The Florida Senate

Interim Project Summary 2002-120 *October 2001*

Committee on Banking and Insurance Senator Bill Posey, Chairman

CANCELLATION OF HEALTH CARE PRACTITIONER CONTRACTS BY INSURERS AND HEALTH MAINTENANCE ORGANIZATIONS

SUMMARY

Health maintenance organizations (HMOs) and certain health insurers[1] enter into contracts with health care practitioners who agree to act as participating or "network" providers under a managed care plan. Florida law affords these practitioners certain protections under managed care plans which range from prompt pay and dispute resolution procedures to contract cancellation or termination provisions (termed "deselections" by managed care organizations).[2] Several of the protections pertaining to contract cancellations came about because the Legislature was concerned that managed care plans were discouraging providers from advocating on behalf of patients and thus authorized certain rudimentary notice and due process procedures such plans must adhere to when terminating a provider.

Recently some practitioners have complained about contract cancellations by the largest HMO in Florida which are alleged to have been done for arbitrary or unspecified business reasons. These providers claim that such terminations are due to the providers advocating patient rights above cost savings.

One terminated provider recently filed a circuit court complaint against Blue Cross and Blue Shield of Florida (BCBS) and Health Options, Inc. (HOI), the BCBS for-profit health maintenance organization, alleging tortious interference of contract, breach of implied covenant of good faith and fair dealing, and unfair and deceptive trade practices by the companies. The Florida Medical Association also filed a complaint this June with the Florida Department of Insurance (DOI) formally requesting the DOI investigate whether the provider in question was terminated due to his communications with his patients regarding medical care which would violate the deceptive practices provisions under Florida law.[3] That statute prohibits an HMO from taking any retaliatory action against a contracted provider, including termination of a contract with the provider, on the basis that the provider communicated with his or her patients information regarding medical care or treatment. If DOI determines BCBS/HOI has engaged in such retaliatory action, the companies could be subject, after a hearing on the merits of the allegations, to fines or have their certificates of authority suspended or revoked.

Representatives with BCBS/HOI respond that the provider was terminated due to the express provisions contained in his contract which allow either party to terminate the contract at any time "without cause."[4] In general, BCBS/HOI and other HMOs state that they drop or add providers for a variety of reasons, ranging from quality of care issues to whether there are too few or too many providers in a particular region. These entities emphasize that it is a routine business practice to make periodic network adjustments to their medical delivery systems and that such adjustments are in the best interests of their subscribers (patients) and the needs of their particular company. The HMOs and insurers further point out that in the great majority of cases, providers leave their health plans voluntarily as opposed to being terminated. In response to these concerns, committee staff reviewed Florida's provider

[1] Some insurers offer other types of managed care products which are referred to as "preferred or exclusive provider organization" (PPO and EPO) contracts.

[2] In general, "for cause" terminations allow an HMO to immediately terminate a provider based on reasons which are enumerated in the contract, e.g., revocation of a provider's license or hospital priviledges. Whereas, either party (the HMO or provider) may terminate the contract "without cause" by giving advance written notice. Florida law requires the party canceling a health care contract to provide a written reason for the termination.

[3] S. 641.3903(14), F.S.

[4] The written reason given by BCBS/HOI for terminating the provider was due to a periodic re-evaluation of the company's medical delivery system and the needs of the company and insureds in each individual market.

termination provisions and similar laws in other states, along with relevant case law. Detailed health plan-practitioner information was obtained from the four largest HMOs in the state as well as state departments, medical and insurance associations, and national and state research institutions.

The Florida Legislature has endeavored to balance the competing interests of health care practitioners and health plans and it is recommended that the current laws provide adequate protections for practitioners whose contract has been cancelled. Florida law mandates that HMOs provide advance notice in writing to providers (and the DOI) who are terminated "without cause," requires written reasons to be given for all terminations, outlaws "gag clauses," and specifies continuity of care requirements.

