

# Cancellation of Health Care Practitioner Contracts by Insurers and Health Maintenance Organizations

---

*Report Number 2002-120*

October 2001

*Prepared for*  
The Florida Senate

*Prepared by*  
Committee on Banking and Insurance

[COMMENT1]

## Table of Contents

Summary .....	separate document
Background .....	1
Health Care Practitioner Contract Cancellations .....	1
HMO-Practitioner Cancellation Provisions and Related Protections under Florida Law .....	3
For Cause and Without Cause Terminations .....	3
Florida Law.....	4
Methodology .....	6
Findings .....	7
Health Maintenance Organizations/Preferred and Exclusive Provider Organizations .....	7
Regulating Contract Cancellation Provisions .....	8
Contract Cancellations by the State’s Largest Health Maintenance Organizations .....	11
Health Options, Inc. (Blue Cross and Blue Shield’s Health Maintenance Organization) .....	11
UnitedHealthCare of Florida, Inc. ....	13
Aetna U. S. Healthcare Inc., a Florida Corporation (Prudential) .....	14
Humana Medical Plan, Inc.....	15
Practitioner Cancellation or Deselection Laws in Other States .....	16
Case Law Concerning “Without Cause” Contract Cancellations .....	19
Policy Considerations.....	20
Conclusions and Recommendations.....	21
Appendixes .....	24
Appendix A.....	25
Appendix B.....	27

## **Background**

### **Health Care Practitioner Contract Cancellations**

Health maintenance organizations (HMOs) and certain health insurers<sup>1</sup> enter into contracts with health care practitioners<sup>2</sup> 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 cover such issues as prompt pay, dispute resolution, appeals, provider-patient communications, and contract cancellations or terminations (termed “deselections” by managed care organizations).<sup>3</sup> 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.<sup>4</sup>

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. They assert that HMOs engaging in this practice violate the unfair method of competition or deceptive trade practices provisions under the Insurance Code and are therefore illegal.<sup>5</sup>

One such 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

---

<sup>1</sup> 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 is a health insurance policy that 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. Another type of managed care product is the exclusive provider organization (EPO). 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 (s. 627.6472, F.S.). See discussion of PPOs and EPOs below.

<sup>2</sup> For the purposes of this report, a health care practitioner or provider means any physician, hospital, or other institution, organization, or person that furnishes health care services and is licensed or otherwise authorized to practice in this state.

<sup>3</sup> Ch. 641, F.S.

<sup>4</sup> The termination protections in law apply to HMO contracts, but not to preferred or exclusive provider organization contracts.

<sup>5</sup> S. 641.3903(14), F.S. Chapters 624-632, 634, 635, 641, 642, 648, and 651 constitute the Florida Insurance Code.

contract, breach of implied covenant of good faith and fair dealing, and unfair and deceptive trade practices by the companies.<sup>6</sup> Dr. Carlos Mendez, who had provided medical care to over 2,600 pediatric patients in the Bradenton area, was terminated from both the BCBS and HOI networks. In his court complaint, Dr. Mendez alleged BCBS/HOI dropped him from their plans for discussing medical choices with his patients and for referring patients to two physicians who were, at the time of the referrals, not contracted with BCBS/HOI. In its March 27, 2001, letter to Dr. Mendez, HOI stated it was terminating him “without cause” and affording him a 60-day advance notice<sup>7</sup> as a result of a “periodic re-evaluation of our medical delivery system and the needs of our company and of our insureds in each individual market area.”

Concerned about Mendez’ deselection, the Florida Medical Association filed a complaint with the Florida Department of Insurance (DOI) formally requesting the DOI investigate whether the doctor was terminated due to his communications with his patients regarding medical care or treatment options for his patients which would violate the deceptive practices provision under s. 641.3903(14), F.S.<sup>8</sup> That provision specifically deems it is unlawful 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 when the provider feels knowledge of such information to be in the best interest of the patient. 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.<sup>9</sup>

Representatives with BCBS/HOI respond that Dr. Mendez was terminated due to the express provisions contained in his contract which allow either party to terminate the contract at any time “without cause.”<sup>10</sup> In general, BCBS/HOI and

---

<sup>6</sup> On June 22, 2001, Dr. Carlos Mendez filed an Amended Complaint in Circuit Court in Manatee County, Florida, against BCBS and HOI (Case No. 2001 CA-2628).

