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 Committee on Banking and Insurance

BILL: SB 144

INTRODUCER: Senators Altman and Soto

SUBJECT: Payment for Services Provided by Licensed Psychologists

DATE: April 4, 2013 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	McElheney	Stovall	HP	**Favorable**
2.	Oh	Burgess	BI	**Pre-meeting**
3.			AHS	
4.			AP	
5.				
6.				

I. Summary:

SB 144 adds licensed psychologists to the list of health care providers who are protected by a 12-month limitation period from claims for overpayment sought by health insurers or health maintenance organizations (HMOs) and adds licensed psychologists to the list of health care providers subject to a 12-month time period for submitting claims for underpayment against health insurers or HMOs. The bill also adds licensed psychologists to the list of non-network providers who are eligible for direct payment for medical services by a health insurer.

The effective date of the bill is July 1, 2013.

This bill substantially amends the following sections of the Florida Statutes: 627.6131, 641.3155 and 627.638.

II. Present Situation:

Claims of Overpayment and Underpayment

Under s. 627.6131(6), F.S. and s. 641.3155(5), F.S., respectively, health insurers and HMOs generally must submit any claim for overpayment to a health care provider within 30 months from the date of payment to the provider. The provider then has a specified time frame within which to pay the overpayment or contest the claim.[1] Under s. 627.6131(18), F.S., and s. 641.3155(16), F.S., however, a health insurer or HMO must submit a claim for overpayment against a health care provider licensed under chapters 458 (physicians), 459 (osteopaths),

[1] S. 627.6131(6)(a)(1), F.S. and s. 627.6131(6)(a)(2), F.S.

460 (chiropractors), 461(podiatrists), and 466 (dental surgeons) within 12 months after the payment of the claim.

Under s. 627.6131(19), F.S., and s. 641.3155(17), F.S., respectively, a health care provider licensed under chapter 458, 459, 460, 461, and 466 must submit any claim of underpayment within 12 months after receiving payment from the insurer or HMO.

Practice of Psychology

Chapter 490, F.S., the "Psychological Services Act," governs the practice of psychology and school psychology in Florida. A person desiring to practice psychology or school psychology in Florida must be licensed by the Department of Health. "Practice of psychology" means the observations, description, evaluation, interpretation, and modification of human behavior, by the use of scientific and applied psychological principles, methods, and procedures, for the purpose of describing, preventing, alleviating, or eliminating symptomatic, maladaptive, or undesired behavior and of enhancing interpersonal behavioral health and mental or psychological health.[2] "Practice of school psychology" means the rendering or offering to render to an individual, a group, an organization, a government agency, or the public any of the following services-assessment, counseling, consultation, and development of programs.[3]

Psychologists who contract as preferred providers[4] or network providers with an insurer receive payment directly from the insurer for the services rendered.[5] Until legislation passed in 2009,[6] however, non-network psychologists were generally paid by the insured. After paying the psychologist, the insured then would file a claim for reimbursement with his or her insurer. In contrast, even prior to 2009, Florida law required that for non-network recognized hospitals, licensed ambulance providers, physicians, and dentists who provided services to the insured in accordance with the provisions of the insurance policy, the insurer must directly reimburse the provider if the insured specifically authorized payment of benefits directly to the provider.[7]

Assignment of Benefits for Health Insurance Claims

Prior to the 2009 Legislative Session, s. 627.638(2), F.S., required that, when specifically authorized by the insured, a health insurer was required to make direct payment to any recognized hospital, licensed ambulance provider, physician, or dentist, unless "otherwise provided in the insurance contract." The pre-2009 law further provided that an insurance contract had to provide for the option of direct payment to a licensed hospital, licensed ambulance provider, physician, or dentist for emergency services or emergency medical transportation services.

[2] S. 490.003(4), F.S.
[3] S. 490.003(5), F.S.
[4] S. 627.6471(1)(b), F.S. It defines preferred provider as, "any licensed health care provider with which the insurer has directly or indirectly contracted for an alternative or a reduced rate of payment…"
[5] S. 627.638(3), F.S.
[6] Ch. 2009-124, L.O.F.
[7] S. 627.638(2), F.S.

In 2009, the Legislature amended s. 627.638(2), F.S., to remove the qualifying language: "otherwise provided in the insurance contract." The amending language also added "other person[s] who provided the services in accordance with the provisions of the policy" to the list of specified professionals who are entitled to direct payment if specifically authorized by the insured.[8] The effect of this legislation was to require that, if specifically authorized by the insured, a health insurer must directly pay all licensed hospitals, licensed ambulance providers, physicians, dentists, and other persons who provide services in accordance with the provisions of the insurance policy.

