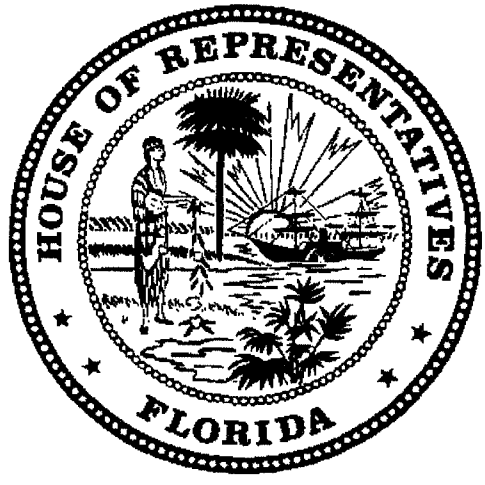

Committee on Health Innovation

Tuesday, February 19, 2008
9:00 AM - 10:15 AM
Morris Hall

Marco Rubio
Speaker

Rene Garcia
Chair

House of Representatives

Committee on Health Innovation

AGENDA

February 19, 2008
9:00 AM - 10:15 AM
Morris Hall

I. Opening Remarks by Chair Garcia

II. Consideration of the following bill:

HB 405 – Insurance Claims Payments by Rep. Galvano

III. Presentation on Insurance Mandates

Kevin Wrege
Regional Director of State Affairs
Council for Affordable Health Insurance
Alexandria, VA

IV. Closing Remarks by Chair Garcia

V. Adjournment

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

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[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.

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[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.

A bill to be entitled

An act relating to health insurance claims payments; amending ss. 627.6131 and 641.31, F.S.; prohibiting health insurance contracts and health maintenance contracts from prohibiting or restricting insureds from assigning plan benefits to certain noncontract providers for certain covered services; requiring payment by an insurer of plan benefits under assignment and acceptance by noncontract providers; requiring noncontract providers accepting such assignments to accept any payments from plan benefit insurers and prohibiting such providers from collecting any balances from insureds; amending s. 627.6471, F.S.; prohibiting insurers and plan administrators from reimbursing preferred providers at alternative or reduced rates for covered services under certain circumstances; providing exceptions; prohibiting preferred provider contract parties from selling, leasing, or transferring contract payment or reimbursement terms information under certain circumstances; amending s. 641.315, F.S.; prohibiting health maintenance organizations from selling, leasing, or transferring contract payment or reimbursement terms information under certain circumstances; amending s. 641.3155, F.S.; decreasing the period of time authorized for overpayment claims of health maintenance organizations against providers; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (18) is added to section 627.6131, Florida Statutes, to read:

627.6131 Payment of claims.--

(18)(a) A contract with a health insurer may not prohibit or restrict an insured from assigning plan benefits to providers not under contract with the insurer for covered health care services rendered by the provider to the insured.

(b) Any assignment by an insured of plan benefits which designates that the assignment has been accepted by a provider not under contract with the health insurer must be paid to the provider pursuant to this section.

(c) Except for providers who are providing services pursuant to ss. 395.1041 and 401.45, any provider who accepts an assignment pursuant to this subsection agrees, by submitting the claim to the health insurer, to accept the amount paid by the health insurer as payment in full for the health care services provided and to not collect any balance from the insured.

Section 2. Subsection (7) is added to section 627.6471, Florida Statutes, to read:

627.6471 Contracts for reduced rates of payment; limitations; coinsurance and deductibles.--

(7)(a) An insurer or an administrator may not reimburse a preferred provider at an alternative or a reduced rate of payment for covered services that are provided to an insured unless:

1. The insurer or administrator has contracted with the preferred provider and has agreed to provide coverage for those health care services under the health insurance policy.

2. The preferred provider has agreed to the contract and to provide health care services under the terms of the contract.

(b) A party to a preferred provider contract may not sell, lease, or otherwise transfer information regarding the payment or reimbursement terms of the contract without the express authority of and prior adequate notification to the other contracting parties.

Section 3. Subsection (41) is added to section 641.31, Florida Statutes, to read:

641.31 Health maintenance contracts.--

(41)(a) A health maintenance organization contract may not prohibit or restrict a subscriber from assigning plan benefits to providers not under contract with the organization for covered health care services rendered by the provider to the subscriber.

