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 Health Regulation Committee

BILL:	CS/SB 1122
INTRODUCER:	Health Regulation Committee; Senator Gaetz and others
SUBJECT:	Health Insurance/Assignment of Benefits
DATE:	April 15, 2009 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson/Johnson	Burgess	BI	**Fav/1 amendment**
2.	Bell	Wilson	HR	**Fav/CS**
3.			GA	
4.				
5.				
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
	X	Significant amendments were recommended

I. Summary:

The Committee Substitute for SB 1122 requires insurers to make payments directly to any provider not under contract with the insurer if the insured makes a written assignment of benefits. Under current law, direct payment by an insurer is only required for emergency services and care.

Current law provides that payment to the medical provider from the insurer may not be more than the payment due to an insured when an assignment of benefits is not made. However, the law does not prohibit the out-of-network provider from balance billing the insured the difference in the amount paid by the insurer and the amount charged by the out-of-network provider.

This bill substantially amends s. 627.638, F.S.

II. Present Situation:

Assignment of Benefits for Health Insurance Claims

Section 627.638, F.S., establishes requirements for the direct payment of claims from an insurer to a medical provider. Under Florida law, a health insurance policy that insures against loss of expense due to hospital confinement or due to medical and related services may pay benefits directly to a recognized hospital, licensed ambulance provider, doctor, or other person who provided the health care services, in accordance with the provisions of the policy. In order to pay such providers directly, the insurance policy must state that benefits may be payable to the provider.

If an insured makes an assignment of benefits to a recognized hospital, licensed ambulance provider, physician, or dentist, the insurer must make payment to the provider *unless the insurance contract provides otherwise*. However, direct payment to a hospital, licensed ambulance provider, physician, or dentist is mandatory for emergency care rendered pursuant to s. 395.1041, F.S., (Access to emergency services and care). 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). If an assignment of benefits (direct payment) to the provider is not permitted, the insurer pays benefits to the policyholder from whom the provider must seek payment for services.

Section 641.513(5), F.S., relating to health maintenance organization (HMO) requirements for reimbursing for services, addresses the payment of out-of-network providers who provide emergency services. This provision requires the payment to be the lesser of the provider's charges, usual and customary provider charges for similar services in the community, or charges mutually agreed to by the parties.

Division of State Group Health Insurance

Pursuant to s. 110.123, F.S., the Department of Management Services (DMS) contracts with a third-party administrator to administer the state's PPO plan and the DMS contracts directly with five fully-insured HMO plans. The Division of State Group Insurance within the DMS is responsible for these programs. Persons eligible for these plans include state officers and employees, surviving spouses of deceased state officers and employees, retired state officers and employees, terminated employees and individuals with continuation coverage.

The self-insured PPO Plan is administered by BlueCross BlueShield (BCBS) of Florida (medical) and Caremark, Inc. (pharmacy). The DMS and the State of Florida are not party to the private business contracts between the PPO administrators or the HMOs and their respective network providers.

III. Effect of Proposed Changes:

The bill amends s. 627.638(2), F.S., to require the direct payment of plan benefits to any person who provides services in accordance with the provisions of the insurance policy whenever the insured specifically authorizes payment to that provider through an assignment of benefits. The bill prevents insurance contract provisions that would "provide otherwise" and limits the direct

payment of providers. The bill retains the requirement that payment from the insurer to the provider may not be more than the amount the insurer would have paid (to the insured) if an assignment had not been executed. Under current law, direct payment is only required for emergency care provided pursuant to s. 395.1041, F.S.

The effective date of the bill is July 1, 2009.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Art. I, s. 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Out-of-network providers would benefit by being entitled to direct payment of benefits from insurers, even if the provider does not participate in the insurer's provider network, assuming that the policyholder executes an assignment of benefits.

The insured would be allowed to assign benefits, rather than paying the provider first and then seeking reimbursement from the insurer. However, the bill would continue to allow out-of-network providers the option to balance bill the insured for the difference between the amount paid by the insurer and the amount charged by the out-of-network provider.