Of the four largest commercial HMOs in the state (Health Options, Inc.; UnitedHealthCare of Florida, Inc.; Aetna U.S. Healthcare Inc., a Florida Corporation (Prudential); and Humana Medical Plan, Inc.) which represent 70 percent of premium, the vast majority of contract terminations emanate from practitioners and not the health plans. In fact, the total number of provider initiated cancellations range from two to nine times the number of HMO initiated terminations. Further, for three of the four plans, the percentage of HMO initiated terminations constitute less than one percent of the total number of providers in each of the health plans. The only HMO that had more than one percent was due to the fact the HMO terminated its Medicare coverage in certain geographic areas which resulted in the plan having to cancel provider contracts in those areas.

Current law also provides appropriate termination protections for health care practitioners in that both the DOI and the Agency for Health Care Administration (AHCA) have regulatory responsibilities in this area. The DOI has broad jurisdiction to investigate and enforce the contractual regulations as to HMOs as well as oversight regarding the unfair practices act. The department may institute suits, levy fines or suspend or revoke an HMO's certificate of authority to operate in this state. The AHCA receives provider termination notices provided by the DOI and the agency analyzes the HMO's provider network to determine whether the termination affects the plans' network adequacy. Further, national accreditation organizations, which must accredit all Florida HMOs, periodically review an HMOs' network adequacy and practitioner availability to ensure an HMO has a sufficient number of providers to meet the needs and preferences of their member population.

The largest HMO in Florida, Health Options, utilizes extensive internal criteria prior to deselecting a practitioner "without cause." Providers recommended for termination are further reviewed by a cross section of company representatives for a determination of whether there were sufficient reasons to terminate the provider in the network.

The allowable reasons for terminating a provider "for cause" are contained within the terms of the health plan contract thus allowing the provider sufficient notice in advance as to specific prohibited behavior. The reasons for provider "without cause" terminations by health plans are varied and range from insufficient membership in certain geographic areas to justify the number of providers to subscriber dissatisfaction with certain network providers. All the largest HMOs in Florida allow for binding arbitration in their contracts for providers who are terminated. Furthermore, overall health care costs would likely increase should the Legislature prohibit "without cause" provisions in health care-provider contracts or allow an appeal process prior to a provider being terminated.

It is also recommended that the AHCA should be given statutory authority to receive provider termination notices directly. Currently, the Department of Insurance receives contract "without cause" termination notices which it subsequently forwards to AHCA. This is inefficient and it is recommended that such notices also be sent directly to AHCA. When AHCA receives these notices it reviews the HMO's provider network to ensure there is adequate access to health care by the subscribers.

BACKGROUND

HMO-Practitioner Cancellation Provisions and Related Protections under Florida Law

For Cause and Without Cause Terminations

In general, the allowable reasons for terminating a health care provider in Florida are subject to the terms of the specific contract with the HMO. Providers can be terminated both "for cause" (which allows the HMO to immediately end its relationship with the provider for specified reasons contained within the contract) or "without cause" (no reason given). Examples of "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 for a felony offense; the invocation of disciplinary action by any court or regulatory agency ; or a material breach of the contract. The more controversial provision in HMO-practitioner contracts is the termination "without cause" that typically allows the HMO to terminate the agreement without an explanation upon giving a certain number of days notice. Such a provision in fact allows either party the right to end the contract at any time.

Florida Law

In an effort to balance the competing interests of health plans and providers, the Florida Legislature has enacted legislation requiring HMOs to comply with rudimentary notice or due process provisions and has afforded providers other protections as outlined below.

Health maintenance organization contracts with health care practitioners must include a provision that the HMO provide 60 days' advance written notice to the provider and the DOI before canceling a provider contract "without cause," e.g., no reason needed. There is an exception to this provision for providers who may endanger the health of a patient or if a physician's ability to practice is impaired by an action by the Board of Medicine or other governmental agency. Likewise, providers must give 60 days' advance written notice to the HMO and DOI before canceling their contract "for any reason." Further, when the HMO receives the 60-day cancellation notice from the provider, the HMO may, if requested by the provider, terminate the contract in less than 60 days if the HMO is not financially impaired or insolvent. Also, the contract must provide that nonpayment for goods or services rendered by the provider to the HMO is not a valid reason for avoiding the 60-day advance notice of cancellation provision (s. 641.315(2), F.S.).

