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 19, 2001 REVISED: 3/21/01

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

I. Summary:

Committee Substitute for Senate Bill 836 prohibits a health insurer or a health maintenance organization 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, osteopaths, chiropractors, podiatrists, and dentists. It further states that a violation of this section is not subject to the criminal penalty provisions of s. 624.15, F.S., which make it a second-degree misdemeanor to willfully violate any provision of the Insurance Code.

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

II. Present Situation:

All Products Clause

Physicians have expressed concern over the past few years regarding so-called "all products" clauses in some health insurance and health maintenance organization (HMO) provider contracts. An all products clause typically requires the health care provider, as a condition of participating, or continuing to participate, in any of the health plan products, to participate in *all* of the health plan's current or future health plan products. The Florida Medical Association (FMA) has argued that such all products clauses are problematic because: physicians may be forced to provide some services at below market rates; such "all or nothing" contracts harm consumers through suppressed market competition; physicians may have to accept future contracts with unknown

and unpredictable business risk; and competing health plans may be unfairly kept out of the marketplace.

According to the FMA, physicians have been critical of such an all-or-nothing approach because of the wide operational disparities among different health plan products. For example, a physician may feel comfortable participating in a PPO (preferred provider organization) product, but may find that a related commercial, Medicare or Medicaid HMO product is operationally cumbersome, high-risk, or less profitable. An HMO risk contract may not be a viable business option for smaller practices due to limited practice size and patient base, enhanced patient acuity or other actuarial and business concerns. A Medicaid plan may not be financially attractive for some providers given the unique demands of the patient population, requisite economies of scale, and billing system demands.

Under certain circumstances utilization of an all products clause may result in excessive competitive restraints on 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 (chapter 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 unfair competitive restraint existed.

From the standpoint of the health insurers, all products clauses may serve to protect individual subscribers and ensure continuity of care. Subscribers often move between and among insurance plans, possibly from an indemnity plan, to a PPO, to an HMO. If providers were to tailor their practices to but a single insurance product line, the above-mentioned patients would necessarily be forced to change doctors three times. Further, permitting providers an unlimited option to "cherry pick" insurance plans might be detrimental to elderly and poor patients.

As to antitrust issues, providers may be as likely to engage in unfair competition as insurers. In many markets, a single specialist (or single group practice of specialists) is the only option for insurers and patients. Such a sole source provider group can demand that it be offered only the most favorable insurance plans, such as a PPO product, and reject more restrictive or less profitable plans such as HMO products. This would necessarily preclude subscriber choice and lock all patients in the area into the PPO favored by the provider or provider group.

Other States

In response to the concerns of physician groups, Alaska, Kentucky, Maryland, Minnesota, Nevada and Virginia have prohibited all products clauses in health care provider contracts. In Nevada, all HMO products clauses are deemed to be coercive and subject HMOs to the imposition of the state's unfair trade practice act, to include potential fines per incident. The Nevada Commissioner of Insurance found the clauses to be violative of that state's laws because they may require a provider to become a member of an HMO network in which he or she did not wish to participate, in order to maintain a preferred contractual status with the organization.

Florida

In Florida, Aetna/U.S. Healthcare, one of the largest insurance companies and HMOs 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 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.

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.

III. Effect of Proposed Changes:

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

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 HMO provider contracts, to prohibit an HMO from requiring a health care provider currently under contract to accept the terms of other health care provider contracts as a condition of continuing or renewing the initial contract. It provides

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

that any contract provision that violates this section is void. The bill applies these provisions to physicians (chapter 458, F.S.), osteopaths (chapter 459, F.S.), chiropractors (chapter 460, F.S.), podiatrists (chapter 461, F.S.), and dentists (chapter 466, F.S.). It further states that a violation of this section is not subject to the criminal penalties for willfully violating any provision of the Insurance Code, a second-degree misdemeanor, under s. 624.15, F.S.

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* under contract.

Section 4. Provides that the act, if it becomes law, 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:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Art. VII, s. 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Art. I, s. 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Art. III, s. 19(f) of the Florida Constitution.

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.

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

Health insurance and HMO subscribers may have their choices of insurance plans and providers limited under the provisions of the bill.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

Lines 19 through 23 on page 1 of the bill, and lines 4 through 8 on page 2 of the bill are incomplete sentences. These technical deficiencies may be remedied by inserting the term "of the original contract" in front of the period on line 23 of page 1, and in front of the period on line 8 of page 2.

VII. Related Issues:

None.

VIII. Amendments:

#1 by Health, Aging and Long-Term Care:
Provides that the continuation or renewal language of the bill refers to the parties' contract, on line 23 of page 1, and line 8 of page 2.