(b) Any assignment by a subscriber of plan benefits which designates that the assignment has been accepted by a provider not under contract with the organization must be paid to the provider pursuant to s. 641.3155.

(c) Except for providers providing service pursuant to s. 641.513, any provider who accepts an assignment pursuant to this subsection agrees, by submitting the claim to the health maintenance organization, to accept the amount paid by the health maintenance organization as payment in full for the health care services provided and to not collect any balance from the subscriber.

Section 4. Subsection (11) is added to section 641.315, Florida Statutes, to read:

641.315 Provider contracts.--

(11) A health maintenance organization may not sell, lease, or otherwise transfer information regarding the payment of reimbursement terms of a contract with a health care practitioner without the express authority of and prior adequate notification to the contracting parties.

Section 5. Subsection (5) of section 641.3155, Florida Statutes, is amended to read:

641.3155 Prompt payment of claims.--

(5) If a health maintenance organization determines that it has made an overpayment to a provider for services rendered to a subscriber, the health maintenance organization must make a claim for such overpayment to the provider's designated location. A health maintenance organization that makes a claim for overpayment to a provider under this section shall give the provider a written or electronic statement specifying the basis for the retroactive denial or payment adjustment. The health maintenance organization must identify the claim or claims, or overpayment claim portion thereof, for which a claim for overpayment is submitted.

(a) If an overpayment determination is the result of retroactive review or audit of coverage decisions or payment levels not related to fraud, a health maintenance organization shall adhere to the following procedures:

1. All claims for overpayment must be submitted to a provider within 6 ~~30~~ months after the health maintenance organization's payment of the claim. A provider must pay, deny, or contest the health maintenance organization's claim for

overpayment within 40 days after the receipt of the claim. All contested claims for overpayment must be paid or denied within 120 days after receipt of the claim. Failure to pay or deny overpayment and claim within 140 days after receipt creates an uncontestable obligation to pay the claim.

2. A provider that denies or contests a health maintenance organization's claim for overpayment or any portion of a claim shall notify the organization, in writing, within 35 days after the provider receives the claim that the claim for overpayment is contested or denied. The notice that the claim for overpayment is denied or contested must identify the contested portion of the claim and the specific reason for contesting or denying the claim and, if contested, must include a request for additional information. If the organization submits additional information, the organization must, within 35 days after receipt of the request, mail or electronically transfer the information to the provider. The provider shall pay or deny the claim for overpayment within 45 days after receipt of the information. The notice is considered made on the date the notice is mailed or electronically transferred by the provider.

3. The health maintenance organization may not reduce payment to the provider for other services unless the provider agrees to the reduction in writing or fails to respond to the health maintenance organization's overpayment claim as required by this paragraph.

4. Payment of an overpayment claim is considered made on the date the payment was mailed or electronically transferred. An overdue payment of a claim bears simple interest at the rate

of 12 percent per year. Interest on an overdue payment for a claim for an overpayment payment begins to accrue when the claim should have been paid, denied, or contested.

(b) A claim for overpayment shall not be permitted beyond 6 ~~30~~ months after the health maintenance organization's payment of a claim, except that claims for overpayment may be sought beyond that time from providers convicted of fraud pursuant to s. 817.234.

Section 6. This act shall take effect July 1, 2008.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. _____ (for drafter's use only)

Bill No. **0405**

COUNCIL/COMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Council/Committee hearing bill: Committee on Health Innovation

Representative Galvano offered the following:

Amendment (with title amendment)

Remove line(s) 29-82 and insert:

Section 1. Section 627.638, Florida Statutes, is amended to read:

627.638 Direct payment for hospital, ambulance, and medical services.--

(1) Any health insurance policy insuring against loss or expense due to hospital confinement or to medical and related services may provide for payment of benefits directly to any recognized hospital, licensed ambulance provider, doctor, or other person who provided the services, in accordance with the provisions of the policy. To comply with this section, the words "or to the hospital, licensed ambulance provider, doctor, or person rendering services covered by this policy," or similar words appropriate to the terms of the policy, shall be added to applicable provisions of the policy.

