The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL: SB 262

INTRODUCER: Senator Steube

SUBJECT: Health Insurance

DATE: February 20, 2017 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Billmeier	Knudson	BI	**Pre-meeting**
2.			JU	
3.			RC	

I. Summary:

SB 262 amends the Health Maintenance Organization Act to provide civil causes of action against health maintenance organizations for violations of the act and for acting in bad faith when failing to provide a covered service. The bill provides that any person may bring a civil action against a health maintenance organization (HMO) if the HMO fails to provide a covered service when the HMO in good faith should have provided such service had it acted fairly and reasonably toward the person and with due regard for his or her interests. The covered service must be medically reasonable or necessary in the independent medical judgment of the treating physician.

The bill creates individual causes of action against HMOs for violations of specified provisions of the HMO Act such as the prompt pay statute, statutes relating to unfair trade practices, and statutes relating to quality assurance.

This bill repeals provisions of law the Legislature passed in 2003 to limit HMO vicarious liability to actual employees of HMOs. The law repealed by this bill currently provides that health insurers, HMOs, prepaid health clinics, and prepaid health service organizations are not liable for the medical negligence of a health care provider with whom the entity has entered into a contract unless the licensed or certified entity expressly directs or exercises actual control over the specific conduct that caused injury or the provider is an employee of the entity.

II. Present Situation:

Health maintenance organizations (“HMOs”) provide, either directly or through arrangements with other persons, comprehensive health care services which subscribers are entitled to receive pursuant to a contract. Services can include emergency care, inpatient hospital services, physician care, ambulatory diagnostic treatment, and preventive health care services. Service

providers, such as physicians, can be employees or partners in the HMO or they can contract with the HMO to provide services.[1] HMOs are regulated by parts I and III of ch. 641, F.S.[2]

Civil Liability of HMOs

In the late 1990s and early 2000s, the Legislature considered creating individual causes of actions against HMOs similar to the causes of action created by s. 624.155, F.S. In 1996, the Legislature passed CS/HB 1853, which created civil causes of action against HMOs, created a bad faith cause of action similar to the cause of action for bad faith against insurers in s. 624.155, F.S., and provided for plaintiff attorney fees in certain situations. The Governor vetoed that bill. The Legislature considered similar bills providing for causes of action against HMOs in 1997-2001 but those bills did not pass.[3]

Section 624.155, F.S., provides for various individual causes of action against insurers, including health insurers. It provides that any person may bring an action against an insurer when the person is damaged when the insurer does not attempt "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."[4] Section 641.201, F.S., provides that the s. 624.155, F.S., requirement that insurers act in good faith does not apply to HMOs.

In *Greene v. Well Care HMO, Inc.*,[5] the court considered whether a patient could bring an action against her HMO under the HMO Act[6] and whether a patient could bring a bad faith action. In that case, the patient's physician recommended treatment but the HMO denied coverage. The patient sought a second opinion and that physician agreed with the first doctor's recommendation. The HMO denied coverage in violation of the policy terms.[7] The court held that the HMO Act did not provide for a private cause of action against a HMO. The court also held that s. 624.155, F.S., did not apply to HMOs.[8]

In 2003, the Florida Supreme Court agreed with the *Greene* court and held that the HMO Act does not provide a private cause of action for violation of the Act's requirements.[9] However, the court held that the fact that there is no statutory cause of action does not preclude a common law negligence claim based on the same facts.[10] In *Villazon*, Villazon alleged that the physicians that had contracted with the HMO were agents or apparent agents of the HMO and, therefore, the HMO was responsible for the physicians' negligence and vicariously liable[11] for the death of his

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[1] Section 641.19(12), F.S.
[2] Section 641.201, F.S.
[3] *See*, *e.g.,* HB 1547 (1997 Regular Session), SB 490 (1998 Regular Session), SB 216 (1999 Regular Session), SB 2154 (2000), and SB 2292 (2001 Regular Session).
[4] Section 624.155(1)(b)1., F.S.
[5] 778 So.2d 1037 (Fla. 4th DCA 2001).
[6] Section 641.17, F.S., names part I of ch. 641, F.S., the "Health Maintenance Organization Act."
[7] 778 So.2d at 1039.
[8] 778 So.2d at 1039-1041.
[9] *Villazon v. Prudential Health Care Plan*, 843 So.2d 842, 852 (Fla. 2003).
[10] *Villazon*, 843 So.2d at 852.
[11] Vicarious liability occurs when one person, although entirely innocent of any wrongdoing, is held responsible for the wrongful act of another. *See* 38 Florida Jurisprudence 2d s. 101. For example, an employer can be held vicariously liable for a tort committed by an employee.