<sup>7</sup> Dr. Mendez also received two other termination notices from BCBS: one letter terminating him without cause from the BCBS Preferred Patient Care Agreement and affording him a 90-day notice and one letter terminating him without cause from the BCBS Traditional Program Participating Physician Agreement and giving him a 45-day notice. Dr. Mendez contracted with HOI in 1994 and with BCBS in 1999.

<sup>8</sup> Letter to DOI on June 19, 2001, by FMA general counsel, John M. Knight (See Appendix A).

<sup>9</sup> Under the Administrative Procedures Act (Ch. 120, F.S.), BCBS/HOI would be afforded an administrative hearing which would require DOI to prove its allegations against the companies.

<sup>10</sup> Blue Cross and Blue Shield and Health Options, Inc., filed a Motion to Dismiss the Mendez’ s Amended Complaint in Circuit Court on July 17, 2001. A court hearing was held on the BCBS/HOI motion on August 21, 2001.

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 vast majority of cases, providers leave their health plans voluntarily as opposed to being terminated.

In response to these concerns, this report will identify the current laws affecting managed care-health care practitioner contract cancellations in Florida and summarize such provisions in other states. It will focus on HMO as opposed to either preferred or exclusive provider organization (PPO and EPO) contract cancellations because the law does not provide the type of protections to providers under PPO or EPO arrangements as it does under HMO contracts. The report will also quantify the number of provider contracts terminated by the largest 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.) and the number of contracts terminated by providers over a one to three-year period. It will review the regulatory responsibilities of both the Department of Insurance and the Agency for Health Care Administration as to provider contract terminations, outline the relevant case law, and review the policy considerations concerning this issue. Finally, the report will provide recommendations for the Legislature's consideration.

## **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 four corners of 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 a provider's professional liability insurance; conviction for a felony offense; the

invocation of disciplinary action by any court or regulatory agency against the provider; or a material breach of the contract.<sup>11</sup>

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. According to some practitioners, there are HMOs who have exploited the “without cause” provisions. For example, while an HMO will initially contract with a large panel of providers to gain entry in a market, after capturing market share, it will narrow the panel by invoking termination “without cause” provisions. Providers assert that this practice results in disruption of patient care and loss of a potentially significant patient base. Others argue that “without cause” provisions allow HMOs to disguise the underlying, and arguably illegal, reason for removing a provider from a panel, such as having a sicker-than-average patient base. Also, there is a stigma attached when a provider is terminated from an HMO panel, regardless of the circumstances.

Health plans assert that they need to control the ability to select and terminate providers to operate effectively, efficiently, and contain costs. For example, a common reason to terminate a provider “without cause” is due to the HMO leaving a particular geographic area because it does not have enough members to support its network. Health plans state that losing the authority to deselect a provider would undermine the basic principles of managed health care. Further, HMOs typically oppose any law which invades the sanctity of a business contract because health care providers are *not* employees, but independent contractors. As such, these providers should not be given preferential treatment which is not afforded to other professionals.

## **Florida Law**

In an effort to balance these competing interests, the Florida Legislature has addressed these issues by 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 Department of Insurance before canceling a provider contract

---

<sup>11</sup> Both parties, a provider and an HMO, may terminate the contract for reasons of a material breach.

“without cause,” e.g., no reason needed.<sup>12</sup> 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.<sup>13</sup> 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.<sup>14</sup>

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.<sup>15</sup> 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.<sup>16</sup> 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.<sup>17</sup> 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

---

<sup>12</sup> S. 641.315(2), F.S. (Ch. 96-223, L.O.F.)

<sup>13</sup> S. 641.315(3), F.S.

<sup>14</sup> S. 641.315(2), F.S.

<sup>15</sup> S. 641.315(5), F.S. (Ch. 97-159, L.O.F.)

<sup>16</sup> S. 641.3903(14), F.S. (Ch. 99-264, L.O.F.)

<sup>17</sup> S. 641.51(8), F.S.

coverage until completion of post-partum care.<sup>18</sup> 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.

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.<sup>19</sup> 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.<sup>20</sup> Also HMO contracts may not contain provisions that prohibit or restrict the provider from entering into a commercial contract with any other HMO or which restricts the HMO from entering into a commercial contract with any other health care provider.<sup>21</sup>

A provision enacted last session 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.<sup>22</sup> 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.

