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 Banking and Insurance Committee

BILL:	CS/SB 1232
INTRODUCER:	Banking and Insurance Committee and Senator Fasano
SUBJECT:	Health Services Claims
DATE:	April 15, 2010 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Burgess	Burgess	BI	**Fav/CS**
2.			CM	
3.			HR	
4.			WPSC	
5.				
6.				

Please see Section VIII. for Additional Information:

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

I. Summary:

The bill creates subsection (3) of s. 626.9541, F.S., which is entitled "UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS." The bill specifies that an insurer that issues health benefit plans may offer a voluntary wellness or health-improvement program, and may grant rewards or incentives to members who participate in the program. The bill specifies that such a reward is not an insurance benefit and does not violate s. 626.9541, F.S., and that the subsection does not prohibit any other incentives or rewards that are otherwise allowed by state or federal law.

The bill provides that if a claim or a portion of a claim is denied by an insurer or health maintenance organization (HMO) because the provider or claimant failed to obtain the necessary authorization due to an unintentional act or error or omission, the insurer or HMO must provide an opportunity for appeal. On appeal, the insurer or HMO must conduct a full retrospective review of medical necessity of the service. If the insurer or HMO determines that the service was medically necessary, the insurer or HMO must pay the claim. If the insurer or HMO determines that the service was not medically necessary, the insurer or HMO must submit written clinical justification for the denial. For insurers, current law requires an insurer to provide an opportunity for an appeal for a claim that has been denied as being not medically necessary, but does not

require an appeal for a claim denied for failure to obtain necessary authorization. For HMOs, current law provides that an HMO may not deny a claim for treatment if the provider follows the HMO's authorization procedures and receives authorization for a covered service for an eligible subscriber.

This bill substantially amends the following sections of the Florida Statutes: 626.9541, 627.6141, and 641.3156.

II. Present Situation:

Regulation of Health Insurers and HMOs
The Office of Insurance Regulation regulates health insurance contracts and rates under Part VI of Chapter 627, F.S., and Health Maintenance Organization (HMO) contracts and rates under Part I of Chapter 641, F.S., while the Agency for Health Care Administration regulates the quality of care provided by HMOs under Part III of Chapter 641, F.S.

Employee Retirement Income Security Act of 1974
The Employee Retirement Income Security Act of 1974 (ERISA) [1] is a federal law that sets minimum standards for retirement and health benefit plans in private industry. ERISA places the regulation of employee benefit plans (including health plans) primarily under federal jurisdiction.[2] ERISA does not require any employer to establish a plan. ERISA only requires that those who establish plans must meet certain minimum standards.[3] 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…."[4] This portion of ERISA was designed to ensure that plans would be subject to the same benefit laws across all states.[5] However, the wording "relates to" is not precise, and as a result, the courts continue to define this term, case by case.[6]

Another provision, s. 514(b)(2)(A), referred to as the "savings" clause, retains state authority over the business of insurance. [7] The business of insurance typically refers to the regulation of plan solvency, marketing, information disclosure, consumer grievances and may also include mandating benefits, taxing insurance premiums, and mandating participation in state risk pools and uncompensated care plans.[8]

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[1] Public Law 93-406.
[2] Congressional Research Service, Report for Congress, ERISA Regulation of Health Plans: Fact Sheet (RS20315), March 6, 2003.
[3] Department of Labor, Employee Benefits Security Administration, Compliance Assistance, available at: http://www.dol.gov/ebsa/compliance_assistance.html (last viewed March 25, 2010).
[4] 29 U.S.C. s. 1144(a).
[5] Congressional Research Service, Report for Congress, ERISA Regulation of Health Plans: Fact Sheet (RS20315), March 6, 2003.
[6] *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, e.g., Arkansas Blue Cross and Blue Shield v. St. Mary's Hospital, Inc.,* 947 F.2d 1341 (8th Cir. 1991).
[7] Congressional Research Service, Report for Congress, ERISA Regulation of Health Plans: Fact Sheet (RS20315), March 6, 2003.
[8] Id.

