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HOUSE OF REPRESENTATIVES
AS REVISED BY THE COMMITTEE ON
INSURANCE
ANALYSIS

BILL #: HB 343

RELATING TO: Managed Care

SPONSOR(S): Representative Fasano and others

TIED BILL(S):

ORIGINATING COMMITTEE(S)/COUNCIL(S)/COMMITTEE(S) OF REFERENCE:

(1) HEALTH PROMOTION YEAS 10 NAYS 0
(2) INSURANCE YEAS 13 NAYS 0
(3) JUDICIAL OVERSIGHT
(4) COUNCIL FOR HEALTHY COMMUNITIES
(5)

I. SUMMARY:

HB 343 prohibits a health maintenance organization (HMO) from terminating a provider contract except under specified circumstances. The bill allows patients to disenroll from the HMO if their health care practitioner's provider contract is terminated by the HMO and enroll in another health plan without penalty. The bill prohibits an HMO from advertising the availability of specific providers if the providers will not be available for the entire duration of the coverage period, except as specified. The bill provides Legislative findings and intent.

The bill takes effect on July 1, 2002, and applies to all HMO contracts entered into or renewed after that date.

On November 27, 2001, the Committee on Health Promotion adopted a "remove everything" amendment. On January 8, 2002, the Committee on Insurance adopted a substitute "remove everything" amendment. Both amendments are traveling with the bill. See Section VI of this analysis for a detailed explanation of these traveling amendments.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes []	No []	N/A [x]
2.	Lower Taxes	Yes []	No []	N/A [x]
3.	Individual Freedom	Yes [x]	No []	N/A []
4.	Personal Responsibility	Yes [x]	No []	N/A []
5.	Family Empowerment	Yes [x]	No []	N/A []

For any principle that received a "no" above, please explain:

B. PRESENT SITUATION:

Background

The Census Bureau reported that in 1999, nationally, 63 percent of Americans obtained their health insurance coverage through employer-based plans. [Source: *Racial and Ethnic Disparities In Access to Health Insurance and Health Care,* UCLA Center for Health Policy and Research and the Kaiser Family Foundation, 2000; http://www.managedcaremag.com] According to the Florida Health Insurance Study (a state-Legislature funded study conducted in 1998 and 1999 of Florida's uninsured population), 62.7 percent of Floridians report that they had health insurance coverage through a current or former employer or union (other than the military). In addition, the Florida study found that employers with one to nine employees had the highest rate of uninsured (24.6 percent); while employers with 100 or more employees had the lowest rate of uninsured (4.76 percent). [Source: http://www.fdhc.state.fl.us/Text/index.html]

As of March 31, 2001, approximately 4.8 million or 31 percent of Floridians were enrolled in HMOs. This included approximately 3,600,241 in commercial HMOs, 589,729 in Medicare HMOs, and 515,152 in Medicaid HMOs. According to the Department of Insurance, total HMO enrollment has declined by 33,108 subscribers since the previous year. [Source: Department of Insurance]

Typically, HMOs and some health insurers enter into contracts with health care providers who agree to act as participating providers under a managed care plan. A managed-care network is created by an HMO through its contracts with hospitals and/or physicians and other providers. The managed-care organization's name is on the providers' contract. Contracts can be with individual providers or with provider groups. A managed-care network can be a local, regional, or national organization. In many cases, the managed-care network enters into an "evergreen" contract with the provider or provider group. An "evergreen contract" is a managed care contract that renews automatically after the initial term has been completed, often with subsequent addendums to the contract, relating to reimbursement, for example.

Florida law provides some protections to managed care providers ranging from prompt payment of claims and dispute resolution procedures to contract cancellation or termination provisions. Recently, there have been complaints by some managed care providers regarding contract cancellations and one provider filed a complaint in the Circuit Court in Manatee County against Blue Cross and Blue Shield of Florida and Health Options, Inc. (Case No. 2001 CA-2628), alleging

tortious interference of contract, breach of implied covenant of good faith and fair dealing, and unfair and deceptive trade practices by the companies (a final decision has not yet been rendered in this case).

In general, a termination of a health care provider's contract is primarily subject to the terms and conditions of the provider's contract with the HMO. Providers can be terminated both "for cause" (permitting the HMO to immediately end its relationship with the provider for specified reasons as provided for within the contract) or "without cause" (no reason given). Typically, "for cause" reasons include:

- Suspension, revocation, or termination of a practitioner's medical license or hospital staff privileges;
- Cancellation or reduction of professional liability insurance;
- Conviction of a felony offense;
- Invocation of disciplinary action by any court or regulatory agency; or
- A material breach of the contract.

However, it is the termination "without cause" which typically generates the most controversy. This type of provision allows either party, the HMO or the provider, to end the contract for no reason by providing advanced written notice to the other party as specified in the contract and by statute.

