STORAGE NAME: h1415a.go
DATE: April 8, 1999

HOUSE OF REPRESENTATIVES
AS REVISED BY THE COMMITTEE ON
GOVERNMENTAL OPERATIONS
ANALYSIS

BILL #: HB 1415

RELATING TO: State Group Insurance Program

SPONSOR(S): Representative Roberts and others

COMPANION BILL(S): SB 800 (similar)

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

(1) HEALTH CARE SERVICES YEAS 7 NAYS 6
(2) GOVERNMENTAL OPERATIONS YEAS 6 NAYS 0
(3) GENERAL APPROPRIATIONS
(4)
(5)

I. SUMMARY:

HB 1415 provides that when a treating health care provider under the state group insurance program or a state-contracted health maintenance organization loses his or her network provider status for any reason other than cause, the state group insurance plan shall allow any enrollee in the state group health insurance plan or any health maintenance organization plan for whom the terminated provider was a treating provider to continue care with the terminated treating provider. The enrollee will be permitted to continue treatment with the terminated provider through the completion of treatment for the condition which the enrollee was receiving care at the time of termination, until the enrollee selects another treating provider, or until the next open enrollment period, whichever comes first, but no longer that one year after the termination of the treating provider.

The bill also requires the state group insurance plan to allow an enrollee who is in the third trimester of pregnancy to continue care with the terminated treating provider, unless the provider was terminated for cause, until completion of postpartum care. For care continued under these circumstance, the program and provider shall continue to be bound by the terms of the terminated contract.

According to the Division of State Group Insurance, the fiscal impact of this bill may include an increase in premiums for the state insurance trust fund and participants, but the increased costs are not determinable at this time.

II. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

Section 110.123, F.S., provides for the state group insurance program, which is "the package of insurance plans offered to state officers and employees, retired state officers and employees, and surviving spouses of deceased state officers and employees pursuant to this section, including the state group health insurance plan, health maintenance organization plans, and other plans required or authorized by this section."

According to s. 110.123(3)(c), F.S., "it is the intent of the Legislature to offer a comprehensive package of health insurance benefits for state employees which are provided in a cost-efficient and prudent manner, and to allow state employees the option to choose benefit plans which best suit their individual needs." Section 110.123(3)(c), F.S., further provides that the state group insurance program may include "the state group health insurance plan, health maintenance organization plans, group life insurance plans, group accidental death and dismemberment plans, and group disability insurance plans."

The state group insurance program is administered by the Division of State Group Insurance within the Department of Management Services and is headed by a director who is appointed by the Governor. Section 110.123(3)(a), F.S., provides that "the division shall be a separate budget entity, and the director shall be its agency head for all purposes."

According to the Division of State Group Insurance, the State Employees' PPO Plan has a standard operating procedure that addresses cases where it would be medically necessary for the original treating provider to continue care. Cases which routinely qualify for continued or transition of care include: second trimester pregnancies through birth, including postpartum care; scheduled surgery up to 30 days; end stage renal disease, up to 30 days; outpatient rehabilitation services, up to 30 days; and chemotherapy and radiation therapy, up to 90 days. Other cases may be considered for transition of care benefits upon appeal to Blue Cross and Blue Shield of Florida and the Division of State Group Insurance.

All HMOs contracted with the state employees' insurance program are subject to the provisions of s. 641.51(7), F.S., which requires that HMOs and providers must allow 60 days of continued care when the treating provider is terminated, or terminates, from the HMO. Continued care must be medically necessary and the patient must have a life-threatening, disabling, or degenerative disease or condition, or must be in the third trimester of pregnancy. In accordance with this section, HMOs and providers are bound to the same terms and conditions of the contract for the continued care.

In February of 1999, a Tallahassee-based HMO "was forced to drop some providers to improve its bargaining position with others after significant financial losses last year." [Pensacola News Journal, Friday, March 5, 1999, at 1A, 6A (quoting the chief operating officer of the HMO)] As a result, many of the HMO's members were required to switch providers. About half of the affected members were state employees covered under the state group insurance program.

B. EFFECT OF PROPOSED CHANGES:

The state group health insurance plan will be required to allow any enrollee in the state group health insurance plan or any contracted health maintenance organization plan to continue care with a treating provider when the treating provider is terminated for any reason except for cause. The enrollee will be permitted to continue treatment with the terminated provider through the completion of treatment for the condition which the enrollee was receiving care at the time of termination, until the enrollee selects another treating provider, or until the next open enrollment period, whichever comes first, but no longer than one year after the termination of the treating provider.

A state health insurance enrollee who is in the third trimester of pregnancy will be allowed to continue care with a terminated treating provider, except when the provider was fired for cause, until completion of postpartum care.

C. APPLICATION OF PRINCIPLES:

1. Less Government:

a. Does the bill create, increase or reduce, either directly or indirectly:

(1) any authority to make rules or adjudicate disputes?

No.

(2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

No.

(3) any entitlement to a government service or benefit?

Enrollees of the state group health insurance plan and any state-contracted health maintenance organization plan will be allowed to continue treatment with a terminated provider through the completion of treatment to an even greater extent than is currently permitted.

b. If an agency or program is eliminated or reduced:

This bill does not eliminate or reduce an agency or program.

(1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

N/A

(2) what is the cost of such responsibility at the new level/agency?

N/A

(3) how is the new agency accountable to the people governed?