Lastly, s. 514(b)(2)(B), referred to as the "deemer" clause, does not allow states to deem an employee benefit plan to be in the business of insurance.[9] The effect of this clause is that self-insured plans are not subject to state rules governing the business of insurance.[10]

According to the Department of Financial Services, ERISA poses the most significant obstacle to state regulators' efforts to expand or enforce provisions governing consumer rights related to health insurance contracts.[11]

Health Insurers
Section 627.6141, F.S., requires each claimant, or provider acting for a claimant, who has had a claim denied as not medically necessary to be provided an opportunity for an appeal to the insurer's licensed physician who is responsible for the medical necessity reviews under the plan or is a member of the plan's peer review group. Currently, an appeal may be by telephone, and the insurer's licensed physician must respond within a reasonable time, not to exceed 15 business days.[12]

Currently s. 627.6686(6), F.S., provides that an insurer may not deny or refuse to issue coverage for medically necessary services, refuse to contract with, or refuse to renew or reissue or otherwise terminate or restrict coverage for an individual because the individual is diagnosed as having a developmental disability.

Health Maintenance Organizations
Section 641.3156, F.S., requires a HMO to pay any hospital service or referral service claim for treatment for an eligible subscriber if the services or referral was authorized by an approved HMO provider who is tasked to direct the patient's utilization of health care services. An HMO does not have to pay for any hospital services or referral services for treatment if the approved HMO provider provided information to the HMO with the willful intention to misinform.[13] In addition, a claim for treatment may not be denied if a provider follows the HMOs authorization procedures and receives authorization for a covered service for an eligible subscriber, unless the provider provided information to the HMO with the willful intention to misinform the HMO.[14] Currently, an HMO is required to provide coverage for medically necessary services under the following circumstances:

- Section 641.315(9), F.S., provides that a contract between a HMO and a contracted primary care or admitting physician may not contain any provision that prohibits such physician from providing inpatient services in a contracted hospital to a subscriber if such services are determined by the organization to be medically necessary and covered services under the organization's contract with the contract holder.

- Section 641.31089(6), F.S. provides that a HMO may not deny or refuse to issue coverage for medically necessary services, refuse to contract with, or refuse to renew or reissue or

[9] Id.
[10] Id.
[11] Department of Financial Services, Bill Analysis and Fiscal Impact Statement of House Bill 243 (January 20, 2009).
[12] s. 627.6141, F.S.
[13] s. 641.31569(1), F.S
[14] s. 641.31569(2), F.S

otherwise terminate or restrict coverage for an individual solely because the individual is diagnosed as having a developmental disability.

In addition HMOs are required to provide coverage for emergency services and care, and may not:[15]

- Require prior authorization for the receipt of pre-hospital transport or treatment or for emergency services and care.[16]
- Indicate that emergencies are covered only if care is secured within a certain period of time.[17]
- Use terms such as "life threatening" or "bona fide" to qualify the kind of emergency that is covered.[18]
- Deny payment based on the subscriber's failure to notify the health maintenance organization in advance of seeking treatment or within a certain period of time after the care is given.[19]

Unfair Methods of Competition and Unfair or Deceptive Acts
Section 626.9541, F.S., defines unfair methods of competition and unfair or deceptive acts. The section specifies 32 different acts that come under the section.[20] Among the prohibited acts relating to rates that may be charged to policyholders are: "unfair discrimination," which is defined as knowingly making an unfair discrimination between individuals of the same actuarially supportable class in the amount of premium charged for a policy, or in the benefits payable under the contract, or in the terms and conditions of the contract;[21] and "unlawful rebates," which prohibits paying, directly or indirectly, any valuable consideration or inducement not specified in the contract.[22]

III. Effect of Proposed Changes:

Section 1. Amends s. 626.9541, F.S., relating to unfair methods of competition and unfair or deceptive acts or practices. The bill creates subsection (3) of s. 626.9541, F.S., which specifies that an insurer that issues health benefit plans may offer a voluntary wellness or health-improvement program, and may grant rewards or incentives to members who participate in the program.[23] The bill provides that a health plan member may be required to provide verification that a medical condition makes it unreasonably difficult or medically inadvisable for the individual to participate in the wellness program. The bill specifies that such a reward is not an insurance benefit and does not violate s. 626.9541, F.S., and that the subsection does not prohibit any other incentives or rewards that are otherwise allowed by state or federal law.