Legislation enacted in 1997 prohibited HMO-provider contracts from containing "gag clauses" which meant that contracts could not 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 to be in the best interest of the health of the patient (s. 641.315(5), F.S.). Two years later the Legislature passed a related provision which made it an unfair method of competition or deceptive practice for an HMO to take any retaliatory action against a contracted provider, including, but not limited to, termination of a contract with the provider, on the basis that the provider communicated with his or her patients information regarding medical care or treatment when the provider feels knowledge of such information to be in the best interest of the patient (s. 641.3903(14), F.S.). The effect of making this provision subject to the unfair trade practices act allows the DOI to investigate, enforce and apply sanctions against an HMO which can range from fines, to suspending or revoking its certificate of authority.

The law also provides that when an HMO-provider contract is terminated for any reason other than for cause, coverage continues for subscribers for whom treatment was active, when medically necessary, through completion of the treatment of the 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 plan, whichever is longer, but not longer than 6 months after termination of the contract. Each party to the terminated contract must allow a subscriber who has initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care and coverage until completion of post-partum care. However, this does 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. Also, for care continued under this provision, the HMO and the provider continue to be bound by the terms of the terminated contract. Further, any changes made within 30 days before termination of a contract are effective only if agreed to by both parties (s. 641.51(8), F.S.).

An HMO or health care provider may not terminate a contract with a health care provider or HMO, unless the party terminating the contract provides a written reason for doing so, which may include termination for business reasons of the terminating party. However, the written reason for termination does not create a new administrative or civil action and cannot be used as substantive evidence in any such action, but it may be used for impeachment purposes (s. 641.315(7), F.S.).

A provision enacted in 2001 prohibits the utilization of "all products clauses" which were used by some HMOs and insurers to require practitioners to agree to participate in "all the products" offered by that insurer or HMO, as a condition of participating in any of the health plan's products. The law prohibits HMOs and insurers from requiring providers to accept the terms of other health care provider contracts with the insurer, any other insurer, or HMO, under common management or control with the insurer or HMO, as a condition of continuation or renewal of the contract. The statute does not apply to providers entering into new health plan contracts or to providers in group

practices. Any contract that violated this law would be deemed void (s. 641.315(10), F.S.).

METHODOLOGY

Staff reviewed Florida's health care provider termination provisions, legislative reports and periodicals on this topic, and similar provisions in other states, along with relevant case law. Detailed HMO-practitioner information was obtained from the four largest HMOs in the state (Health Options, Inc., United HealthCare of Florida, Inc., Aetna U.S. Healthcare Inc., a Florida Corporation (Prudential), and Humana Medical Plan, Inc.), the Florida Department of Insurance, the Agency for Health Care Administration, the Florida Medical Association, the American Medical Association, national and state research institutions and various insurance associations.

FINDINGS

Health Maintenance Organizations/Preferred and Exclusive Provider Organizations

Approximately 4.8 million Floridians or 31 percent of the population are enrolled in health maintenance organizations (3,600,241 in commercial, 689,729 in Medicare, and 515,152 in Medicaid). There are currently 31 HMOs operating in the state with Health Options, Inc., UnitedHealthCare of Florida, Inc., Aetna U.S. Healthcare Inc., a Florida Corporation (Prudential), and Humana Medical Plan, Inc., comprising the largest share (62 percent) of the commercial HMO market or 70 percent of the total premium. Health Options has 928,963 members or 19.3 percent of the total commercial market share; United HealthCare of Florida has 859,584 members or 17.9 percent of the total; Aetna U. S. Healthcare (Prudential) has 756,640 members or 15.7 percent of the total; and Humana Medical Plan has 447,484 members or 9 percent of the total.

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

Some health insurers offer a type of managed care product which is referred to as a preferred provider organization (PPO) contract (s. 627.6471, F.S.). A PPO insurance contract provides greater benefits if an insured obtains services from a network provider, and lesser benefits (greater deductibles and coinsurance) if the insured obtains services from a non-network provider. The insurer must have these policies approved by the DOI, but not the AHCA. The DOI does not maintain separate statistical data for PPOs.

Certain health insurers may also offer a managed care type product which is called an exclusive provider organization (EPO) contract (s. 627.6472, F.S.). Under an EPO, health insurers contract with a group of health care providers and then offer subscribers a health benefit plan reflecting the aggregate of services from those providers under contract, often at discounted rates. Subscribers must obtain these services from the exclusive provider as a condition of receiving any benefits. The DOI does not maintain separate statistical information for EPOs.

