The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	SB 7026
INTRODUCER:	Governmental Oversight and Accountability Committee
SUBJECT:	State Group Insurance Program
DATE:	March 16, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
	McVaney	McVaney		**GO SPB 7026 as introduced**
1.	Johnson	Knudson	BI	**Pre-meeting**
2.			AP	

I. Summary:

SB 7026 requires the Department of Management Services (DMS) to ensure that each contracted health maintenance organization (HMO) within the state group insurance program provides to covered members under the age of 21 reasonable access to covered medical services within 3 months of the request for early and periodic screening, diagnostic, and treatment requirements.

The bill sets forth contractual requirements between the DMS and HMOs and specifies grievance or complaint procedures. Each HMO is required to submit quarterly reporting to the DMS regarding grievances or complaints. The DMS is required to establish financial consequences and fines if the network adequacy, timely referral and the reasonable access provisions of this bill are not met.

This bill may have a negative indeterminate fiscal impact to the State Employees' Health Insurance Trust Fund.

This bill provides an effective date of July 1, 2015.

II. Present Situation:

Regulation of Health Maintenance Organizations

The Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers, health maintenance organizations, and other risk-bearing entities.[1] The Agency for Health Care Administration (agency) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the agency pursuant to part III of ch. 641, F.S.[2]

[1] Section 20.121(3)(a)1., F.S.
[2] Section 641.21(1), F.S.

Under part III of ch. 641, F.S., HMOs are subject to accreditation requirements. Section 641.495(4), F.S., requires an HMO to ensure that the health care services it provides to subscribers, including physician services as required by s. 641.19(12)(d) and (e), F.S., are accessible to the subscribers, with reasonable promptness, with respect to geographic location, hours of operation, provision of after-hours service, and staffing patterns within generally accepted industry norms for meeting the projected subscriber needs.

In addition, HMOs are subject to Rule 59A-12.006, F.A.C, regarding the quality of care provided. Specifically, paragraph (3) states in part:

> [The HMO shall] [e]nsure that the health care services it provides or arranges for are accessible to the subscriber with reasonable promptness. Such services shall include, at a minimum:
> (a) Establishment of an appointment system;
> (b) A method to distinguish among emergency, urgent, and routine cases.
> 1. Emergencies will be seen immediately;
> 2. Urgent cases will be seen within 24 hours;
> 3. Routine symptomatic cases will be seen within two weeks; and
> 4. Routine non-symptomatic cases will be seen as soon as possible.

Further, the rule requires HMOs to comply with the following requirements:

> (f) Maintenance of staffing patterns within generally accepted HMO industry norms for meeting projected subscriber needs and for expeditiously satisfying the requirements of the benefit package as offered by the HMO; and
> (g) Maintenance of a professional staff or arrangements with providers, duly licensed as required to practice in Florida.

The federal Patient Protection and Affordable Care Act (PPACA)[3] requires health insurers, including HMOs, to allow subscribers to request an external review, including an expedited external review, when the HMO has denied a patient's request for payment of a claim under certain circumstances.[4] The external review process is limited to the denial of a patient's request for payment of a claim when the denial involves a medical judgment. The term "medical judgment" includes, but is not limited to, a decision based on medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment requested, or a determination that the treatment is experimental or investigational. The expedited external review process under PPACA is limited to patients with life threatening conditions that would seriously jeopardize the patient's life or health or ability to regain maximum function or in the opinion of the physician would subject the patient to severe pain that could not be managed with the care or treatment subject to the urgent appeal.

[3] Section 1001 of Pub. L. No. 111-148.
[4] 45 CF 147.

State Group Insurance Program

Under the authority of s. 110.123, F.S., the Department of Management Services (DMS), through the Division of State Group Insurance, administers the state group insurance program by providing employee benefits such as health, life, dental, and vision insurance products under a cafeteria plan consistent with section 125, Internal Revenue Code. To administer the state group health insurance program, DMS contracts with third party administrators, health maintenance organizations (HMO), and a pharmacy benefits manager for the State Employees' Prescription Drug Plan pursuant to s. 110.12315, F.S.

Regulations relating to scheduling appointments and adequacy of access of plans are specified in Rule 59A-12.006, F.A.C, as discussed earlier. According to DMS, in rare instances and based on the realities of a clinical practice, it may take more time than specified in the timeframes above for a subscriber or member to receive a service.[5] Some examples of when the time may extend beyond the prescribed timeframes include when:

- Requested care is for a rare subspecialty;
- The physician needs more time to review medical records or order special testing before scheduling an appointment;
- The physician has an extended wait time for routine care; or
- In some areas, demand is high and there is a shortage of health care providers.

All HMOs provide a customer service line to assist subscribers with finding access to care in a reasonable amount of time for circumstances such as these. To ensure patients can be seen as quickly as possible, subscribers may be given the option to choose a different health care provider than their preferred choice.[6]

Current contracts of DMS require access standards to health care providers, and performance guarantees are in place for these access standards with financial consequences for failure to comply. However, DMS is not a party to the private business contracts between the HMOs and their network providers.

Complaint and grievance procedures are established pursuant to state laws[7] applicable to HMOs. Chapter 120, F.S., and Chapter 60P, F.A.C., govern the appeal process for self-insured HMOs. The DMS's current contracts require HMOs to maintain a record of all grievances or appeals, as applicable, and provide a summary to DMS quarterly or more frequently, if requested. The report provides a narrative summary of the reasons for the grievance, disposition, and corrective actions because of the grievance.

