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 General Government Appropriations Committee

BILL:	CS/CS/SB 1012
INTRODUCER:	General Government Appropriations Committee, Banking and Insurance Committee, Senator Gaetz, and others
SUBJECT:	Health Insurance
DATE:	April 10, 2008 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson	Deffenbaugh	BI	**Fav/CS**
2.	Pugh	Cooper	CM	**Fav/3 amendments**
3.	Garner	Wilson	HR	**Fav/1 amendment**
4.	Garner	Wilson	HP	**Favorable**
5.	Kynoch/Pigott	DeLoach	GA	**Fav/CS**
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

The bill makes a number of changes to current law regarding payment of health insurance policy benefits, third party access to preferred provider networks, authorization of a health maintenance organization (HMO) to require a provider to make available a written attestation of assignment of benefits, decreasing the amount of time in which any insurer can recoup overpayments to providers and information to be provided to an insured in determining financial responsibility.

The bill allows the Office of Insurance Regulation (OIR) to waive the requirement that each multiple-employer welfare arrangement maintain its principal place of business in this state if the arrangement meets certain specified conditions and has a specified minimum fund balance at the time of licensure.

The bill requires insurers to directly pay licensed ambulance providers, in addition to licensed hospitals, physicians, or dentists, regardless of whether they are part of the insurers' provider networks. Payment to the medical provider may not be greater than the payment the insurer would have paid without an assignment of benefits by the policyholder.

HMOs may not prohibit , and claims forms must provide an option for the direct payment of benefits to licensed hospitals, ambulance transporters and treatement provider pursuant to part III of chapter 401, physicians, or dentists for covered services provided pursuant to s. 395.1041. The HMO may require a written attestation of assignment of benefits.

Additionally, the bill:

- Establishes requirements in order for a health insurer or administrator to lease, rent, or grant access to the health care services of a preferred provider or exclusive provider to a third party (sometimes referred to as a "silent Preferred Provider Organization") not involved in the original contract.
- Requires an HMO to have express contractual authority of, and to give adequate prior notice to, a health care practitioner, in order to sell, lease, or transfer information relating to the payment terms of the contract with the health care practitioner.
- Reduces the maximum time period from 30 months to 12 months for an insurer to make a claim for overpayment, based on a retroactive review or audit of coverage decisions or payment levels.

The bill could have a negative fiscal impact to the state group insurance program as it relates to the look back period being reduced from 30 months to 12 months.

The bill is effective July 1, 2008, and applies to contracts entered into, issued, or renewed on or after that date.

The bill substantially amends sections 624.443, 627.638, 627.662, 641.31, 641.3155, and 627.6131, F.S.

The bill creates sections 627.6471(7) and 627.64731, F.S.

II. Present Situation:

Medically Uninsured

The issue of the medically uninsured is a health policy concern for a number of reasons. Research demonstrates that lack of insurance coverage has adverse effects on the uninsured themselves. Despite being in worse health status than people with coverage, the uninsured use fewer services and face higher out-of-pocket spending than their insured counterparts. Also, uninsured persons with medical expenses associated with illness and injury represent an important segment of persons contributing to U.S. bankruptcy filings.[1] In addition, hospitals, physicians and other health care providers face increasing demands for care by the uninsured for which there is little or no reimbursement, straining their financial viability, which ultimately limits access to health care.[2]

[1] D.U. Himmelstein et al. "Illness and Injury as Contributors to Bankruptcy," Health Affairs (2005): w5-63 (published online February 2, 2005.)
[2] National Coalition on Health Care. Facts About Health Care. Found at: http://www.nchc.org/facts/coverage.shtml (last visited on March 29, 2008)

According to the U.S. Census Bureau, both the number and percentage of persons without health insurance in the United States are increasing. The percentage of persons without health insurance increased from 15.3 percent in 2005 to 15.8 percent in 2006, and the number of uninsured increased from 44.8 million to 47.0 million.[3] While the percentage of persons covered by employer-sponsored plans and those enrolled in government programs did not statistically change during this timeframe, some argue that the long-term trend demonstrates a decline in employer-based coverage.[4]

