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 232

SPONSOR: Senator Latvala and others

SUBJECT: Health Maintenance Organizations: unfair trade practices and contracts

DATE: March 17, 1999 REVISED: _____ _____ _____ _____

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

I. Summary:

Committee Substitute for Senate Bill 232 declares it to be an unfair or deceptive act if a health maintenance organization (HMO) takes any retaliatory action against a health care provider for communicating information to the provider's patient regarding medical care or treatment options. This supplements the current law which prohibits a contract between a HMO and a health care provider from containing any provision restricting the provider's ability to make such communications.

The bill prohibits a HMO or health care provider from terminating a contract with a health care provider or HMO without providing the terminated party with a written reason for the contract termination, which may include termination for business reasons of the terminating party. Such notice may not be used as substantive evidence in a subsequent action relating to the termination.

The bill revises the requirement that HMOs allow subscribers to continue care with a terminated treating provider under certain circumstances. Currently, HMOs are required to allow subscribers to continue care for 60 days with a provider whose contract is terminated, other than for cause, provided the subscriber has a life-threatening condition or a disabling and degenerative condition. Each HMO must allow a subscriber who is in the third trimester of pregnancy to continue care with a terminated treating provider until completion of postpartum care.

As required by the bill, when a contract between a HMO and a treating provider is terminated by either party for any reason other than for cause, each party must allow subscribers for whom treatment was active to continue coverage when medically necessary, through completion of treatment, until the subscriber selects another treating provider, or during the next open enrollment period offered by the HMO, whichever is longer, but not to exceed 6 months after termination of the contract. A subscriber who has initiated prenatal care must be allowed to continue care until completion of postpartum care. However, these requirements do not prevent a provider from refusing to continue to provide care to a subscriber who is abusive, noncompliant, or in arrears in payments for services provided.

This bill substantially amends the following sections of the Florida Statutes: 641.3903, 641.315, and 641.51.

II. Present Situation:

Health Maintenance Organizations; Background

Health maintenance organizations (HMOs) provide a comprehensive range of health care services for a prepaid premium. Health maintenance organizations stress preventive care and make efforts to avoid unnecessary hospitalization and expensive tertiary care. Subscribers must surrender certain freedom-of-choice selections of health care providers and health-care-related services. Subscriber choice is typically restricted to a "gatekeeper" physician or other health care professional who is either an employee of, or has contracted to provide professional services on behalf of, the subscriber's HMO. Furthermore, subscribers are restricted in their choice of hospitals and other health care delivery facilities that they may utilize.

As of June 1998, more than 4.7 million Florida residents were receiving their health care coverage through commercial HMOs. Even more state residents were receiving health care coverage through other managed care programs. The number of Florida residents receiving health care coverage through managed care plans has steadily increased since the early 1980's when the state's HMO industry began to grow. Since 1988, the number of commercial HMOs has decreased from a high of 47 to the current 35, however, enrollment has increased. Enrollment in most other types of managed care programs continues to increase as well. Regulation of HMOs is divided between the Department of Insurance and the Agency for Health Care Administration (AHCA).

The Department of Insurance regulates HMO finances, contracting, and marketing activities under part I of chapter 641, F.S. The department is responsible for ensuring that these entities are financially solvent and conduct their marketing activities in accordance with guidelines contained in chapter 641, F.S. A major role the department performs in the regulation of HMOs is to ensure that the contracts under which these entities provide services do not contain terms that are inconsistent, ambiguous, or misleading. Additionally, the department is charged with ensuring that rates charged to subscribers are not excessive, inadequate, or unfairly discriminatory. Agent activities, relating to solicitation of contracts to provide HMO services, and permissive handling of HMO assets and investments, among others, are under the department’s jurisdiction as well.

The Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of chapter 641, F.S. The quality requirements under this part include: accreditation; demonstrating, to AHCA's satisfaction, that the HMO is capable of providing health care of a quality consistent with prevailing professional standards of health care delivery; establishing an ongoing internal quality assurance program; ensuring the right of HMO subscribers to receive a second medical opinion, as specified; providing grievance reporting and resolution requirements; and establishing an internal risk management program.

Present law authorizes AHCA to provide for a chapter 120, F.S., administrative hearing when it has reason to believe that a HMO has engaged in any unfair method of competition or unfair or deceptive act under s. 641.3901, F.S. If it is determined that the HMO engaged in such an unfair

or deceptive practice, then AHCA may enter a final order imposing an administrative fine, or suspend or revoke the HMOs certificate of authority to operate in Florida.