## **Methodology**

Staff reviewed Florida’s health care provider termination provisions, legislative reports and periodicals on this topic, and similar provisions in other states. Detailed HMO-practitioner information was obtained from the four largest HMOs in the state (Health Options, Inc.; UnitedHealthCare of Florida, Inc.; Aetna U.S. Healthcare Inc., a Florida Corporation (Prudential); and Humana Medical Plan,

---

<sup>18</sup> S. 641.51(8), F.S. (Ch. 99-264, L.O.F.)

<sup>19</sup> S. 641.315(7), F.S. (Ch. 99-264, L.O.F.)

<sup>20</sup> This provision is restricted to a physician licensed under chapters 458 (allopathic), 459 (osteopathic), 460 (pediatric), or 461 (chiropractic), or a dentist licensed under chapter 466, F.S.

<sup>21</sup> S. 641.315(6), F.S.

<sup>22</sup> Ch. 2001-107, L.O.F.

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. Staff also reviewed the case law on this topic.

## **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).<sup>23</sup> 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; UnitedHealthCare 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 Department of Insurance regulates contractual, financial, and other operational requirements relating to HMOs under Part I, while AHCA administers HMO quality-of-care practices under Part III. Quality-of-care requirements for HMOs includes accreditation, internal quality assurance programs, and demonstration, to AHCA's satisfaction, of the HMOs' capability to provide health care services of a quality consistent with prevailing standards of medical practice in the community. To become a commercially licensed HMO, the organization must receive a health care provider certificate from AHCA and a certificate of authority from DOI.

Some health insurers offer a type of managed care product which is referred to as a preferred provider organization (PPO) contract. 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 Department of Insurance, but not the Agency for Health Care Administration. There is not a separate license or certificate that is issued to a

---

<sup>23</sup> March 31, 2001, Department of Insurance. The HMO enrollment has declined by 33,108 subscribers since last year.

health insurer for this purpose as there is for HMOs. Section 627.6471, F.S., regulates PPO contracts and provides, among other requirements, for limitations on the amount of the difference between the network and non-network deductible and coinsurance that the insurer may impose. The Department of Insurance 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. In addition to obtaining a certificate of authority as a health insurer from the Department of Insurance, an insurer must have its plan of operation approved by the Agency for Health Care Administration to determine the adequacy of the EPO provider network and assurance of quality of care, similar to an HMO. Normally, an EPO policy does not require the subscriber to designate a primary care physician (“gatekeeper”) nor does the EPO law refer to this practice, but the department has approved such provisions for EPO policies. The Department of Insurance does not maintain separate statistical information for EPOs.

## **Regulating Contract Cancellation Provisions**

The Department of Insurance has broad jurisdiction to investigate and enforce the regulations for HMOs<sup>24</sup> 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.<sup>25</sup> 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 complied 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 Agency for

---

<sup>24</sup> Each HMO must file a report of its activities at the end of each fiscal year with the department and undergo a complete examination by the department at least once every 3 years. In this way, the department can monitor every HMO and require an organization to take corrective action if deemed necessary to protect the interests of Florida consumers (ss. 641.26 and 641.27, F.S.).

<sup>25</sup> Explained above under the “Florida Law” section.

Health Care Administration for review as to whether the termination of the provider affects the network adequacy of the health plan.

As noted earlier in this report, 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.<sup>26</sup> 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 Agency for Health Care Administration 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”<sup>27</sup> 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.<sup>28</sup> Also, HMOs must ensure health care services are accessible to their subscribers with reasonable promptness. Specifically, 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.<sup>29</sup> 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

---

<sup>26</sup> S. 641.3903(14), F.S. The investigation by the DOI is confidential.

<sup>27</sup> Comprehensive health care services means services, medical equipment and supplies furnished by a provider which range from medical, surgical and dental care, to home health services, hospital services and lab services (s. 641.19(4), F.S.).

<sup>28</sup> AHCA staff point out that some of the larger HMOs utilize their own ratios as to the number of providers per subscribers by zip code. Under Medicaid, an HMO must have one primary care physician (PCP) per 1,500 HMO subscribers and one primary care staff physician per 2,500 subscribers. This ratio is affected if an advanced registered nurse practitioner or physician’s assistant is affiliated with the PCP. Staff with ACHA state that some of the larger HMOs have adopted internal ratio standards specifying the number of primary care providers and specialists per the number of subscribers.

<sup>29</sup> S. 641.495, F.S.

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.<sup>30</sup> 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 reaccreditation every 3 years.

