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

BILL #: HB 953 (Passed as sections 13 and 14 of HB 2231)

RELATING TO: Access to Obstetrical & Gynecological Service

SPONSOR(S): Rep. Sanderson & others

COMPANION BILL(S): SB 1554 (s)

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) HEALTH CARE SERVICES YEAS 14 NAYS 0
(2) HEALTH AND HUMAN SERVICES APPROPRIATIONS YEAS 9 NAYS 0
(3)
(4)
(5)

I. FINAL ACTION STATUS:

06/11/99 Approved by Governor; Chapter No. 99-356

II. SUMMARY:

HB 953, as adopted as sections 13 and 14 of HB 2231, requires an exclusive provider organization and a health maintenance organization to allow, without prior authorization, a female subscriber to visit a contracted obstetrician/gynecologist for one annual visit and for medically necessary follow-up care detected at that visit. This authorization shall not prevent an organization from requiring that an obstetrician/gynecologist treating a covered patient coordinate the medical care through the patient's primary care physician, if applicable. These provisions are effective July 1, 1999. (See the COMMENTS section of this analysis regarding the effective date provisions.)

There is an indeterminate fiscal impact associated with this bill. Exclusive provider organizations and health maintenance organizations may be forced to offer access to services that are currently being provided through a primary care "gatekeeper." Those insured individuals may see some cost increase as exclusive provider organizations and health maintenance organizations pass on to covered persons any costs associated with compliance with these provisions. Conversely, if exclusive provider organizations and health maintenance organizations are currently requiring a primary care visit in order to provide a referral to an obstetrician or gynecologist, the cost associated with this intermediate step will be eliminated.

III. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

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 provides very few exceptions to the “gatekeeper” regulatory apparatus of HMOs. Examples of existing exceptions include the requirement that HMOs cover emergency services and care at non-contract hospitals under certain circumstances. In 1997, 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., consisting of ss. 641.17-641.3923, 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., consisting of ss. 641.47-641.75, 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. Specific HMO quality assurance issues addressed under s. 641.51, F.S., include those relating internal quality assurance programs, physician professional judgment, second medical opinions, out-of-network specialty referrals, standing referrals, continuity of care, reporting of quality-of-care indicators to AHCA, customer satisfaction surveys, and preventive pediatric services.

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. Under s. 627.6472, F.S., 1998 Supplement, 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. In addition, as with 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.

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.; ss. 409.9122(1)(b) and 641.19(7)(e), F.S. [currently codified in 641.19(13)(e), F.S.]). The following year the Legislature (via ch. 96-195, L.O.F.) addressed maternity length of stay related issues pertaining to various health insurance coverage categories: s. 627.6406, F.S., relating to health insurance; s. 627.6574, F.S., relating to group, blanket, and franchise insurance; and s. 641.31, F.S., relating to health maintenance organizations. 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 obstetrical/gynecological-related condition.

Under the State of Florida Group Health Insurance Program (s.110.123, F.S.), HMO members are able to visit an obstetrician/gynecologist without a referral, once per year, for a routine gynecological exam. A female HMO member can also have an obstetrician/gynecologist as her primary care physician. Other services provided by an obstetrician/gynecologist 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 obstetrician/gynecologist. Other officials with HMOs assert that providing direct access to obstetrical/gynecological services for one or more 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 HMO's 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 and gynecologists counter that the revenue impact upon EPOs and HMOs 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 obstetrician/gynecologist 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.

B. EFFECT OF PROPOSED CHANGES:

The bill will:

- Add a new subsection (18) to s. 627.6472, F.S., 1998 Supplement, relating to exclusive provider organization service coverage requirements, to require an exclusive provider organization to allow, without prior authorization, a female subscriber to visit a contracted obstetrician/gynecologist for one annual visit and for medically necessary follow-up care detected at that visit. This authorization shall not prevent an organization from requiring that an obstetrician/gynecologist treating a covered patient coordinate the medical care through the patient's primary care physician, if applicable.

- Add a new subsection (11) to s. 641.51, F.S., relating to health maintenance organization quality assurance and second medical opinion requirements, to require a health maintenance organization to allow, without prior authorization, a female subscriber to visit a contracted obstetrician/gynecologist for one annual visit and for medically necessary follow-up care detected at that visit. This authorization shall not prevent an organization from

requiring that an obstetrician/gynecologist treating a covered patient coordinate the medical care through the patient's primary care physician, if applicable.

These provisions will take effect July 1, 1999. (See the COMMENTS section of this analysis regarding the effective date provisions.)

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?

Exclusive provider organizations and health maintenance organizations may be forced to offer access to services that are currently being provided only through a "gatekeeper."

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

No.

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

(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?

