HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 405 Health Insurance Claims Payments
SPONSOR(S): Healthcare Council; Galvano and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1012

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Health Innovation	7 Y, 0 N	Quinn-Gato	Calamas
2) Healthcare Council	16 Y, 1 N, As CS	Calamas/ Massengale	Gormley
3) Policy & Budget Council			
4)			
5)			

SUMMARY ANALYSIS

Council Substitute for House Bill 405 prohibits insurers and health maintenance organizations ("HMOs") from restricting the ability of an insured to assign plan benefits for covered services to certain health care providers not under contract with the insurer or HMO, and certain preferred providers.

The bill also prevents insurers from reimbursing preferred providers at alternative or reduced rates for covered services unless the insurers or plan administrators and the providers have entered into a contract incorporating such an arrangement. The bill further requires that both the preferred provider and the insurer or plan administrator must expressly agree, with adequate prior notice, to the sale, lease, or transfer of information regarding the payment or reimbursement terms of their preferred provider contracts. Similarly, the bill provides that HMOs are precluded from selling, transferring, or leasing information regarding the payment or reimbursement terms of the contracts with a health care practitioner without adequate notice to and the express permission of the health care practitioner.

Finally, the bill requires HMOs to submit claims for overpayment to a provider within 12 months of the HMO's payment of the claim.

There will be a significant but indeterminate negative fiscal impact to the State Employees' Health Insurance Trust Fund. See Fiscal Comments.

The effective date of the bill is July 1, 2008.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Less Government – The bill provides for additional regulation of health insurers licensed under chapter 627 and health maintenance organizations licensed under chapter 641.

Empowers Families – The bill provides families with greater choice in health care providers by allowing assignment of covered benefits to non-contracted providers. Greater choice of providers could come at a cost to the insured in the form of rate increases by insurers and HMOs as well as higher out-of-pocket expenditures.

B. EFFECT OF PROPOSED CHANGES:

Present Situation

Regulation of Health Insurers and HMOs

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.

Before receiving a certificate of authority from OIR, an HMO must receive a Health Care Provider Certificate from AHCA. Any entity that is issued a certificate of authority and that is otherwise in compliance with the licensure provisions under Part I may enter into contracts in Florida to provide an agreed-upon set of comprehensive health care services to subscribers.

Assignment of Benefits

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]

Several states have enacted some form of assignment of benefits law that requires health insurers to accept an assignment of benefits[2], while other states have enacted laws that either make acceptance of assignment optional on the part of the insurer or allow parties to negotiate for assignment of benefits in provider contract.[3] In Idaho, insurers may decline assignment of benefits.[4]

In Florida, insurance contracts cannot prohibit, and claims forms must provide an option for, an insured to assign benefits directly to a licensed hospital, physician or dentist when emergency services or care

[1] Definition obtained from medterms.net; located on February 15, 2008 at http://www.medterms.com/script/main/art.asp?articlekey=24244.

[2] *See* Ala. Code s. 27-1-19; Colo. Rev. Stat. s. 10-16-317.5; Conn. Gen. Stat. s. 38a-472; Ga. Code Ann. s. 33-24-54; 215 Ill. Comp. Stat. 5/370a; La. Rev. Stat. Ann. s. 40:2010; Me. Rev. Stat. Ann. tit. 24-A, s. 2755; Mo. Rev. Stat. s. 376.427.1; Nev. Rev. Stat. s. 689A.135; N.H. Rev. Stat. Ann. s. 420-B:8-n; N.C. Gen. Stat. s. 58-3-225; Tenn. Code Ann. s. 56-7-120; Wash. Rev. Code s. 48.44.026; Wyo. Stat. Ann. s. 26-15-136.

[3] *See* N.J. Stat. Ann. s. 17B:24-4; N.D. Cent. Code s. 26.1-36-24; Or. Rev. Stat. s. 743.531; Tex. Code Ann. s. 1204.053.

[4] Idaho Code Ann. s. 41.5604.

is provided pursuant to s. 395.1041.[5] Insurers may require the assignment to be made through a written attestation of assignment of benefits.[6]

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.[7] 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…."[8]

The U.S. Supreme Court broadly interpreted the "relates to" provision of the ERISA preemption clause,[9] which resulted in a number of factors being developed by courts to determine whether a state law "relates to" ERISA plans.[10] 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 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.[11]

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.[12] 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.[13] 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."[14] 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.

In summary, 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.[15] The validity of a statute either banning or requiring compliance with assignment of benefits is not a settled point.