wife.[12] The court held that the existence of an agency relationship is generally a question to be determined by the trier of fact and reversed the lower court's ruling on vicarious liability.[13]

In response to *Villazon*, the Legislature amended ss. 641.19 and 641.51, F.S., to provide that the HMO is not vicariously liable for the negligence of health care providers unless the provider is an employee of the HMO. The statutory amendments prohibited causes of action based on agency or apparent agency relationships.[14] The Legislature also created s. 768.0981, F.S., which provides:

> An entity licensed or certified under chapter 624, chapter 636, or chapter 641 shall not be liable for the medical negligence of a health care provider with whom the licensed or certified entity has entered into a contract, other than an employee of such licensed or certified entity, unless the licensed or certified entity expressly directs or exercises actual control over the specific conduct that caused injury.

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. ERISA may preempt civil remedies in state courts, whether pursued under common law theories of liability or pursuant to a statutory cause of action. Most employer-sponsored health insurance and HMO plans are ERISA plans. ERISA does not apply to governmental plans and church plans. The act also has no application to individual health insurance plans. ERISA has a civil enforcement clause that provides a remedy in federal court for denied employee benefits. Employees and enrollees have 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.[15] State tort remedies, on the other hand, allow for pain and suffering, lost wages and cost of future medical services.

In *Villazon*, the Florida Supreme Court held that ERISA did not preempt an action against an HMO alleging common law negligence and violations of the HMO Act.[16] A year after *Villazon*, the United States Supreme Court considered whether a Texas statute imposing liability on HMOs for failure to exercise ordinary care in making coverage decision was preempted by ERISA.[17] The court held that federal preemption applied and the remedies were limited to federal remedies.

Whether a claim against an ERISA plan is preempted is a fact-specific question. In *Badal v. Hinsdale Mem. Hosp.*,[18] the court held that claim was not preempted when the HMO was a defendant in the case under a theory of vicarious liability where the plaintiff alleged the HMO was responsible for the acts of its employees or agent. In determining whether ERISA

[12] *Villazon*, 843 So.2d at 845.
[13] *Villazon*, 843 So.2d at 853.
[14] *See* 2003-416, Laws of Florida.
[15] 29 U.S.C. s. 1132(a)(1).
[16] *Villazon*, 843 So.2d at 850-851.
[17] *Aetna Health v. Davila*, 542 U.S. 200 (2004).
[18] 2007 U.S. Dist. LEXIS 34713 (U.S. District Court Northern District of Illinois May 8, 2007).

preemption applies in medical malpractice cases, courts seem to look to see whether the malpractice is based on actions of a treating physician versus whether the injury was caused by a denial of coverage. In *Land v. Cigna Healthcare of Fla.*,[19] the court found ERISA preemption in a case where the treating physician ordered hospital admission for a patient but the HMO nurse did not approve a hospital stay.

III. Effect of Proposed Changes:

Vicarious Liability

The bill repeals provisions in ss. 641.19 and 641.51, F.S., providing that an HMO arranging the provision of heath care services does not create an actual agency, apparent agency, or employer-employee relationship for purposes of vicarious liability except when the provider is an actual employee of the HMO. This creates more situations where plaintiffs may allege negligence against HMOs on theories of vicarious liability.

Repeal of Section 768.0981, F.S.

The bill repeals s. 768.0981, F.S. That statute provides that an entity such as an insurer, prepaid limited health service organization, HMO, or prepaid health clinic[20] is not liable for the medical negligence of a health care provider with whom the entity has entered into a contract unless the entity expressly directs or exercises actual control over the specific conduct that caused injury. Repeal of this statute will allow more litigation against entities over whether they were vicariously liable for the medical negligence of health care providers under theories of actual or apparent agency.