Staff with ACHA emphasize that an HMOs' network adequacy and practitioner availability is thoroughly reviewed during both the accreditation and reaccreditation 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."<sup>31</sup> Four national accreditation organizations have reviewed and accredited the 31 HMOs operating in Florida.<sup>32</sup>

---

<sup>30</sup> S. 641.512, F.S., and Rule 12.0071, F.A.C.

<sup>31</sup> Managed Care Organization Guidelines for the National Committee for Quality Assurance, effective July 1, 2000.

<sup>32</sup> The four accreditation organizations are: National Committee for Quality Assurance; Accreditation Association for Ambulatory Health Care; Joint Commission for the Accreditation of Health Care Organizations; and American Accreditation Health Care Commission.

## **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,<sup>33</sup> 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<sup>34</sup> with 33,513 providers.

The table below shows the approximate number of practitioners in Health Options for the past 3 years and the number and percentage of plan initiated provider terminations for the same period.

**Health Options-Provider Terminations  
(1999-2001)**

Year	1999	2000	2001 <sup>35</sup>
<b>Total Number of Providers</b>	<b>15,036</b>	<b>15,136</b>	<b>15,236</b>
<b>Plan Initiated Terminations (includes “for cause” and “without cause” terminations)</b>	<b>124 (0.8%)</b>	<b>114 (0.8%)</b>	<b>118 (0.8%)</b>

As the information above indicates, the percentage of providers terminated by Health Options constitutes less than one percent of the total number of providers in the health plan. Further, officials with BCBS/HOI point out that the number of

<sup>33</sup> As of March 31, 2001. This figure does not include the 147,617 members in the Medicare+Choice HMO.

<sup>34</sup> This figure does not include the 124,858 members in the Medigap plan.

<sup>35</sup> As of July 31, 2001.

providers who have terminated contracts with HOI is twice the number of deselections they have initiated over the past several years.

According to representatives with BCBS/HOI, there were several considerations which supported the recent increase in the number of HOI initiated provider terminations for the first half of 2001.<sup>36</sup> 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. Company officials state that 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 or 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 terminations 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.<sup>37</sup>

---

<sup>36</sup> August 30, 2001, letter to Senator Ginny Brown-Waite from Daniel Lestage, M.D., Vice President, Healthcare Programs, Health Options, Inc. (See Appendix B).

<sup>37</sup> Dr. Mendez did not request binding arbitration after he was terminated.

## **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.<sup>38</sup> The table below shows the number of practitioners in UnitedHealthCare of Florida for 2001 (data for 1999 and 2000 was not available), the number of practitioners terminated by the plan and the number of practitioner initiated terminations for the past 3 years.

### **UnitedHealthCare of Florida-Provider Terminations (1999-2001)**

<b>Year</b>	<b>1999</b>	<b>2000</b>	<b>2001<sup>39</sup></b>
<b>Total Number of Providers</b>	<b>N/A</b>	<b>N/A</b>	<b>27,634</b>
<b>Plan Initiated Terminations (includes “for cause” and “without cause” terminations)</b>	<b>166</b>	<b>140</b>	<b>243 (0.9 %)</b>
<b>Provider Initiated Terminations</b>	<b>775</b>	<b>632</b>	<b>547 (2.0 %)</b>

As the information in the table above illustrates, the number of provider initiated contract cancellations is twice the number of plan initiated terminations for 2001 and over four times the number of plan initiated terminations for the 2 prior years.

According to representatives with UnitedHealthCare, there were a variety of reasons that the HMO terminated 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

---

<sup>38</sup> As of March 31, 2001.

<sup>39</sup> As of July 31, 2001.

notice,<sup>40</sup> 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. The table below shows the percentage of practitioners terminated by Aetna U.S. Healthcare Inc., a Florida Corporation, for the past three years for both its HMO and the PPO plan sold by Aetna Life Insurance Co. and the percentage of plan initiated and provider initiated terminations for the same period.