There are many reasons why the number and percentage of individuals without insurance is increasing, but the most common problem cited is affordability. For the employer, rapidly rising health insurance premiums are the main reason cited by all small firms for not offering coverage. Health insurance premiums for small firms are rising at an average rate of 12 percent annually, while overall inflation has risen only 2.5 percent.[5]

At the individual level, higher incomes are associated with a greater ability to access health coverage. In 2006, 75.1 percent of people in households with annual incomes of less than $25,000 had health insurance coverage, but coverage rates increase to 91.5 percent for those in households with incomes of $75,000 or more (the highest income group in the population survey).[6] But, even with higher incomes and access to employer-sponsored coverage, many individuals are unable to always afford their portion of the premium. This is partially because, as a cost savings measure, employers are shifting a larger portion of the health care costs to the employee. Between 2000 and 2006, employee spending for health insurance coverage (employee's share of family coverage) increased 126 percent, while the employers' costs have increased 76 percent during this timeframe.[7]

Assignment of Benefits for Health Insurance Claims

An assignment of benefits is defined as "an arrangement by which a patient requests that their health benefit payments be made directly to a designated person or facility, such as a physician or hospital."[8] An assignment of benefits typically comes into play when health care services are provided by a health care professional or facility that has no contract with the patient's health plan.

In Florida, s. 627.638, F.S., establishes requirements for the direct payment of claims from an insurer to certain health care providers. Under Florida law, a health insurance policy that insures against loss or expenses due to hospital confinement or due to medical and related services may pay benefits directly to a recognized hospital, doctor, or other person who provided the health

[3] U.S. Census Bureau. *Income, Poverty, and Health Insurance Coverage in the United States: 2006*. Found at: http://www.census.gov/prod/2007pubs/p60-233.pdf (last visited on March 29, 2008)
[4] Robinson, James C. "The Commercial Health Insurance Industry in an Era of Eroding Employer Coverage." *Health Affairs*. Vol. 25, Iss. 6. November/December 2006.
[5] The Henry J. Kaiser Family Foundation. *Employee Health Benefits: 2007 Annual Survey*. September 2006. Found at: http://www.kff.org/insurance/7672/index.cfm (last visited on March 29, 2008)
[6] U.S. Census Bureau. *Income, Poverty, and Health Insurance Coverage in the United States: 2006*. Found at: http://www.census.gov/prod/2007pubs/p60-233.pdf (last visited on March 29, 2008)
[7] Hewitt Associates LLC. *Health Care Expectations: Future Strategy and Direction 2005*. November 2004. Found at: http://www.hewittassociates.com/_MetaBasicCMAssetCache_/Assets/Articles/11-17-04_exec.pdf (last visited on March 29, 2008)
[8] http://www.medterms.com/script/main/art.asp?articlekey=24244 (last visited on March 29, 2008)

care services, in accordance with the provisions of the health care policy. In order to directly pay these providers, the insurer must state in the health insurance policy that benefits may be payable to the provider.

If an insured makes an assignment of benefits to a recognized hospital, physician, or dentist, the insurer must make payment to the provider *unless the insurance contract provides otherwise* (emphasis added).[9] Some insurance contracts do not allow direct payment to out-of-network providers. However, direct payment to a hospital, physician, or dentist is mandatory for emergency care rendered, pursuant to s. 395.1041, F.S.

Generally, an insurer will permit the policyholder to make an assignment of benefits for direct payment to providers with whom the insurer has contracted to be part of a network, such as a Preferred Provider Organization (PPO). The ability to receive direct payment from the insurer is one of the reasons healthcare providers agree to become part of a preferred provider network, often in exchange for a reduced payment from the insurer. If assignment of benefits (or "direct payment") to the provider is not permitted, the insurer pays benefits to the policyholder from whom the provider must then seek payment for services rendered.

Health Maintenance Organizations & Point-of-Service Riders

An HMO is an organization that provides a wide range of health care services, including emergency care, inpatient hospital care, physician care, ambulatory diagnostic treatment and preventive health care pursuant to contractual arrangements with preferred providers in a designated service area.

