By Representatives Roberts, Lawson, Turnbull, Goode, Henriquez, Peaden and Ritchie

A bill to be entitled

An act relating to the state group insurance program; amending s. 110.123, F.S.; requiring the state group insurance plan to provide an enrollee continued access to a treating health care provider who loses provider status under the program; providing limitations; providing applicability; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (h) of subsection (3) of section 110.123, Florida Statutes, 1998 Supplement, is amended to read:

110.123 State group insurance program.--

(3) STATE GROUP INSURANCE PROGRAM.--

(h)1. A person eligible to participate in the state group health insurance plan may be authorized by rules adopted by the division, in lieu of participating in the state group health insurance plan, to exercise an option to elect membership in a health maintenance organization plan which is under contract with the state in accordance with criteria established by this section and by said rules. The offer of optional membership in a health maintenance organization plan permitted by this paragraph may be limited or conditioned by rule as may be necessary to meet the requirements of state and federal laws.

2. The division shall contract with health maintenance organizations to participate in the state group insurance program through a request for proposal based upon a premium and a minimum benefit package as follows:

a. A minimum benefit package to be provided by a participating HMO shall include: physician services; inpatient and outpatient hospital services; emergency medical services, including out-of-area emergency coverage; diagnostic laboratory and diagnostic and therapeutic radiologic services; mental health, alcohol, and chemical dependency treatment services meeting the minimum requirements of state and federal law; skilled nursing facilities and services; prescription drugs; and other benefits as may be required by the division. Additional services may be provided subject to the contract between the division and the HMO.

b. A uniform schedule for deductibles and copayments may be established for all participating HMOs.

c. Based upon the minimum benefit package and copayments and deductibles contained in sub-subparagraphs a. and b., the division shall issue a request for proposal for all HMOs which are interested in participating in the state group insurance program. Upon receipt of all proposals, the division may, as it deems appropriate, enter into contract negotiations with HMOs submitting bids. As part of the request for proposal process, the division may require detailed financial data from each HMO which participates in the bidding process for the purpose of determining the financial stability of the HMO.

d. In determining which HMOs to contract with, the division shall, at a minimum, consider: each proposed contractor's previous experience and expertise in providing prepaid health benefits; each proposed contractor's historical experience in enrolling and providing health care services to participants in the state group insurance program; the cost of the premiums; the plan's ability to adequately provide service

coverage and administrative support services as determined by the division; plan benefits in addition to the minimum benefit package; accessibility to providers; and the financial solvency of the plan. Nothing shall preclude the division from negotiating regional or statewide contracts with health maintenance organization plans when this is cost-effective and when the division determines the plan has the best overall benefit package for the service areas involved. However, no HMO shall be eligible for a contract if the HMO's retiree Medicare premium exceeds the retiree rate as set by the division for the state group health insurance plan.

e. The division may limit the number of HMOs that it contracts with in each service area based on the nature of the bids the division receives, the number of state employees in the service area, and any unique geographical characteristics of the service area. The division shall establish by rule service areas throughout the state.

f. All persons participating in the state group insurance program who are required to contribute towards a total state group health premium shall be subject to the same dollar contribution regardless of whether the enrollee enrolls in the state group health insurance plan or in an HMO plan.

3. The division is authorized to negotiate and to contract with specialty psychiatric hospitals for mental health benefits, on a regional basis, for alcohol, drug abuse, and mental and nervous disorders. The division may establish, subject to the approval of the Legislature pursuant to subsection (5), any such regional plan upon completion of an actuarial study to determine any impact on plan benefits and premiums.

4. In addition to contracting pursuant to subparagraph 2., the division shall enter into contract with any HMO to participate in the state group insurance program which:

a. Serves greater than 5,000 recipients on a prepaid basis under the Medicaid program;

b. Does not currently meet the 25 percent non-Medicare/non-Medicaid enrollment composition requirement established by the Department of Health and Human Services excluding participants enrolled in the state group insurance program;

c. Meets the minimum benefit package and copayments and deductibles contained in sub-subparagraphs 2.a. and b.;

d. Is willing to participate in the state group insurance program at a cost of premiums that is not greater than 95 percent of the cost of HMO premiums accepted by the division in each service area; and

e. Meets the minimum surplus requirements of s. 641.225.