Regulating Contract Cancellation Provisions

The DOI has broad jurisdiction to investigate and enforce the regulations for HMOs and insurance companies, to institute suits or other legal actions, levy fines or suspend or revoke an entity's certificate of authority to operate in this state under various provisions of the Insurance Code, e.g., chapters 624-632, 634, 635, 641, 642, 648, and 651, F.S. Specifically, the DOI has authority to investigate the HMO-provider contract cancellation protections enumerated under s. 641.315, F.S., and to investigate whether HMOs have retaliated against providers under the unfair practices provisions of s. 641.3901(14), F.S. According to representatives with DOI, when the department receives the 60-day provider termination notices, staff reviews them to ensure the time period has been compiled with by the HMO or provider. If the time period has not been adhered to, the DOI contacts the parties and requires compliance with the law. The DOI forwards these notices to the AHCA for review as to whether the termination of the provider effects the network adequacy of the health plan.

The DOI is currently investigating a complaint from the Florida Medical Association which requested an investigation of the termination of Dr. Carlos Mendez by BCBS/HOI to determine whether the companies violated the unfair practices act by retaliating against the doctor due to his communications with his patients regarding medical care. According to representatives with the DOI, this is the first such complaint the department has ever received under this provision of law. Department officials also point out that although they periodically receive provider termination complaints from subscribers against HMOs, they believe the number of complaints for this year have not

increased over prior years. The typical response from the DOI to these complaints is that HMOs are allowed to make "business decisions" to terminate providers under their contracts.

The AHCA is responsible for monitoring provider cancellation notices to determine whether the cancellation affects the HMOs' network adequacy. Representatives with AHCA state that while there are no specific standards in statute or rule which require a certain ratio as to the number of providers per subscribers, HMOs are required to have sufficient providers to offer comprehensive health care services to subscribers within their network area and if an HMO is unable to contract for those services, it must arrange and pay for the provider services out of contract.

Under Florida law, HMOs must ensure that the health care services it provides to subscribers are accessible, with reasonable promptness, with respect to geographic location, hours of operation, after-hours service, and staffing patterns within generally accepted industry norms for meeting subscriber needs.[5] Furthermore, Rule 59A-12.006, F.A.C., requires HMOs to establish time parameters within which providers must see subscribers depending upon whether the case involves an emergency, urgent, or routine matter. Further, the average travel time from the HMO geographic services area boundary to the nearest primary care provider and nearest general hospital must be no longer than 30 minutes, and in cases involving specialty provider services and inpatient hospital services, no longer than 60 minutes travel time under normal circumstances.

According to AHCA representatives, when they receive a provider cancellation notice for a pediatrician, for example, staff studies the existing HMO-provider network as to pediatricians to ensure that it is adequate for the membership base and to ensure there are a sufficient number of pediatricians who meet the accessibility criteria noted above. Should AHCA staff have a concern, they contact the HMO to determine whether it will replace the pediatrician or work out some other arrangement which is satisfactory to AHCA. This monitoring process is rather informal and the procedures are not in writing. In the case of the termination of Dr. Mendez, ACHA staff received three to four complaints from subscribers concerning the doctor's deselection by Health Options and determined that the HMO was in compliance with all regulations as to network adequacy.

Health maintenance organizations must also undergo an accreditation process which requires every HMO to be thoroughly reviewed by a nationally recognized accreditation organization whose standards have been approved by AHCA.[6] An HMO is required to be accredited within 2 years of receiving its certificate of authority from DOI and such accreditation must be maintained as a condition of doing business in the state. Accreditation is a process to measure how an HMO performs using an industry recognized set of quality standards. By looking at internal processes of monitoring and evaluating health care given to HMO subscribers, the subscribers are assured of quality services rendered in the most cost effective manner. The plans must also undergo reaccredidation every three years.