Traditionally, an HMO member must use the HMO's network of health-care providers. The use of a health-care provider outside the HMO's network generally will result in the HMO limiting or denying benefits to the member. However, under s. 641.31(38), F.S., an HMO may sell a *point-of-service rider* to a subscriber permitting the subscriber to choose a health-care provider that is not under contract with the HMO. The choice of provider is left up to the subscriber, not the HMO, as the point-of-service rider does not require a referral from the HMO in order to utilize non-contracted health care providers. The point-of-service rider may require the subscriber to pay a reasonable co-payment for each visit for services provided by a non-contracted provider.

Preferred Provider Networks

Insurers contract with health-care providers for alternative or reduced rates of payment. Such providers are called "preferred providers" and make up a "preferred provider network" within a PPO. An insurer using a PPO will typically offer its policyholders alternate or reduced rates and a higher percentage of reimbursement for obtaining health care services from a preferred provider, as compared to a non-preferred provider. Section 627.6471, F.S., contains various requirements for insurers using PPO plans. Similarly, health insurers may utilize exclusive provider organizations (EPOs), which condition the payment of benefits on the use of exclusive

[9] Section 627.638(2), F.S.

providers, thereby paying no benefits for services outside the EPO network, with certain exceptions such as emergency care, as authorized by s. 627.6472, F.S.

Sometimes, insurers and administrators of preferred provider networks will sell or lease the preferred provider network they have negotiated to other networks and health care payers, including self-funded employer health care groups such as the Florida State Group Health Plan. This practice is commonly referred to as a "silent PPO," and occurs when an insurer negotiates discounts with physicians and other health care providers, then "sells" access to these discounts to other, non-related insurers after the provider renders services to patients covered by the non-related insurers.[10]

Florida law does not restrict this practice or require the notification of health care providers when access to the preferred provider network they have entered into is sold or transferred to another entity.

Health Maintenance Organizations & Review of Claims Overpayment

Subsection (5) of s. 641.3155, F.S., contains the process by which an HMO may make a claim for overpayment against a provider to whom it had previously tendered payment. The HMO must send a written or electronic statement specifying the basis for the retroactive denial or payment adjustment to the provider of the specific provider claim(s) for which the overpayment claim is submitted. Often, overpayment claims are the result of a retroactive review or audit of coverage decisions and payment levels.

If the overpayment is not related to fraud, the HMO must submit its claim for overpayment within 30 months after the HMO paid the claim. After receiving the claim for overpayment, the provider has 40 days in which to pay, deny, or contest the claim. A contested claim for overpayment must be paid or denied by the provider within 120 days after receipt. If, after 140 days, the provider has not paid or denied the overpayment claim, an uncontestable obligation is placed on the provider to pay the insurer's claim. A provider that chooses to deny or contest an HMO's claim must notify the HMO in writing of the provider's decision within 35 days after the provider received the claim for overpayment. If the claim is contested, the provider must request additional information, which the HMO has 35 days to give the provider after receiving the request. After receiving the additional information, the provider has 45 days to pay or deny the claim.

III. Effect of Proposed Changes:

Section 1 amends s. 624.443, F.S., to allow the OIR to waive the requirement that each multiple-employer welfare arangement maintain its principal place of business in this state if the arrangement has been operating in another state for at least 25 years, has been licensed in such state for at least 10 years, and has a minimum fund balance of $25 million at the time of licensure.

[10] http://library.findlaw.com/2000/Oct/12/127454.html. (Last visited March 29, 2008).

Section 2 amends s. 627.638(1), F.S., regarding the direct payment of health care providers by insurers, to include licensed ambulance providers.

Section 627.638(2), F.S., is amended to include ambulance providers in the list of providers authorized to receive direct payment of plan benefits.

Section 627.638(3), F.S., is added to require any insurer who has contracted with a preferred provider for the delivery of health care services to make payments directly to the preferred provider.

