Health Insurers Besieged with Major Issues This Session

From the Florida Insurance Council:

The Florida Legislature is in recess the week of April 13 in observation or religious holidays. When it returns to Tallahassee April 21, there will be two weeks remaining in the 2014 session and the 2014-2015 state budget will begin to take center stage.

FIC has prepared a series of updates on major issues entering this final stage.

This report covers health insurance. Issues in the report below include the Florida Medical Association package attacking step therapy, prior authorization and retroactive denial of claims, legislation to promote telemedicine, and a trio of pharmacy bills.

Tougher than Usual Challenges for Health Plans

The 60-day legislative session is never easy. This year, for health insurers, HMOs and managed care lobbyists, it's been even tougher than usual, say seasoned veterans familiar with the Florida Capitol. The uptick in activity, in part, is attributable to an aggressive agenda by the FMA and other provider groups, navigation of the post-Obamacare environment and the midterm elections.

"There are a lot of bills out there, but we hope most of them are not going anywhere," said Paul Sanford, FIC lobbyist for life and health issues.

The FMA's package (HB 1001, SB 1354) is the greatest challenging facing the health insurance community. FIC lobbyist Sanford says it wipes out step therapy and other important tools allowing health plans to control costs, without producing health care any better than Floridians have available today.

Telemedicine and a barrage of pharmacy-related issues round out the list of issues that the Florida Insurance Council and its life and health members are facing this session.

Steven Smith, Florida Blue Director of Government Relations and incoming FIC Chair, has lobbied for nearly 20 years and has seen hundreds of insurance and health care bills filed in the Capitol. “This is literally the costliest bill I have ever seen. I don't know that it's close," Steven says. “And that's not hyperbole."

The bill requires managed care plans which restrict medications through a step therapy or fail first protocol to establish a “clear and convenient process” for a provider to request an override. Managed care plans would have 24 hours to respond to the override request and would have to grant it if the provider believes the treatment required under the step therapy has been ineffective or is likely to be ineffective or may cause an adverse reaction or other physical harm to the patient.

The bill also requires HMOs to use standardized prior authorization forms adopted by the Financial Services Commission when granting prior authorization for a medical procedure, a course treatment, or prescription drug benefits. Providers may submit the completed form electronically to the HMO which will have two days to respond. Grandfathered health plans under the Affordable Care Act are exempt from the provision.

The measure also prevents health plans from retroactively denying claims and requires that insurance companies pay claims if the patient presented a card and they were verified as eligible at the time of service. The provision stems from an Obamacare rule that allows newly covered patients who enrolled through the exchange to maintain their eligibility for 90 days even if they stopped paying their premiums. While insurers are responsible for paying claims within the first 30 days of coverage, the rules do not require health plans to pay any claims for services after the first month.

Joy Ryan, America's Health Insurance Plans Florida lobbyist and shareholder in the Tallahassee lobbying firm, Meenan, P.A., said understanding the Affordable Care Act and implementing it is "opening up some grey areas." "I think what we are seeing are the concerns of the providers and they are afraid they aren't going to get paid," says Joy, a 20-year lawyer/lobbyist veteran. "The payor and provider have to understand how it's going to work and nobody wants to be the party that got caught in the middle," she said adding that everybody "needs to be more vigilant to the status of where the enrollee is with their new coverage."

The Senate Banking and Insurance Committee approved the bill April 8 and it was initially slated to head to the Senate Floor. However, it was referred to the Senate Appropriations Committee on April 11, just before legislators left town for a week in observation on religious holidays. It is expected to be reviewed by the Appropriations Committee on April 22, after the Passover/Easter recess.

The House companion (CS/HB 1001) has been slower moving. It was given an additional committee reference midway through the session and appears stuck in four committees or subcommittees in the House. Never say never, however, Steven opines, as there is strong support for the FMA measure among some House members.

Additionally, there are a number of insurance-related bills in the House that could be used as a vehicle for amendments containing the FMA supported positions.

FIC intends to remain vigilant. "We are continuing to fight this." FIC President Cecil Pearce said. "Beating it is our top health insurance priority of the 2014 session."

Telemedicine Debate Includes Role of Out-of-State Providers

The health insurance industry also has been busy debating telemedicine (HB 751 and CS/ HB 7113) and opposing the Florida Medical Association on still another issue. The FMA favors restricting telemedicine participation by out-of-state providers. Health plans want out-of-state providers in.

"The House is considering a limited regulatory scheme that will permit the expansion and growth of telemedicine services and then revisit the issue in the future to determine whether any additional regulation is necessary," Paul Sanford says. The Senate package has been much stronger in its regulation of out-of-state providers, to the extent that it may be unlikely this important category of physicians could participate, Paul notes.

Initially, the telehealth issue only was addressed, in the House, in HB 751. On April 10, the House Health Regulatory Affairs Committee included the issue in CS/HB 7113, a bill that focused on trauma centers. The bill was amended to include telehealth, scope of practice expansion for nurse practitioners, medical tourism and a number of other units

Meanwhile, a pair of State Board of Medicine rules laying out how medical and osteopathic doctors must react in the new marketplace has gone into effect which could make the issue moot in the Legislature. Given the new rules Steven and Paul say, the insurance community is fine if no bill passes. The rules (64B8-9.0141 and 64B 15-14.0081) define telemedicine as the practice of medicine by a Florida physician or physician assistant" but later includes a provision that states "nothing contained in this rule shall prohibit consultations between physicians or the transmission and review of digital images, pathology specimens, test results, or other medical data by physicians or other qualified providers related to the care of Florida patients." The rules also makes it clear that the standard of care remains the same regardless of whether a Florida licensed physician or physician assistant provides health care by telemedicine or in person.

Pharmacy Fights

There are a trio of pharmacy related bills outside the FMA package that FIC is bird dogging.

Legislation on pharmacy benefits managers (HB 765, SB 1014) would limit the ability of health plans to manage growing pharmaceutical costs appears to be on life support. Though it is moving through the Senate and sponsor Rene Garcia, R-Hialeah remains committed, there appears to be little appetite for it in the House. The House companion (HB 765) has not been heard in subcommittee and under House rules any bill that hasn't cleared a subcommittee cannot be further considered.

Another pharmacy bill (CS/HB 323, CS/CS/CS/SB 278) being watched by the insurance community removes from statute the cap of three pharmacy technicians which one pharmacist can supervise. This decision is now let to the Florida Board of Pharmacy.

The Senate bill goes further, revising the makeup of the board. It would increase the number of institutional pharmacists on the board and decrease the number of "at large" pharmacists. The bill stipulates that the changes will occur as current members' terms expire or as vacancies occur. The House measure does not address the board's makeup.

Lastly there is the pharmacy audit bill (HB 745) CS/SB 702) laying out the "rights" a pharmacy has when being audited. Under the Senate bill by Aaron Bean, R-Jacksonville, the rights include: at least seven days prior notice of each initial on-site audit; consent of the pharmacist if the audit is to be scheduled during the first three days of the month; limiting the audit period to 24 months after the date a claim is submitted to or adjudicated by the entity.