Early and Periodic Screening, Diagnostic and Treatment Benefits

In the Medicaid program, Florida is required to provide comprehensive services and furnish covered services that are appropriate, medically necessary and needed to correct and ameliorate health conditions, based on certain federal guidelines. The Early and Periodic Screening,

[5] Department of Management Services, SB 7026 Analysis, February 12, 2015 (on file with Banking and Insurance Committee).
[6] *Id.*
[7] See s. 641.511, F.S.

Diagnostic and Treatment (EPSDT) benefits[8] include the following screening, diagnostic, and treatment services:

1. Screening Services
   - Comprehensive health and developmental history
   - Comprehensive unclothed physical exam
   - Appropriate immunizations (according to the Advisory Committee on Immunization Practices)
   - Laboratory tests (including lead toxicity screening)
   - Health Education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention)
2. Vision Services
   - At a minimum, diagnosis and treatment for defects in vision, including eyeglasses. Vision services must be provided according to a distinct periodicity schedule developed by the state and at other intervals as medically necessary.
3. Dental Services
   - At a minimum, dental services include relief of pain and infections, restoration of teeth, and maintenance of dental health. Dental services may not be limited to emergency services. Each state is required to develop a dental periodicity schedule in consultation with recognized dental organizations involved in child health.
4. Hearing Services
   - At a minimum, hearing services include diagnosis and treatment for defects in hearing, including hearing aids.
5. Other Necessary Health Care Services
   - States are required to provide any additional health care services that are coverable under the Federal Medicaid program and found to be medically necessary to treat, correct or reduce illnesses and conditions discovered regardless of whether the service is covered in a state's Medicaid plan. It is the responsibility of states to determine medical necessity on a case-by-case basis.
6. Diagnostic Services
   - If a screening examination indicates the need for further evaluation of an individual's health, diagnostic services must be provided. Necessary referrals should be made without delay and there should be follow-up to ensure the enrollee receives a complete diagnostic evaluation. States should develop quality assurance procedures to assure that comprehensive care is provided.
7. Treatment
   - Necessary health care services must be made available for treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures.

These benefits are not necessarily covered services under the State Group Insurance Program administered by DMS. For example, the vision (eyeglasses) and dental treatments are not typically covered services under the State Group Insurance Program.

[8]See http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html (last viewed on February 15, 2015).

III. Effect of Proposed Changes:

SB 7026 creates s. 110.12303, F.S., to ensure "reasonable access" to "health services" for persons under age 21 covered by HMOs under the state group insurance program.

"Health services" include those services that are both Early and Periodic Screening, Diagnostic and Treatment benefits in the Medicaid program and covered services under the state group insurance program.

"Reasonable access" means that health services are initiated within the guidelines for national standards for medical services or no later than 3 months of the initial request for the particular health service.

DMS is required to include in its contracts with HMOs standards for network adequacy, timely referral, and reasonable access to health services. The contracts must also specify the financial consequences that apply when the HMO fails to meet those particular standards. According to DMS, existing state law and national standards relating to access for certain health services require such services to be provided more quickly than under this bill.[9]

The HMO contract must contain specific provisions granting members of the State Group Insurance Program the right to submit a complaint or grievance and to request an external review, including an expedited review, if an HMO denies reasonable access. The bill appears to require DMS to guarantee a right to members of the program to submit complaints relating to reasonable access to health services and request for external reviews of such denials of reasonable access.

In terms of these complaints, the contract must require the HMOs to report to DMS at least quarterly the number of filed complaints, the types of health services at issue, and the resolution of those complaints. The contract must also specify a fine to be assessed against the HMO in each instance the HMO has failed to provide reasonable access to health services under this bill.

The bill takes effect July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

[9] 2015 Legislative Bill Analysis for SPB 7026 by the Department of Management Services, dated February 12, 2015, and on file with the Committee on Governmental Oversight and Accountability.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill may provide HMO subscribers under the State Group Insurance Program with timelier access to medical services. An HMO that fails to meet standards for network adequacy, timely referrals, and reasonable access would be subject to financial risks and additional administrative burdens.

C. Government Sector Impact:

According to the DMS, this bill could have a negative indeterminate fiscal impact to the State Employees' Health Insurance Trust Fund. HMOs may seek to negotiate higher administrative fees or premiums, as applicable, at renewal or as part of a competitive procurement to account for financial risk and administration associated with the provisions of this bill.

VI. Technical Deficiencies:

The DMS suggests that the bill should provide the DMS with rulemaking authority to set and enforce fines and suggests the bill should establish parameters for the fines.[10]

The DMS also suggests that the bill should state whether the administrative penalties would apply to current HMO contracts or contracts with an effective date of January 1, 2016. The bill provides a July 1, 2015, effective date.

VII. Related Issues:

According to the DMS, network adequacy, timely referral, and reasonable access would not qualify for an external review.[11] The external review process is limited to a denial of a patient's request for payment of a claim and the denial involves a medical judgment including, but not limited to, a decision based on medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment requested, or a determination that the treatment is experimental or investigational.

The expedited external review process under federal law is limited to patients with life threatening conditions that would seriously jeopardize the patient's life or health or ability to

[10] Department of Management Services, SB 7026 Analysis, February 12, 2015 (on file with Senate Banking and Insurance Committee).
[11] *Id.*

regain maximum function or in the opinion of the physician would subject the patient to severe pain that could not managed with the care or treatment subject to the urgent appeal. Periodic screenings would not meet the criteria for an expedited external review, nor would a delay in receiving health services, as defined in this bill, qualify for an expedited external review. It is unclear whether the right to an external review, as provided in this bill, is limited by the federal law or is more expansive based on the terms of the contract.

VIII. Statutes Affected:

This bill creates section110.12303 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.