SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

BILL: CS/SB 1554

SPONSOR: Banking and Insurance Committee and Senator Dawson-White

SUBJECT: Access to Obstetrical and Gynecological Services

DATE: April 12, 1999 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Emrich	Deffenbaugh	BI	Favorable/CS
2.			FP	
3.				
4.				
5.				

I. Summary:

Committee Substitute for Senate Bill 1554 mandates that exclusive provider organizations (EPOs) and health maintenance organizations (HMOs) provide, under certain circumstances, direct patient access for their female subscribers for obstetrical-gynecological care with contracted obstetricians and gynecologists. The term "obstetrical-gynecological care" is defined to mean up to two annual visits, to include one well woman visit and one additional visit to address acute gynecological problems, as well as all medically necessary follow-up care, to treat the obstetrical-gynecological condition detected by the OB/GYN during these visits. Nothing in the bill shall prevent an EPO or HMO plan from requiring that the OB/GYN treating a covered patient coordinate the medical care through the patient's primary care physician, if applicable. Current law does allow each female subscriber in an HMO to select as her primary physician an obstetrician/gynecologist (OB/GYN) who has agreed to serve as a primary physician and is in the HMOs provider network.

The committee substitute would also require health maintenance organizations to include a summary of subscriber referral and continuation of care information in their member handbooks.

There is an undetermined fiscal impact associated with this committee substitute. Exclusive provider organizations and health maintenance organizations would be required to offer their female subscribers direct access to OB/GYN services for at least one or possibly more visits annually that are now being provided through a primary care physician or "gatekeeper." In essence, a patient would be allowed to self-refer to these specialists under the restrictions noted above.

This committee substitute amends the following sections of the Florida Statutes: 627.6472, 641.31, and 641.51.

II. Present Situation:

Background

Health Maintenance Organizations

Health maintenance organizations (HMOs) provide a comprehensive range of health care services for a prepaid premium. Such organizations stress preventive care and make efforts to avoid unnecessary hospitalization and expensive tertiary care. Subscribers must surrender certain freedom-of-choice selections of health care providers and health-care-related services and are restricted as well in their choice of hospitals and other health care delivery facilities. Subscriber choice is typically restricted to a "gatekeeper" physician (primary care physician) who sees the patient first and then makes a referral to a specialist. These provisions enable HMOs to manage utilization, quality of care, and the cost of medical services which contribute to the savings that managed care plans achieve relative to fee-for-service providers (indemnity plans). Florida law does not provide significant exceptions to the “gatekeeper” regulatory apparatus endemic to HMOs except for allowing direct access to dermatologists, amended in 1997. The law also requires HMOs to cover emergency services and care at non-contract hospitals under certain circumstances. That year the Legislature provided direct access for subscribers to dermatologists in HMOs and EPOs without the need for the subscriber to go through a primary care physician (ch. 97-171, L.O.F.).

As of June 1998, more than 4.7 million Florida residents were receiving their health care coverage through commercial HMOs. Even more state residents were receiving health care coverage through other managed care programs, such as preferred provider organizations and Medicaid managed care programs. The number of Florida residents receiving health care coverage through managed care plans has steadily increased since the early 1980's when the state's HMO industry began to grow. Since 1988, the number of commercial HMOs has decreased from a high of 47 to the current 35, however, enrollment has increased. Enrollment in most other types of managed care programs continues to increase as well. Regulation of HMOs is divided between the Department of Insurance and the Agency for Health Care Administration (AHCA).

The Department of Insurance regulates HMO finances, contracting, and marketing activities under part I of chapter 641, F.S. The department is responsible for ensuring that these entities are financially solvent and conduct their marketing activities in accordance with established guidelines. The Agency for Health Care Administration regulates the quality of care provided by HMOs under part III of chapter 641, F.S. The quality requirements under this part include demonstrating, to AHCA's satisfaction, that the HMO is capable of providing health care of a quality consistent with prevailing professional standards of health care delivery.

