Providers Assault on Managed Care Moves to Full Senate

From the Florida Insurance Council

The Senate Appropriations Committee this afternoon approved and cleared for the full Senate probably the most expensive assault on health insurance and managed care in recent legislative history. A major amendment produced some improvements, but FIC and other health plan lobbyists continued to oppose the package, which assaults step therapy and prior authorization and also impacts the ability of carriers to retroactively deny claims when the insurance premium is not paid.

Paul Sanford, lobbyist for FIC and Florida Blue, commended the Senate sponsor, Denise Grimsley, R-Sebring, "for how hard she has worked with us." Sen. Grimsley is trying to structure the package "to do all of the things people would like it to do" and still provide health insurers the tools to manage costs, Paul said.

He singled out a huge remaining issue, two provisions not found in any other state "allowing the physician to terminate step therapy at will…This effectively eliminates step therapy."

The package will mean "significant increases in cost" for Medicaid, the state employee health plan and private plans, Paul testified.

The package (CS/SB 1354) is a big priority for the Florida Medical Association and other provider groups. It goes to the full Senate now.

The House companion bill (HB 1001) remains stuck in House committees, but the Senate bill will be coming over to the House once it is adopted. In addition, the package may be broken up into amendments which Senate leaders could place onto – potentially - dozens of others bills going to the House.

The 2014 session has about ten days remaining and this almost certainly will be a huge fight until the very end.

Also testifying against the package today were Joy Ryan, representing America's Health Plans, Audrey Brown, Florida Association of Health Plans, Tammy Purdue, Associated Industries of Florida, and representatives of other health insurance and business groups. The common theme was that the package will still hike insurance costs and premiums.

The strike-all amendment (782304) does contain an agreement on provision in the Patient Protection and Affordable Care Act which could allow enrollees to receive care for 90 days without paying a premium. This Obamacare provision has resulted in a tug of war between providers who want to be paid for the care they render and insurers who want to receive premium for the benefit they provide.

Under the strike-all amendment, insurers could not retroactively deny a claim unless the company advised the provider at the time of service that the patient was delinquent in paying the premium. The change comports with PPACA, said Steven Smith, Florida Blue director of government affairs.

The amendment also eliminates the universal prior authorization form. Instead of having one PA form developed by the Financial Services Commission (Cabinet), each health plan is allowed to develop its own form.

AHIP's Joy Ryan testified that Medicare and Medicaid participating doctors have been given financial incentives to electronically prescribe and--to that end--there are guidelines being developed that they must follow. The state should not do anything to jeopardize those incentives. Florida should "continue toward the electronic system of prescribing," she said. "We need to make sure it is the uniform system and that it is all electronic."

Audrey Brown of FAHP, expressed appreciation for provisions in the redrafted package that eliminate the uniform prior authorization form and increase time for health plan review. Still an issue is the requirement that Internet sites for health plans be updated within 24 hours, including weekends.

And, like Paul Sanford, she emphasized that the bill "undermines managed care by overriding step therapy."

With respect to step therapy the broad reaching bill still requires managed care plans and insurance companies to approve a physician's override request within 72 hours if the provider meets this new standard. The provider documents, based on sound clinical evidence, that the preferred treatment required under the step therapy or fail first protocol has been ineffective in the treatment of the enrollee's disease or medical condition or it is likely to be ineffective based on the enrollee's known physical or mental characteristics.

If an enrollee enters the step therapy program and a provider can demonstrate the treatment is clinically ineffective, managed care plans cannot exceed the customary period for the use of the medication.

Conversely, if a managed care plan can, through sound clinical evidence, demonstrate that the originally prescribed medication is likely to require more than the customary period to provide any relief or amelioration to the enrollee, the step therapy can be extended for an additional period but no longer than the original customary period for use of the medication.

Prescribing providers can terminate step therapy plans if they determine that the enrollee is having an adverse reaction or is suffering from other physical harm resulting from the use of the medication.

The provisions don't impact grandfathered health plans.