(2) Whenever, in any health insurance claim form, an insured specifically authorizes payment of benefits directly to

any recognized hospital, licensed ambulance provider, physician, or dentist, the insurer shall make such payment to the designated provider of such services~~, unless otherwise provided in the insurance contract~~. The insurance contract may not prohibit, and claims forms must provide an option for, the payment of benefits directly to a licensed hospital, licensed ambulance provider, physician, or dentist for care provided ~~pursuant to s. 395.1041~~. The ~~insurer may require written~~ attestation of assignment of benefits may be in written or electronic form. Payment to the provider from the insurer may not be more than the amount that the insurer would otherwise have paid without the assignment.

Section 2. Subsection (7) is added to section 627.6471, Florida Statutes, to read:

627.6471 Contracts for reduced rates of payment; limitations; coinsurance and deductibles.--

(7)(a) An insurer or an administrator may not reimburse a preferred provider at an alternative or a reduced rate of payment for covered services that are provided to an insured unless:

1. The insurer or administrator has contracted with the preferred provider and has agreed to provide coverage for those health care services under the health insurance policy.

2. The preferred provider has agreed to the contract and to provide health care services under the terms of the contract.

(b) A party to a preferred provider contract may not sell, lease, or otherwise transfer information regarding the payment or reimbursement terms of the contract without the express authority of and prior adequate notification to the other contracting parties.

Amendment No. _____ (for drafter's use only)

Section 3. Subsection (41) is added to section 641.31, Florida Statutes, to read:

641.31 Health maintenance contracts.--

(41) Whenever, in any health maintenance organization claim form, a subscriber specifically authorizes payment of benefits directly to any hospital, ambulance provider, physician, or dentist, the health maintenance organization shall make such payment to the designated provider of such services, provided any benefits are due to the subscriber under the terms of the agreement between the subscriber and the health maintenance organization. The health maintenance organization contract may not prohibit, and claims forms must provide an option for, the payment of benefits directly to a licensed hospital, ambulance provider, physician, or dentist for covered services provided, for services provided pursuant to s. 395.1041, and for ambulance transport and treatment provided pursuant to part III of chapter 401. The attestation of assignment of benefits may be in written or electronic form. Payment to the provider from the health maintenance organization may not be more than the amount that the insurer would otherwise have paid without the assignment. Nothing in this subsection affects the applicability of ss. 641.3154 and 641.513 with respect to services provided and payment for such services provided pursuant to this subsection.

T I T L E A M E N D M E N T

Remove line(s) 3-19 and insert:

amending s. 627.638, F.S.; including licensed ambulance providers under provisions for direct payment for certain services; deleting an insurance contract limitation on payment of benefits directly to providers; authorizing forms for attestations of assignment of benefits; amending s. 627.6471, F.S.; prohibiting insurers and plan administrators from reimbursing preferred providers at alternative or reduced rates for covered services under certain circumstances; providing exceptions; prohibiting preferred provider contract parties from selling, leasing, or transferring contract payment or reimbursement terms information under certain circumstances; amending s. 641.31, F.S.; requiring health maintenance organizations to pay benefits directly to certain providers under certain circumstances; prohibiting health maintenance contracts from prohibiting and requiring claims form to provide the option for payment of benefits directly to certain providers; amending s. 641.315, F.S.;