Section 3 creates s. 627.64731, F.S., to regulate the "silent PPO" arrangement. The new section of law provides requirements in order for an insurer or administrator to lease, rent, or grant access to the health care services of a preferred provider or exclusive provider to a third party. The requirements are:

- The health care contract between the insurer or administrator and the provider must expressly authorize leasing, renting, or granting access to the provider's services.
- The insurer must, to the extent possible, identify in the contract with the preferred or exclusive provider any third party to which the insurer or administrator has granted access to the provider's health care services.
- A third party that is granted access must comply with all applicable terms of the health care contract.
- The insurer or administrator must notify a preferred provider or exclusive provider in writing, within 5 business days, of the identity of any third-party that has been granted access to the health care services of the provider. The provider may opt out of participating in a third party's health care plan by providing written notification to the insurer or administrator within 30 days after receiving notice.
- The insurer or administrator must maintain an Internet website or toll-free telephone number through which the provider may obtain a listing, updated at least biannually (twice a year), of the third parties that have been granted access to the provider's health care services.
- The insurer or administrator must ensure that the provider receives an explanation of benefits or remittance advice that identifies the contractual source of any applicable discount.
- The rights of a third-party granted access to the provider's health care services terminate when the provider's PPO or EPO contract is terminated.

The provisions of Section 3 do not apply if the third party that is granted access to the health care services of the provider is:

- An employer or entity providing health care coverage to its own employees or members and the employer or entity has a contract with the insurer or administrator (or affiliate) for the administration or processing of claims for payment or services under the health care contract. This allows the insurer or administrator to provide access to a provider network to employers seeking to provide health insurance for their employees or organizations without having to notify all providers or otherwise meet this section's requirements.
- An affiliate or subsidiary of the insurer or administrator.

- An entity providing administrative services to, or receiving administrative services from, the insurer or administrator or the insurer's or administrator's affiliate or subsidiary.

Section 3 of the bill also authorizes insurance contracts to provide for the arbitration of disputes that arise under this section.

Section 4 adds a new subsection (11) to s. 627.662, F.S., to apply the provisions in section 3 of the bill to group health insurance, blanket health insurance, and franchise health insurance.

Section 5 adds subsection (41) to s. 641.31, F.S., to prohibit HMO contracts from prohibiting payments of benefits directly to a licensed hospital, ambulance transport and treatment provider pursuant to part III of ch. 401, F.S., physician, or dentist for covered emergency services provided pursuant to s. 395.1041, F.S. Also, it requires that HMO claims forms must provide an option for payment of benefits directly. The HMO may require a provider to retain and make available upon request a written attestation of assignment of benefits. The attestation of benefits may be submitted in electronic form.

Section 6 amends subsection (5) of s. 641.3155, F.S. as it relates to the prompt payment of claims. The bill reduces the maximum period, from 30 months to 12 months after an HMO pays a claim to a health care provider, for the HMO to make a claim for overpayment against the provider, based on a retroactive review or audit of coverage decisions or payment levels.

Section 7 amends subsection (6) of section 627.6131, F.S., as it relates to the payment of claims. The bill reduces the maximum period, from 30 months to 12 months after a health insurer pays a claim to a health care provider, for the health insurer to make a claim for overpayment against the provider, based on a retroactive review or audit of coverage decisions or payment levels.

Section 8 adds subsection (7) in s. 627.6471, F.S., and specifies that if a PPO patient requests services from a nonpreferred provider and requests information from the insurer or the provider in order to determine patient financial responsibility: a) the nonpreferred provider shall provide the insured with an estimated average charge for the service and a statement notifying the insured that the final charge may exceed the estimated charge; and b) the insurer shall provide the insured and the nonpreferred provider with an estimate of the payment to the provider and a statement notifying the insured that the final charge may exceed the estimated allowable payment amount. The nonpreferred provider and the insurer are not liable if the total charges of the provider or the insurer's actual payment differs from the estimate.

Section 9 provides an effective date of July 1, 2008, applicable to insurance or HMO contracts entered into, issued, or renewed on or after that date.

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.

B. Private Sector Impact:

Section 2 provisions should reduce some providers' problems with collecting payments from their patients, so the bill could have an indeterminate, but positive impact on health care providers.

The reduction from 30 to 12 months for an HMO to make a claim for overpayment against a provider may result in higher costs to HMOs, due to lower overpayment recoveries. The HMOs assert that overpayment is often found using long term data trending, which can take a year or longer. Thus, their ability to keep costs down via auditing the appropriateness of claims payments would be compromised. Medical providers have stated that the current 30-month period often inhibits their ability to collect monies from patients who often cannot be located.