**Aetna - Provider Terminations (1999-2001)**

Year	1999	2000	2001 <sup>41</sup>
<b>Total Number (approx.) of Providers<sup>42</sup></b>	<b>30,500</b>	<b>29,000</b>	<b>30,500</b>
<b>Plan Initiated Terminations (includes both “for cause” and “without cause” terminations)</b>	<b>54 (0.18%)</b>	<b>243 (0.84%)</b>	<b>709 (2.3%)</b>
<b>Provider Initiated Terminations</b>	<b>597 (1.96%)</b>	<b>932 (3.2%)</b>	<b>1,307 (4.3%)</b>

As the data above indicates, most provider terminations were initiated by providers, rather than by Aetna. Providers voluntarily cancelled their employment contract for reasons similar to the other health plans: retirement; death of the provider; or dissatisfaction with the HMO. Among the four plans surveyed, Aetna reported the highest number of plan-initiated provider terminations for 2001. Aetna reports that over 90 percent of these terminations were due to the fact that Aetna terminated its Medicare-HMO coverage in certain areas. Other reasons for “without cause” terminations provided by Aetna representatives echoed the reasons offered by other HMOs, e.g., loss of membership in certain geographic areas; providers with a low volume of member contacts over a given period; or

---

<sup>40</sup> An exception is provided where a subscriber’s health is subject to imminent danger or the provider’s ability to practice medicine is impaired. This provision tracks Florida law under s. 641.315(2), F.S.

<sup>41</sup> As of July 31, 2001.

<sup>42</sup> The company did not separately identify its provider terminations for its HMO or PPO.

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. In the table below, the company provided physician termination information for the past year for both its HMO and PPO.<sup>43</sup>

**Humana-Provider Terminations  
(2001)**

Year	2001
<b>Total Number of Providers</b>	<b>15,062</b>
<b>Plan-Initiated Terminations (includes “for cause” and “without cause” terminations)</b>	<b>83 (0.6%)</b>
<b>Provider Initiated Terminations</b>	<b>769 (5.0 %)</b>

As illustrated in the above table, the number of provider initiated terminations is more than nine times the number of Humana initiated deselections. According to representatives with Humana, 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.

<sup>43</sup> The company was not able to separately identify the figures for its HMO or PPO.

## **Practitioner Cancellation or Deselection Laws in Other States**

While most state efforts are aimed at strengthening consumer protections under managed care, a number of states are trying to improve protections for practitioners as well. According to information compiled by the National Council of State Legislatures and staff with the Florida Senate Banking and Insurance Committee, 28 states (including Florida) have enacted laws or administrative rules that require some form of written notice of contract termination.<sup>44</sup> Furthermore, 13 of the 28 states have passed laws concerning due process that establish contract termination hearings or reviews or provider grievance procedures.<sup>45</sup>

California passed the first provider protection provision in 1994 which required managed care plans to give the reasons for terminating a provider contract when the termination occurs during the contract year. In 1995, Mississippi and Oregon enacted other forms of provider protection statutes. The Mississippi provision directs health care plans to provide 60-days' advance notice of termination to providers while the Oregon provision directs that all medical services contracts grant the provider adequate notice and hearing procedures prior to termination or nonrenewal of the contract when such termination or nonrenewal is based upon the quality of patient care rendered by the provider. The law also mandates that contracts state the criteria used in contract terminations and renewals.

In 1996, six states (Indiana, Maryland, Michigan, New York, Rhode Island and Virginia) adopted provider protection mandates. All these provisions affect either contract termination rules, criteria for network selection or other contract protections. Further, the provider protection laws in New York and Rhode Island establish due process criteria for providers who are terminated from a network, e.g., opportunity for a hearing or review concerning termination. That same year, California adopted an "anti-gag" clause which prohibits any retaliation against providers who advocate on behalf of their clients.

In 1997, twelve states (Arkansas, Colorado, Connecticut, Idaho, Louisiana, Maine, Missouri, Montana, New Jersey, Ohio, Oklahoma and Texas) enacted practitioner protection laws. All the laws, except in Louisiana, specify rules for contract terminations, criteria for network selection or other contract protections.

---

<sup>44</sup> Alaska, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Idaho, Illinois, Indiana, Maine, Maryland, Michigan, Mississippi, Missouri, Montana, Nebraska, New Jersey, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Texas, Vermont (administrative rule) and Virginia.

<sup>45</sup> Delaware, Idaho, Maine, Missouri, Montana, Nebraska, New Jersey, New York, North Dakota, Ohio, Oregon, Rhode Island, and Texas.