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[5] s. 627.638(2), F.S.
[6] *Id.*
[7] 29 USC s. 1056(d)(1).
[8] 29 U.S.C. s. 1144(a).
[9] *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).
[10] *See, e.g., Arkansas Blue Cross and Blue Shield v. St. Mary's Hospital, Inc.,* 947 F.2d 1341 (8th Cir. 1991).
[11] *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).
[12] *Louisiana Health Service & Indemnity Co. v. Rapides Healthcare System, et al.*, 461 F.3d 529 (5th Cir. 2006).
[13] *Id.*
[14] *Id.*
[15] 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).

Silent Preferred Provider Organizations

A "silent preferred provider organization" ("silent PPO"), refers to a situation in which a third party, usually unbeknownst to a preferred provider, contracts with a PPO in order to gain access to the PPO's contracted discounts with its preferred providers.[16] When a patient insured by the third party goes to a preferred provider, the third party pays the preferred provider the rate the preferred provider negotiated with its PPO.[17] As a result, the preferred provider is paid a discounted rate for its services absent a contractual arrangement with the third party.[18]

A number of states have passed "silent PPO" laws. For example, in North Carolina, it is considered an unfair trade practice for any insurer or entity subject to North Carolina insurance laws to intentionally misrepresent, or to knowingly substantially assist an insurer or entity in making a misrepresentation, to a provider that the insurer or entity is entitled to a preferred provider discount when it is not so entitled.[19] In Texas, an insurer or third party administrator is prohibited from reimbursing a provider for covered services on a discounted basis unless the third party administrator or insurer has entered into an agreed-upon contract with the provider for the specific services provided at that rate.[20] Additionally, the parties to a preferred provider contract are prohibited from selling, leasing, or transferring information regarding payment or reimbursement terms without the prior adequate notice to and express consent of the other parties.[21]

The 11th Circuit Court of Appeal, which is binding in Florida, struck down a silent PPO arrangement finding that the leasing of plan discounts to third parties through a series of contracts "deprives plan participants of their contractual expectations" when the providers were not aware of and had not agreed to the discounted fees.[22]

Recoupment of Overpayments

Current law requires providers to submit claims for payment or reimbursement within 6 months of the date of service of the patients and the provider has received the name and address of the patient's HMO.[23] HMOs must pay or deny claims within 90 days of receipt of electronic claims or within 120 days of receipt of mailed claims, and failure to pay or deny an electronic claim within 120 days or a mailed claim within 140 days creates an uncontestable obligation to pay the claim.[24]

HMOs have 30 months from the time a claim is paid to submit a claim for overpayment to a provider, while providers must pay, deny or contest the claim within 40 days after receipt of the claim for overpayment.[25] A contested overpayment claim must be paid or denied within 120 days of receipt of the claim, and failure to pay or deny overpayment and claim within 140 days after receipt creates an uncontestable obligation on the part of the provider to pay the claim.[26]

Effect of Proposed Changes

The bill addresses assignment of insurance benefits to out-of-network providers. It deletes current provisions allowing an insurance contract to prohibit assignment of benefits to hospitals, physicians and

[16] Sharon L. Davies and Timothy Stoltzfus Jost, *Managed Care: Placebo or Wonder Drug for Health Care Fraud and Abuse,* 31 Ga. L. Rev. 373, 391-92 (Winter 1997).
[17] Id.
[18] Id.
[19] N.C. Gen. Stat. s. 58-63-70.
[20] Tex. Code Ann. S. 1301.001.
[21] *Id.*
[22] *HCA Health Services of Georgia, Inc. v. Employers Health Insurance Co.*, 240 F.3d 982 (11th Cir. 2001)
[23] s. 641.355(2)(b), F.S.
[24] s. 641.355(3)(e) and (4)(e), F.S.
[25] s. 641.355(5)(a), F.S.
[26] *Id.*

dentists, effectively prohibiting contract agreement to assign benefits. The bill adds licensed ambulance providers and "other person who provided the services" to the group of providers for whom assignment of benefits must be honored by insurers, and adds emergency transportation services to the types of services for which assignment of benefits must be honored by insurers. The bill amends current law requiring patients to attest to assignment of benefits by allowing patients to attest to assignment of benefits in written or electronic form. The bill would prohibit insurers from requiring attestation in both written and electronic forms.

The bill requires insurers to directly pay providers of emergency services when insureds assign benefits to licensed hospitals. In addition, the bill provides that assigned payments cannot be more than the amount the insurer would have paid absent the assignment.

The bill addresses assignment of insurance benefits to preferred providers. It requires insurers to directly pay preferred providers when insureds assign benefits to preferred providers, forbids contract provisions that would prohibit such assignment, and requires claims forms to include an option for assignment of benefits.