Due to concerns that these provisions might lead to increased costs to the state's group health plan as a result of providers leaving the network,[9] language was included in ch. 2009-124, L.O.F., providing for the amendments to be automatically repealed on July 1, 2012, and the language in s. 627.638(2), F.S., to revert to the language that existed on June 30, 2009, if the Office of Program Policy Analysis and Government Accountability (OPPAGA) made certain findings in a study to be published on or before March 1, 2012. The language was to be repealed if the OPPAGA found that:

- The amendments caused the third-party administrator of the state's group health plan to suffer a net loss of physicians from its preferred provider plan network; and
- As a direct result, the state's group health plan incurred an increase in costs.[10]

In January 2012, the OPPAGA issued the requisite report, and summary statements about the report are as follows:

- Statutory changes made by the 2009 Legislature that require the state group health plan's third party administrator to directly pay non-network providers for services did not result in a loss of network physicians. Since December 2009, the number of physicians participating in Blue Cross and Blue Shield of Florida's (BCBS) preferred provider network for the state group has increased by 12.5 percent. In addition, while the number and amount of non-network physician and other profession claims has increased slightly since 2009, the proportion of these claims to overall physician and other profession claims for the state group has remained at about 2 percent. Moreover, the discount rate BCBS negotiates with network providers for the state group has remained relatively unchanged.
- Overall costs for state group health participants have increased; per enrollee per month costs increased from $479 in Fiscal Year 2008-09 to $541 in Fiscal Year 2010-2011. However, these increased costs cannot be directly linked to the 2009 law because many factors contribute to rising health care costs.[11]

[8] Ch. 2009-124, L.O.F.
[9] 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 health care providers agree to become part of a preferred provider network, often in exchange for a reduced payment from the insurer.
[10] S. 2, ch. 2009-124, L.O.F.
[11] The Florida Legislature, Office of Program Policy Analysis and Government Accountability, *Negative Effects on the State's Third Party Provider Network from 2009 Law Not Apparent*, Report No. 12-01, January 2012, pages 2 and 4, available at http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/1201rpt.pdf(last viewed April 4, 2013) (on file with Health Innovation Subcommittee staff).

III. Effect of Proposed Changes:

Section 1 amends s. 627.6131, F.S., relating to overpayment or underpayment of claims by health insurers to a provider, to include psychologists and school psychologists in the list of providers:

- To whom an insurer must submit a claim for overpayment within 12 months after the health insurer's payment of the claim; and
- Who must submit a claim for underpayment to an insurer within 12 months after the health insurer's payment of the claim.

Section 2 amends s. 641.3155, F.S., relating to overpayment or underpayment of claims by an HMO to a provider, to include psychologists and school psychologists in the list of providers:

- To whom an insurer must submit a claim for overpayment within 12 months after the health insurer's payment of the claim; and
- Who must submit a claim for underpayment to an insurer within 12 months after the health insurer's payment of the claim.

Section 3 amends s. 627.638(2), F.S., to include non-network psychologists in the specified list of providers, contingent upon the Office of Program Policy Analysis and Government Accountability not presenting the finding specified in section 2 of chapter 2009-124, Laws of Florida:

- To whom an insurer must make direct payment, if the insured specifically authorizes the payment of benefits directly to a recognized hospital, licensed ambulance provider, physician, dentist, psychologist, or other person who provided the services in accordance with the policy;
- For which an insurance contract may not prohibit the direct payment of benefits; and
- For which an insurer must provide a claim form with an option for direct payment of benefits.

Section 4 amends s. 627.638(2), F.S., to include psychologists in the list of providers, contingent upon the Office of Program Policy Analysis and Government Accountability presenting the finding specified in section 2 of chapter 2009-124, Laws of Florida:

- To whom an insurer must make direct payment to, if the insured specifically authorizes payment of benefits directly to the psychologist, unless otherwise provided in the insurance contract,
- For which an insurance contract may not prohibit the direct payment of benefits for emergencies services and care; and
- For which an insurer must provide a claim form with an option for direct payment of benefits for emergency services and care.

Section 5 provides an effective date of July 1, 2013.

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:

Psychologists will have a quicker turnaround time for receiving claims for overpayment from insurers or HMOs.

Health insurance carriers and HMOs will incur some administrative costs for revising health insurance forms to allow for the selection of a psychologist for direct payment for services rendered for hospital and emergency medical services.

C. Government Sector Impact:

The OIR anticipates an increase in health form review as a result of the additional category of provider eligible for direct payment on any health insurance form, but the increased form review can absorbed within current resources.[12]

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill includes two alternative changes to s. 627.638(2), F.S. The bill was drafted with these two alternative versions of s. 627.638(2), F.S., because when it was initially drafted, the proper version of s. 627.638, F.S., was contingent upon the findings of the OPPAGA report required by chapter 2009-124, L.O.F. At this time, however, the report has been issued, and the OPPAGA found that the 2009 changes to s. 627.638(2), F.S., did not result in a loss of network physicians

[12] Florida Office of Insurance Regulation, Legislative Affairs, *HB 1237*, March 13, 2013, page 3 (on file with Health Innovation Subcommittee staff).

in the state group health insurance plan, and that the cost increases could not be directly attributed to the 2009 statutory changes.

Based on the findings of the OPPAGA report, section 4 of the bill, which is the alternative language that would have been necessary only if the OPPAGA report had found a loss of physicians and resulting cost increases to the state group health plan, can be deleted. In addition, the conditional provision contained in the directory of section 3 of the bill is unnecessary because the referenced contingency has been met.

Because of the findings by the OPPAGA, the provisions of s. 627.638(2), F. S., are no longer contingent. Accordingly, s. 627.638(2), F.S., in its present form, requires that, if specifically authorized by the insured, a health insurer must directly pay all licensed hospitals, licensed ambulance providers, physicians, dentists, and "other person[s] who provide services" in accordance with the provisions of the insurance policy. The term "other person who provided the services" appears to be a catch-all provision that covers all health care providers, including psychologists.

VIII. Additional Information:

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

None.

B. Amendments:

None.