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 Policy Committee

BILL:	CS/SB 1012
INTRODUCER:	Banking and Insurance Committee, Senator Gaetz, and others
SUBJECT:	Health Insurance
DATE:	March 31, 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.			GA	
6.				

Please see Section VIII. for Additional Information:

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

I. Summary:

Committee Substitute for Senate Bill 1012 makes a number of changes to current law regarding assignment of benefits by policyholders or subscribers, third party access to preferred provider networks, and recouping of certain overpayments to providers.

Committee Substitute for Senate Bill 1012 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, if the policyholder makes a written assignment of benefits. 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.

Health maintenance organizations (HMOs) are required to directly pay licensed hospitals, ambulance providers, physicians, and dentists *for covered emergency services only* if their subscribers make a written assignment of benefits. Also, HMO claims forms must provide an option for written assignment to covered emergency service providers. Payment to the medical provider may not be more than the payment due in the absence of an assignment of benefits.

Additionally, CS/SB 1012:

- 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 after an HMO pays a provider for the HMO to make a claim for overpayment, based on a retroactive review or audit of coverage decisions or payment levels.

Committee Substitute for Senate Bill 1012 is effective June 1, 2008, and will apply to contracts entered into, issued, or renewed on or after that date.

Committee Substitute for Senate Bill 1012 substantially amends ss. 627.638, 627.662, 641.31, 641.315, and 641.3155, F.S. It creates s. 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]

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

[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)
[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)

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 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*

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[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)

(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 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

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

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. 627.638(1), F.S., regarding the direct payment of health care providers by insurers, 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 eligible providers also is amended to replace "doctor" with "physician." Neither term is defined for purposes of this section, leaving uncertainty as to who may be considered a physician, although ch. 458, F.S., defines "physician," ch. 459, F.S., defines "osteopathic physician," ch. 460, F.S., defines "chiropractic physician," and ch. 461, F.S., defines "podiatric physician" as persons licensed to practice these types of medicine under those chapters respectively.

Section 627.638(2), F.S., is amended to require the direct payment of plan benefits to a licensed hospital, licensed ambulance provider, physician, or dentist whenever the policyholder *specifically authorizes payment to that provider through an assignment of benefits*. The

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

assignment of benefits must be in writing, as required in current law, but under CS/SB 1012 the assignment paperwork may be transmitted to the insurer in electronic form.

The bill retains the current requirement that payment from the insurer to the provider may not be more than the amount the insurer would have paid to the policyholder if an assignment had not been executed. This means the insurer will pay out-of-network providers the amount of reimbursement, as specified in the insurance contract's fee schedule, that it otherwise would have paid the policyholder.

Section 2. 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 2 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 2 also 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 (or an insured) from assigning plan benefits to a licensed hospital, ambulance transport and treatment provider pursuant to part II of ch. 401, F.S., physician, or dentist for covered emergency services provided pursuant to s. 395.1041, F.S. Also, HMO claims forms must provide an option for written assignment to covered emergency service providers. The assignment of benefits must be in writing but may be transferred to the HMO in electronic form. Payments to these providers *may not be greater* than the amount the HMO would have paid without the assignment.

This new provision allowing assignment of benefits to providers of covered emergency medical services does not affect existing statutory requirements governing HMO billing responsibilities (s. 641.3154, F.S.) and HMO emergency care (s. 641.513, F.S.).

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

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 Article I, Section 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:

Pursuant to **Section 1** of the bill, 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. Pursuant to **Section 4** of the bill, direct payment also would be required from an HMO, but only for the provision of emergency services. These provisions may reduce some providers' problems with collecting payments from their patients, so CS/SB 1012 could have an indeterminate, but positive impact on health care providers.

These provisions also provide convenience to the policyholder or the HMO subscriber, who would be able to assign benefits, rather than paying the provider and seeking reimbursement from the insurer or HMO.

However, representatives from health insurers and HMOs expressed concerns to the Banking and Insurance Committee staff that **Sections 1 and 4** will result in higher costs and higher premiums for policyholders or HMO subscribers due to the elimination of one of the primary incentives for a provider to join an insurer's provider network: the right to obtain payment directly from the insurer or HMO, rather than being required to bill the policyholder or subscriber.

One concern is that insurers 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 could be passed on to policyholders in higher premium costs. This concern is lessened with regard to HMOs, since the direct-assignment requirement only applies to the provision of emergency services. Other 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 also have expressed concern with the requirement in **Section 2** of CS/SB 1012, which 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 section's 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. 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:

Department of Management Services

According to an analysis by the Department of Management Services' (DMS) Division of State Group Insurance (DSGI) provided to the Senate Health Policy Committee on March 31, 2008, the fiscal impact of the bill on state revenues will have negative financial consequences.

In 2006, Buck Consultants provided a financial analysis of the pricing offers associated with the Department's competitive solicitation for the State PPO third-party administrator. That analysis demonstrated that over a four-year period Blue Cross Blue Shield of Florida (BCBSFL) would cost $442 million less than the nearest competitor and $544 million less than the next competitor. If SB 1012 reduces the ability to maintain the PPO network's deep provider discounts the fiscal impact could be significant.