Under s. 641.31, F.S., a health maintenance organization contract, certificate, or member handbook must state all of the services to which a subscriber is entitled under the contract as well as limitations on services, including copayment features or schedule of benefits. Health maintenance organizations must also develop certain policies concerning member referrals and continuation of care provisions (s. 641.51(5),(6),(7), F.S.). The referral provisions include when exceptional referrals should be provided to out-of-network providers to address the unique medical needs of a subscriber and provisions for standing referrals to subscribers with chronic and

disabling conditions which require ongoing specialty care. As to continuation of care, HMOs must allow subscribers, with life-threatening conditions, disabling and degenerative conditions, or subscribers who are in their third-trimester of pregnancy, to continue care for 60 days with a terminated treating provider when medically necessary.

Exclusive Provider Organizations

Under an EPO or indemnity plan arrangement, 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. Policies or certificates issued by the EPO may condition payment of health care benefits on the subscriber's use of contract providers, if such benefits are accessible and available through the EPO. The Agency for Health Care Administration is responsible for regulating the delivery of services by EPOs and has currently approved the plan of operation for 10 EPOs. Like HMOs, the Department of Insurance regulates the fiscal, contractual, and marketing activities of insurers who provide services to their policy holders and certificate holders through EPOs. Normally an EPO policy does not require the policy holder to designate a primary care physician ("gatekeeper") nor does the EPO law refer to this practice, but the department has recently approved such provisions for EPO policies.

Women's Health Provisions/Managed Care Issues

In 1995, Florida enacted legislation authorizing a female managed care enrollee to select as her primary care provider an obstetrician/gynecologist who has agreed to serve as a primary physician and is in the managed care plan's network (ch. 95-281, L.O.F.). The following year the Legislature addressed maternity length of stay related issues pertaining to health insurance, group, blanket, and franchise insurance as well as health maintenance organizations (Ch. 96-195, L.O.F). One year later, HMOs were mandated to develop policies and procedures allowing standing referrals to subscribers with chronic and disabling conditions which require ongoing speciality care (ch. 97-159, L.O.F.). The term "chronic and disabling conditions" was not defined, but could include an OB/GYN-related condition.

Under the State of Florida Group Health Insurance Program, HMO members are able to visit an OB/GYN without a referral, once per year, for a routine gynecological exam. A female HMO member can also have an OB/GYN as her primary care physician. Other services provided by an OB/GYN are obtained through referrals by the patient's primary care physician. Direct access of any in-network or out-of-network provider is offered to preferred provider members (PPO Plan) with different reimbursement arrangements according to provider network status.

According to a representative with the Florida Association of Health Maintenance Organizations, the larger HMOs in Florida already allow their female subscribers one annual visit (a so-called "well woman visit") to their OB/GYN. Other officials with HMOs assert that providing direct access to OB/GYN for one or possibly two annual visits, plus follow-up visits, is unnecessary and inappropriate because there is no evidence that HMO subscribers have insufficient access to these specialists. They also assert that the effect of allowing direct access, however limited, would increase utilization of these services, thereby raising the costs to HMOs of providing care as enrollees would seek treatment from higher-paid specialists who would be more likely to make greater use of costly procedures and treatments. This would have the concomitant effect of

reducing the HMOs ability to manage utilization of medical services, an activity which is a major part of the cost savings that managed care plans achieve.

Representatives of obstetricians or gynecologists counter that the revenue impact upon EPOs and HMOs of the committee substitute will not be significant because the costs of examination by a primary care physician will be eliminated. Further, the delay in obtaining needed care, that could ultimately result in necessitating more expensive treatment, will be minimized and the costs of misdiagnosis by a nonspecialist provider, that can occur due to inadequate knowledge or lack of the appropriate equipment for making an accurate assessment of the patient's condition, will be reduced. They also state that the health care relationship between a female member and her OB/GYN provider is important because a woman's general health is often dependent upon her reproductive health.

A June 1998 assessment by the American College of Obstetricians and Gynecologists indicates that Florida is one of 16 states that has authorized an obstetrician/gynecologist to be a primary care physician. A total of 27 states permit direct access to non-primary care physician obstetrician/gynecologists. (Florida is not one of the 27.) Of these 27 states, 13 permit access to non-physician obstetrician/gynecologist providers; 7 have an option of informing the primary care physician of visits to the obstetrician/gynecologist providers; 7 require that the primary care physician be informed of the obstetrician/gynecologist visit; 11 states require a notice to the enrollee regarding the availability of direct access for obstetrician/gynecologist visits; and 10 states prohibit additional fees for direct obstetrician/gynecologist provider visits.