C. Government Sector Impact:

Office of Insurance Regulation

An analysis prepared by the OIR states, "...freedom to assign payment to any provider may result in premium increases and should be further studied. The right of assignment could raise issues regarding balance billing."[11]

The bill's operational fiscal impact on the OIR and the Agency for Health Care Administration, which oversees some HMO activities, will be limited or minimal, according to those agencies. The DSGI estimates that the bill may cost it approximately $74,000 in non-recurring funds, to pay for notifying state PPO enrollees about changes to their insurance plan in the middle of the coverage year.

Department of Management Services

The reduction from 30 to 12 months for an HMO to make a claim for overpayment against a provider may result in higher costs to HMOs, due to lower overpayment

[11] Analysis of SB 1012 prepared by the Office of Insurance Regulation, dated March 10, 2008. On file with the Senate Commerce Committee.

recoveries. The HMOs assert that overpayment is often found using long term data trending, which can take a year or longer. Thus, their ability to keep costs down via auditing the appropriateness of claims payments would be compromised. Medical providers have stated that the current 30-month period often inhibits their ability to collect monies from patients who often cannot be located. As a result, an indeterminate negative fiscal impact could be passed to the state group insurance program.

Additionally, the bill provides for a July 1, 2008 implementation date. Such notification may result in additional administrative processess and unbudgeted costs for the Department if such notification cannot be included as part of the regular annual open enrollment period which is generally mid September through October. The open enrollment notification would be for a January 1 coverage effective date.

VI. Technical Deficiencies:

In section 8 on line 282, it appears that the word "to" should be deleted.

VII. Related Issues:

In general, there appears to be some confusion among the parties over the interpretation of provisions in the bill. For example, the bill as originally filed included a provision specifically prohibiting non-network providers who accepted direct assignment from billing policyholders or subscribers for the balance of the providers' service charges. That provision is not in the current version of the reworked bill, but DSGI staff say it is unclear whether balance-billing will be allowed, since it is not specifically prohibited. The OIR's updated analysis of the bill also states, "The right of assignment could raise issues regarding balance billing."[12]

Also, the bill's effective date of July 1, 2008, occurs in the middle of the state's insurance coverage year, which runs from January 1 to December 31. Typically, the DSGI notifies state insurance plan enrollees about changes to their plans for the coming year during the annual "Open Enrollment" period in September and October. Conforming the effective date of the bill to that of the insurance coverage year (January 1) may reduce the potential for unbudgeted DSGI administrative costs related to implementing the bill.

VIII. Additional Information:

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

CS by General Government Appropriations on April 10, 2008:

This committee substitute includes the following provisions:

- Allows the Office of Insurance Regulation to waive the requirement that each multiple-employer welfare arrangement maintain its principal place of business in this

[12] Analysis of SB 1012, prepared by the Office of Insurance Regulation, dated March 4, 2008. On file with the Senate Commerce Committee.

state if the arrangement meets certain specified conditions and has a specified minimum fund balance at the time of licensure.
- Requires insurers to directly pay licensed ambulance providers.
- Requires any insurer who has contracted with a preferred provider for the delivery of health care services to its insureds shall make payments directly to the preferred provider.
- HMOs may not prohibit and claims forms must provide an option for payment of benefits directly.
- Reduces the look back period for billing claim adjustments from 30 months to 12 months.
- Requires the insurer and nonpreferred provider to provide information upon request to the insured regarding financial responsibility.

CS by Banking and Insurance on February 19, 2008:

- Requires insurers to directly pay specified medical providers if an insured makes a written assignment of benefits.
- Requires health maintenance organizations to directly pay specified providers for covered emergency services if the subscriber makes a written assignment of benefits.
- Establishes requirements for a health insurer or administrator to lease, rent, or grant access to the health care services of a preferred provider or exclusive provider to a third party.
- Establishes requirements for a health maintenance organization to sell, lease or transfer information relating to the payment terms of the contract with the health care practitioner.
- Reduces the maximum time period from 30 to 12 months after a health maintenance organization pays a claim to a provider, for the HMO to make a claim for overpayment based on a retroactive review or audit of payment.

B. Amendments:

None.