HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 855 Direct Payment of Benefits
SPONSOR(S): Llorente and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1122

	REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1)	Insurance, Business & Financial Affairs Policy Committee	16 Y, 3 N	Barnum	Cooper
2)	General Government Policy Council	17 Y, 0 N	Barnum	Hamby
3)	Government Operations Appropriations Committee	(W/D)		
4)	Full Appropriations Council on General Government & Health Care	(W/D)		
5)				

SUMMARY ANALYSIS

Currently, a health insurer is required to provide the option for assignment of benefits to a select population of providers on its claim form, accept assignment of benefits, and make payment directly to hospitals, licensed ambulance providers, physicians and dentists, if the insured so indicates on the form.

HB 855 expands the pool of providers to whom an insurer would be required to make payment to include any other person who provided the services in accordance with the provisions of the policy.

The bill removes language which specifically provides for assignment of benefits for care provided pursuant to s. 395.1041, F.S. (Access to emergency services and care) or Part III, Chapter 401, F.S. (Raymond H. Alexander, M.D., Emergency Medical Transportation Services Act).

Department of Management Services indicates there will be a negative financial impact to the State Employees' Group Health Self-Insurance Trust Fund. Its third-party administrator has quantified that impact as follows:

- Fiscal Year 2009-2010 – $4.95 – 12.85 million.
- Fiscal Year 2010-2011 – $9.9 - 27 million.

The bill provides for an effective date of July 1, 2009.

HOUSE PRINCIPLES

Members are encouraged to evaluate proposed legislation in light of the following guiding principles of the House of Representatives

- Balance the state budget.
- Create a legal and regulatory environment that fosters economic growth and job creation.
- Lower the tax burden on families and businesses.
- Reverse or restrain the growth of government.
- Promote public safety.
- Promote educational accountability, excellence, and choice.
- Foster respect for the family and for innocent human life.
- Protect Florida's natural beauty.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background:

The Office of Insurance Regulation (OIR) regulates health insurance contracts and rates under Part VI of Chapter 627, F.S., and HMO contracts and rates under Part I of Chapter 641, F.S., while the Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under Part III of Chapter 641, F.S.

Assignment of benefits is an arrangement by which an insured patient authorizes payment of their health insurance benefits directly to a certain provider, such as a physician or hospital, for covered medical services rendered.[1]

State laws requiring insurers to accept assignment of benefits have been challenged by insurers under the Employee Retirement Income Security Act ("ERISA"). ERISA is silent on the issue of assignment of benefits for health insurance plans; however, ERISA expressly prohibits the assignment of benefits available under pension plans.[2] ERISA contains an express preemption provision that provides, "[ERISA] supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan…."[3]

The U.S. Supreme Court broadly interpreted the "relates to" provision of the ERISA preemption clause,[4] which resulted in a number of factors being developed by courts to determine whether a state law "relates to" ERISA plans.[5] Accordingly, when faced with the issue of whether Congress' silence on the issue of assignment of health insurance benefits under ERISA preempts states from adopting their own laws on this issue, federal court decisions have produced mixed results. For example, both the 8th and

[1] Definition obtained at http://www.medterms.com/script/main/art.asp?articlekey=24244 last viewed March 25, 2009.
[2] 29 USC s. 1056(d)(1).
[3] 29 U.S.C. s. 1144(a).
[4] *See, e.g., Shaw v. Delta Air Lines*, 463 U.S. 85 (1983) (finding that a state law "relates to" an employee benefit plan "if it has a connection with or reference to such plan," while recognizing that some state actions may be too remote or tenuous to warrant a finding that the law relates to an employee benefits plan); *see also Arkansas Blue Cross and Blue Shield v. St. Mary's Hospital, Inc.,* 947 F.2d 1341 (8th Cir. 1991).
[5] *See, e.g., Arkansas Blue Cross and Blue Shield v. St. Mary's Hospital, Inc.,* 947 F.2d 1341 (8th Cir. 1991).

10th Circuit Courts of Appeal have concluded that assignment of benefits laws are preempted by ERISA, with the 10th Circuit determining that the decision of whether assignment of benefits is acceptable should be left to the contracting parties.[6]

More recently, however, an insurer in Louisiana challenged Louisiana's assignment of benefits statute in federal court alleging that the Louisiana law, which requires insurers to honor all assignment of benefits by patients to hospitals, was preempted by ERISA.[7] The 5th Circuit Court of Appeal recognized that because ERISA expressly precludes the assignment of pension plan benefits but is silent as to the assignment of employee health insurance benefits, Congress must have intended to leave room for state regulation of this issue, particularly because it falls within a traditional area of state regulation.[8] The 5th Circuit recognized that since the 8th and 10th Circuit decisions in *St. Francis Regional Medical Center* and *St. Mary's Hospital,* the U.S. Supreme Court has moved toward what has been recognized as a more "traditional analysis of preemption," which focuses on whether the state regulation "frustrate[s] the federal interest in uniformity."[9] Thus, Louisiana's assignment of benefits law was not preempted by ERISA. On appeal, the U.S. Supreme Court declined to review the 5th Circuit's decision.

Court decisions on assignment of benefits laws are mixed: Earlier cases ruled that states cannot regulate assignment of benefits because that area of law is preempted by ERISA; while a later case ruled that ERISA does not preempt states from passing such laws. The 11th Circuit Court of Appeal, which includes Florida in its jurisdiction, has not addressed the validity of assignment of benefits statutes.[10] The validity of a statute either banning or requiring compliance with assignment of benefits is not a settled point.

