STORAGE NAME: h0953a.hhs
DATE: April 9, 1999

HOUSE OF REPRESENTATIVES
AS REVISED BY THE COMMITTEE ON
HEALTH AND HUMAN SERVICES APPROPRIATIONS
ANALYSIS

BILL #: HB 953

RELATING TO: Access to Obstetrical & Gynecological Service

SPONSOR(S): Rep. Sanderson & others

COMPANION BILL(S): SB 1554

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. SUMMARY:

HB 953 requires an exclusive provider organization and health maintenance organization to provide direct patient access to services provided by licensed obstetricians or gynecologists who are under contract with the respective organization. The term “direct patient access” is defined for purposes of this context. The organization is prohibited from imposing any additional copayments or deductibles for such access. These provisions are made applicable to contracts entered into or renewed on or after October 1, 1999.

There is an indeterminate fiscal impact associated with this bill. Exclusive provider organizations and health maintenance organizations may be forced to offer direct access to services that are currently being provided through a “gatekeeper.” Those insured individuals may see some cost increase as exclusive provider organizations and health maintenance organizations pass any costs on to covered persons. 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.

II. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

Most managed care plans are organized around the fundamental principle that enrollees select, or are assigned to, a primary care provider. In addition to providing basic health care, the primary care provider authorizes specialty care as needed. Most of women's health care, including reproductive health care in general and, most specifically, family planning, does not fit neatly into the primary care versus specialty rubric. American women, who often tend to view their gynecologist as their primary physician, have consistently opposed prior authorization requirements for what is to them basic health care.

The underlying purpose of the primary care physician prior authorization system is to prevent unnecessary or excessive utilization of health care while ensuring that medical conditions are properly diagnosed and that appropriate referrals are made. For many reproductive health care services, these rationales rarely apply. It is generally the woman, in accordance with her personal goals, rather than the provider making a medical determination, who identifies a need for something like family planning services and decides whether to take action to avoid unintended pregnancy. Over-utilization in this context is not an issue, and prior authorization may only serve to impede or delay access to appropriate care. In addition, prior authorization may also be difficult, if not impossible, in some cases, since definitions of appropriate care may be subject to the opinions and values of the primary care physician.

The transition to managed care has not always been smooth. The issue of women's health care in the managed care context has been the subject of debate and review in recent years. For example, the issue of so-called "drive-through deliveries" received attention and was addressed by the passage of laws at the state level, including here in Florida, as well as at the national level. In 1995, Florida enacted authorization for 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.). Chapter 96-195, L.O.F., amended several sections of statute to address maternity length of stay related issues. The impacted statutes were: 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.

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.

The provisions of chapter 627, F.S., relate to insurance coverage requirements. Part VI of this chapter, consisting of ss. 627.601-627.6499, F.S., relates to health insurance policies. Section 627.6472, F.S., governs exclusive provider organizations. In addition, part I of chapter 641, F.S., consisting of ss. 641.17-641.3923, F.S., provides health maintenance organization coverage requirements. Section 641.31, F.S., specifically addresses health maintenance organization contracts.

B. EFFECT OF PROPOSED CHANGES:

HB 953 requires an exclusive provider organization and health maintenance organization to provide direct patient access to services provided by licensed obstetricians or gynecologists who are under contract with the respective organization. The term "direct patient access" is defined for purposes of such services. The organization is prohibited from imposing any additional copayments or deductibles for such access. These provisions are made applicable to contracts entered into or renewed on or after October 1, 1999.

There is an indeterminate fiscal impact associated with the bill.

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 direct access to services that are currently being provided 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 any costs on to covered persons.

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 direct access to their obstetrician/gynecologist, 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 641.31, F.S.

E. SECTION-BY-SECTION ANALYSIS:

Section 1. Adds a new subsection (18) to s. 627.6472, F.S., relating to exclusive provider organization service coverage requirements, to require an exclusive provider organization to provide direct patient access to services provided by a board-certified or board-eligible obstetrician or gynecologist who is under contract with the health maintenance organization if the exclusive provider organization covers obstetrical or gynecological services. The term “direct patient access” is defined as the ability of the subscriber to obtain services without a referral or other authorization before receiving services. An exclusive provider organization is prohibited from imposing any coinsurance or deductible upon a subscriber who obtains services under the provisions of this subsection unless the additional copayment or deductible is imposed on all other primary care physician services.

Section 2. Adds a new subsection (36) to s. 641.31, F.S., relating to health maintenance organization contracts, to require a health maintenance organization to provide direct patient access to services provided by a board-certified or board-eligible obstetrician or gynecologist who is under contract with the health maintenance organization. The term “direct patient access” is defined as the ability of the subscriber to obtain services without a referral or other authorization before receiving services. The health maintenance organization is prohibited from imposing any additional copayment for such services unless the additional copayment is imposed on all other primary care physician services.

Section 3. Makes the provisions of the bill applicable to contracts entered into or renewed on or after October 1, 1999.

Section 4. Provides for an effective date of October 1, 1999.

III. 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 direct access to services by obstetricians and gynecologists if the implementation date doesn’t 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. If the implementation date is January 1, 2000, then the notification process would be incorporated into the normal open enrollment period and no additional costs would be incurred.

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 direct access to obstetricians and gynecologists, 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 direct access to obstetricians and gynecologists, 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 direct access to obstetricians and gynecologists would be allowed to do so.

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

   Unknown.

D. FISCAL COMMENTS:

If the bill's effective date were changed to January 1, 2000, there would be no cost to the Division of State Group Insurance associated with notifying state employees of the availability of direct access to obstetrician and gynecologist services as provided under the bill.

IV. 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 contain a legislative finding to this effect at present.

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.

V. 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.

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.

VI. 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 specifies 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 contracted obstetrician-gynecologists. "Obstetrical-gynecological care" is specifically defined in this context. Finally, the amendment specifies 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.

VII. 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:

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