The Louisiana provision creates only provider grievance procedures. The legislation passed in Idaho, Maine, Missouri, Montana, New Jersey, Ohio and Texas establish provider grievance procedures or a contract termination appeals process. Idaho's law also provides for a reasonable period of time for providers to cure a breach in a contract prior to termination or nonrenewal.<sup>46</sup>

In 1998, four states (California, Delaware, Nebraska and Pennsylvania) enacted practitioner protection laws relating to written notification of contract termination or due process provisions. California's law directs health plans to make available to any providers with whom it contracts the criteria used to credential individual providers, terminate contracts, or fail to renew contracts with providers. The California provision also requires 90 days of continued care by the provider to a subscriber (patient) after the provider is terminated.

The measure enacted in Delaware requires insurers and health service corporations that propose to terminate or not renew a contract with a practitioner to give a minimum of 60 days' written notice to the practitioner prior to the effective date of the termination of the contract. This notice must include an explanation of the reasons for the termination and the provider is allowed to request an internal administrative review of the termination decision within 20 days. However, health plans may still terminate providers with or without cause for economic or other reasons.

Nebraska's comprehensive provider protection provision addresses written notice of contract termination along with a corrective action plan. A health carrier and participating provider must provide a minimum of 60 days' written notice to each other before terminating the contract "without cause." The law requires that prior to initiation of termination, the provider must be given an opportunity to enter into and complete a corrective action plan, except in cases of fraud, imminent harm to patient health, or when the provider's ability to provide services has been restricted by an action by the licensing board or a governmental agency.

Pennsylvania's consumer rights bill prohibits a health plan from terminating a provider for any of the following reasons: 1) advocating for medically necessary and appropriate health care consistent with their practice; 2) filing a grievance; and 3) protesting a decision, policy, or practice that the provider reasonably believes interferes with his or her ability to provide medically necessary care. The law also requires plans to establish a provider credentialing process and disclose this information to providers. In addition, it requires plans to notify a provider if the plan terminates or refuses to renew the provider's contract.

---

<sup>46</sup> However, if the breach is a willful breach, one based on fraud, or a breach which would pose immediate danger to the public health or safety, the contract may be immediately terminated or not renewed.

In 1998, Georgia enacted legislation that extended due process rights to practitioners in preferred provider organizations (PPOs) by giving rural hospitals or health clinics a “reasonable opportunity” to correct the deficiency which is the basis for the action, after receiving a written termination notice, and a right to a hearing before the Department of Insurance.<sup>47</sup>

In 1999, two states (Illinois and North Dakota) enacted practitioner protection laws relating to notification of contract termination or due process. Illinois provisions mandate written notification of contract termination by the plan while the North Dakota law requires that practitioners considered for sanction, termination or nonpayable status be given the opportunity to be present and to be heard by a committee appointed by the health care entity. The committee must include at least one representative of the practitioner's specialty.<sup>48</sup>

Alaska was the only state in 2000 to enact a law that requires a health plan-provider contract which provides for discretionary termination by either party to apply “equitably” to both parties.

### ***VOLUNTARY INITIATIVES***

Although Iowa has not enacted provider protection laws, a voluntary agreement between the Iowa Managed Care Association, the Association of Iowa Hospitals and Health Systems, John Deere Health Care Inc., the Iowa Medical Society, the Iowa Academy of Family Physicians, Wellmark, Blue Cross and Blue Shield of Iowa and other organizations addresses many of these issues. Participating managed care organizations agree to disclose their criteria for network selection, furnish reasons for rejecting providers from their network, develop an appeal system for providers who are not selected into the network, give notice to providers who are terminated from a plan, and provide an opportunity to appeal the termination decision.

A voluntary agreement in Colorado between the Colorado Medical Society and most of the state's HMOs establishes provider protections apart from state law.<sup>49</sup> This agreement recommends the development of contracting standards for primary care physicians and each physician specialty and a full explanation by the physician or HMO for terminations. While HMOs are not bound to review

---

<sup>47</sup> In 2000, these provisions were extended to rural hospitals and health clinics for HMOs.

<sup>48</sup> The North Dakota law also provides that if a health plan informs a provider as to the manner in which his or her practice is “excessive or inappropriate,” the provider has 6 months to “modify” his or her practice pattern, after which, if corrective action is not taken, the health plan may impose sanctions or terminate the provider's contract.

<sup>49</sup> Colorado law allows either party to terminate a contract “without cause” pursuant to specific notice requirements that are the same for both parties.

terminations, the agreement calls for a mediation procedure for the affiliation/termination process.