N/A

2. Lower Taxes:

a. Does the bill increase anyone's taxes?

No.

b. Does the bill require or authorize an increase in any fees?

No.

c. Does the bill reduce total taxes, both rates and revenues?

No.

d. Does the bill reduce total fees, both rates and revenues?

No.

e. Does the bill authorize any fee or tax increase by any local government?

No.

3. Personal Responsibility:

a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

No.

b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

No.

4. Individual Freedom:

a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs?

Enrollees of the state group health insurance plan and any contracted health maintenance organization plan will be allowed to continue treatment with a terminated provider through the completion of treatment to an even greater extent than is currently permitted.

b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

No.

5. Family Empowerment:

a. If the bill purports to provide services to families or children:

This bill does not purport to provide services to families or children.

(1) Who evaluates the family's needs?

N/A

(2) Who makes the decisions?

N/A

(3) Are private alternatives permitted?

N/A

(4) Are families required to participate in a program?

N/A

(5) Are families penalized for not participating in a program?

N/A

b. Does the bill directly affect the legal rights and obligations between family members?

No.

c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

This bill does not create or change a program providing services to families or children.

(1) parents and guardians?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. STATUTE(S) AFFECTED:

Section 110.123, F.S.

E. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 110.123, F.S., relating to state group health insurance, to provide that when a treating health care provider under the state group insurance program or any health maintenance organization loses his or her network provider status for any reason other than cause, the state group insurance plan shall allow any enrollee in the state group health insurance plan or any health maintenance organization plan for whom the terminated provider was a treating provider to continue care with the terminated treating provider through completion of treatment of a condition for which the enrollee was receiving care at the time of termination, until the enrollee selects another treating provider or the next open enrollment period designated by the division, whichever comes first, but no longer than one year after termination of the treating provider. The state group insurance plan must also allow an enrollee who is in the third trimester of pregnancy to continue care with the terminated treating provider until completion of postpartum care. For care continued under these circumstances, the program and provider shall continue to be bound by the terms of the terminated contract for such continued care, and such continued care will not apply to treating health care providers who have been terminated by the program for cause.

Section 2. Provides for the act to take effect upon becoming law.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

See fiscal comments.

2. Recurring Effects:

See fiscal comments.

3. Long Run Effects Other Than Normal Growth:

See fiscal comments.

4. Total Revenues and Expenditures:

   See fiscal comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

   None.

2. Recurring Effects:

   None.

3. Long Run Effects Other Than Normal Growth:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

   None.

2. Direct Private Sector Benefits:

   Enrollees of the state group health insurance plan and any contracted health maintenance organization plan will be allowed to continue treatments with a terminated provider through the completion of treatment to an even greater extent than is currently permitted.

3. Effects on Competition, Private Enterprise and Employment Markets:

   Unknown.

D. FISCAL COMMENTS:

According to the Division of State Group Insurance: “Increased mandates on a private health care provider’s contracts with insurers and HMOs may negatively impact the provider’s willingness to participate or accept lower discounts. Lower discounts with health care providers could result in fewer providers in a health plan and higher costs to the health plan. Higher costs to Blue Cross Blue Shield and our contracted HMOs would ultimately result in higher premiums for the state insurance trust fund and participants. Increased costs as a result of these concerns are not determinable.”

The division also states that: “Without a definition of ‘completion of treatment of a condition’ and comparing such definition to the HMO statute and PPO plan transition of care standard operating procedure, the fiscal impact on the trust fund and plan participants is not determinable.”

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

A. APPLICABILITY OF THE MANDATES PROVISION:

The bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that municipalities or counties have to raise revenues.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

It is unclear what the phrase "completion of treatment of a condition" should be interpreted to include. Without a more specific definition, this phrase might be interpreted to include minor or routine treatment.

In addition, the bill refers to a third trimester threshold for pregnancies, but the current State Insurance PPO Plan transition of care guidelines provide for a second trimester threshold. The Division of State Group Insurance is concerned that the legislation would override the current provision, and therefore, provide less protection to women in their second trimester.

Related language, applicable to HMO coverage generally, was adopted by the Committee on Health Care Services as part of CS/HB 337 on March 11, 1999. To avoid conflicts, the chapter 110 provisions of this bill should be conformed to the chapter 641 provisions of CS/HB 337.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On March 29, 1999, the Committee on Health Care Services adopted the following amendment:

Amendment #1 (offered by Rep. Roberts): On page 5, lines 3-24: This amendment is necessary to avoid conflicts with related language, applicable to HMO coverage generally, that was recently adopted by the Committee on Health Care Services as part of CS/HB 337 and in CS/SB 232. The amendment specifies that in termination of a contract between a treating provider and a state contracted health maintenance organization for any reason other than cause, each party to the contract shall allow enrollees for whom treatment was active to continue coverage and care when medically necessary through completion of treatment of a condition for which the subscriber was receiving care at the time of the termination, until the enrollee selects another treating provider, or during the next open enrollment period offered, whichever is longer, but no longer than 6 months after termination of the contract. The amendment also allows an enrollee who has initiated a course of prenatal care irrespective of the trimester in which care is initiated, to continue care and coverage until completion of postpartum care.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:	Staff Director:
Amy K. Guinan	Phil E. Williams

AS REVISED BY THE COMMITTEE ON GOVERNMENTAL OPERATIONS:

Prepared by:	Staff Director:
Jimmy O. Helms	Jimmy O. Helms