Those insured individuals may see some cost increase as exclusive provider organizations and health maintenance organizations pass on to covered persons any costs associated with compliance with these provisions.

4. Individual Freedom:

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

The bill gives women the option of having access to a contracted obstetrician/gynecologist for any medical condition identified as part of an annual visit, an option that may not be available currently.

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:

(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:

(1) parents and guardians?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. STATUTE(S) AFFECTED:

Sections 627.6472 and 641.51, F.S.

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:

The Division of State Group Insurance will incur costs associated with notifying state employees of the availability of access to services by obstetricians and gynecologists since the implementation date does not coincide with the beginning of the calendar year. The Division of State Group Insurance estimates it will incur non-recurring expenditures related to the notification of benefit changes of $17,500 based on an HMO enrollment of 58,058 subscribers.

2. Recurring Effects:

To the extent that exclusive provider organizations and health maintenance organizations under contract with the state for services for state employees do not currently allow access to obstetricians and gynecologists as specified in these provisions, these plans may incur some costs associated with such access. Conversely, if such plans currently require a woman to see a primary care physician in order to receive a referral to obstetricians and gynecologists, the plans could avoid costs associated with this required step.

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:

   Unknown.

2. Recurring Effects:

   See above comments related to state impact.

3. Long Run Effects Other Than Normal Growth:

   Unknown.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

   To the extent that exclusive provider organizations and health maintenance organizations do not currently allow access to obstetricians and gynecologists without a referral from a primary care physician, these plans may incur some costs associated with such access. Conversely, if such plans currently require a woman to see a primary care physician in order to receive a referral to obstetricians and gynecologists, the plans could avoid costs associated with this required step.

2. Direct Private Sector Benefits:

   Women enrolled in exclusive provider organizations and health maintenance organizations who wish to have access to obstetricians and gynecologists would be allowed to do so.

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 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 not contain a legislative finding to this effect.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

The bill does not reduce the ability of local governments to raise revenue.

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

The bill does not reduce tax shared with counties and municipalities.

VI. COMMENTS:

As previously mentioned, the bill does not provide a statement of public necessity relative to any local government mandates applicability, and it is also unclear if the bill's fiscal impact would rise to a level of mandates concern.

The effective date of HB 2231 reads: "This act shall take effect July 1, 1999, except that sections 10 and 11 of this act shall take effect October 1, 1999, and shall apply to contracts issued or renewed on or after that date." The referenced sections 10 and 11 are part of the "Florida Community Health Protection Act" as created by sections 10, 11, and 12 of the act. The effective date reference appears to be a "scrivener's error" that should have been a reference to sections 13 and 14, since these insurance-related coverage provisions are applicable to "contracts" as referenced. This issue has been brought to the attention of the Division of Statutory Revision of the Office of Legislative Services.

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 for this coverage benefit.

VII. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

When this bill was heard by the Committee on Health Care Services on March 18, 1999, the committee adopted a strike-everything amendment that specified that exclusive provider organizations (regulated under s. 627.6472, F.S.) and health maintenance organization quality assurance-referrals guidance (as indicated under s. 641.51(6), F.S.) shall not require prior authorization for female subscribers for obstetrical/gynecological care with a contracted obstetrician/gynecologist. "Obstetrical-gynecological care" was specifically defined in this context. Finally, the amendment specified that nothing in the subsection prevents a plan from requiring that an obstetrician-gynecologist treating a covered patient coordinate the medical care through the patient's primary care physician, if applicable.

When the bill as amended was heard in the House Health and Human Services Appropriations Committee on April 9, 1999, the committee unanimously approved the bill.

When the bill was heard on the House floor on April 26, 1999, the bill as amended was unanimously approved.

When the similar companion measure, SB 1554, was heard by the Senate Banking and Insurance Committee on April 12, 1999, that bill was amended to delete the requirement that health maintenance organizations and exclusive provider organizations provide direct patient access to contracted obstetrician/gynecologists and instead provided that such organizations provide direct patient access for their female subscribers' obstetrical/gynecological care under certain enumerated restrictions, including a requirement relating to coordination of care with the subscriber's primary care provider. Health maintenance organizations were also required to include a summary of subscriber referral and continuation of care information in their member handbooks.

As adopted as sections 13 and 14 of HB 2231, these provisions were further modified to reflect the final version of the adopted language.

VIII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:	Staff Director:
Phil E. Williams	Phil E. Williams

AS REVISED BY THE COMMITTEE ON HEALTH AND HUMAN SERVICES APPROPRIATIONS:

Prepared by:	Staff Director:
Tom Weaver	Lynn Dixon

FINAL ANALYSIS PREPARED BY THE COMMITTEE ON HEALTH CARE SERVICES:

Prepared by:	Staff Director:
Phil E. Williams	Phil E. Williams