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 Governmental Oversight and Accountability

BILL: SPB 7026

INTRODUCER: For consideration by the Governmental Oversight and Accountability Committee

SUBJECT: State Group Insurance Program

DATE: February 16, 2015 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	McVaney	McVaney		**Pre-meeting**

I. Summary:

SPB 7026 requires the Department of Management Services (DMS) to ensure that a contracted health maintenance organization (HMO) provides a member under the age of 21 with access to medical services within three months of the request for early and periodic screening, diagnostic, and treatment requirements if they are covered under the state group health insurance plan.

The bill sets forth contractual requirements between DMS and the HMOs and specifies grievance or complaint procedures. HMO quarterly reporting to DMS regarding grievances or complaints is required. 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:

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.

HMOs are subject to the accreditation requirements of s. 641.512, F.S. Further, s. 641.495(4), F.S., states in part, "the organization shall 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 Florida Administrative Code Rule 59A-12.006, regarding the quality of care provided. Specifically, paragraph (3) states in pertinent 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.
> …
> (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 time required to schedule appointments and adequacy of access is currently regulated as specified above. 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. Some examples of when the time period may extend beyond the prescribed timeframes include when: 1) requested care is for a rare subspecialty, 2) the physician needs more time to review medical records or order special testing before scheduling an appointment, 3) the physician has an extended wait time for routine care, or 4) 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.[1]

DMS's current contracts require access standards to health care providers, and performance guarantees are in place for these access standards with financial consequences for failure to comply. It is important to note that DMS is not a party to the private business contracts between the HMOs and their network providers.

[1] 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.

Complaint and grievance procedures are currently established as required by the state laws[2] applicable to HMOs. The appeal process for self-insured HMOs is governed by Chapter 120, F.S. and Florida Administrative Code Rule 60P.

The federal Patient Protection and Affordable Care Act[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. 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. 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 federal law 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 managed with the care or treatment subject to the urgent appeal.

The DMS's current contracts require HMOs to maintain a record of all grievances or appeals, as applicable, and provide a summary to the Department quarterly or more frequently, if requested. The report provides a narrative summary of the reasons for the grievance, disposition, and corrective actions as a result of the grievance.

Early and Periodic Screening, Diagnostic and Treatment Benefits

In the Medicaid program, Florida is required to provide comprehensive services and furnish services that are covered under Medicaid, appropriate, medically necessary and needed to correct and ameliorate health conditions, based on certain federal guidelines. The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits[4] are made up of 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.

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[2] See s. 641.511, F.S.
[3] Section 1001 of Pub. L. No. 111-148.
[4]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).

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.

III. Effect of Proposed Changes:

SPB 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 health insurance program.

"Health services" include those services that are both EPSDT benefits in the Medicaid program and covered services under the state group health insurance program.

"Reasonable access" requires the health services be initiated within the lesser of the guidelines for national standards for medical or three months of the initial request for the particular health service.

DMS is required to include in its contracts with HMOs participating in the State Group Insurance Program 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.

The contract must contain specific provisions granting members of the State Health Insurance Program the right to submit a complaint or grievance and to request an external review if reasonable access is denied by an HMO.

In terms of these complaints, the contract must require the HMOs to report at least quarterly the number of complaints filed, 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.

According to DMS, existing state law and national standards relating to the timeframes for certain health services require such services to be provided more quickly than under this bill.[5] This bill does not supersede the existing laws or national standards. This bill appears to establish contractual performance metrics that may subject the HMOs to financial consequences if not met. In addition, the bill appears to require DMS to guarantee a right to members of the state group insurance program to submit complaints relating to reasonable access to health services and request for external reviews of such denials of reasonable access.

Network adequacy, timely referral and reasonable access would not qualify for an external review. For clarification, 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. It is unclear whether the right to external review under this bill is limited by the federal law or is more expansive based on the terms of the contract.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

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[5] 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.

B. Private Sector Impact:

HMOs participating in the state group insurance program may be subject to financial risks and additional administrative burdens.

C. Government Sector Impact:

This bill may 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:

If the intent is to apply the requirements of this legislation to both the self-insured health insurance plans and the fully-insured plans, line 26 should be modified to refer to the "state group insurance program" rather than the "state group health insurance plan."

VII. Related Issues:

The intent of this legislation appears to apply the requirements to all HMOs participating in the state group insurance program. However, it appears some, if not all, HMOs participating in the state group health insurance plan (the self-insured portion of the insurance program) claim that they are not acting as HMOs in their current capacities. Rather, these HMOs claim they are merely third-party administrators of a portion of the self-insured plans.

If the intent is to apply the requirements of this legislation to all HMOs participating in the state group insurance program, regardless of the services provided, the definition of "HMO" should be expanded to include the following or similar language: "or an entity under contract with the department to participate in the state group insurance program by administering health services offered in a geographic region of the state."

VIII. Statutes Affected:

This bill creates section 110.12303 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.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.