Staff with ACHA emphasize that an HMO's network adequacy and practitioner availability is thoroughly reviewed during both the accreditation and reaccredidation process. An HMO must ensure that its network is sufficient in numbers and types of practitioners, establishes standards for the number and geographic distribution of primary care practitioners and specialists, and ensures that its provider panels can meet the "racial, ethnic, cultural and linguistic needs and preferences of the member population." Four national accreditation organizations have reviewed and accredited the 31 HMOs operating in Florida.

Contract Cancellations by the State's Largest Health Maintenance Organizations

Health Options, Inc. (Blue Cross and Blue Shield's Health Maintenance Organization)

The entire Blue Cross and Blue Shield (BCBS) health plan comprises more than 3.3 million Floridians. Health Options, Inc. (HOI), the BCBS's for-profit health maintenance organization, is the state's largest HMO with 928,963 members, or almost 20 percent of the market, with access to more than 15,236 in-network primary care physicians and specialists, as well as 170 in-network hospitals. The BCBS's preferred provider organization (PPO) plan, termed Preferred Patient Care, has more than 1.74 million members with 26,474 in-network practitioners and 194 hospitals, while its "traditional" fee-for-service plan has 367,809 members with 33,513 providers.

According to representatives with HOI, they have over 15,000 providers in their HMO and terminated 124 in 1999, 114 in 2000, and 118 providers during the first 7

[5] S. 641.495, F.S.

[6] S. 641.512, F.S., and Rule 12.0071, F.A.C.

months of 2001 for both "for cause" and "without cause" reasons. These figures represent less than one percent of the total number of providers in the entire health plan for each year. Further, company officials assert that the number of providers who have voluntarily left HOI is twice the number of deselections the company initiated over the past several years.

There were several considerations which supported the recent increase in the number of HOI initiated provider terminations for the first half of 2001, according to company officials. First, HOI had to "impose premiums and reduce benefits in most of the counties we serve." These changes resulted in a rather significant loss of membership in those counties and as a result, some providers were terminated. Further, there is "a logical correlation to the number of members we serve in a particular county and the number of health care professionals needed to serve those members." Second, increased administrative costs due to providers who sustained a low volume of member contacts over a given period, e.g., less than 25 member contacts per year. Third, certain providers had a "high utilization of tests, procedures and referrals." Fourth, some providers either failed or blatantly disregarded network contractual requirements as to coordination and continuity of care, and fifth, subscribers expressed dissatisfaction with certain network providers.

Another consideration as to possible provider contract termination by HOI includes comparative peer review results. Providers who fell outside "two standard deviations" from the peer norm, as determined by other providers, were evaluated for potential contract termination. According to HOI officials, prior to being noticed for termination, every provider recommended for deselection was reviewed by a cross section of company representatives for a determination as to whether there were reasons to keep the provider in the network.

The standard HOI-provider contract specifies that either party may at any time terminate the contract "without cause" by giving at least 60 days advance written notice. A contract may be terminated by HOI immediately "for cause" for enumerated reasons which range from revocation of a provider's professional license and loss of hospital staff privileges to conviction of a felony. The employment contract contains a binding arbitration provision which allows a terminated provider to submit that issue to an arbitration panel for final resolution.

UnitedHealthCare of Florida, Inc.

UnitedHealthCare of Florida operates the second largest health maintenance organization plan in Florida with a current enrollment of 859,584 members or almost 18 percent of the total market share for the state.[7] According to representatives with United, they have 27,634 providers in their HMO and they terminated 243 providers in 2001 (both "for cause" and "without cause") while 547 providers voluntarily left their network. Furthermore, in 2000, the plan terminated 140 providers while 632 voluntarily left the HMO and in 1999, the HMO terminated 166 providers and 775 providers voluntarily left the plan.

There were a variety of reasons that the United HMO terminates its providers which include the failure of the provider to obtain credentialing, loss of hospital privileges, disciplinary issues, breach of contract, or an insufficient number of subscribers in the network area. The reasons given for a provider to voluntarily leave the plan include dissatisfaction with the fee schedule, retirement, death, moving out of the service area, office closure, or a provider's unwillingness to participate in the plan's health care programs.