As managed care continues to grow, the relationships among hospitals, physicians, and other providers, and other healthcare professionals are undergoing change and, in many cases, strain. Increasingly providers are reporting to their provider associations that insurers and HMOs are terminating contracts with providers "without cause" apparently based on the increased cost of coverage when providers refer patients to out-of-network providers of services including x-rays, ambulatory surgery, laboratories, etc. In June 2001, the Florida Medical Association sent a letter to the Department of Insurance requesting an investigation by the department on behalf of a Florida terminated physician claiming that the insurer had taken an "adverse action against a provider" as an unfair method of competition and unfair or deceptive act or practice in violation of s. 641.3903(7), F.S., which provides that "[a]ny retaliatory action by a health maintenance organization against a contracted provider, including, but not limited to, termination of a contract with the provider, on the basis that the provider communicated information to the provider's patient regarding medical care or treatment options for the patient when the provider deems knowledge of such information by the patient to be in the best interest of the patient." The complaint is still under investigation by the department.

Health Maintenance Organizations – Contract-Related Statutory Provisions

Health maintenance organizations in Florida are jointly regulated under parts I and III of ch. 641, F.S., by the Agency for Health Care Administration (agency) and the Department of Insurance (department). The agency administers HMO quality-of-care practices under part III, while the department regulates contractual, financial, and other operational requirements relating to HMOs under part I.

HMO contracts with providers must include a provision that the HMO will provide 60 days' advance written notice to the provider and the department before canceling a provider contract "without cause." In addition, the provider must also give 60 days' advance written notice to the HMO and the department before canceling their contract "for any reason." In addition, the HMO, after receiving the provider's written notice may, if requested by the provider, terminate the contract in less than 60 days if the HMO is not financially impaired or insolvent. The contract must also

provide that nonpayment of goods or services rendered by the provider to the HMO is not a valid reason for avoiding the 60-day advance written notice cancellation provision. [s. 641.315(2), F.S.]

HMO-provider contracts are prohibited from containing "gag clauses" meant to restrict the provider's ability to communicate with a patient concerning medical care or treatment options for the patient when the provider feels such information is in the best interest of the health of the patient. [s. 641.315(5), F.S.] The HMO is also prohibited from taking any retaliatory action against a contracted provider, including, but not limited to, termination of a contract with the provider, because the provider communicated with his or her patients information regarding medical care or treatment. Such action by an HMO is defined as "an unfair method of competition or deceptive practice." [s. 641.3903(14), F.S.]

When an HMO-provider contract is terminated "without cause", coverage is required to continue for subscribers who were receiving active treatment, when medically necessary, through the completion of the treatment of the condition for which the subscriber was receiving the care at the time of the termination, until the subscriber selects another treating provider, or during the next open enrollment period offered by the plan, whichever is longer, but in no case longer than 6 months after termination of the contract. With regard to a subscriber who has initiated a course of prenatal care, regardless of the trimester in which care was initiated, the contract must allow the continuation of care and coverage until the completion of post-partum care. However, this provision does not require a provider to continue providing care to a subscriber who is abusive, noncompliant, or in arrears in payments for services provided. In addition, for care continued under this provision, both the HMO and the provider continue to be bound by the terms of the terminated contract, excluding any changes made to the contract within 30 days before termination of a contract unless agreed to by both parties. [s. 641.51(8), F.S.]

An HMO or provider is prohibited from terminating a contract with a provider or HMO, unless the party terminating the contract provides a written reason for doing so, including termination for business reasons. However, the written reason for the termination does not create a new administrative or civil action and is specifically excluded as substantive evidence in any such action, however such information may be used for impeachment purposes. [s. 641.315(7), F.S.]

An HMO or insurer is prohibited from including an "all products clause" in provider contracts. An "all products clause" is a contractual requirement for the provider to agree to participate in all of the products offered by that HMO or insurer, as a condition of participating in any of the health plan's products. This prohibition does not apply to providers entering into new health plan contracts or to providers in group practices. Any contract that violates this statute is deemed void. [s. 641.315(10), F.S.]

Health Maintenance Organizations – Subscriber Protections

HMO subscribers are statutorily provided certain subscriber protections as specified in s. 641.185, F.S., including the continuity of health care, even after the provider is no longer with the HMO [s. 641.51(8), F.S.]; and flexibility to transfer to another Florida HMO regardless of health status [ss. 641.228, 641.3104, 641.3107, 641.3111, 641.3921, and 641.3922, F.S.].

In addition, a health maintenance organization that issues a group health plan is required to provide for special enrollment periods, under certain circumstances, during which certain individuals are allowed to enroll in the plan (without having to wait until the plan's next regular enrollment season). [s. 641.31072, F.S.]

