep pockets." (2) *Current state of the market is fragile*. Cost and premium increases are already occurring, making managed care coverage increasingly less affordable to persons and businesses and threatening the solvency of existing HMO plans in the state. (3) *Inappropriateness of negligence remedies.* Opponents assert that seeking financial awards for negligence under tort law is not the best way to remedy disputes over plan coverage. Other mechanisms exist today, particularly the Statewide Subscriber and Assistance Panel, as a more effective, timely, and cost-efficient way to address adverse decisions by managed care entities and other consumer grievances.

ERISA Preemption

The Employee Retirement Income Security Act of 1974 (ERISA), limits the remedies available to persons covered under private sector employer plans and preempts certain state laws. Therefore, civil remedies in state courts, whether pursued under common law theories of liability or pursuant to a statutory cause of action, may be preempted by the federal ERISA law.

ERISA was enacted by Congress primarily to regulate employer pension programs. Congress provided a uniform body of laws for "employee benefit plans," which focuses on pension and retirement programs, but includes employer-sponsored insurance plans. All employer-sponsored health insurance and HMO plans, whether self-insured or fully insured, are covered by ERISA, except that the act does not apply to governmental plans and church plans. The act also has no application to individual health insurance plans.

Congress furnished ERISA with a civil enforcement clause which provides a remedy in federal court for denied employee benefits. Employees and enrollees are provided with a federal cause of action to either obtain the actual benefit that was denied, payment for the benefit, or a decree granting the administration of future benefits. State tort remedies, on the other hand, allow for pain and suffering, lost wages and cost of future medical services.

ERISA expressly preempts state laws in two ways. ERISA, in s. 502(a), authorizes a claimant to file an action in federal court to recover a benefit, enforce rights, or clarify future benefits under the terms of an employee benefit plan. This federal remedy preempts state laws that provide alternate enforcement mechanisms for employees to obtain ERISA plan benefits. If a claim challenges a denial of benefits due under the terms of the plan, courts have generally determined that the claim is preempted. But, this may depend upon the theory of liability that is pursued.

A state law may also be preempted by ERISA if it "relates to" an employee benefit plan under section 514(a). However, this section is limited by section 514(b)(2) which preserves any state law "which regulates insurance." The U.S. Supreme Court, in *Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. 724 (1985), held that a state mandated benefit requirement for health insurance policies was not preempted by ERISA. The Court stated that the regulation of substantive terms of insurance contracts is within the savings clause as that "which regulates insurance."

Subsequent Supreme Court and federal appellate court decisions have involved a complicated and often conflicting analysis of whether a state law relates to an employee benefit plan and whether it is saved from preemption as regulating insurance, and other related theories of analysis. Some cases rely on the distinction made in the 1990 Supreme Court case of *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), in which the Court observed that Congress intended for ERISA to preempt state laws pertaining to the *administration* of employee-benefit plans while acquiescing to state regulation pertaining to the *quality of care* that the benefits provided.

The Supreme Court has more recently emphasized the traditional powers of the state, notably in the 1995 decision of *New York Conference of Blue Cross v. Travelers Insurance*, 514 U.S. 645 (1995). In *Travelers*, Justice Souter, writing for the Court, began his analysis of ERISA preemption by stating that in areas traditionally regulated by the states, the historic police powers of the states may not be superseded by the federal act unless this was the clear and manifest intent of Congress. The Court also stated that "nothing in the language or [ERISA] or in the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern."

The issue of whether the Texas Health Care Liability Act was preempted by ERISA was determined by the U.S. District Court for the Southern District of Texas in *Corporate Health Insurance Inc. v. The Texas Department of Insurance* (No. H-97-2072, 1998). The Court noted that state laws that provide alternate enforcement mechanisms for employees to obtain ERISA plan benefits are preempted, citing *Travelers*. However, the Court determined that the civil liability provision of the act provided a cause of action for challenging the *quality* of benefits received and that such a lawsuit would not create an alternate enforcement mechanism for employees to obtain ERISA benefits. Whether a claim is seeking a review of an adverse benefit determination or, instead, seeking to secure quality coverage should be determined on a case-by-case-basis, according to the Court. However, the Court also determined that the provisions for review of an adverse determination by an independent review organization improperly mandated the administration of employee benefits and were preempted by ERISA. But, the Court determined that such provisions were severable from the civil liability provisions of the act.