UnitedHealthCare's provider contract specifies that it may be terminated for the following reasons: by mutual agreement of both parties; by either party upon 90 days written notice; by either party in the event of breach of the agreement; by United immediately upon written notice to the provider due to the provider's loss of licensure or certification or loss of insurance; by the provider for any reason upon 60 days written notice; by United "without cause" upon 60 days written notice, and by United in accordance with its credentialing process. The contract also provides for binding arbitration.

Aetna U.S. Healthcare Inc., a Florida Corporation (Prudential)

In August 1999, Aetna U.S. Healthcare (Aetna) purchased Prudential HealthCare making it the country's largest provider of health benefits with more than 21 million members. In Florida, the Aetna HMO, which includes Prudential HealthCare, has almost 16 percent of the total market with 756,640 members. Aetna officials reported data for both its HMO and PPO plans which showed that in 2001 they had 30,500 providers in their plans and they terminated 709 providers while 1,307 left the plans voluntarily. Among the four plans surveyed, Aetna reported the highest number of plan-initiated provider terminations for

[7] As of March 31, 2001.

2001. However, Aetna reports that over 90 percent of these terminations were due to the fact that Aetna terminated its Medicare-HMO coverage in certain areas which resulted in it having to cancel provider contracts in those areas. The majority of the providers voluntarily cancelled their employment contract for reasons similar to the other health plans: retirement; death of the provider; or dissatisfaction with the HMO/PPO. The reasons for "without cause" terminations provided by Aetna representatives also echoed the reasons offered by the other HMOs, e.g., loss of membership in certain geographic areas; providers with a low volume of member contacts over a given period; or consumer dissatisfaction with particular providers. Likewise, the reasons for "for cause" deselections also mirrored the reasons offered by the other HMOs, e.g., credentialing problems; suspension, non-renewal or revocation of the provider's medical license; loss of hospital privileges; or breach of contract.

Under the provisions of the Aetna U.S. Healthcare-provider contract, either party may terminate the contract for "business reasons", e.g., "without cause," subject to a 90-day advance written notice and may terminate the contract for breach or default upon a 60-day advance written notice. Aetna U.S. Healthcare may immediately terminate a provider for specified reasons which are similar to the other HMO contracts, e.g., suspension or termination of a provider's medical license, DEA certification, Medicare or Medicaid participation, or hospital staff privileges; indictment, arrest or conviction of a felony; or reduction or termination of insurance. The contract also allows for binding arbitration after a provider is terminated.

Humana Medical Plan, Inc.

The Humana HMO (Humana Medical Plan, Inc.) has 447,484 members or 9 percent of the total market share while its PPO (Humana Health Insurance Co. of Florida) has 197,223 members. According to representatives with the Humana HMO and PPO,[8] they have 15,062 providers and during the first half of 2001, 769 providers voluntarily left the plan while 83 were terminated by the health plan. Of the 769 provider initiated cancellations, 259 of the providers left the plan because they "no longer wanted to treat our members," whereas 510 providers initiated termination due to retirement, moving out of the geographic area, or death. Like the other HMOs noted above, Humana deselected providers for a variety of reasons ranging from a reduction in subscriber membership to failure or blatant disregard of various contractual obligations.

Practitioner Cancellation or Deselection Laws in Other States

According to information compiled by the National Council of State Legislatures and staff with the Florida Banking and Insurance Committee, 28 states (including Florida) have enacted laws or administrative rules that require some form of written notice of contract termination. Furthermore, 13 of the 28 states have passed laws concerning due process that establish contract termination hearings or reviews or provider grievance protections.[9] Several of the thirteen states provide that prior to termination, the provider be given an opportunity for a review or hearing, except in cases where there is imminent harm to patient health or action by a medical board that impairs the provider's ability to practice medicine, or in a case of fraud or malfeasance. For example, under North Dakota's provisions, a provider considered for termination must be given the opportunity to be present and to be heard by a committee appointed by the health plan. The committee must include as least one representative of the practitioner's specialty.

Policy Considerations

Provider groups generally support either eliminating "without cause" contract termination provisions or at a minimum specifying the criteria used to deselect providers "without cause." This recommendation would also include written notice of termination, a period of time for the provider to correct the problem resulting in the proposed termination, a thorough appeal process prior to termination, and other contract provisions that protect providers. These organizations argue that only comprehensive protection measures offer fairness and the ability to contest improper termination decisions made by HMOs. Practitioners maintain that the threat of deselection may force them to reduce the use of certain services and high-cost procedures. Also, they believe that high turnover may adversely affect patient care.