Termination of HMO Provider Contracts; Continued Care to Subscribers

In general, current Florida law does not restrict the authority of a HMO from terminating the contract of a health care provider. The allowable reasons for termination of the contract by either party would be subject to the terms of the contract itself. It is a long established rule in Florida for private employment contracts that employees may be discharged at any time, with or without cause. This provision is known as the employment-at-will rule and Florida courts have long held firm to this rule. However, exceptions to the employment-at-will provision may be made by the Legislature. For example, the current law requires that HMOs provide at least 60 days' written notice prior to canceling a contract with a health care provider, without cause, except in a case in which a patient's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action by the Board of Medicine or other governmental agency. The law also requires the health care provider to give the HMO at least 60 days' notice prior to canceling the contract, but allows the HMO and the provider to agree to terminate the contract in less than 60 days if the HMO is not financially impaired or insolvent. (s. 641.315, F.S.)

HMOs are required to allow subscribers to continue care for 60 days with a terminated treating provider when medically necessary, provided the subscriber has a life-threatening condition or a disabling and degenerative condition. Each HMO must allow a subscriber who is in the third trimester of pregnancy to continue care with a terminated treating provider until completion of postpartum care. The HMO and the provider must continue to be bound by the terms of the contract for such continued care. However, these requirements do not apply to a provider who has been terminated for cause. (s. 641.51(7), F.S.)

"Gag Clauses" Prohibited

Present law also prohibits HMO contracts with health care providers from containing any provision restricting the provider's ability to communicate 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 health of the patient. (s. 641.315(8), F.S.)

The current HMO law further provides that the professional judgment of a physician licensed under chapter 458, 459, 460, or 461, concerning the proper course of treatment of a subscriber shall not be subject to modification by a HMO, unless the course of treatment prescribed is inconsistent with the prevailing standards of medical practice in the community. (s. 641.51(3), F.S.)

III. Effect of Proposed Changes:

Section 1. Amends s. 641.3903, F.S., to declare it to be an unfair or deceptive act or practice for a HMO to take any retaliatory action against a 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 bill provides additional methods of department enforcement and sanctions against a HMO to supplement the current law that prohibits HMO contracts from containing any provision restricting the provider's ability to communicate such information.

Section 2. Amends s. 641.315, F.S., related to provider contracts, to prohibit a HMO or health care provider from terminating a contract with a health care provider or HMO unless the party terminating the contract provides the terminated party with a written reason for the contract termination, which may include termination for business reasons of the terminating party.

The bill provides that no new administrative or civil action is created by the reason provided in the notice or any other information relating to the reason for termination. Also, the bill prohibits any such information from being used as substantive evidence in any such action, but allows its use for impeachment purposes.

The bill defines "health care provider" for the purposes of this subsection to mean any physician licensed under chapter 458 (medical practice), 459 (osteopath), 460 (chiropractor), 461 (podiatrist), or 466 (dentist).

Section 3. Amends s. 641.51, F.S., to revise the law to expand and revise the requirement that HMOs allow subscribers to continue care with a terminated treating provider under certain circumstances.

Under the bill, when a contract between a HMO and a treating provider is terminated for any reason other than for cause, each party must allow subscribers for whom treatment was active to continue coverage when medically necessary, through completion of treatment of a condition for which the subscriber was receiving care at the time of the termination, until the subscriber selects another treating provider, or during the next open enrollment period offered by the HMO, whichever is longer. However, in no event would this period extend longer than 6 months after termination of the contract.

The bill also requires each party to the contract to allow a subscriber who has initiated prenatal care to continue care until completion of postpartum care.

However, the bill provides that these requirements do not prevent a provider from refusing to continue to provide care to a subscriber who is abusive, noncompliant, or in arrears in payments for services provided. The reference to "arrears in payments" apparently refers to the copayments or deductibles for which a HMO subscriber is responsible. Currently subscribers may not be held liable to any health care provider for any services covered by the HMO (s. 641.315, F.S.).

For care continued under these provisions, the HMO and the provider continue to be bound by the terms of the terminated contract. Changes made within 30 days after termination are effective only if agreed to by both parties. (The relevance of this 30-day period is not clear. It may imply that the parties are prohibited from mutually agreeing to change the terms of the contract after this 30-day period.)

Section 4. Provides that the act takes effect upon becoming a law and applies only to contracts entered into after the effective 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:

HMOs and contract physicians, whichever is the terminated party, and their subscriber patients, would have the benefit of maintaining coverage under the terms of the terminated contract as provided by the bill, when the other party terminates the contract.

To the extent that either the HMO or the physician as the terminating party is able to enter into new contracts at more favorable terms than contained in existing contracts, the requirement for continuing to be bound by the terms of a terminated contract for up to 6 months for certain subscribers may add costs to the HMO, which may be reflected in higher premiums, or may restrict the income opportunity of the terminating physician, during the period of extension.

The interests of physicians are protected by allowing a physician who terminates a contract to refuse to continue to provide care to a subscriber who is abusive, noncompliant, or in arrears in payments for services provided. (Subscribers are responsible for paying only limited copayments or deductibles.)

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None

VII. Related Issues:

None

VIII. Amendments:

None.