III. Effect of Proposed Changes:

Section 1. Adds a new subsection (18) to s. 627.6472, F.S., relating to exclusive provider organization service coverage requirements, to require that EPOs shall not require prior authorization for female subscribers for obstetrical-gynecological care with contracted obstetrician-gynecologists. The term "obstetrical-gynecological care" means up to two annual visits, including one well woman visit, one additional visit to address acute gynecological problems, as well as all medically necessary follow-up care to treat the obstetrical-gynecological condition detected by the OB/GYN during these visits. Nothing in this provision shall prevent a plan from requiring that the OB/GYN treating a covered patient coordinate the medical care through the patient's primary care physician, if applicable.

Section 2. Amends s. 641.31, F.S., 1998 Supplement, relating to health maintenance contracts, to require HMOs to include in their contract, certificate, or member handbook a summary of referral policies and procedures available from the HMO under s. 641.51 (5), (6), and (7), F.S. The noted subsections provide for the following: subsection (5) refers to exceptional referrals to out-of-network providers who are allowed to address the unique medical needs of a subscriber; subsection (6) provides for standing referrals to subscribers with chronic and disabling conditions which require ongoing specialty care; and, subsection (7) allows subscribers, with life-threatening conditions, disabling and degenerative conditions, or subscribers who are in their third-trimester of pregnancy, to continue care for 60 days with a terminated treating provider when medically necessary.

Section 3. Amends s. 641.51, F.S., relating to quality assurance programs for health maintenance organizations, to provide that health maintenance organizations shall not require prior authorization for female subscribers for obstetrical-gynecological care with contracted obstetrician-gynecologists. The term "obstetrical-gynecological care" means up to two annual visits, including one well woman visit, one additional visit to address acute gynecological problems, as well as all medically necessary follow-up care to treat the obstetrical-gynecological condition detected by the OB/GYN during these visits. Nothing in this provision shall prevent a plan from requiring that the OB/GYN treating a covered patient coordinate the medical care through the patient's primary care physician, if applicable.

Section 4. Provides that the act shall take effect on October 1, 1999, and shall apply to contracts issued or renewed on or after the effective date.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The health insurance benefits required by this bill would apply to local government health insurance plans to the extent that such coverage is provided via exclusive provider organizations or health maintenance organizations. To the extent this bill requires local governments to incur expenses, i.e., to pay additional health insurance costs, the bill falls within the purview of Article VII, Section 18 of the Florida Constitution, which provides that cities and counties are not bound by general laws requiring them to spend funds or to take action which requires the expenditure of funds unless certain specified exemptions or exceptions are met.

This bill may qualify for the exemption for bills having an insignificant fiscal impact.

An exemption would apply if a legislative determination is made that the bill fulfills an important state interest. The bill does contain a legislative finding to this effect at present.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Female members of EPOs and HMOs (who do not have an OB/GYN as their primary care physician) will benefit by being able to visit their OB/GYN annually for a routine medical check-up, without prior authorization. Similarly such members may self-refer if they should experience an acute gynecological problem.

Exclusive provider organizations and HMOs can be anticipated to encounter some fiscal impact as a result of the provisions of this committee substitute. Direct access to obstetricians or gynecologists, even with the noted restrictions on OB/GYN visits, may reasonably be expected to inhibit the ability of an HMO or EPO to control costs and utilization of such services.

One factor which could possibly limit the committee substitute's fiscal impact is that prior authorization could impede or delay access to appropriate care and in the long run cost more, especially in cases where a woman has an "acute gynecological problem." This is because such a serious medical problem could worsen because of delayed access to necessary care.

C. Government Sector Impact:

According to the Division of State Group Insurance, female HMO subscribers are able to visit an OB/GYN without a referral, once per year, for a routine gynecological exam (well woman visit). A HMO member can also have an OB/GYN as her primary care physician. It is undetermined what impact the provision allowing for self-referral due to an acute gynecological problem (and necessary follow-up care) would have on the plan.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Section 624.215, F.S., requires organizations seeking consideration of a legislative proposal that would mandate a health benefit to prepare a report to the Agency for Health Care Administration and the legislative committee with jurisdiction over the proposal to assess the proposal's financial and social impact. No such report has been prepared.

VIII. Amendments:

None.