HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1237 Payment for Services Provided By Licensed Psychologists
SPONSOR(S): Schwartz
TIED BILLS: **IDEN./SIM. BILLS:** SB 144

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee		Poche	Shaw
2) Insurance & Banking Subcommittee			
3) Appropriations Committee			
4) Health & Human Services Committee			

SUMMARY ANALYSIS

In general, after a payment is made to a health care provider for services rendered to an insured, health insurers and HMOs are time-limited to making a claim for overpayment to the provider within 30 months from the date of that payment. If a claim for overpayment is made, the health care provider has a certain timeframe within which to pay it, or contest the claim for overpayment. Claims of overpayment by health insurers and HMOs for services rendered by allopathic physicians, osteopathic physicians, chiropractic physicians, and dentists, however, must be submitted to the provider within 12 months after the health insurer's payment of the claim.

House Bill 1237 adds psychologists, licensed under chapter 490, F.S., to the list of providers from which claims for overpayment, by insurers or health maintenance organizations, cannot be made more than 12 months after payment for services rendered to an insured or subscriber. The bill also adds psychologists to the list of providers limited to making claims for underpayment up to 12 months after the date of payment for services rendered to an insured or subscriber. Lastly, the bill permits an insured to authorize direct payment to a psychologist for services rendered and requires an insurer to make the payment as directed.

The bill appears to have an insignificant negative fiscal impact on state government.

The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Psychologists and Payment for Services

Chapter 490, F.S., the "Psychological Services Act," governs the practice of psychology and school psychology in Florida. A person desiring to practice psychology or school psychology in Florida must be licensed by the Department of Health. "Practice of psychology" means the observations, description, evaluation, interpretation, and modification of human behavior, by the use of scientific and applied psychological principles, methods, and procedures, for the purpose of describing, preventing, alleviating, or eliminating symptomatic, maladaptive, or undesired behavior and of enhancing interpersonal behavioral health and mental or psychological health.[1] "Practice of school psychology" means the rendering or offering to render to an individual, a group, an organization, a government agency, or the public any of the following services- assessment, counseling, consultation, and development of programs.[2]

After payment is made to most preferred providers, including psychologists, for services rendered to an insured, health insurers, and health maintenance organizations (HMOs) are time-limited to making a claim for overpayment within 30 months from the date of that payment.[3] If a claim for overpayment is made, the preferred provider has a certain timeframe within which to pay the overpayment, or deny or contest the claim.[4][5] In comparison, claims of overpayment by health insurers and HMOs for services rendered by allopathic physicians, osteopathic physicians, chiropractic physicians, and dentists must be submitted to the provider within 12 months after the health insurer's payment of the claim.[6]

Psychologists who contract as preferred providers[7] or network providers with an insurer receive payment directly from the insurer, instead of the insured, for services rendered.[8] In contrast, non-network psychologists are generally paid by the insured. After paying the psychologist, the insured then files a claim for reimbursement with the insurer. In comparison, non-network recognized hospitals, licensed ambulance providers, physicians, dentists, and other persons who provided services to the insured, in accordance with the provisions of the policy between the insured and the insurer, are directly reimbursed by the insurer if the insured specifically authorizes payment of benefits to the provider of services.[9]

Assignment of Benefits to Health Care Providers

Prior to the 2009 Legislative Session, s. 627.638(2), F.S., required direct payment by health insurers to certain health care providers if the patient authorized assignment of benefits, unless otherwise provided in the insurance contract.[10] Statutory amendments by the 2009 Legislature in ch. 2009-124, L.O.F., to s. 627.638(2), F.S., required health insurers and HMOs to directly pay non-network hospitals, licensed ambulance providers, physicians, dentists, and other persons who provide services to an insured, in

[1] S. 490.003(4), F.S.
[2] S. 490.003(5), F.S.
[3] SS. 627.6131(6)(a)(1), F.S. and 641.3155, F.S.
[4] S. 627.6131(6)(a)(1), F.S.
[5] S. 627.6131(6)(a)(2), F.S.
[6] SS. 627.6131(18), F.S. and 641.3155(14), F.S.
[7] S. 627.6471(1)(b), F.S. defines preferred provider as, "any licensed health care provider with which the insurer has directly or indirectly contracted for an alternative or a reduced rate of payment…"
[8] S. 627.638(3), F.S.
[9] S. 627.638(2), F.S.
[10] An exception existed that the insurance contract could not prohibit the assignment of benefits and direct payment for emergency services and care.

accordance with the provisions of the policy between the insured and the insurer, if the insured specifically authorizes payment of benefits to the provider of services.