HMO Bad Faith Liability

The bill creates a cause of action for bad faith against HMOs in specified situations. Specifically, it provides that a person may bring a civil action against an HMO if a person to whom a duty is owed suffers damage because of an HMO's failure to provide a covered service. The covered service must be one that the HMO should have been provided had the HMO acted in good faith and had acted fairly and reasonably toward the person with due regard for his or her interests. The service must have been medically reasonable or necessary in the independent medical judgment of a treating physician under contract with, or another physician authorized by, the HMO.

The court may award damages, including damages for mental anguish, loss of dignity, and any other intangible injuries, and punitive damages. In a bad faith action brought pursuant to the provisions of this bill, the court shall award a prevailing plaintiff reasonable attorney fees as part of the costs.

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[19] 381 F.3d 1274 (11th Cir. 2004).
[20] Section 768.0981, F.S., specifically refers to entities licensed or certified under ch. 624, F.S., ch. 636, F.S., or ch. 641, F.S.

Causes of Action for Violations of the HMO Act

The bill creates an individual cause of action against an HMO if a person to whom a duty is owed suffers damage as a result of an HMO's violation of specified statutes: s. 641.3155, s. 641.3903(5), (10), (12), (13), or (14), and s. 641.51, F.S. In an action alleging violations of these statutes, the court shall award a prevailing plaintiff reasonable attorney fees as part of the costs.

Section 641.3155, F.S., is known as the "prompt pay" law. It requires the HMO to provide notice of receipt of provider claims within specified times, to deny or contest provider claims within specified times, and to pay provider claims within specified times.

Subsection 641.3903(5), F.S., prohibits certain unfair claim settlement practices by HMOs. An HMO may not:
- Attempt to settle claims on the basis of an application or any other material document which was altered without notice to, or knowledge or consent of, the subscriber or group of subscribers to a health maintenance organization; or
- Make a material misrepresentation to the subscriber for the purpose and with the intent of effecting settlement of claims, loss, or damage under a health maintenance contract on less favorable terms than those provided in, and contemplated by, the contract.

It is an unfair claim settlement practice if an HMO performs the following with such frequency as to indicate a general business practice:
- Failing to adopt and implement standards for the proper investigation of claims;
- Misrepresenting pertinent facts or contract provisions relating to coverage at issue;
- Failing to acknowledge and act promptly upon communications with respect to claims;
- Denying claims without conducting reasonable investigations based upon available information;
- Failing to affirm or deny coverage of claims upon written request of the subscriber within a reasonable time not to exceed 30 days after a claim or proof-of-loss statements have been completed and documents pertinent to the claim have been requested in a timely manner and received by the health maintenance organization;
- Failing to promptly provide a reasonable explanation in writing to the subscriber of the basis in the health maintenance contract in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement;
- Failing to provide, upon written request of a subscriber, itemized statements verifying that services and supplies were furnished, where such statement is necessary for the submission of other insurance claims covered by individual specified disease or limited benefit policies;
- Failing to provide any subscriber with services, care, or treatment contracted for pursuant to any health maintenance contract without a reasonable basis to believe that a legitimate defense exists for not providing such services, care, or treatment; or
- Engaging in systematic downcoding with the intent to deny reimbursement otherwise due.

Subsection 641.3903(10), F.S., prohibits an HMO from knowingly collecting any sum as a premium or charge for health maintenance coverage which is not then provided or is not in due course to be provided. An HMO may not knowingly collect as a premium or charge for health

maintenance coverage any sum in excess of or less than the premium or charge applicable to health maintenance coverage, in accordance with the applicable classifications and rates as filed with the Office of Insurance Regulation.

Subsection 641.3903(12), F.S., prohibits an HMO from engaging in or attempting to engage in discriminatory practices that discourage participation on the basis of the actual or perceived health status of Medicaid recipients. The statute also prohibits an HMO from refusing to provide services or care to a subscriber solely because medical services may be or have been sought for injuries resulting from an assault, battery, sexual assault, sexual battery, or any other offense by a family or household member or by another who is or was residing in the same dwelling unit.

Subsection 641.3903(13), F.S., prohibits an HMO from knowingly misleading potential enrollees as to the availability of providers.

Subsection 641.3903(14), F.S., prohibits any retaliatory action by an HMO against a contracted provider on the basis that the provider communicated information to the provider's patient regarding care or treatment options when the provider deems knowledge of such information by the patient to be in the best interest of the patient.