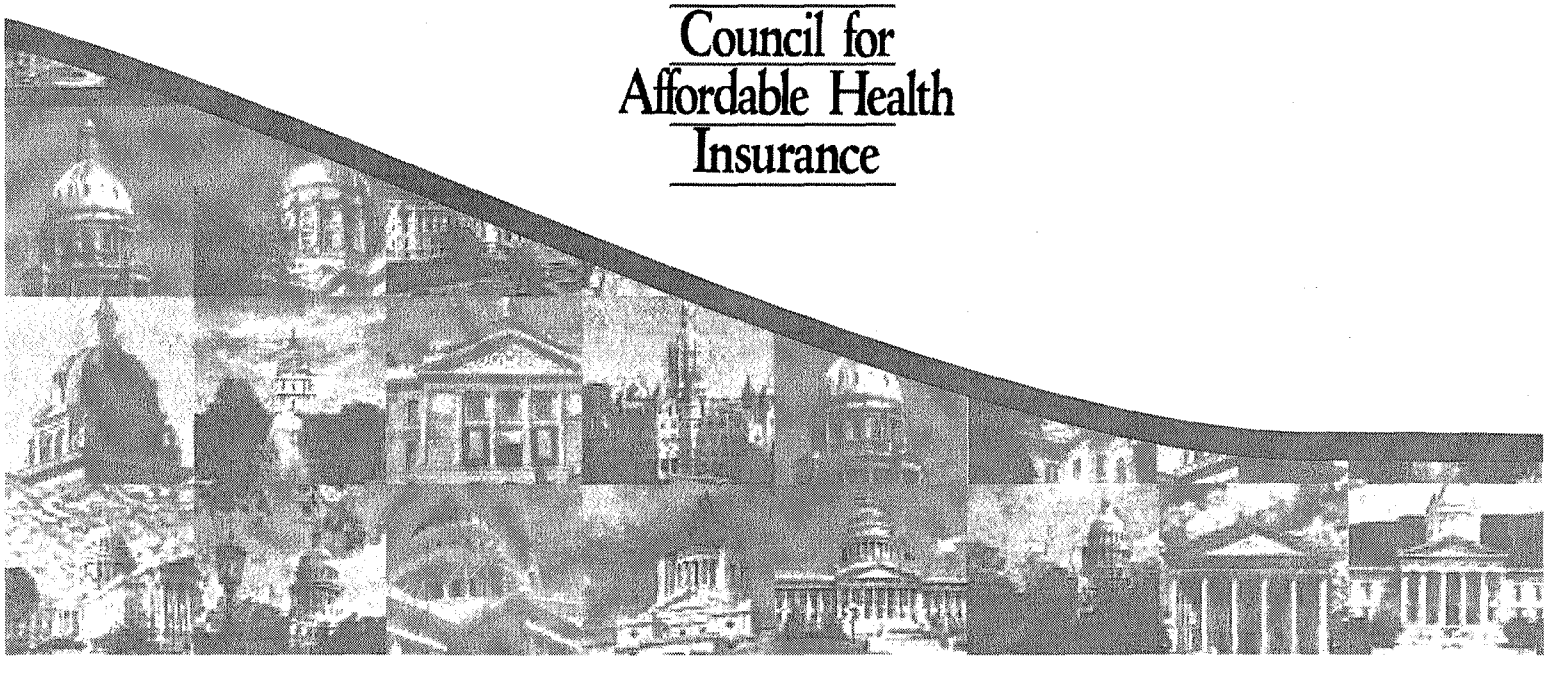
Insurance Mandates

State Health Insurance Index 2006:

A 50-State Comparison of the Nation's Health Insurance Market

Merrill Matthews, Ph.D., Director
Victoria Craig Bunce, Director of Research and Policy
JP Wieske, Director of State Affairs

Council for Affordable Health Insurance



Since the early 1990s, the Council for Affordable Health Insurance (CAHI) has tracked health insurance legislation in all 50 states. Once implemented, some of the laws have had a dramatic impact on the individual and small group health insurance markets, sometimes improving the markets and sometimes harming them. And in some cases virtually destroying the market. As state legislators consider future health insurance legislation, they need to understand how state laws affect insurance coverage.

Purpose of the Index. CAHI's 2006 State Health Insurance Index provides a snapshot of the health insurance environment in each state.

- Which states provide a dynamic, competitive market for health insurance, where consumers have a wide range of affordable options?
- And which states undermine their markets so that consumers have few health insurance options, and what is available is very expensive?

Surveys of the uninsured consistently show that the cost of health insurance is the primary reason for their being uninsured. Thus, the most efficient way to reduce the number of uninsured Americans is to ensure that people have access to a wide range of affordable health insurance polices. Some states largely achieve that goal, some don't. This Index identifies those states that are doing the best and worst jobs of ensuring access to affordable coverage. Health insurance may not be cheap in any state, but it can be available and affordable if states implement the right policies.

