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: SB 800

SPONSOR: Senator Thomas and others

SUBJECT: State Group Insurance Program

DATE: April 19, 1999 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Wilson	Wilson	GO	Fav/1 amendment
2.	Woodham	Deffenbaugh	BI	Fav/3 amendments
3.	Hendon	Hadi	FP	Favorable
4.				
5.				

I. Summary:

The bill provides a state employee or dependent enrolled in a state group health plan with continued access to a treating health care provider through completion of the treatment for which the provider was treating the enrollee, unless the provider has lost provider status for cause. The bill provides for a 1 year limit on the continued access to the provider who has lost provider status. An enrollee who is in the third trimester of pregnancy is allowed to continue care with a terminated treating provider until completion of postpartum care.

The program and the provider shall continue to be bound by the terms of the terminated contract for continued care.

This bill amends section 110.123 of the Florida Statutes.

II. 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."

At the beginning of employment, state employees and their dependents are afforded the opportunity to choose or decline health insurance coverage. During the annual open enrollment period, all employees are permitted to choose between indemnity or managed care options for coverage, or to elect no coverage at all. During the plan year, each covered employee is bound by the contractual provisions of the provider company and their coverage limitations. The indemnity plan permits a wider employee choice among providers, but assesses a higher employee contribution for providers not in the physician network. Managed care plans generally have a smaller provider panel from which to choose, and their network may have additional geographic constraints based upon their market area.

The state has a self-insured PPO plan and a fully-insured HMO plan. In the event a provider leaves either of the two plan networks, an employee-patient may experience an interruption or termination in care. The employee-patient may then have to choose another physician who is unfamiliar with the patient's history or incur additional personal expense for continued care with the provider who the plan no longer recognizes.

According to the division, the state employees' PPO plan has a standard operating procedure which addresses situations 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/Blue Shield of Florida and the Division of State Group Insurance.

The state purchases only fully insured HMOs which are licensed and regulated by Chapter 641, F.S. The division rules do not alleviate any provision of ch. 641 for its contracted HMOs, and, according to the division, its HMOs are expected to comply with the provisions of ch. 641. All HMOs contracted with the state employees' insurance program are subject to the provisions of s. 641.51(7), F.S., which require that HMOs and providers allow 60 days of continued care, under certain conditions, 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, unless the provider was terminated for cause.

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. The state employees' next open enrollment is not scheduled until October 1999.

Applicability of Mandated Benefit Laws to the State Group Plan

It is unclear whether or not the state PPO plan is required to comply with the provisions of ch. 627 regarding group health insurance. It appears that the provisions of part VII of ch. 627 do apply to the state PPO plan. Section 627.651, F.S., states that:

> (1) Except as otherwise provided by law, a group health insurance policy or certificate insuring more than one individual delivered or issued for delivery in this state must be delivered or issued to one of the groups provided for in ss. 627.653 - 627.656 [Employee groups, labor union and association groups, debtor groups, teacher and student groups]. **A plan of self-insurance providing health coverage benefits to residents of this state must comply with s. 627.419 [construction of policies] and the applicable provisions of this part relating to the rights of individuals to specified benefits and coverages**.
>
> (4) This section does not apply to any plan which is established or maintained by an individual employer in accordance with the Employee Retirement Income Security Act of 1974 [ERISA] . . .

Governmental insurance plans are specifically excluded from the requirements of ERISA, so the exemption in subsection (4), above, would not apply to the state group plan. Also, s. 627.652(2)(a)-(b), F.S., states that "[t]he terms 'policy,' 'insurance policy,' 'health insurance policy,' 'group health policy,' and 'group health insurance policy' include plans of self-insurance providing health insurance benefits . . . The terms 'amount of insurance' and 'insurance' include the benefits provided under a plan of self-insurance." These definitions seem to indicate that the state PPO plan would be subject to the provisions of part VII of ch. 627.

There is no provision in part II of ch. 627, relating to general insurance contracts, which specifically states that Part II applies to self-insurance plans. This part contains miscellaneous requirements that are applicable to various types of insurance policies and includes statutes that require certain health insurance benefits. Each section in this part specifies the types of insurance that it applies to, (subject to the types of policies that are *excluded* from all sections of part II, specified in s. 627.401, F.S., which does not reference self-insurance plans) The sections that relate to required health insurance benefits generally refer to a "health insurer" or to a "health insurance policy" but the definition of "insurer" in s. 624.03, F.S. and "policy" in s. 627.402, F.S., are fairly broad and generic and may include plans of self-insurance. One of the sections of part II, s. 627.4235, F.S., relating to coordination of benefits, refers specifically to self-insurance plans.