Proponents of the bill state that a correlation between direct assignment of benefits and increased health insurance premiums has not been established.[1] Also, the cost-

[1] *Research Concerning Insurance Premium Rate Changes for the Florida Medical Association.* Tallahassee, FL: MGT of America (2008).

effectiveness of the networks has not been weakened as a result of the passage of mandatory assignment of benefits legislation in other states.[2]

According to insurers, the ability to pay the patient directly, rather than the provider, for out-of-network services provides a financial incentive for providers to join an insurer's network. Representatives from health insurers and HMOs have expressed concerns that the bill will result in higher costs and higher premiums for insureds due to the elimination of one of the primary financial incentives for a provider to join an insurer's provider network, which is the right to obtain payment directly from the insurer rather than being required to bill the policyholder. The concern is that the insurer will not be able to negotiate as low of a reimbursement rate if the insurer cannot use, as a bargaining tool, the prohibition of direct payment to providers outside the network. If this results in a higher reimbursement rate to contract providers, it would be passed on to policyholders in higher premium costs.

However, other insurance representatives have stated that some major insurers allow assignment of benefits to out-of-network providers, and have not found it necessary to use this bargaining tool in establishing reimbursement rates.

C. Government Sector Impact:

According to the DMS and based on information provided by BCBS, the expansion of the mandatory assignment to all providers will interfere with BCBS's ability to maintain their network strength and current level of provider discounts. Diminished provider discounts will result in higher PPO plan costs. Additionally, the loss of network providers and lower provider discounts would result in higher out-of-pocket costs to plan members as network care becomes more costly and out-of-network care becomes more prevalent due to fewer network treatment options. The potential for higher out-of-pocket costs could cause some enrollees to migrate from the PPO plan to an HMO. Since the annual cost to the state for an employee enrolled in an HMO is about $2,400 more than for an employee enrolled in the PPO plan, migration to the HMO plans results in a negative fiscal impact to the state.

If mandatory assignment results in either lower provider discounts or weakens BCBS's ability to attract and retain providers, the State Employees' Health Insurance Trust Fund will be negatively impacted. The BCBS provided an analysis indicating that Year 2009 cost from $9.9 million to $25.7 million. However, there is uncertainty associated with predicting provider behavior and the extent to which mandatory assignment could result in additional costs to the state.

The DMS commissioned Gabriel Roeder Smith & Company to conduct an independent review of the BCBS actuarial analysis.[3] Gabriel Roeder Smith & Company reviewed the BCBS methodology and moderated two key BCBS assumptions to develop their best estimate of an $11 million fiscal impact, with a potential impact range from $5.1 million

[2] *Assignment of Benefits Legislation for Healthcare Provider.* Anderson, Diane (2005). Richmond VA Healthcare Consultants, LLC.
[3] *Review of Mandatory Assignment Model*, April 7, 2009, Gabriel Roeder Smith & Company.

to $18.5 million in fiscal year 2010-11. Gabriel Roeder Smith & Company's analysis also estimates that out-of-pocket costs for the insureds will increase by 75 percent.

Since the effective date of the bill is July 1, 2009, the DMS may need to notify all PPO plan enrollees of mid-year benefit changes. If required, the notification would cost the DMS $41,110. This non-recurring expenditure estimate is based on an approximate PPO plan enrollment of 97,880 and a mailing cost of $0.42 per piece of mail.

VI. Technical Deficiencies:

Due to the revision of subsection (2) of s. 627.638, F.S., by the bill, some of the requirements of subsection (1) appear unnecessary. For instance, subsection (1) states that an insurance contract may provide for direct payment of physicians, while subsection (2) requires direct payment for physicians if an assignment of benefits is executed.

The bill applies to individual and group insurers. Section 641.31(43), F.S., would need to be amended to include health maintenance organizations.

VII. Related Issues:

None.

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 Health Regulation Committee on April 15, 2009:
The CS conforms the second sentence in s. 627.638(2), F.S., to reflect the health care providers subject to the provisions in the first sentence in the bill.

B. Amendments:

Barcode 961258 by Banking and Insurance on April 6, 2009:
The amendment limits the fees for any out-of-network provider accepting direct assignment to 80 percent of the current Medicare fee schedule. This payment from the insurer would be deemed payment in full and the out-of-network provider could not balance bill the insured for any balance of charges not paid by the insurer. This provision would not apply to emergency services. **(WITH TITLE AMENDMENT)**