III. Effect of Proposed Changes:

Section 1 (creates an unnumbered statute) and names the act the Managed Care Organization's Patient's Bill of Rights."

Section 2 (creates an unnumbered statute) and provides legislative findings and intent that the health, safety, and welfare of the people of this state are fundamental state interests and that the manner in which health care is provided has a direct impact upon the health, safety, and welfare of state residents. The bill declares that the Legislature intends that the act apply to all *managed care organizations* (MCOs), defined to include health insurance carriers; health maintenance organizations; health service plans; other managed care entities that provide health care or health benefits; and entities regulated under chapters 624 through 631, F.S., and chapter 641, F.S., [in the Florida Insurance Code] which provide health care benefits. The terms *health service plans* and *managed care entities* are not defined and their meaning is unclear. MCOs are deemed to engage in the business of insurance in Florida as that term is defined under the McCarran-Ferguson Act, (which provides that state regulation of the business of insurance is not preempted by federal law, unless otherwise specified in federal law).

The bill declares that managed care organizations (MCOs) owe a *fiduciary duty* to the people of Florida to ensure appropriate quality health care and health benefits. This section also states that the act creates substantive rights for quality health care and health benefits and provides remedies under state law for persons who are harmed by the failure of a MCO to meet appropriate standards for care and benefits guaranteed under this act. Other legislative intent is provided in the bill.

Even though this section provides legislative findings and intent that the act creates substantive rights and remedies against a *managed care organization*, defined to include many entities in addition to HMOs, the only specific rights provided in this act are in Section 3, below, which is limited to subscribers of HMOs. Section 2 also provides that managed care organizations have a *fiduciary duty* to ensure appropriate quality health care and health benefits. But, again, the only specific rights in the bill that would clearly authorize a right of action are limited to HMOs and limited to a violation of one of 20 current statutory requirements specified in that section. However, the intent language might be interpreted to provide legislative support for lawsuits against other managed care organizations and lawsuits based on broader grounds than the specific violations listed.

Section 3 creates s. 641.275, F.S., titled, "Subscriber's rights and responsibilities under health maintenance contracts; required notice." The bill provides that it is the intent of the Legislature that the rights and responsibilities of subscribers who are covered under HMO contracts be recognized and summarized in a statement of subscriber rights, which this section provides. The bill effectively re-states current law by stating that an HMO is prohibited from requiring a subscriber to waive his or her rights as a condition of coverage or treatment and must operate in conformity with such rights.

The bill requires that each HMO provide subscribers with a copy of their rights and responsibilities as set forth in this section in such form as approved by the department.

The 20 rights of HMO subscribers specified in this section are the same 20 requirements for HMOs that are listed in Present Situation of this analysis, on page 5, above. The bill states that this section provides a summary of selected statutory requirements for HMOs and does not alter the requirements of the cited statutory provisions.

The list of *responsibilities* created by the bill provide that it is the responsibility of: (1) patients and providers to provide accurate and complete information about the patient's health status; (2) a patient to report unexpected changes in his or her condition; (3) a patient to report to the physician whether he or she understands a contemplated medical course of action and what is expected of him or her; (4) a patient to follow the treatment plan recommended; (5) a patient to keep appointments and notify, as appropriate, when unable to keep an appointment; (6) a patient to follow the MCO's procedures for selecting a primary care physician and obtaining referrals; (7) a patient to read and ensure accuracy of information submitted on an application and to not sign any blank, incomplete, or inaccurate form; (8) a patient to read and understand the contract of his or her MCO; (9) a patient to pay the monthly premium, even if the patient is involved in a financial dispute with the MCO; (10) a patient to pay his or her coinsurance, deductibles, or copayments; and (11) a patient to arrange for prior approval before accepting care from a noncontract provider, except as authorized under state law, and for understanding the financial consequences of failing to obtain prior approval.

The bill does not specify the consequences for the failure of a patient or provider to meet his or her responsibilities.

Section 4 (creates an unnumbered statute) and creates a statutory cause of action against an MCO or provider for a person whose rights, as established in s. 641.275, F.S., are violated by the MCO or provider. Such actions may also be brought by the personal representative of the estate of a deceased person.