It is important to note, however, that the Index does not measure whether consumers can choose from different types of benefit plans. For example, consumers in Minnesota and California have access to affordable health coverage. But restrictive rating rules have driven many for-profit carriers from Minnesota, and Californians face a market dominated by HMOs. Consumers have *some* choice, but they could have more.

State Laws Affect Premiums. The general public and the media are largely unaware that state legislatures have a significant impact on the cost of health insurance premiums in the small group (i.e., 2 to 50 employees) and individual (i.e., individuals buy their own policies) health insurance markets. Because regulations vary from state to state, the cost of health insurance premiums can differ widely depending on the state where one lives.

Of course, a number of state legislatures have implemented a type of price control known as "community rating" or "modified community rating," which severely limits the amount insurance companies can charge. The result is that the young and healthy — typically those who earn the least and are most likely to be uninsured — are forced to subsidize the rates of older and generally wealthier individuals. Like any price control mechanism, community rating can drive insurers out of the market, reducing competition and increasing prices.

Some Insurance Is Exempt from State Law. This index only looks at the individual and small group markets. That's because large employers generally self-insure under the Employee Retirement and Income Security Act of 1974 (ERISA), and are governed by federal law outside of state regulation and oversight. Since this is a state health insurance index, it makes no evaluation of ERISA plans pre-empted from state law.

Indices Are Subjective. Like all indices — e.g., the Index of Leading Economic Indicators, the Dow Jones Industrial Average and the Russell 2000 Index — there is an element of subjectivity in choosing the factors that make up this Index. Knowledgeable people can differ on which factors to include, how much weight to give them and whether adjustments need to be made to control for distorting variables. However, the CAHI staff has vetted the measures included in this Index and their weights by numerous actuaries and health policy experts. So while we acknowledge that some may differ with our approach, we believe this Index provides a fair and accurate snapshot of each state's health insurance environment.

Blending the Individual and Small Group Markets. Certain measures blend the individual and small group markets. For example, the Index includes each state's percentage of uninsured. That rate can be a result of laws and regulations affecting both the individual and small group markets. But other factors also affect the number of uninsured, such as the state's average annual income or generosity of Medicaid coverage. Generally speaking, states with lower per capita income have a higher percentage of uninsured.

In addition, while the individual and small group markets tend to mirror each other — it is, after all, the same state legislature regulating both — that isn't always true. In some states the individual markets function better than their small group

markets. For example, Maryland and Colorado have pretty good individual markets, but struggle in the small group. Conversely, Georgia tends to have a functioning small group market, but struggles in the individual market.

The CAHI State Health Insurance Index. CAHI's Index includes six important measures of state health insurance viability that total to 100 points (the best score). It is important to note that we do not measure the effect of the Health Insurance Portability and Accountability Act's (HIPAA) guaranteed issue requirements in the small group market — which are common to every state — but we do measure the way states choose to implement the guaranteed issue requirement in the individual market.

The Index measures are:

1. *The percentage of uninsured.* This is one of two components receiving a smaller weight (10 points maximum for those with the lowest percentage) because so many other factors largely outside of state control have a direct impact on the number of uninsured. In other words, state laws and regulations affect the number of uninsured, but they are not the only factors to do so.

2. *The number of state mandates.* Although CAHI and many others have long asserted that mandates increase the cost of health insurance, determining how much depends on what is being mandated and the specifics of each piece of mandate legislation. So the mandate measure, like the percentage of uninsured, also receives a lower weight (10 points maximum for those with the fewest mandates). (See CAHI's "Health Insurance Mandates in the States" for a full listing of all state mandates.)

3. *State regulatory environment.* CAHI has developed an index that measures the impact of several state regulations. It is a snapshot of the state regulatory environment rather than a comprehensive assessment. State regulations, especially guaranteed issue and community rating, can have a significant impact on the availability and cost of health insurance. Those states with the best regulatory environment receive 20 points. (For a more extensive discussion of the regulatory index, see the Methodology at www.cahi.org.)