[15] s. 641.315(1), F.S.
[16] s. 641.315(1)(a), F.S.
[17] s. 641.315(1)(b), F.S.
[18] s. 641.315(1)(c), F.S.
[19] s. 641.315(1)(d), F.S.
[20] s. 626.9541(1)(a) through (ff), F.S.
[21] s. 626.9541(1)(g), F.S.
[22] s. 626.9541(1)(h), F.S.
[23] The incentives may take the form of merchandise, gift cards, debit cards, premium discounts or rebates, contributions toward a member's health savings account, modifications to copayment, deductible, or coinsurance amounts, or any combination of these incentives.

Section 2. Amends s. 627.6141, F.S., relating to denial of claims. The bill provides that if a hospital claim or a portion of a hospital claim is denied because the hospital failed to obtain the necessary authorization due to an unintentional act or error or omission, the hospital may appeal the denial. On appeal, the insurer must conduct a full retrospective review of medical necessity of the service. If the insurer determines that the service was medically necessary, the insurer must pay the claim. If the insurer determines that the service was not medically necessary, the insurer must submit written clinical justification for the denial to the hospital. Current law requires an insurer to provide an opportunity for an appeal for a claim that has been denied as being not medically necessary, but does not require an appeal for a claim denied for failure to obtain necessary authorization.

The bill provides that the health insurer must complete its retrospective review within 30 business days. Current law that remains unchanged by the bill requires that an insurer must respond within 15 business days to an appeal of a claim that was denied on the basis of being not medically necessary.

Section 3. Amends s. 641.3156, F.S., relating to treatment authorization and payment of claims. The bill provides that if a hospital claim or a portion of a hospital claim is denied because the hospital failed to obtain the necessary authorization due to an unintentional act or error or omission, the hospital may appeal the denial. On appeal, the HMO must conduct a full retrospective review of medical necessity of the service within 30 business days. If the HMO determines that the service was medically necessary, the HMO must pay the claim. If the HMO determines that the service was not medically necessary, the HMO must submit written clinical justification for the denial to the hospital. Current law provides that an HMO may not deny a claim for treatment if the provider follows the HMO's authorization procedures and receives authorization for a covered service for an eligible subscriber.

Section 4. Provides an effective date of July 1, 2010.

Other Potential Implications:

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:

C. Government Sector Impact:

According to the Department of Management Services, the bill would have a negative fiscal impact on the State Group Insurance Program.[24] The provisions could negate the pre-admission certification provisions contained within the PPO Plan resulting in the payment of hospital admissions that would have otherwise been denied or subject to a penalty.[25]

In addition, the provisions of the bill may reduce the ability of the health plans in the State Group Insurance Program to implement cost control measures (i.e. referrals and prior authorization).[26] To the extent that the bill limits the effectiveness of prior authorization programs, there could be an indeterminate negative fiscal impact to the contracted State PPO Plan and State HMO Plans. Data from the Division of State Group Insurance indicates that as of March, 2010, there are 326,486 active members and a total enrollment of 375,040 members.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Current law which remains unchanged by the CS requires an insurer to provide an opportunity for an appeal for a claim that has been denied as being not medically necessary, and the insurer must respond to the appeal within 15 business days. The bill provides that if a claim or a portion of a claim is denied because a hospital failed to obtain the necessary authorization due to an unintentional act or error or omission, the hospital may appeal, and the insurer must conduct a full retrospective review of medical necessity of the service within 30 business days.

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 Committee on April 13, 2010:
The CS creates subsection (3) of s. 626.9541, F.S., which specifies that an insurer that issues health benefit plans may offer a voluntary wellness or health-improvement program, and may grant rewards or incentives to members who participate in the

[24] Department of Management Services 2009 Analysis of House Bill 243 (March 25, 2009).
[25] *Id.*
[26] Department of Management Services 2010 Analysis of House Bill 715 (March 26, 2010).

program. The CS specifies that such a reward is not an insurance benefit and does not violate s. 626.9541, F.S., and that the subsection does not prohibit any other incentives or rewards that are otherwise allowed by state or federal law.

The CS reinstates subsection (1) of s.627.6141, F.S., which had been repealed in the original SB 1232. That subsection requires an insurer to provide an opportunity for an appeal for a claim that has been denied as being not medically necessary, and the insurer must respond to the appeal within 15 business days.

The CS limits the new right to appeal to hospitals. The original SB 1232 granted the new right to appeal to "[e]ach claimant, or provider acting for a claimant…."

B. Amendments:

None.