Even though this section provides that it is providing a cause of action against *managed care organizations* which is defined in section 2 to include health insurers and other entities in addition to HMOs, the only rights specified in this section are those provided in s. 641.275, F.S., which is limited to subscribers of HMOs. Therefore, the bill is unclear and inconsistent on this important issue.

That being stated, a person whose rights have been violated may bring an action in a court of competent jurisdiction to enforce those rights, as established in s. 641.275, F.S., through recovery of actual and punitive damages for all reasonably foreseeable harm caused by the violation of such rights, in addition to other specified grounds for recovery of damages. Damages, as provided in the bill, are expressly exempted from limitation by other state law. A prevailing plaintiff may recover reasonable attorney's fees, costs of the action, and damages, unless the court determines the plaintiff has acted in bad faith, with malicious purpose, or there was a complete absence of a justiciable issue of law or fact. A prevailing defendant may claim reasonable attorney's fees, as provided under existing law, s. 57.105, F.S. The remedies provided for are expressly deemed

remedial and are in addition to and cumulative with all other legal, equitable, administrative, contractual, or informal remedies available to the people of Florida or state agencies.

As a condition of bringing an action under this section, the patient must submit a written grievance to the MCO and receive a final disposition of the grievance from the MCO, or must comply with other procedural requirements relating to processing of internal grievances. If a patient attempts to file a lawsuit to litigate against an MCO before meeting these conditions and harm to the patient has not already occurred or is not imminent, the court may not dismiss the action, but may: (1) order the patient to complete the MCO's internal grievance procedure, as required in the bill; (2) require the patient to give 60-days' written notice, as required by the bill, to the MCO of the patient's intent to pursue a civil action for a violation of the MCO's patient bill of rights; or (3) the court may postpone court action for not more than 90 days to allow for completion of the internal grievance process. A patient also has the option, under the bill, to pursue a court challenge for nonmonetary relief without first completing the internal grievance process prior to initiating litigation if immediate relief is necessary to prevent potential death or serious bodily harm. The court is required to provide an expedited hearing to resolve the matter in a manner designed to avoid potential death or serious bodily harm.

An adverse adjudication against a defendant renders such a defendant subject to the greater of: (1) liability for actual and punitive damages, as provided in the bill or (2) $500 per violation of the MCO's patient's bill of rights. In either instance, the defendant is also liable for court costs and reasonable attorney's fees incurred by the plaintiff.

Employers, employees of the patient's employer, and certain specified organizations are explicitly excluded from liability, unless the employer or organization is the patient's managed care entity and makes coverage determinations under a managed care plan.

Section 5 is a severability clause, if any provision or its application is held invalid.

Section 6 provides that the act shall take effect July 1, 2000, and shall apply to contracts issued or renewed on or after that date.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill exposes HMOs to civil liability for actual damages, punitive damages, and attorney's fees for a violation of specified current statutory requirements. The bill may also be interpreted to expose managed care organizations, as defined, to civil liability. The costs of judgments or settlements of such lawsuits would result in higher premiums to policyholders. The threat of such lawsuits and potential liability may also result in a relaxation of cost containment measures utilized by managed care plans and a greater allowance for policyholders and subscribers to obtain desired treatment. The threat of such costs may also reduce the number of managed care entities offering coverage in the state.

Persons injured by a violation of the rights specified in this act would be entitled to actual damages, punitive damages, and attorney's fees. HMO subscribers (and, possibly, managed care members) may also be more likely to have certain treatments and procedures authorized by MCOs due to the threat of liability.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

Even though section 4 states that it is providing a cause of action against *managed care organizations* which is defined in section 2 to include health insurers and other entities in addition to HMOs, the only rights specified in this section are those provided in s. 641.275, F.S. (section 3 of the bill), which is limited to subscribers of HMOs. Similarly, section 2 provides legislative findings and intent that the act creates substantive rights and remedies against a *managed care organization*, defined to include many entities in addition to HMOs. But, the only specific rights provided in this act are in Section 3, which is limited to subscribers of HMOs. Therefore, the bill is unclear and inconsistent on this important issue.

The definition of managed care organizations, includes (among other entities) health service plans, and other managed care entities that provide health care or health benefits. The terms *health service plans* and *managed care entities* are not defined and their meaning is unclear.

VII. Related Issues:

Causes of action pursued under this act may be preempted by the federal ERISA law. See the discussion of "ERISA Preemption" in Present Situation.

VIII. Amendments:

None.