With regard to the HMO coverage offered to state employees, as stated above, the state purchases only fully insured HMO contracts with HMOs which are licensed and regulated by Chapter 641, F.S. The division rules do not alleviate any provision of ch. 641 for its contracted HMOs, and, according to the division, its HMOs are expected to comply with all mandatory benefit requirements and all other provisions of ch. 641.

III. Effect of Proposed Changes:

Section 1. The bill permits enrollees in either of the two state health insurance programs to continue treatment with a provider who has lost his or her network provider status for any reason other than for cause. The care may continue with the terminated provider until completion of treatment of the condition for which the enrollee was being treated, until the enrollee chooses another treating provider, or until the next open enrollment period, whichever occurs first, but not longer than 1 year after termination of the treating provider.

Enrollees in the third trimester of pregnancy shall be allowed to continue treatment with the terminated treating provider until the completion of postpartum care, unless the termination of the treating provider was for cause.

For continued care, the program and the provider shall continue to be bound by the terms to the terminated contract.

Section 2. The bill shall take effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

The provider network in the indemnity insurance program operated by the Division of State Group Insurance is owned by Blue Cross/Blue Shield of Florida. Managed care organizations may be configured on a staff or individual provider organization basis. In the latter circumstance, each provider enters into a contractual relationship with the managed care organization.

One effect of the bill is to legislatively require provider adherence to a terminated contract, possibly to the adverse financial interests of the former parties to the contract. The Legislature may not constitutionally alter, amend or impair the obligation of existing contracts. Art. I, Sec. 10, Fla. Const.; Dewberry v. Auto Owners Insurance Co., 363 So.2d 1077 (Fla. 1978); Smith v. Dept. Of Insurance, 507 So.2d 1080 (Fla. 1987).

In this circumstance, the bill directs adherence to a terminated contractual relationship. An alternative to this dilemma would be to amend the bill to have it apply only to contracts arising or renewed after the effective date of the statute or to a date certain that is after the effective date of the next state contract.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill provides an option to those enrolled in a state group insurance plan to continue treatment with a provider who has been terminated from the state contract, for a reason other than for cause, until the enrollee completes treatment for the condition for which he/she was seeing the terminated treating provider, until the enrollee chooses a new provider, or until the next open enrollment period, but not longer than one year. This bill provides protection to state employees and allows them to continue treatment with a provider, in the event the provider is terminated during the plan period, but before the next open enrollment.

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 allowed, except in the case of pregnancy. Currently under the state group plan, an employee in the second trimester of pregnancy is allowed to continue treating with a terminated provider through postpartum care. Under the bill, the continued coverage is limited to the third trimester pregnancies. This would provide less protection for women in their second trimester of pregnancy.

The bill would require physicians or other health care providers to treat enrollee/patients for a group plan with whom the physician is no longer under contract, possibly to his or her financial detriment. The insurer would be forced to pay health care providers, who they have terminated, in order to provide continuation of care for enrollees/patients.

C. Government Sector Impact:

According to the Division of State Group Insurance, the proposed legislation would significantly extend the provisions of the state employees' PPO plan and the state contracted HMO plans. Furthermore, the proposed legislation would only effect HMOs with state enrollees and only for those state enrollees. Non-state employee members would not benefit from this legislation. (See Related Issues, below.)

The division also states, “[i]ncreased mandates on a private health care provider's contracts with insurers and HMOs may negatively impact the providers 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 BCBSF [Blue Cross/Blue Shield of Florida] 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 further states, "[w]ithout 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."

VI. Technical Deficiencies:

None.

VII. Related Issues:

CS/SB 232 Regarding HMO Coverage:
Related language, applicable to HMO coverage generally, was adopted by the Banking and Insurance Committee and the Health, Aging and Long-Term Care Committee as part of CS/SB 232.

CS/SB 232, which relates to continuation of care requirements by HMOs generally, requires treatment to continue for a period not longer than 6 months, as compared to the maximum 1 year period in this bill. Under the bill, when a contract between an HMO and a treating provider is terminated for any reason other than for cause, each party must allow subscribers for whom treatment was active to continue coverage 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 subscriber selects another treating provider, or during the next open enrollment period offered by the HMO, whichever is longer. However, in no event would this period extend longer than 6 months after termination of the contract.

The bill also requires each party to the contract to allow a subscriber who has initiated prenatal care to continue care until completion of postpartum care. However, the bill provides that these requirements do 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. The reference to "arrears in payments" apparently refers to the copayments or deductibles for which an HMO subscriber is responsible. Currently subscribers may not be held liable to any health care provider for any services covered by the HMO (s. 641.315, F.S.).

