SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

BILL: CS/SB 836

SPONSOR: Banking and Insurance Committee, Senator Crist and others

SUBJECT: Health Insurance Contracts-Unfair Methods of Competition and Unfair or Deceptive Acts or Practices

DATE: March 13, 2001 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Emrich	Deffenbaugh	BI	Favorable/CS
2.			HC	
3.				
4.				
5.				
6.				

I. Summary:

Committee Substitute for Senate Bill 836 prohibits a health insurer or a health maintenance organization (HMO) from requiring a health care provider, who is currently under contract with the subject insurer or HMO, to accept the terms of other health care provider contracts as a condition of continuing or renewing the initial contract. It provides than any contract provision that violates this section is void. The bill applies these provisions to physicians, osteopaths, chiropractors, podiatrists, and dentists, but not to hospitals. It further states that a violation of this section is not subject to the criminal penalty provision under s. 624.15, F.S. That section subjects entities to criminal prosecution, e.g., a second degree misdemeanor, for willfully violating any provision of the Insurance Code.

This bill substantially amends sections 627.6474, 627.662, and 641.315, Florida Statutes.

II. Present Situation:

Background - All Products Clause

Over the past several years' physicians have become concerned that some insurance companies and health maintenance organizations (HMOs) have utilized "all products" clauses in their provider contracts. In general, such a clause requires the health care provider, as a condition of participating, or continuing to participate, in any of the health plan products, that the provider participate in *all* of the health plan's current or future health plan products. Oftentimes, such "all products" or "all or nothing" clauses are non-negotiable and, as noted by the Florida Medical Association (FMA), are unacceptable for several reasons: physicians are forced to provide services at below market rates; such provisions result in shortchanging consumers through less

market competition; these provisions require physicians to accept future contracts with unknown and unpredictable business risk; and, these clauses unfairly keep competing health plans out of the marketplace.

Further, according to the FMA, health plan products differ substantially in operation. For example, a physician may feel comfortable participating in a PPO (preferred provider organization) product, but may have valid reasons for not wanting to participate in an HMO product, which is a dramatically different product that requires physicians to assume insurance risk. A risk contract may not be a viable business option for smaller practices with smaller patient basis because of practice size, patient risk or other valid actuarial and business concerns. (For counter-arguments, see *Florida*, below.)

Under certain circumstances utilization of the all products clause may result in coercion or intimidation resulting in a monopoly or may impose competitive restraints with respect to the "business of insurance" within the meaning of either the unfair and deceptive trade provisions of the Insurance Code (s. 626.9541(1)(d), F.S.) or the antitrust law (ch. 542, F.S.). In at least one case involving a large insurer, this issue was brought to the attention of the Florida Department of Insurance and the Attorney General. However, it was never determined as to whether a monopoly or competitive restraint existed. This issue has not been fully researched by committee staff.

Other States

In response to the concerns of physician groups, a total of five states have prohibited all-products clauses in health care provider contracts. These states are: Alaska, Kentucky, Maryland, Minnesota, and Virginia. In Nevada, the Commissioner of Insurance prohibited all products clause provisions through the regulatory authority of the department. Such a clause is deemed to be coercive and violators are subject to the imposition of the state's unfair trade practice act and are fined per incident. The Nevada Commissioner found the clause to be violative of the act because it required a provider to become a member of a provider network for which he or she did not wish to contract in order to maintain a preferred contractual status with the organization. The Nevada provision only applies to contracts between HMOs and providers.

Florida

In Florida, Aetna/U.S. Healthcare, one of the largest insurance companies and health maintenance organizations in the state, recently announced that it would relax its all products policy and allow independently contracted non-hospital-based physicians to choose to participate in either or both Aetna HMO-based or Aetna PPO-based plans by notifying Aetna 90 days prior to their contract renewal.[1] According to company representatives, Aetna/U.S. Healthcare decided to eliminate its all products clause to respond to physician concerns and to improve its relationships with the physician community. The company will not change its all products policy as to hospital-based physicians because the company believes it enables physicians to best maintain continuity of care and sustain longstanding physician-patient relationships. The

[1] December 19, 2000, Aetna/U.S. Healthcare news release.

company still encourages physicians to participate in all Aetna/U.S. Healthcare products to give its members the maximum choice of physicians regardless of their type of health plan.

Committee staff has found that the larger health care plans that cover most Floridians do not generally utilize all product provisions in their provider contracts. However, representatives from these same health plans assert that under limited circumstances, all product provisions are a necessary tool to utilize under certain situations. For example, some plans may use such provisions when contracting with PHOs (physician hospital organizations) because not doing so would result in the PHO physician being able to pick and choose which patients to treat in a hospital setting. If physicians were allowed such choice, Medicaid and Medicare patients would most likely suffer, as would patients residing in rural areas.

More fundamentally, representatives with health plans assert that this legislation impermissibly intrudes into legitimate contractual negotiations by HMOs and insurance companies with providers at the time of continuation or renewal of the provider contract. For example, insurers and HMOs would be prohibited from requiring participation by a physician in other plans, at the time a physician renews his or her contract.

III. Effect of Proposed Changes:

Section 1. Creates s. 627.6474, F.S., to prohibit a health insurer from requiring a health care provider, who is currently under contract with the subject insurer, to accept the terms of other health care provider contracts as a condition of continuing or renewing the initial contract. It provides than any contract provision that violates this section is void. The bill applies these provisions to physicians (ch. 458), osteopaths (ch. 459), chiropractors (ch. 460), podiatrists (ch. 461), and dentists (ch. 466), but not to hospitals. It further states that a violation of this section is not subject to the criminal penalty provision under s. 624.15, F.S. That section subjects entities to criminal prosecution, e.g., a second degree misdemeanor, for willfully violating any provision of the Insurance Code.

Section 2. Amends s. 627.662, F.S., to cross-reference the provisions contained in s. 626.6474, F.S. (Section 1 of the bill), to apply to group health insurance, blanket health insurance, and franchise health insurance.

Section 3. Amends s. 641.315, F.S., relating to health maintenance organization (HMO) provider contracts, to prohibit an HMO from requiring a health care provider, who is currently under contract with the subject HMO, to accept the terms of other health care provider contracts as a condition of continuing or renewing the initial contract. It provides than any contract provision that violates this section is void. The bill applies these provisions to physicians (ch. 458), osteopaths (ch. 459), chiropractors (ch. 460), podiatrists (ch. 461), and dentists (ch. 466), but not to hospitals. It further states that a violation of this section is not subject to the criminal penalty provision under s. 624.15, F.S. That section subjects entities to criminal prosecution, e.g., a second degree misdemeanor, for willfully violating any provision of the Insurance Code.

While the bill does prohibit contract renewals being conditioned on provider participation in other plans or requiring future participation by the provider in other plans, it does allow insurers

and HMOs to "bundle" all their plans in a health care provider contract for those providers who are *not currently* in any of their plans.

Section 4. Provides that the act shall take effect July 1, 2001, and shall apply to contracts entered into 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:

Health care providers would benefit under the provisions of this bill because they could not be required to accept renewal contracts with insurers and HMOs that may have unknown or unpredictable risk, or less advantageous terms, as a condition of continuing to participate in the insurer or HMO contract. However, patients may have their choices of providers limited under the provisions of the bill.

This bill would negatively impact insurance companies and HMOs because they would be precluded from utilizing all product provisions in their renewal contracts.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.