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 Banking and Insurance Committee

BILL:	CS/SB 1012
INTRODUCER:	Senator Gaetz
SUBJECT:	Health Insurance Claims Payments
DATE:	February 19, 2008 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson	Deffenbaugh	BI	**Fav/CS**
2.			CM	
3.			HP	
4.			GA	
5.				
6.				

I. Summary:

The Committee Substitute for Senate Bill 1012 requires insurers to directly pay licensed hospitals, licensed ambulance providers, physicians, or dentists if the insured makes a written an assignment of benefits. Payment to the medical provider may not be more than the payment due an insured when an assignment of benefits is not made. Under current law, direct payment by an insurer is only required for emergency care, but licensed ambulance providers are not included in the list of providers to whom direct payment must be made.

The bill also requires health maintenance organizations to directly pay licensed hospitals, ambulance providers, physicians, and dentists for covered emergency services if the HMO subscriber makes a written assignment of benefits. Payment to the medical provider may not be more than the payment due an insured when an assignment of benefits is not made.

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:

- The health care contract between the insurer/administrator and the provider must expressly authorize leasing, renting, or granting access to the provider's services.
- Third parties that are granted access to the provider's services must comply with all applicable terms of the health care contract between the provider and the insurer/administrator.
- When access is granted to a third party, the insurer/administrator must notify the preferred provider within 5 days, after which the provider has 30 days to opt out of participating in the third party's health care plan.

- The insurer/administrator must maintain an Internet website or toll-free telephone number for providers to obtain a listing of the third parties that have been granted access.
- The insurer/administrator must ensure that the provider is furnished with information that identifies the contractual source of any applicable discount.
- None of these requirements apply if the insurer/administrator is granting such access to an employer or entity that has contracted with the insurer or administrator to provide health care coverage to its employees or members. Additional exceptions are provided.

The bill 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.

The bill reduces the maximum time period from 30 months to 12 months after an HMO pays a claim to a 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.

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

This bill substantially amends the following sections of the Florida Statutes: 627.638, 627.64731, 627.662, 641.31, 641.315, and 641.3155.

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, doctor, or other person who provided the health care services, in accordance with the provisions of the health care policy. In order to directly pay such providers, the insurance policy must state that benefits may be payable to the provider in the health insurance policy.

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*. 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 why health care providers agree to become part of a preferred provider network, often in exchange for a reduced payment from the insurer. If 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.

Preferred Providers and Contracts for Reduced Payment
Insurers that have preferred provider organizations 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 or EPOs, which condition the payment of benefits on the use of exclusive 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.

Currently, insurers and administrators of preferred provider networks will sometimes sell or lease the preferred provider network they have negotiated to other networks and health care payers, such as insurers, third-party administrators, self-funded employer health care groups such as the Florida State Group Health Plan, or other entities. Florida law does not restrict this practice or require the notification of providers when the PPO they have entered is sold or transferred to another entity.

Health Maintenance Organizations & Point-of-Service Riders
A health maintenance organization 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 for the provision of health care. The use of a non-contracted 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 that permits 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.

Health Maintenance Organizations & Review of Claims Overpayment
Subsection (5) of s. 641.3155, F.S., contains the process by which a 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. 627.638, F.S., regarding the direct payment of health care providers by insurers. Subsection (1) is amended to include licensed ambulance providers among the health care providers to whom direct payment of health insurance benefits *may* be made in accordance with the provisions of the insurance policy. The list of providers is also amended to include a "physician" rather than a "doctor." Neither term is defined for purposes of this section, leaving uncertainty as to who may be considered a physician. Physician is only defined in Ch. 627, F.S., in s. 627.6482(10), F.S., for purposes of the Florida Comprehensive Health Association Act. In that statute, the term includes physicians licensed under ch. 458, F.S., osteopaths licensed under ch. 459, F.S., chiropractors licensed under ch. 460, F.S., podiatrists licensed under ch. 461, F.S., and (for oral surgery only) dental surgeons licensed under ch. 466, F.S.

Subsection (2) is amended to require the direct payment of plan benefits to a licensed hospital, licensed ambulance provider, physician, or dentist whenever the insured specifically authorizes payment to that provider through an assignment of benefits. 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. This retains the ability of an insurer to pay non-contracted providers the reimbursement the insurance contract requires. The assignment of benefits must be in writing (current law allows the insurer to require it) but may be transferred to the insurer in electronic form. Under current law, direct payment is only required for emergency care provided pursuant to s. 395.1041, F.S. Additionally, under current law licensed ambulance providers are not included in the list of providers to whom direct payment must be made.

Due to the revision of subsection (2) 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.

Section 2. Creates s. 627.64731, F.S. The section 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. 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 health care services of the provider.
- 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 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, 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 the section 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 seeking to provide health coverage to their members 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.

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

Section 3. Adds a new subsection (11) to s. 627.662, F.S., to apply the provisions in section 2 of the bill to group health insurance, blanket health insurance, and franchise health insurance.

Section 4. Adds subsection (41) to s. 641.31, F.S., to prohibit HMO contracts from prohibiting or restricting a subscriber (insured) from assigning plan benefits to a licensed hospital, ambulance transport and treatment provider pursuant to part II of chapter 401, physician, or dentist for covered emergency services provided pursuant to s. 395.1041, F.S. The assignment of benefits must be in writing but may be transferred to the HMO in electronic form.

Section 5. Adds subsection (11) to s. 641.315, F.S., requiring an HMO to notify a health care practitioner and receive the practitioners express authority in order to sell, lease, or transfer information regarding the payment or reimbursement terms of a contract with a health care practitioner.

Section 6. Amends subsection (5) of s. 641.3155, F.S. 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. The bill is effective July 1, 2008, and applies to 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:

Specified health care providers (hospitals, ambulance providers, physicians and dentists) 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.(Section 1) Direct payment would also be required from an HMO for the provision of emergency services. (Section 4) This also provides the convenience to the insured or subscriber of being allowed to assign benefits, rather than paying the provider and seeking reimbursement from the insurer or HMO.

Representatives from health insurers and HMOs have expressed concerns that the provisions of this bill (sections 1 and 4) will result in higher costs and higher premiums for insureds or HMO subscribers due to the elimination of one of the primary incentives for a provider to join an insurer's provider network, which is the right to obtain payment directly from the insurer or HMO, rather than being required to bill the policyholder or subscriber. The concern is that the insurer will not be able to negotiate as low 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. This concern is lessened with regard to HMO's as the requirement only applies to the provision of emergency services. Also, insurance representatives have stated that some

major insurers allow assignment of benefits to non-contracted providers, and have not found it necessary to use this bargaining tool in establishing reimbursement rates. Health insurers have also expressed concern with the requirement in section 2 that allows a preferred or exclusive provider to opt out of participating in a third party's health care plan. A third party that is granted access to the provider network will not know which providers it will have access to until after the 30 day period expires and this is likely to add administrative costs to comply with this requirement and the sections other notice and informational requirements.

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. 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 day period often inhibits their ability to collect monies from patients who often cannot be located.

C. Government Sector Impact:

The private sector impact summarized above would apply to government funded health care plans.

VI. Technical Deficiencies:

None.

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.)

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.