Section 641.51, F.S., requires an HMO to establish a quality assurance program and creates a requirement for second medical opinions in some cases. The HMO:

- Shall ensure that the health care services provided to subscribers shall be rendered under reasonable standards of quality of care consistent with the prevailing standards of medical practice in the community;
- Shall have an ongoing internal quality assurance program for its health care services;
- Shall not have the right to control the professional judgment of a physician;
- Shall ensure that only a physician holding an active, unencumbered license may render an adverse determination regarding a service provided by a physician licensed in Florida;
- Shall give the subscriber the right to a second medical opinion in any instance in which the subscriber disputes the organization's or the physician's opinion of the reasonableness or necessity of surgical procedures or is subject to a serious injury or illness;
- Shall develop and maintain a policy to determine when exceptional referrals to out-of-network specially qualified providers should be provided to address the unique medical needs of a subscriber;
- Shall develop and maintain written policies and procedures for the provision of standing referrals to subscribers with chronic and disabling conditions which require ongoing specialty care;
- Shall allow subscribers undergoing active treatment to continue coverage and care when medically necessary, through completion of treatment of a condition for which the subscriber was receiving care at the time of the termination of a provider contract;
- Release specified data to the AHCA;
- Adopt recommendations for preventive pediatric health care which are consistent with the requirements for health checkups for children developed for the Medicaid program;
- Allow, without prior authorization, a female subscriber, to visit a contracted obstetrician/gynecologist for one annual visit and for medically necessary followup care; and

- Allow a contracted primary care physician to send a subscriber to a contracted licensed ophthalmologist under specified circumstances.

The bill provides that a person bringing an action for these violations of the HMO Act need not prove that the violation was committed with such frequency as to indicate a general business practice.

The bill provides that an HMO is liable for all of the claimant's damages or $500 per violation, whichever is greater, for violations of the above-cited statutes. The court may award damages, including damages for mental anguish, loss of dignity, and any other intangible injuries, and punitive damages.

Effective Date

The bill has an effective date of October 1, 2017.

Retroactivity

This bill provides that the repeal of s. 768.0981, F.S., and amendments to ss. 641.19, 641.51, and 641.3917, F.S., apply to causes of action accruing on or after October 1, 2017. The bill is not retroactive and does not apply to ongoing litigation or to causes of action accruing before October 1, 2017.

ERISA Preemption

Federal preemption may limit this bill's application in situations where an ERISA plan makes a decision to deny coverage. As discussed in *Davila* and subsequent cases, courts will have to review the facts of each case to determine whether preemption applies in cases related to coverage decisions. In addition to cases related to denial of coverage, courts have found ERISA preemption in cases related to a prompt pay law[21] and related to payment to medical providers.[22]

The provisions of the bill will apply to non-ERISA plans. It is not known how many persons covered under HMO plans are covered under plans that would be excluded from portions of this bill and how many persons are covered under plans that would be subject to all the provisions of the bill. A court noted that there is a trend in Georgia for employers to provide self-funded ERISA plans to their employees.[23] Subsequent to *Davila*, Texas passed a law to specifically exclude ERISA plans from the Texas Health Care Liability Act.[24] A 2005 bill analysis noted that there are only a few non-ERISA group health plans offered in Texas.[25]

[21] *America's Health Ins. v. Hudgens*, 742 F.3d 1319 (11th Cir. 2014).
[22] *Gables Ins. Recovery, Inc. v. Blue Cross & Blue Shield of Fla., Inc.*, 813 F.3d 1333 (11th Cir. 2015).
[23] *America's Health Ins. v. Hudgens*, 742 F.3d at 1324-1325.
[24] Texas Civil Practice and Remedies Code s. 88.0015.
[25] SB 554 Bill Analysis, Texas, March 17, 2005 (on file with the Committee on Banking and Insurance).

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The number of HMOs that will be affected by this bill and the extent that the bill will apply to each HMO is not known. Therefore, the fiscal impact of this bill is not known.

C. Government Sector Impact:

If there is an increase in litigation due to this bill, the state court system could see an increased workload.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 641.19, 641.51, and 641.3917.

This bill repeals section 768.0981 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.