4. *High risk pools.* It is very clear that states with well-functioning high risk pools provide a valuable safety net for individuals who have a pre-existing medical condition and have been denied health insurance coverage. However, since each risk pool's structure and funding depend on state enabling legislation, some high risk pools function better than others. For example, Florida has had a risk pool for years but never funded it, so it is of little use. And California caps enrollment time at three years, which limits access to needed coverage. Like the regulatory environment, CAHI has developed a short index (20 points maximum) to assess those risk pools that do the best job. (For a more extensive discussion of the high risk pool index, see the Methodology at www.cahi.org.)

5. *Individual and small group premiums.* Few indicators provide more information about the availability of affordable insurance than the average premiums people actually pay for their coverage. America's Health Insurance Plans (AHIP) has created a survey drawn from actual premiums in the individual market (Note: for those states not included in AHIP's survey, we extrapolated from another survey). And the U.S. Medical Expenditure Survey (MEPS) regularly tracks premiums for the small group market. Those states with the lowest premiums in the individual and small group markets receive a maximum of 20 points for each market segment.

Application of Points. So there are four measures with a maximum of 20 points each and two measures with a maximum of 10 points each — for a total of 100 points.

The four measures receiving a total of 20 points each are broken down into quintiles, with the top states receiving 20 points, the next quintile receiving 15 points, etc., and the bottom getting a 0. The two 10-point categories are broken down into thirds, with the best score being 10 points, then five points and 0.

Accuracy of the Index. Are these six factors the only, or even the best, ingredients for the Index? Fortunately, there is a retrospective way to test the accuracy of the Index. Those states with high scores should have vibrant, competitive health insurance markets, with more and more insurers eager to provide a product in the state. Those with low scores will likely have seen an exodus of insurers from the state, and premiums will be much higher than normal.

And that is exactly what the Index shows.

It would be a mistake, however, for someone to look too closely at a state's specific ranking. It would be very hard, for example, to compare the viability of a state that comes in at, say, 25 (the middle) on the list from one that is 23 or 27.

Rather, the Index should be viewed as a snapshot. Those states receiving 65 points or more generally have well-functioning health insurance markets. There could be improvements, of course, but people have access to affordable coverage and they have a safety-net option if they are uninsurable.

Those states receiving between 45 and 65 points may be functioning, but are in need of improvement. Those states receiving 40 points or less are generally dysfunctional; people there have very few health insurance options and what options they do have are often very expensive. Those states need reform — and they need it now.

Alternative Approaches. In some cases where states have undermined their health insurance markets, people and insurers have found alternative ways to get affordable coverage. For example, Florida's individual market is burdened with regulations and an overzealous insurance department, which has made those policies expensive and reduced competition. As a result, a number of insurers are selling policies in the association group market, where individuals gain access to usually less-regulated and less-expensive policies from licensed insurance companies, due to their membership in an association. In other words, individuals do have access to more-affordable policies in Florida, but primarily through the association group rather than the individual market.

However, people shouldn't be forced to look for alternative avenues to affordable coverage. Ensuring residents have access to those policies should be the goal of every state.

What Can States Do? The good news is it is never too late to reform. Both Kentucky and South Carolina had passed laws that devastated their health insurance markets. They saw the error of their ways, changed the laws and insurers are returning with more options at affordable prices — and more people are getting coverage once again.

Eliminate guaranteed issue. Guaranteed issue laws require insurers to accept all applicants regardless of a pre-existing medical condition. We have a decade of experience and know that guaranteed issue may provide access to health insurance in the short term, but these laws eventually drive the cost of health insurance out of reach for all but the richest Americans.

Establish a high risk pool. Every state that does not have a high risk pool should start one. As evidenced by the high premiums, it is clear that states with community rating and guaranteed issue do not fairly manage health insurance costs. High risk pools spread risk more broadly, and provide a cost-effective way for those with medical conditions to obtain insurance. High risk pools are a better, more equitable and affordable way to provide universal access to health insurance.

Eliminate community rating. States with community rating, which requires insurers to charge everyone the same price regardless of age or medical condition, should eliminate that requirement. In addition, narrow rate bands, which severely limit premium variations, should be relaxed in favor of rate bands that balance affordability with the needs of those with medical conditions. Establishing rate bands that mirror those once supported by the National Association of Insurance Commissioners' small group model rate (that is, +/-25 percent of the standard premium, or wider) will go a long way in ensuring coverage is both accessible and affordable.