For care continued under these provisions, the HMO and the provider continue to be bound by the terms of the terminated contract. Changes made within 30 days after termination are effective only if agreed to by both parties. (The relevance of this 30-day period is not clear. It may imply that the parties are prohibited from mutually agreeing to change the terms of the contract after this 30-day period.)

State Regulated Managed Care:
Writing in the March 1999 issue of *State Legislatures*[1], Richard Cauchi reviews standard features incorporated within state-regulated managed care statutes. Many states permit out-of-plan service by enrollees for pharmacies and obstetrics/gynecology. For Florida, ss. 641.31094, 641.31095, and 641.31096, F.S., respectively, place additional specific service or treatment requirements on managed care organizations for the provision of certain surgical procedures involving bones or joints, mammograms, and breast cancer follow-up care.

As currently drafted, the bill may have some unanticipated results. *First*, a provider may have reached a legal understanding with the managed care organization in which the termination of professional services was specifically deemed *not* to be for cause. This professional separation may have emanated from a variety of reasons, some of which may have caused the managed care organization to advise the Board of Medicine, or other regulatory and licensing authorities, of departures from the quality of care.

Second, the bill provides that the enrollee-patient may seek the services of the existing provider, but does not address whether the providing entity is itself required to maintain the professional relationship until closure of the next open enrollment period.

Third, the bill provides coverage expansion for state employee and dependent contracted health care providers which are more stringent than those required of entities operating in other public or private markets. With the attrition of managed care organizations from the state managed care network during the past two years, specifically, Health Options and Aetna, more stringent treatment requirements may affect the competitiveness of the State of Florida as a desirable customer in an increasingly cost-sensitive, consolidated provider environment.

Fourth, the bill uses a nonspecific definition of "continuity of care" which could be inclusive of long-term treatment for complicated burn injuries and reconstructive surgery as well as for well-understood care for many chronic and treatable conditions such as diabetes, macular degeneration, allergies and asthma, arthritis, hypo- and hyperthyroidism, high blood pressure, and cataracts. The Division of State Group Insurance reports that there are only five benefit exceptions contained in transition care guidelines for the state-operated indemnity plan: pregnancy, scheduled surgery, end stage renal disease, outpatient rehabilitation services initiated prior to provider termination, and chemotherapy/radiation therapy.

[1]*Managed Care: Where Do We Go From Here?*, pp. 14-18.

VIII. Amendments:

#1 by Governmental Oversight and Productivity:
Permits continued care with a non-participating treatment provider but limits the state group insurance or managed care plan's financial exposure to the previous contract reimbursement amount. The enrollee-patient will be responsible for the balance of the bill during the transition period. The amendment clears up the constitutional problem of forcing a terminated provider to comply with a terminated contract, even to his or her financial detriment, by requiring the enrollee-patient to pay for any difference between the contract amount and the services provided.

#1 by Banking and Insurance Committee:
Addresses continuation of care and coverage with a terminated provider, who was terminated for reasons other than for cause, for the HMO portion of the state group insurance plan. The amendment does not affect the self-insured PPO plan.

The amendment requires continuation of treatment and coverage with a terminated provider 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, but the continuation of treatment and coverage with a terminated provider is not to exceed 9 months. A subscriber who has initiated prenatal care, regardless of the trimester, shall be allowed to continue care and coverage until completion of postpartum care.

A terminated provider may refuse to continue to provide care to a subscriber who is abusive, noncompliant, or in arrears in payment for services.

The amendment requires the parties to be bound by the terms of the terminated contract, with regard to continued care. Changes made within 30 days after termination of a contract are effective only if agreed to by both parties.

#2 by Banking and Insurance Committee:
Creates paragraph (e) of s. 110.12315, F.S., to disallow the Division of State Group Insurance to implement a prior authorization prescription drug program or a restricted formulary program, which restricts access to prescription drugs for an enrollee of a state-contracted HMO. The amendment terminates the prescription drug prior authorization program, which was implemented by the division pursuant to Section 8 of the 1998-99 General Appropriations Act. In the Act, the division was directed to improve the management of the prescription drug program in response to rapidly increasing prescription drug costs.

Currently, there are thirty-three prescription drugs on the division's prior authorization list. The patient must undergo a trial of one or more of the alternative drugs to those on the list. If the patient has already tried one or more of the alternatives, and the physician submits documentation to this effect, then prescriptions will be authorized. If a patient tries an alternative drug, and it does not work for the patient, or if there are other factors that make the alternative inappropriate for the patient, then the prescription will be authorized.

#3 by Banking and Insurance Committee:
Changes the effective date to January 1, 2000, to prevent impairment of existing HMO contracts.