Florida health plans and insurers typically oppose eliminating the "without cause" provision in provider contracts or enacting any further protection rules. These plans assert that health care costs will greatly increase should plans have to eliminate "without cause" provisions in contracts or afford providers

[8] Humana was unable to separately identify the figures for its HMO or PPO.

[9] Delaware, Idaho, Maine, Missouri, Montana, Nebraska, New Jersey, New York, North Dakota, Ohio, Oregon, Rhode Island, and Texas.

appeal rights prior to deselection. These organizations argue that they need to control the ability to select and terminate providers to operate effectively and contain costs. Health plans state that losing this authority undermines the basic principles of a managed health care system.

Representatives with health plans further assert that medicine delivery systems have changed over the years and that now "medical economics and the law" control medical care and medical costs. Further, by eliminating the "without cause" clause does not change the underlying economic realities of provider over-supply and lowered consumer demand for the multitude of high-priced specialists services. In many communities, there are more primary care physicians than needed to meet patient demands. The influx of physician assistants and nurse practitioners further reduces the demand for providers.

RECOMMENDATIONS

Recommendation: Maintain the current laws as to HMO-practitioner contract termination protections.

In an effort to balance the competing interests of health care providers and HMOs, the Florida Legislature has provided adequate protections for providers when they are either terminated "for cause" or "without cause." by health plans. Florida law mandates HMOs provide advance notice in writing to providers (and the Department of Insurance) who are terminated "without cause," requires written reasons to be given for all terminations, outlaws "gag clauses," and specifies continuity of care requirements.

As outlined in the main report, in all of the four largest HMOs in the state which represent 70 percent of premium, the vast majority of contract terminations emanate from practitioners and not the health plans. In fact, the total number of provider initiated cancellations range from two to nine times the number of HMO initiated terminations. Further, for three of the four plans, the percentage of HMO initiated terminations constitute less than one percent of the total number of providers in each of the health plans. The only HMO that had more than one percent was due to the fact the HMO terminated its Medicare coverage in certain geographic areas which resulted in the plan having to cancel provider contracts in those areas.

Current law also provides appropriate termination protections for health care practitioners in that both the DOI and the AHCA have regulatory responsibilities in this area. The DOI has broad jurisdiction to investigate and enforce the contractual regulations as to HMOs as well as oversight regarding the unfair practices act. The department may institute suits, levy fines or suspend or revoke an HMOs certificate of authority to operate in this state. In fact, the DOI is currently investigating a doctor who was terminated by an HMO "without cause."

The AHCA receives provider termination notices provided by the DOI and the agency analyzes the HMOs' provider network to determine whether the cancellation affects the plans' network adequacy. Further, the national accreditation organizations review an HMOs' network adequacy and practitioner availability to ensure an HMO has a sufficient number of providers to meet the needs and preferences of their member population.

The allowable reasons for terminating a provider "for cause" are contained within the terms of the health plan contract thus allowing the provider sufficient notice in advance as to specific prohibited behavior. The reasons range from loss of provider credentialing to arrest or conviction of a felony. The reasons for provider "without cause" terminations by plans are varied and range from an insufficient membership in certain areas to subscriber dissatisfaction with specific network providers.

The largest HMO in Florida, Blue Cross and Blue Shield's Health Options, Inc., utilizes extensive internal criteria prior to deselecting a practitioner "without cause." Providers recommended for termination are further reviewed by a cross section of company representatives for a determination of whether there were sufficient reasons to terminate the provider in the network. Overall health care cost would likely increase should the Legislature prohibit "without cause" provisions in health care-provider contracts or allow an appeal process prior to a provider being terminated.

Recommendation: The Agency for Health Care Administration (AHCA) should be given statutory authority to receive provider termination notices directly.

Currently, the Department of Insurance receives contract "without cause" termination notices which it subsequently forwards to AHCA. This is inefficient and it is recommended that such notices also be sent directly to AHCA. When AHCA receives these notices it reviews the HMOs provider network to ensure there is adequate access to health care by the subscribers.