Similarly, the bill addresses assignment of HMO benefits by subscribers to certain providers. The bill requires HMOs to honor assignment of benefits to hospitals, ambulance providers, physicians, and dentists. Likewise, the bill forbids HMO contract provisions that would prohibit such assignment, and requires claims forms to include an option for assignment of benefits for emergency services and transportation. The bill allows patients to attest to assignment of benefits in written or electronic form, and prohibits insurers from requiring attestation in both written and electronic forms. In addition, the bill provides that assigned payments cannot be more than the amount the insurer would have paid absent the assignment.

The bill would govern reimbursement rates for preferred providers. It provides that insurers may not reimburse preferred providers at alternative or reduced rates without a contract agreement as to the health care services to be provided. The bill prohibits a party to a preferred provider contract from selling, leasing, or otherwise transferring information on the contract's terms of remuneration without prior notice to and express authority of the other parties. Similarly, the bill addresses reimbursement rates for HMO providers. The bill prohibits HMOs from selling, leasing, or otherwise transferring information on the terms of remuneration of a contract with a health care practitioner without prior notice to and express authority of the other parties.

Finally, the bill amends s. 641.3155, F.S., by requiring HMOs to submit a claim for overpayment to providers within 12 months after the HMO's payment of the claim.

C. SECTION DIRECTORY:

Section 1. Amends s. 627.638, F.S., relating to direct payment for hospital, ambulance and medical services.

Section 2. Creates s. 627.6471(7)(a)-(b), F.S., relating to contracts for reduced rates of payment.

Section 3. Creates s. 641.31(41)(a)-(c), F.S., relating to direct payment of claims by health maintenance organizations.

Section 4. Creates s. 641.315(11), F.S., relating to the sale, lease or transfer of provider contract terms.

Section 5. Amends s. 641.3155, F.S., relating to prompt payment of claims.

Section 6. Provides an effective date of July 1, 2008.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The Office of Insurance analyzed the economic impact of the bill as originally filed, as follows:

The allowance of utilization services by non-contracted providers could result in an increased cost to insurers and HMOs, thereby resulting in rate increases to consumers.[27] Moreover, because HMOs receive a monthly capitation payment based on the number of subscribers assigned to them, in lieu of payment for individual services, it would be difficult for health maintenance organizations to determine what a non-contracted provider would be owed in an assignment of benefits situation and could result in the loss of savings associated with managed care.[28] Finally, by reducing the review time for HMOs to determine whether overpayments were made from 30 months to 6 months, health maintenance organizations may conduct audits of provider billing on a more frequent basis and could pass the increase costs associated with such on the consumer in the form of rate increases.[29]

House staff has not received an updated economic impact analysis from the Office; however, the bill as amended may result in rate increases to consumers and loss of savings associated with managed care.

D. FISCAL COMMENTS:

House staff has not received an updated economic impact analysis from the Department of Management Services; however, the bill as amended will result in a significant but indeterminate negative fiscal impact on the State Group Health Plan. An analysis of similar legislation by the Department of Management Services was reviewed as it relates to the mandatory assignment of payment to physicians.

Blue Cross Blue Shield of Florida estimated the impact of mandatory assignment of payment to physicians contained in the proposed legislation to be 11.3% for the State Group. In 2007, this estimate of the impact would have resulted in an additional charge to the State Employees' Health Insurance Trust Fund of approximately $56.1M and caused the members of the State Group to incur an additional $60.7M in costs associated with higher premiums and co-pays.

[27] Office of Insurance Regulation, 2008 – HB 405 Bill Analysis.
[28] *Id.*
[29] *Id.*

The department obtained an independent analysis of BCBS of Florida's estimate of the impact of the proposed legislation concerning mandatory assignment of payment to physicians. The conclusion by Mercer, shown below, and based upon the bill, anticipates an estimated impact in the range of 1-2%, or $2.589 million to $5.177 million, based upon the PPO plan's projected 2008 professional claims expense. The report's conclusion is shown below:

> ***Conclusion***
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> *Because the two critical assumptions producing a 10%+ cost impact appear unreasonably conservative, we conclude that the cost estimate produced by BCBS is excessive. Using the BCBS actuarial model and revising the key assumptions above to (1) in-network utilization at 85% and (2) 5% discount erosion produces an estimated cost impact of around 4.5%, which we view as a more reasonable representation of the worst-case impact.*
>
> *Our best guess is that a cost impact in the 1-2% range ultimately (not first year) could result. This is more in line with the estimates cited above based on our limited research.*
>
> *Finally, we must emphasize that we could not support a conclusion that the cost impact would be 0%. In addition to the actuarial model they produced, BCBS of Florida has identified a number of other factors that could lead to increased cost.*

In addition, the language included in CS HB 405 also impacts the assignment of benefits in Health Maintenance Organizations not only for emergency situations, but for routine, non-emergency services. This would increase the estimated negative fiscal impact to the State Employees' Health Insurance Trust Fund.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   None.