Enactment of SB 1012 may limit and/or interfere with a health insurer's or HMO's ability to contract with providers that agree to discount their fees based on an agreement that other non-network providers will not receive direct reimbursement. Enactment of SB 1012 may have an impact on both the State Employees' PPO plan and the HMO plans contracted with and offered by the DMS. To maintain network strength, insurers may need to increase reimbursement rates which will result in higher PPO plan costs and higher premium rates for the HMO plans.

Additionally, the DMS expects that a loss of network providers would result in movement from the State PPO plan to the State HMO plans as employees react to increases in out-of-pocket expenses associated with receiving more out-of-network services. Currently, annual enrollment cost to the state for the HMO plans is about $2,400 per contract more than PPO enrollment.

Additionally, SB 1012 provides for a July 1, 2008 implementation date. The DMS typically issues notification to plan enrollees for mid-year plan changes). Such notification may result in additional administrative processes and unbudgeted costs for the DMS if such notification cannot be included as part of the regular annual open enrollment period that is generally mid-September through mid-October. The open enrollment notification would be for a January 1 coverage effective date.

Assessment from the State PPO Plan Administrator:
This bill is expected to result in a negative fiscal impact to the State Employees' Health Insurance Trust Fund. The extent of the impact depends on provider behavior and is difficult to ascertain. The financial impact provided by the plan administrator (BCBSFL) for the State PPO plan is shown below. Recognizing that the plan administrator believes

that withholding assignment is integral to its business model and to its ability to provide significant savings to the State PPO plan, **DSGI is in the process of verifying the assumptions through an independent third party**.

Because SB 1012 reduces the downside to not participating in the BCBSFL network, the BCBSFL projects that some providers will exit the State PPO network or will demand increased reimbursement to maintain their network status. The BCBSFL reports the following anticipated impact on the State's self-insured PPO plan due to the enactment of SB 1012:

- The model provided by the BCBSFL anticipates a "conservative" impact of this bill on the State PPO plan of 11.3 percent. This anticipated impact, applied to payments for the 2007 plan year, would have resulted in additional charge to the State Employees' Health Insurance Trust Fund of approximately $56.1 million and caused the members of the State PPO plan to incur an additional $60.7 million in out-of-pocket expenses. The underlying assumptions to this estimate are:
    - A significant percentage of providers would opt not to participate in-network, because they would weigh the freedom of direct payment of a reasonable amount of reimbursement coupled with the ability to balance-bill (to as much as charges, typically multiples of what Medicare pays) against the in-network prohibition on balance billing coupled with other network requirements of credentialing, reporting, following medical/quality policies, electronic medical records, etc.; and
    - Many providers would have greater leverage to negotiate higher in-network reimbursement.

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]

Committee Substitute for Senate Bill 1012'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 CS/SB 1012 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.

VI. Technical Deficiencies:

Due to the revision of s. 627.638(2), F.S., some of the requirements of s. 627.638(1), F.S., 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.

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

VII. Related Issues:

As mentioned in **Section III. Effect of Proposed Changes**, the word "physician" replaces the existing term "doctor" in s. 627.638(1), F.S., making that subsection consistent with subsection (2). "Physician" is not defined for the purposes of implementing the statute changes proposed in CS/SB 1012, potentially allowing different parties to interpret the term as broadly or as narrowly as they choose. Yet, definitions for "physician" can be found in several chapters of Florida law and are narrowly drawn to the purposes of those chapters. In ch. 627.6482(10), F.S., "physician" is defined specifically for purposes of the Florida Comprehensive Health Association Act, citing physicians licensed under ch. 458, F.S., osteopathic physicians licensed under ch. 459, F.S., chiropractic physicians licensed under ch. 460, F.S., podiatric physicians licensed under ch. 461, F.S., and (for oral surgery only) dental surgeons licensed under ch. 466, F.S.

In general, there appears to be some confusion among the parties over the interpretation of provisions in CS/SB 1012. For example, the bill as 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 **Sections 1** and **4** 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 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.

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

- 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:

Barcode 578626 by Commerce on March 11, 2008:
This amendment adds "or other person who provided the services, in accordance with the provisions of the policy," to the list of entities that have to be paid directly by the insurer if assigned the right to payment by the patient. This phrase already appears within the same section. The amendment also requires the provider to retain a written attestation of direct assignment and be able to provide it to the insurer upon request. (WITH TITLE AMENDMENT)

Barcode 430208 by Commerce on March 11, 2008:
This amendment deletes cross-references to existing law that some affected groups felt might be confusing in implementation, and deletes unnecessary language related to regulating the use of "silent PPO-type" contracts by HMO's. (WITH TITLE AMENDMENT)

Barcode 457874 by Commerce on March 11, 2008:
This amendment adds a section that reduces the "look-back period" for billing claim adjustments for PPO's from 30 months to 12 months. It mirrors provisions already in the bill for HMO's. It also requires a non-participating provider treating a PPO patient out of network to provide that patient with an estimate of charges, upon request, and a statement that costs might exceed insurance coverage. (WITH TITLE AMENDMENT)

Barcode 786384 by Health Regulation on March 26, 2008:
This amendment to amendment barcode 457874, 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. (WITH TITLE AMENDMENT)