Create laws that streamline the regulatory requirements. Health insurers face a complicated patchwork of state regulations, which are difficult to navigate. Some states have further complicated that environment by using subjective standards, or by taking months to review rate and form filings, or by creating impossible standards for certain kinds of products. There are many proposed efforts to deal with this problem, including the Health Care Choice Act, the interstate compact, optional federal charter, the State Modernization and Regulatory Transparency Act, and others. (See CAHI's "State Legislators' Guide to Health Insurance Solutions.")

Stop passing laws that increase the cost of health insurance. Health insurance mandates and minimum coverage levels continue to be popular in a number of states. Legislators need to stop passing these additional costs to their constituents. Short of that, many states have enacted mandate-study commissions that at least provide legislators with an estimate of the cost of the mandate they have proposed.

(Note: Breakdowns of all six categories and explanations of how the points are attributed to each category are available in the Methodology Section of this paper, available at www.cahi.org.)

	REGULATION SCORE	MANDATE SCORE	% UNINSURED SCORE	HIGH-RISK POOL SCORE	INDIVIDUAL MARKET SCORE	SMALL GROUP MARKET SCORE	INDEX TOTAL
AK	20	10	0	20	5	0	55
AL	20	10	5	20	10	15	80
AR	20	5	0	20	0	15	60
AZ	15	10	0	0	10	10	45
CA	15	0	0	10	20	15	60
CO	10	5	5	20	20	0	60
CT	10	0	10	20	0	0	40
DE	10	10	5	0	20	5	50
FL	10	0	0	10	10	0	30
GA	15	5	5	0	0	15	40
HI	10	10	10	0	0	10	40
IA	15	10	10	20	20	20	95
ID	15	10	5	20	20	15	85
IL	20	5	5	15	10	10	65
IN	20	5	5	20	15	10	75
KS	15	5	10	20	20	10	80
KY	20	5	5	15	20	15	80
LA	15	5	0	10	0	10	40
MA	0	5	10	0	0	10	25
MD	15	0	5	20	0	10	50
ME	0	0	10	0	0	0	10
MI	20	10	10	0	20	0	60
MN	20	0	10	20	20	20	90
MO	15	5	10	20	15	15	80
MS	10	10	0	10	5	10	45
MT	15	5	0	20	10	15	65
NC	10	0	5	0	10	5	30
ND	15	5	10	15	10	20	75
NE	20	10	10	15	15	10	80
NH	10	5	10	20	0	5	50
NJ	5	5	5	0	0	0	15
NM	20	0	0	20	20	10	70
NV	15	0	0	0	15	10	40
NY	0	0	5	0	0	0	5
OH	15	10	10	0	15	10	60
OK	15	5	0	15	0	5	40
OR	5	10	0	20	20	10	65
PA	20	5	10	0	20	5	60
RI	10	5	10	0	20	0	45
SC	20	10	5	20	0	10	65
SD	15	10	5	20	0	10	60
TN	15	5	5	5	0	5	35
TX	20	0	0	20	0	5	45
UT	20	10	5	15	20	20	90
VA	15	0	5	0	15	15	50
VT	0	10	10	0	0	5	25
WA	5	0	5	20	0	10	40
WI	20	5	10	20	15	0	70
WV	20	5	0	5	0	10	40
WY	15	5	5	15	5	10	55

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Other CAHI state health reform publications available at www.cahi.org

"2006 State Legislators' Guide to Health Insurance Solutions," by JP Wieske

"Health Insurance Mandates, 2006," by Victoria Craig Bunce, JP Wieske and Vlasta Prikazsky

"Trends in State Mandates, 2006," by Victoria Craig Bunce

"HSA State Implementation Report," by Victoria Craig Bunce

About the Council for Affordable Health Insurance

The Council for Affordable Health Insurance (CAHI) is a research and advocacy association of insurance carriers active in the individual, small group, HSA and senior markets. CAHI's membership includes health insurance companies, small businesses, physicians, actuaries and insurance brokers. Since 1992, CAHI has been an advocate for market-oriented solutions to the problems in America's health care system.

