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 Committee on Health Policy

BILL:	SB 144
INTRODUCER:	Senator Altman
SUBJECT:	Payment for Services Provided by Licensed Psychologists
DATE:	March 12, 2013
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	McElheney	Stovall	HP	**Pre-meeting**
2.			BI	
3.			AHS	
4.			AP	
5.				
6.				

I. Summary:

SB 144:

- Amends provisions relating to health insurance policies and health maintenance organizations (HMOs) to add psychologists to the list of health care providers protected by a 12-month limitations period from claims by health insurers or health maintenance organizations for *overpayment*, and adding psychologists to the list of health care providers subject to a 12-month limitations period for submitting claims to health insurers or health maintenance organizations for a claim for *underpayment*;
- Adds psychologists to the list of health care providers eligible for direct payment for medical services by a health insurer in accordance with the provisions of each policy; and
- Makes technical and grammatical changes.
- Provides an effective date of July 1, 2013.

This bill substantially amends the following sections of the Florida Statutes: 627.6131, 641.3155, and 627.638.

II. Present Situation:

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:[2] assessment, counseling, consultation, and development of programs.

Psychologists who contract as preferred providers[3] (also network providers) with an insurer receive payment directly from the insurer, instead of the insured, for services rendered.[4] 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.[5]

After payment is made to a psychologist for services rendered to an insured, health insurers and HMOs are time-limited to making a claim for overpayment within 30 months (2-½ years) from the date of that payment.[6] If a claim for overpayment is made, the psychologist has 40 days to pay it.[7] If the psychologist denies or contests the claim, he/she must do so in writing within 35 days of receiving the claim.[8] In comparison, claims of overpayment by health insurers and HMOs for service 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.[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., require 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 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.

[1] S. 490.003(4), F.S.
[2] S. 490.003(5), F.S.
[3] 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…"
[4] S. 627.638(3), F.S.
[5] S. 627.638(2), F.S.
[6] SS. 627.6131(6)(a)(1), F.S. and 641.3155, F.S.
[7] S. 627.6131(6)(a)(1), F.S.
[8] S. 627.6131(6)(a)(2), F.S.
[9] SS. 627.6131(18), F.S. and 641.3155(14), 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.

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: 1) 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 2) as a direct result, the state's group health plan incurred an increase in costs.[11]

In January 2012, the OPPAGA issued Report No. 12-01 as required by s. 2 of ch. 2009-124, L.O.F.[12] The OPPAGA's report found that the statutory changes made in 2009: 1) did not result in a loss of network physicians in the state's group health plan and 2) that no cost increase in the state's group health plan could be directly attributed to the 2009 changes.

III. Effect of Proposed Changes:

Section 1 amends s. 627.6131, F.S., relating to overpayment or underpayment of claims by health insurers to a provider, to include psychologists and school psychologists in the list of providers:

- To whom an insurer must submit a claim for overpayment within 12 months after the health insurer's payment of the claim; and
- Who must submit a claim for underpayment to an insurer within 12 months after the health insurer's payment of the claim.

Section 2 amends s. 641.3155, F.S., relating to overpayment or underpayment of claims by an HMO to a provider, to include psychologists and school psychologists in the list of providers:

- To whom an insurer must submit a claim for overpayment within 12 months after the health insurer's payment of the claim; and
- Who must submit a claim for underpayment to an insurer within 12 months after the health insurer's payment of the claim.

Section 3 amends s. 627.638(2), F.S., to include non-network psychologists in the list of providers:

- To whom an insurer must make direct payment, if the insured specifically authorizes the payment of benefits directly to the psychologist;
- For which an insurance contract may not prohibit the direct payment of benefits; and
- For which an insurer must provide a claim form with an option for direct payment of benefits.

[11] Ch. 2009-124, L.O.F.

[12] *Negative Effects on the State's Third Party Provider Network from 2009 Law Not Apparent*, Report No. 12-01, January 2012, Office of Program Policy Analysis and Government Accountability. Available at: <http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/1201rpt.pdf> (Last visited on Jan. 30, 2012).

This section is contingent upon the language in s. 627.638(2), F.S., *not* reverting to that in existence on June 30, 2009. Since the condition for reversion was not met, this section would take effect.

Section 4 amends s. 627.638(2), F.S., to include psychologists in the list of providers:

- To whom an insurer must make direct payment to, if the insured specifically authorizes payment of benefits directly to the psychologist, unless otherwise provided in the insurance contract;
- For which an insurance contract may not prohibit the direct payment of benefits for emergencies services and care; and
- For which an insurer must provide a claim form with an option for direct payment of benefits for emergency services and care.

This section is contingent upon the text of s. 627.638(2), F.S., reverting to that in existence on June 30, 2009. Since the text would not revert, this section has no effect.

Section 5 provides an effective date of July 1, 2013.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Psychologists will have a shorter time frame for bringing insurance claims for services to conclusion.

Non-network psychologists will benefit by being entitled to direct payment of benefits from insurers, assuming that the insured executes an assignment of benefits.

The insured will be able to assign benefits to non-network psychologists, instead of paying the psychologist first and then seeking reimbursement from the insurer.

Health insurers and HMOs may have to update their claim forms to reflect psychologists as an option for assignment of benefits.

The carriers would acquire an administrative cost for revising forms to comply with the required payment to providers licensed pursuant to chapter 409.

C. Government Sector Impact:

Required changes to the insurance contracts and claims forms would impact the Office of Insurance Regulation's health forms review section, but the increased form reviews can be absorbed within current resources.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Sections 3 and 4 assume in conditional language that the OPPAGA report has not been released yet. As it has been released, and as it has shown that the test for automatic reversion has not been met, section 4 is not needed and the conditional provision in the directory clause in section 3 is unnecessary.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.