2. Other:

   There is a possibility that this bill may implicate Article I, Section 10 of the Florida Constitution regarding impairment of contracts.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

D. STATEMENT OF THE SPONSOR

It is getting harder and harder for physicians to provide healthcare in the state of Florida. This physician friendly bill is an effort to make the business environment in which physicians practice more reasonable and equitable.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

On February 19, 2008 the Health Innovation Committee adopted one amendment to the bill. This amendment:

- Amends section 1 of the bill by deleting requirements added to s. 627.6131 relating to assignment of benefits.

- Amends s. 627.638, F.S., relating to direct payment for hospital and medical services by: (1) adding licensed ambulance providers to the list of providers to which patients can assign health care benefits; (2) deleting provisions that limit payment of benefits in health insurance contracts; and (3) allowing patients to attest to assignment of benefits in written or electronic form.
- Removes provisions in the bill pertaining to balance billing to insureds under health insurance policies.
- Amends subsection (41) of s. 641.31, related to assignment of benefits by:
  - requiring HMOs to honor a patient's assignment of benefits to hospitals, dentists, ambulance transport providers, and physicians if benefits are due under the patient's agreement with their HMO;
  - requiring HMOs to provide the option for payment of benefits directly to licensed hospitals, ambulance providers, physicians, or dentists on claims forms and to allow for payment of claims so long as services provided are covered services, emergency services provided pursuant to s. 395.1041, F.S., or ambulance treatment and transport provided pursuant to part III of chapter 401;
  - allowing patients to attest to the assignment of benefits in written or electronic form;
  - providing that payments from HMOs to providers cannot be more than the amount the HMO would have paid absent the assignment; and
  - clarifying that other provisions of law relating to balance billing and coverage for the emergency treatment of patients are not affected by the amendment.

The bill was reported favorably with one amendment.

On April 10, 2008, the Healthcare Council adopted the traveling amendment, an amendment to the traveling amendment, and an amendment to the bill. The amendments:

- Amends s. 627.638, F.S., relating to assignment of benefits by:
  - deleting provisions allowing an insurance contract to prohibit assignment of benefits to hospitals, physicians and dentists;
  - adding licensed ambulance providers and "other person who provided the services" to the group of providers for whom assignment of benefits must be honored by insurers;
  - adding emergency transportation services to the types of services for which assignment of benefits must be honored by insurers;
  - allowing patients to attest to assignment of benefits in written or electronic form and prohibiting insurers from requiring attestation in both forms.

- Amends s. 627.638, F.S., to require insurers to directly pay preferred providers when insureds assign benefits to preferred providers, and to require insurers to directly pay providers of emergency services when insureds assign benefits to licensed hospitals, and providing that payments from insurers to providers cannot be more than the amount the insurer would have paid absent the assignment.

- Amends s. 627.6471, F.S., relating to contracts for reduced rates of payment, to: require that insurers may not reimburse preferred providers at reduced rates without a contract agreement as to the health care services to be provided; and prohibit a party to a preferred provider contract from selling, leasing, or otherwise transferring information on the contract's terms of remuneration without prior notice to and express authority of the other parties.

- Amends subsection 641.31(41), related to assignment of benefits by:
  - requiring HMOs to honor a patient's assignment of benefits to hospitals, dentists, ambulance providers, and physicians if benefits are due under the patient's agreement with their HMO;
  - prohibiting HMO contracts from prohibiting assignment of benefits, and requiring HMOs to provide an option for assignment of benefits directly to licensed hospitals, ambulance providers, physicians, or dentists on claims forms, and to allow for payment of claims so long as the services provided are covered services, emergency services provided pursuant

to s. 395.1041, F.S., or ambulance treatment and transport provided pursuant to part III of chapter 401;
    - allowing patients to attest to the assignment of benefits in written or electronic form;
    - providing that payments from HMOs to providers cannot be more than the amount the HMO would have paid absent the assignment; and
    - clarifying that other provisions of law relating to balance billing and coverage for the emergency treatment of patients are not affected by that subsection.

- Amends subsection 641.3155(5), F.S., to require HMOs to submit claim for overpayment to providers within 12 months after the HMO's payment of the claims.

The bill was reported favorably as a Council Substitute. The analysis reflects the Council Substitute.