## **Case Law Concerning “Without Cause” Contract Cancellations**

Although courts around the country have historically enforced termination “without cause” provisions in contracts, two recent state court opinions represent a shift in thinking. The appellate courts in California and New Hampshire recognized that canceling a practitioner “without cause” in an era of managed care has social and policy ramifications. However, two other state courts in Colorado and Ohio have declined to follow their lead.<sup>50</sup>

In *Potvin v. Metropolitan Life Ins. Co.*, 997 P.2d 1153 (Cal. 2000), the California Supreme Court held that a physician terminated “without cause” was entitled to a fair procedure when an insurer possessed market power so substantial that removal impaired the physician’s ability to practice, thereby affecting a substantial economic interest, even when the physician’s contract included a termination “without cause” provision. The Supreme Court in New Hampshire in *Harper v. Healthsource*, 674 A.2d 962 (N.H. 1996), held that an HMO’s decision to terminate a physician must comport with the covenant of good faith and fair dealing and thus must not be made for a reason that is contrary to public policy. The court held that a physician terminated “without cause” was entitled to review of the HMO’s decision when he or she believed that the decision was made in bad faith or in a manner that was contrary to public policy.

A Colorado Court of Appeals recently upheld the validity of a “without cause” termination clause in the context of an HMO and a health care provider (*Grossman v. Columbine Medical Group*, 12 P.3d 269 (Colo. App. 2000)). Dr. Grossman had entered into a service agreement with an independent practice association (IPA) to provide services to patients who were members of certain managed care plans. Dr. Grossman was terminated “without cause” by the IPA and he appealed alleging the termination was unenforceable because of its alleged negative impact on the physician-patient relationship and its disruption of continuity of care. The Court rejected this argument and found nothing improper or invalid about the termination provision which gave either party the right to cancel the agreement “without cause.” Also, the Court refused to allow Dr. Grossman to invoke the doctrine of implied covenant of good faith to undermine the clear terms of the provider contract.

---

<sup>50</sup> Staff was unable to locate any relevant Florida cases.

In Ohio, an appellate court likewise affirmed the right of insurers to cancel their relationship with providers where the agreement contained a provision authorizing termination “without cause” (*Sammarco v. Anthem Ins. Co. Ins.*, 723 N.E.2d 128 (Ohio App. 1998)). The physicians in *Sammarco* sued a group of insurers for tortious interference, breach of implied covenant of good faith and fair dealing, and wrongful discharge and alleged the insurers had terminated them without any reason other than their own profit motive. The Court rejected this argument and stated that the at-will termination cause in the contract in “no way prohibits a physician from treating certain patients and places no affirmative restrictions on the physician’s ability to practice in the manner he wants. Even though not on Anthem’s provider panel, the physician may still treat any patient who wants treatment, even those patients insured by Anthem--although the physician would have to require payment by the patient rather than the insurer.”

## **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 would also include written notice of termination, a period of time for the provider to correct the problem, 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.

The written policies of both the Florida Medical Association (FMA) and the American Medical Association (AMA) reflect these concerns. The FMA policies call for prohibiting the “termination of any provider from a managed care plan without just cause” and it seeks “to enact legislation which would grant physicians due process and access to the data and deliberations used by a managed care company which resulted in the termination.”<sup>51</sup> The AMA policies mirror the FMA policies by recognizing the substantial economic impact that termination may have on a physician’s practice and on his or her patients. These policies state that prior to initiating termination, the physician must be given notice specifying the grounds for termination, a defined appeal process, and an opportunity to initiate and complete remedial activities, except in cases with imminent harm to patients or when an action by a state medical board or other government agency effectively limits the physician’s ability to practice medicine.<sup>52</sup>

---

<sup>51</sup> 2000 FMA Policy Compendium.

<sup>52</sup> 1998 AMA Principles of Managed 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 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.<sup>53</sup> 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.

## **Conclusions and 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 this 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 constituted 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

---

<sup>53</sup> Bruce P. Barnett, M.D. and J.D. in “*No-Cause Termination Bar is No Cure*,” Los Angeles County Medical Association Physician Magazine, 1996.

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 Department of Insurance and the Agency for Health Care Administration have regulatory responsibilities in this area. The Department of Insurance 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 Agency for Health Care Administration receives provider termination notices provided by the Department of Insurance 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 enumerated in such contracts include loss of credentialing, licensure or hospital staff privileges by the provider; arrest or conviction of a felony; breach of contract; cancellation of insurance; or disciplinary action resulting in sanctions from state regulators.

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.

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.

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.

## **Appendixes**

# **Appendix A**



# **Appendix B**