# 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: March 9, 1999 REVISED: 3/11/99

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Wilson | Wilson | GO | Fav/1 amendment |
| 2. | | | BI | |
| 3. | | | FP | |
| 4. | | | | |
| 5. | | | | |

## I. Summary:

The bill provides for continued access by a state employee or dependent to a treating health care provider for up to 1 year following loss of provider status from the state group health insurance plan or any health maintenance organization. Continued access shall not be required if the provider termination was for cause.

This bill amends section 110.123, Florida Statutes.

## II. Present Situation:

State employees and their dependents are afforded the opportunity to choose or decline health insurance coverage at their initial employment. 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.

An employee-patient may receive discontinuous care in the event a provider exits either of the two plan networks. The employee-patient may then have to choose another physician unfamiliar with the patient history or incur additional personal expense for continued care with the provider which the plan will no longer recognize.

## III. Effect of Proposed Changes:

The bill permits enrollees in either of the two state health insurance programs to continue treatment with a provider who exits the program for up to one year or the sooner cessation of the

current course of treatment. For enrollees in the third trimester of pregnancy treatment shall be continued until the completion of postpartum care.

## 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 force provider adherence to a terminated contract possibly to the adverse treating interests, and quite probably to the adverse financial interests, of the former parties. It is well understood that the Legislature may not impair the obligation of contracts. *Dartmouth College v. Woodward,* 4 Wheaton 518 (1819). In this circumstance the bill directs adherence to a terminated contractual relationship. An alternative to this dilemma would be replacement language specifying that a patient may continue with a terminated provider for the 1 year period, but the health insurance plan's reimbursement would be limited to contract amounts. The enrollee-patient would be responsible for the balance of the payment. This circumstance, known as balance billing, is not permitted under s. 641.315, F.S., and is otherwise not permitted for Medicaid and Medicare patients. It may be permitted in this transitional circumstance since the provider does not have a contractual relationship with the state group insurance or managed care organization recognized under s. 641.315, F.S.

## V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

See, *Related Issues*, below.

C. Government Sector Impact:

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

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, provide 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, only 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.

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[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.