

STORAGE NAME: h1415z.hcs

DATE: June 7, 1999

****FINAL ACTION****

****SEE FINAL ACTION STATUS SECTION****

**HOUSE OF REPRESENTATIVES
AS REVISED BY THE COMMITTEE ON
HEALTH CARE SERVICES
FINAL ANALYSIS**

BILL #: HB 1415 (passed as section 4 of CS/SB 232)

RELATING TO: State Group Insurance Program

SPONSOR(S): Representative Roberts and others

COMPANION BILL(S): SB 800 (s) SB 232 (c)

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. FINAL ACTION STATUS:

06/08/99 Approved by Governor; Chapter No. 99-264

II. SUMMARY:

HB 1415, as adopted as section 4 of CS/SB 232, specifies that in termination of a contract between a treating provider and the state-contracted health maintenance organization for any reason other than for 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 enrollee was receiving care at the time of the termination, until the enrollee selects another treating provider, or until the next open enrollment period offered, whichever is longer, but no longer than 6 month after termination of the contract. The bill also allows an enrollee who has initiated a course of prenatal care, regardless of the trimester in which care is initiated, to continue care and coverage until completion of postpartum care.

These provisions do not prevent a provider from refusing to continue to provide care to a an enrollee who is abusive, noncompliant, or in arrears in payments for services provided. For care continued under these circumstances, the program and the provider shall continue to be bound by the terms of the terminated contract. Changes made within 30 days before termination of a contract are effective only if agreed to by both parties.

The bill shall take effect upon becoming a law and shall apply only to contracts entered into after the effective date.

III. 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:

When a contract between a treating provider and the state-contracted health maintenance organization is terminated for any reason other than for cause, each party will be required to allow any enrollee for whom treatment was active to continue coverage and care when medically necessary, through completion of treatment of a condition for which the enrollee was receiving care at the time of the termination, until the enrollee selects another treating provider, or until the next open enrollment period offered, whichever is longer, but no longer than 6 month after termination of the contract. An enrollee who has initiated a course of prenatal care regardless of the trimester in which care is initiated, will be permitted to continue care and coverage until completion of postpartum care.

These provisions will not prevent a provider from refusing to continue to provide care to a an enrollee who is abusive, noncompliant, or in arrears in payments for services provided.

For care continued under these circumstances, the program and the provider will continue to be bound by the terms of the terminated contract. Changes made within 30 days before termination of a contract will be effective only if agreed to by both parties.

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 a 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 a 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(3)(h), F.S., 1998 Supplement

E. SECTION-BY-SECTION ANALYSIS:

See EFFECT OF PROPOSED CHANGES above.

IV. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

Unknown.

2. Recurring Effects:

Unknown.

3. Long Run Effects Other Than Normal Growth:

Unknown.

4. Total Revenues and Expenditures:

Unknown.

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 a greater extent than is currently permitted.

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

Unknown.

D. **FISCAL COMMENTS:**

None.

V. 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.

VI. COMMENTS:

None.

VII. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On March 29, 1999, the Committee on Health Care Services adopted an amendment that was necessary to avoid conflicts with related language, applicable to HMO coverage generally, that was adopted by the Committee on Health Care Services as part of CS/HB 337 and in CS/SB 232. The amendment specified 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,

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whichever is longer, but no longer than 6 months after termination of the contract. The amendment also allowed 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.

Although HB 1415 died in the House Committee on General Appropriations, language similar to the above amendment passed by the Committee on Health Care Services was adopted by the House and Senate in an amendment to CS/SB 232.

VIII. 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

FINAL ANALYSIS PREPARED BY THE COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:

Staff Director:

Amy K. Guinan

Phil E. Williams