Under the authority of s. 110.123, *Florida Statutes*, the Department of Management Services (DMS) contracts with a third-party administrator (TPA) for the state's self-insured preferred provider organization plan (PPO Plan). Persons eligible for this plan includes state officers and employees, surviving spouses of deceased state officers and employees, retired state officers and employees, terminated employees and individuals with continuation coverage, i.e. COBRA. The medical component of the PPO Plan is administered by BlueCross BlueShield of Florida (BCBSFL). As the TPA for the PPO Plan, BCBSFL is responsible for providing and maintaining a network of providers. DMS and the State of Florida are not party to the private business contracts between BCBSFL and its network providers.

Current Situation:

In Florida, if the health insurance claim form provides an option for the insured to specifically authorize payment to any recognized hospital, physician or dentist and the insured so elects, the insurer is required to make the payment directly to the provider. In addition, insurance contracts cannot prohibit, and claims forms must provide an option for, an insured to assign benefits directly to a licensed hospital, licensed ambulance provider, physician or dentist. when emergency services or care is provided pursuant to s. 395.1041, F.S. or the Raymond H. Alexander, M.D., Emergency Medical Transportation Services Act.[11] Insurers may require the assignment to be made through a written attestation of assignment of benefits.[12] Payment to the provider can not exceed what the insurer would have paid without the assignment.

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[6] *St. Francis Regional Medical Center v. Blue Cross and Blue Shield of Kansas, Inc.*, 49 F.3d 1460 (10th Cir. 1995) and *Arkansas Blue Cross and Blue Shield v. St. Mary's Hospital, Inc.,* 947 F.2d 1341 (8th Cir. 1991).

[7] *Louisiana Health Service & Indemnity Co. v. Rapides Healthcare System, et al.*, 461 F.3d 529 (5th Cir. 2006).

[8] Id.

[9] Id.

[10] The 11th Circuit has, however, determined that anti-assignment of benefits provisions in ERISA plan documents are not prohibited by ERISA, and that "congressional silence on the issue [of assignability] does not mandate a Congressional intent to mandate assignability" but, rather, leaves it up to the agreement of the contracting parties. *Physicians Multispecialty Group v. Health Care Plan of Horton Homes, Inc.*, 371 F.3d 1291 (11th Cir. 2004).

[11] s. 627.638(2), F.S.

[12] Id.

Effect of Proposed Changes

HB 855 requires that health insurers, in addition to paying claims directly to hospitals, licensed ambulance providers, physicians and dentists, shall pay claims directly to an "other person who provided the services in accordance with the provisions of the policy" when specifically authorized by an insured on the health insurance claim form.

The bill removes the language by which the insurance contract is barred from prohibiting, and is required to provide an option for, direct payment of benefits for care provided pursuant to s. 395.1041, F.S. (Access to emergency services and care) or Part III, ch. 401, F.S. (Raymond H. Alexander, M.D., Emergency Medical Transportation Services Act) on the claim form. In removing this specific prohibition, the statutory prohibitory language and mandatory option is broadened to encompass all providers.

B. SECTION DIRECTORY:

Section 1. Amends s. 627.638(2), F.S., by modifying assignment of benefits.

Section 2. Provides for an effective date of July 1, 2009.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:[13,14]

	(FY 09-10) Amount	(FY 10-11) Amount
State Group Self-Insurance PPO Plan	$4.95-12.85 million	$9.9-27 million

See fiscal comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

Indeterminate. See fiscal comments.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Changes to administrative costs, network composition, or contracted reimbursement rates experienced by health insurers as a result of the bill, either positive or negative, may impact premiums.

[13] Figures developed by BCBSFL which Division of State Group Insurance does not dispute, but notes that the exact amount is difficult to ascertain.

[14] Department of Management Services Draft Bill Analysis and Fiscal Impact Statement dated March 29, 2009 on file with the Insurance, Business and Financial Affairs Policy Committee.

D. FISCAL COMMENTS:

The self-insured PPO Plan covers approximately 56% of those enrolled in the State Group Health Insurance Program. DMS reports its TPA has indicated a potential negative fiscal impact to the State Employees' Group Health Self-Insurance Trust Fund of $9.9-25.7 million per calendar year as a result of loss of network providers and diminished discounts. In addition, the potential for higher out-of-pocket costs could cause some enrollees to migrate from the PPO plan to an HMO offering. Since the annual cost to the state for an employee enrolled in an HMO is more than for an employee enrolled in the PPO Plan, migration to the HMO plans would result in further negative fiscal impact to the state.[15]

For the State Group Health Insurance Program, increases in the cost of providing health insurance coverage can be addressed by increasing the employer and/or employee premium contribution, modifying the benefits, or any combination thereof. Full funding of the State Group Health Insurance Program is required. The Legislature is required to provide for the necessary premium level in the General Appropriations Act.[16]

The local government and private sector impact of an expansion of the provider population eligible to receive assignment of benefits can not be quantified at this time. The magnitude of negative fiscal impacts will vary based upon individual offerings, funding structures, and contractual arrangements.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to: require counties or municipalities to spend funds or take an action requiring the expenditure of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with counties or municipalities.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

As drafted, the bill applies to individual and group health insurers. It is not applicable to health maintenance organizations.

IV. AMENDMENTS/COUNCIL OR COMMITTEE SUBSTITUTE CHANGES

None.

[15] Id.

[16] s. 110.1239, F.S.