C. EFFECT OF PROPOSED CHANGES:

HB 343 provides the following:

- Provides Legislative intent;
- Prohibits the termination of provider contracts except for specified reasons;
- Prohibits the modification of reimbursement arrangements under contract except for specified reasons;
- Allows patients of a provider whose contract has been terminated or not renewed to immediately disenroll in that HMO and enroll in another health plan without penalty to the patient; and
- Prohibits HMOs from advertising availability of certain providers unless the provider or provider group will be available to provide care for the duration of the subsriber's coverage period.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Provides the Legislative intent for the prohibition of certain practices relating to enrolling patients in managed care plans, and makes findings, including the following:

- Patients often select a managed care plan based upon whether their physician or other health care provider is available under the plan;
- Patients are third party beneficiaries of the contracts between managed care plans and the providers of health care;
- Maintaining the physician-patient relationship is an important state interest; and
- Requiring enrollees in a managed care plan to pay for services that would have been covered under the plan but for the disruption caused by the termination of the provider contract constitutes an unfair business practice.

Section 2. Adds subsection (11) to s. 641.315, F.S., relating to provider contracts, to provide for the protection of an enrolled patient in or covered by an HMO from a disruption in his or her relationship to a contracted health care provider who is providing health care to the patient in the HMO, by prohibiting an HMO from:

- Terminating a contract;
- Modifying reimbursement arrangements under a contract,

unless:

- The health care practitioner's license has been revoked, suspended, or placed on probation; or
- The health care practitioner has been excluded as a provider of Medicaid or Medicare, as a result of a finding of fraud or illegal billing practices.

Provides that if a provider contract is terminated or not renewed, a patient of that health care practitioner may immediately disenroll in that HMO and enroll in another health plan without penalty to the patient.

Section 3. Amends subsection (13) of s. 641.3903, F.S., relating to defining unfair methods of competition and unfair or deceptive acts or practices, to prohibit an HMO from advertising the availability of any particular provider or group of providers unless the provider or group will be available to provide care to enrollees and covered family members for the duration of the coverage

period. Excludes from the definition of unfair method of competition or an unfair deceptive act or practice, the advertisement of availability of a particular provider or group who, subsequent to the advertisement, has his or her license revoked or suspended, or who is excluded as a provider of Medicaid or Medicare, and is, therefore, no longer available to provide care to enrollees for the remainder of the coverage period.

Section 4. Provides that the bill take effect July 1, 2002, and apply to all contracts entered into or renewed on or after July 1, 2002.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Unknown.

D. FISCAL COMMENTS:

None

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure 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:

A. CONSTITUTIONAL ISSUES:

None.

B. RULE-MAKING AUTHORITY:

None.

C. OTHER COMMENTS:

None.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On November 27, 2001, the Committee on Health Promotion adopted the following amendment:

Amendment by the Committee on Health Promotion ("remove everything"): The "remove everything "amendment would delete proposed legislative findings and intent and proposed changes relating to provider contracts and to unfair methods of competition. It would amend s. 641.31072, F.S., relating to special enrollment periods of HMOs, and s. 627.65615, F.S., relating to special enrollment periods of health insurers, authorizing a special enrollment period for an employee or an enrollee's dependent when the HMO terminates their individual primary care physician's contract prior to the renewal date of the group health plan. It also would amend s. 110.123, F.S., relating to the State Group Insurance Program, authorizing a special open enrollment period for an enrollee or an enrollee's dependent when the HMO terminates their individual primary care physician's contract.

On January 8, 2002, the Committee on Insurance adopted the following amendment:

Substitute Amendment by the Committee on Insurance ("remove everything") for the amendment by the Committee on Health Promotion ("remove everything"): Like the "remove everything" amendment by the Committee on Health Promotion, the substitute amendment would delete proposed legislative findings and intent, proposed changes related to provider contracts and to unfair methods of competition. It also would include a number of technical changes. The substitute amendment would make several substantive additions to that amendment.

First, for the purposes of triggering special enrollment periods under the State Group Insurance Program, it would add primary care physician contract terminations by an insurer to contract terminations by an HMO.

Second, it would add a new provision, expanding the permissible grounds for an insurer to nonrenew individual coverage to include failure to make required copayments.

Third, it would provide more operational detail concerning the proposal. When an insurer or HMO terminates an employee's primary care physician, the employee would be given the opportunity to enroll in another plan if available.

VII. SIGNATURES:

COMMITTEE ON INSURANCE:

Prepared by:	Staff Director:
Tonya Sue Chavis, J.D.	Phil E. Williams

AS REVISED BY THE COMMITTEE ON INSURANCE:

Prepared by:	Staff Director:
Stephen Hogge	Stephen Hogge