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

- The amendments have caused the third-party administrator of the state's group health plan to suffer a net loss of physicians from its preferred provider plan network; and
- As a direct result, the state's group health plan incurred an increase in costs.[11]

In January 2012, the OPPAGA issued the requisite report, which found that the statutory changes made in 2009:

- That the statutory changes made in 2009 did not result in a loss of network physicians in the state's group health plan; and
- That no cost increase in the state's group health plan could be directly attributed to the 2009 changes.[12]

Effect of Proposed Changes

The bill adds psychologists, licensed under chapter 490, F.S., to the list of providers to whom claims of overpayment of services rendered made by insurers or HMOs must be sent within 12 months after payment of the claim. The bill also adds psychologists to the list of providers who must file a claim of underpayment with an insurer or HMO within 12 months after payment of the claim.

The bill contains two sections of proposed language for s. 627.638(2), F.S., that are contingent upon the findings of the OPPAGA report, required by the 2009 statutory changes. If the report finds that the changes caused a loss in network physicians and increased costs to the state group health insurance plan, the language for the subsection reverts back to its form prior to the statutory changes. If the report does not find that the changes caused both issues, the language in the subsection remains the same as it existed on July 1, 2009. The two sections each permit an insured to authorize direct payment to a psychologist on any health insurance form and require the insurer to make the payment as directed.

The bill provides an effective date of July 1, 2013.

B. SECTION DIRECTORY:

Section 1: Amends s. 627.6131, F.S., relating to payment of claims.
Section 2: Amends s. 641.3155, F.S., relating to prompt payment of claims.
Section 3: Amends s. 627.638, F.S., relating to direct payment for hospital, medical services, contingent upon the Office of Program Policy Analysis and Government Accountability not presenting the finding specified in section 2 of chapter 2009-124, Laws of Florida.
Section 4: Amends s. 627.638, F.S., relating to direct payment for hospital, medical services, contingent upon the Office of Program Policy Analysis and Government Accountability presenting the finding specified in section 2 of chapter 2009-124, Laws of Florida.
Section 5: Provides an effective date of July 1, 2013.

[11] S. 2, ch. 2009-124, L.O.F.
[12] The Florida Legislature, Office of Program Policy Analysis and Government Accountability, *Negative Effects on the State's Third Party Provider Network from 2009 Law Not Apparent*, Report No. 12-01, January 2012, pages 2 and 4, available at http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/1201rpt.pdf (last viewed March 21, 2013) (on file with Health Innovation Subcommittee staff).

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

OIR anticipates an increase in health form review as a result of the additional category of provider eligible for direct payment on any health insurance form, but the increased form review can absorbed within current resources.[13]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

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

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

OIR has sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill includes contingent language that revises s. 627.638(2), F.S., depending upon the findings of the OPPAGA report required by chapter 2009-124, L.O.F. The language appears to assume that the

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

report has not yet been issued. However, the report was issued in January 2012 and found that the 2009 changes to s. 627.6131, F.S., and s. 641.3155, F.S., regarding prompt payments of claims, did not result in a loss of network physicians in the state group health insurance plan. The report also found that no cost increase could be directly attributed to the 2009 statutory changes.

Based on the findings of the report, section 4 of the bill, providing contingent language effective if the OPPAGA report found that the statutory changes referenced above caused a loss in network physicians, and caused increased costs, to the state group health insurance plan, can be deleted. Also, the contingency language contained in the directory of section 3 of the bill can be deleted due to the fact that the contingency has been met.

Section 627.638(1), F.S., permits payment by an insurer for benefits under a health insurance policy to be made directly to any recognized hospital, licensed ambulance provider, doctor, or other person who provided the services, in accordance with the terms of the policy. The term "other person who provided the services" appears to be a catch-all provision that allows for direct payment of benefits to any health care provider who provided covered services under the policy to the insured.

Further, s. 627.638(2), F.S., permits the insured to direct payment to, among others, "…any…other person who provided the services in accordance with the provisions of the policy,…" and requires the insurer to make the payment as directed. These statutory provisions, taken together, do not require specific health care providers to be listed in the statute in order to permit an insured to authorize direct payment, and require an insurer to acknowledge the authorization and make direct payment, to any health care provider, as long as services were provided in a manner consistent with the terms of the policy. Therefore, it appears that the addition of "psychologists" to the statute is not necessary in order to permit an insured to authorize direct payment to a psychologist and require the insurer to make direct payment to a psychologist.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES