HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 405 Health Insurance Claims Payments

SPONSOR(S): Galvano and others

TIED BILLS: **IDEN./SIM. BILLS:** SB 1012

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Health Innovation		Quinn-Gato	Calamas
2) Healthcare Council			
3) Policy & Budget Council			
4)			
5)			

SUMMARY ANALYSIS

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 health care providers not under contract with the insured's insurer or HMO when the health care provider provides covered services. The bill requires providers under such assignment circumstances to accept the insurer's or HMO's payment as payment in full, and prohibits the provider from seeking additional payment from the insured. If hospital emergency services or emergency pre-hospital treatment or transport are provided pursuant to ss. 395.1041 and 401.45 (for insurance contracts) or s. 641.513 (for HMOs) then the restrictions and limitations on the amount a provider can recover are removed.

House Bill 405 also prevents insurers and plan administrators 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.

For HMO contracts, the bill provides that an HMO is precluded from selling, transferring, or leasing information regarding the payment or reimbursement terms of its contract 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 6 months of the HMO's payment of the claim.

Per the Department of Management Services, there is likely to be a significant but indeterminate fiscal impact on the State Group Health Plan.

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 access to an insured's choice of provider could come at a cost to the insured in the form of rate increases by insurers and HMOs.

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 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]

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[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.
[5] s. 627.638(2), F.S.
[6] *Id.*

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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[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

HB 405 amends ss. 627.6131 and 641.31, F.S., by providing that HMOs and health insurers may not prohibit or restrict an insured from assigning plan benefits for covered health care services to providers who are not under contract with the insurer. The bill provides that acceptance of the assignment of

[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.*

benefits by such non-contract providers requires the insurer or HMO to pay the provider directly for the services, that such payment is payment in full for the covered services provided, and prohibits providers from collecting any balance for covered services from the insured. If hospital emergency services or emergency pre-hospital treatment or transport is provided pursuant to ss. 395.1041 and 401.45 (for insurance contracts) or s. 641.513 (for HMOs) then the restrictions and limitations on the amount a provider can recover are removed. The bill does not address s. 627.6471(4), F.S., which authorizes higher deductibles and increased coinsurance for insureds that use non-contracted providers, thus potentially making it unclear whether a non-contract provider is able to collect such deductibles and coinsurance from insureds under an assignment of benefits situation.

The bill amends s. 627.6471, F.S., by providing that insurers may not reimburse preferred providers at alternative or reduced rates of payment unless the insurer or administrator has contracted with the preferred provider regarding coverage for those health care services under the policy and the preferred provider has agreed to the contract and to provide health care services under the terms of the contract. The bill also prohibits the preferred provider and the insurer from selling, leasing, or transferring information regarding the payment or reimbursement terms of the contract without prior notice to and the express authority of the other party to the contract.

The bill also amends s. 641.315, F.S., by prohibiting an HMO from selling, leasing, or transferring information regarding the payment or reimbursement terms of its contract with a health care practitioner without adequate notice to and the express permission of the health care practitioner. While this language is similar to the amendment to s. 627.6471, F.S., the prohibition applies only to the HMO whereas the prohibition in s. 627.6471, F.S., applies to both the health insurer and preferred provider.

Finally, the bill amends s. 641.3155, F.S., by requiring HMOs to submit a claim for overpayment to providers within 6 months after the HMO's payment of the claim.

SECTION DIRECTORY:

Section 1. Creates s. 627.6131(18)(a)-(c), F.S., relating to payment of claims by health insurers.

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 health maintenance contracts.

Section 4. Creates s. 641.315(11), F.S., relating to provider contracts.

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:

2. Expenditures:

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

2. Expenditures:

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

According to the Office of Insurance Regulation, 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]

D. FISCAL COMMENTS:

Per the Department of Management Services there may be an impact on the State Group Health Plan: "We do not yet have the results of the actuarial analysis being performed by our third-party administrator, Blue Cross Blue Shield of Florida. However, we have to assume that there is likely to be a significant financial impact on recoveries due to shortening the allowable "look-back" period from 30 months to 6 months."

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:

Section 1 of the bill creates a new subsection in s. 627.6131, F.S., and allows an insured to assign payment of benefits to a provider that is not under contract with the insured's health insurer and, except in certain emergency situations, requires the provider to receive the insurer's payment as payment in full for services rendered and does not allow the provider to "collect any balance from the insured." Section 627.6471(4), F.S., however, provides that an insured may be responsible for higher deductibles or increased coinsurance when a non-contracted provider is used. The amendments to s. 627.6131, F.S., do not cross reference s. 627.6471(4), F.S., and it is unclear how these two provisions interact.

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

Additionally, according to the Office of Insurance Regulation, the changes to s. 627.6131, F.S., appear to be in conflict with s. 627.6472, F.S., which allows for exclusive provider organizations.[30] Section 627.6472, F.S., is not addressed in the bill.

Section 2 and Section 4 of the bill both address the restriction on selling, leasing, or transferring information regarding the payment or reimbursement terms of contracts between health insurers or HMOs and providers; however, Section 2 of the bill provides that neither the health insurer nor the provider may share such information without prior notice and consent to the other party, while Section 4 of the bill places the restriction solely on the HMO.

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

[30] Office of Insurance Regulation, 2008 – HB 405 Bill Analysis.