The division is authorized to contract with HMOs that meet the requirements of sub-subparagraphs a. through d. prior to the open enrollment period for state employees. The division is not required to renew the contract with the HMOs as set forth in this paragraph more than twice. Thereafter, the HMOs shall be eligible to participate in the state group insurance program only through the request for proposal process described in subparagraph 2.

5. All enrollees in the state group health insurance plan or any health maintenance organization plan shall have the option of changing to any other health plan which is offered by the state within any open enrollment period

designated by the division. Open enrollment shall be held at least once each calendar year.

6. When a treating health care provider under the state group insurance program or any health maintenance organization loses his or her network provider status for any reason other than for cause, the state group insurance plan shall allow any enrollee in the state group health insurance plan or any health maintenance organization plan for whom the terminated provider was a treating provider to continue care with the terminated treating provider through completion of treatment of a condition for which the enrollee was receiving care at the time of termination, until the enrollee selects another treating provider, or until the next open enrollment period designated by the division, whichever occurs first, but no longer than 1 year after termination of the treating provider. The state group health insurance plan shall allow an enrollee who is in the third trimester of pregnancy to continue care with a terminated treating provider until completion of postpartum care. For care continued under this subparagraph, the program and the provider shall continue to be bound by the terms of the terminated contract for such continued care. This subparagraph shall not apply to treating health care providers who have been terminated by the program for cause.

7.~~6.~~ Any HMO participating in the state group insurance program shall, upon the request of the division, submit to the division standardized data for the purpose of comparison of the appropriateness, quality, and efficiency of care provided by the HMO. Such standardized data shall include: membership profiles; inpatient and outpatient utilization by age and sex, type of service, provider type,

and facility; and emergency care experience. Requirements and timetables for submission of such standardized data and such other data as the division deems necessary to evaluate the performance of participating HMOs shall be adopted by rule.

8.~~7.~~ The division shall, after consultation with representatives from each of the unions representing state and university employees, establish a comprehensive package of insurance benefits including, but not limited to, supplemental health and life coverage, dental care, long-term care, and vision care to allow state employees the option to choose the benefit plans which best suit their individual needs.

a. Based upon a desired benefit package, the division shall issue a request for proposal for health insurance providers interested in participating in the state group insurance program, and the division shall issue a request for proposal for insurance providers interested in participating in the non-health-related components of the state group insurance program. Upon receipt of all proposals, the division may enter into contract negotiations with insurance providers submitting bids or negotiate a specially designed benefit package. Insurance providers offering or providing supplemental coverage as of May 30, 1991, which qualify for pretax benefit treatment pursuant to s. 125 of the Internal Revenue Code of 1986, with 5,500 or more state employees currently enrolled may be included by the division in the supplemental insurance benefit plan established by the division without participating in a request for proposal, submitting bids, negotiating contracts, or negotiating a specially designed benefit package. These contracts shall provide state employees with the most cost-effective and comprehensive coverage available; however, no state or agency

funds shall be contributed toward the cost of any part of the premium of such supplemental benefit plans.

b. Pursuant to the applicable provisions of s. 110.161, and s. 125 of the Internal Revenue Code of 1986, the division shall enroll in the pretax benefit program those state employees who voluntarily elect coverage in any of the supplemental insurance benefit plans as provided by sub-subparagraph a.

c. Nothing herein contained shall be construed to prohibit insurance providers from continuing to provide or offer supplemental benefit coverage to state employees as provided under existing agency plans.

Section 2. This act shall take effect upon becoming a law.

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HOUSE SUMMARY

Requires the state group insurance plan to provide an enrollee continued access to a treating health care provider who loses provider status under the program, for any reason other than for cause, through completion of treatment of a condition for which the enrollee was receiving care at the time of loss of provider status, until the enrollee selects another treating provider, or until the next open enrollment period, whichever occurs first. Provides a 1-year limit on such continued access. Allows an enrollee who is in the third trimester of pregnancy to continue care with a terminated treating provider until completion of postpartum care. Provides limitations.