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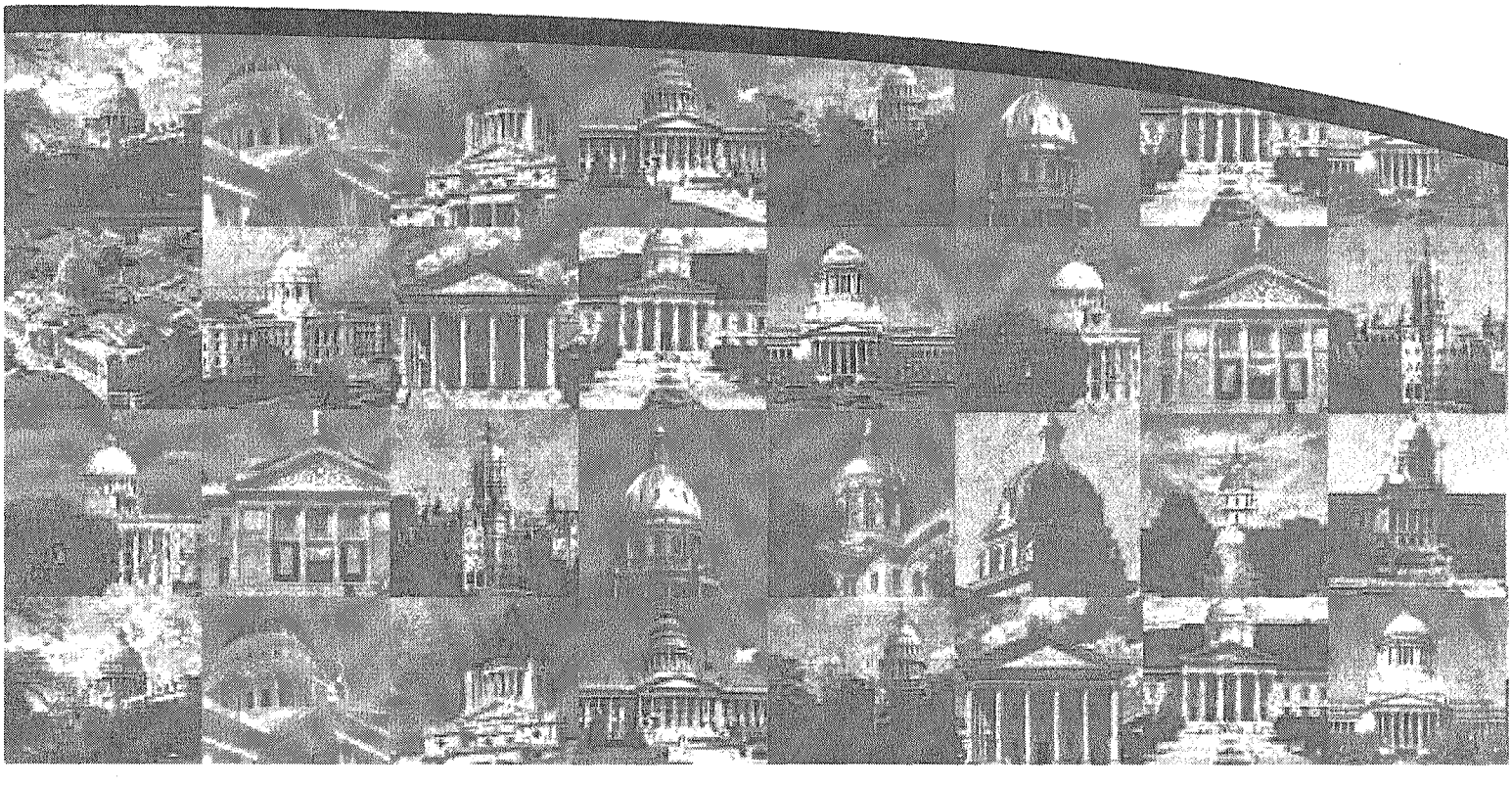

Health Insurance Mandates in the States 2008

Victoria Craig Bunce, Director of Research and Policy
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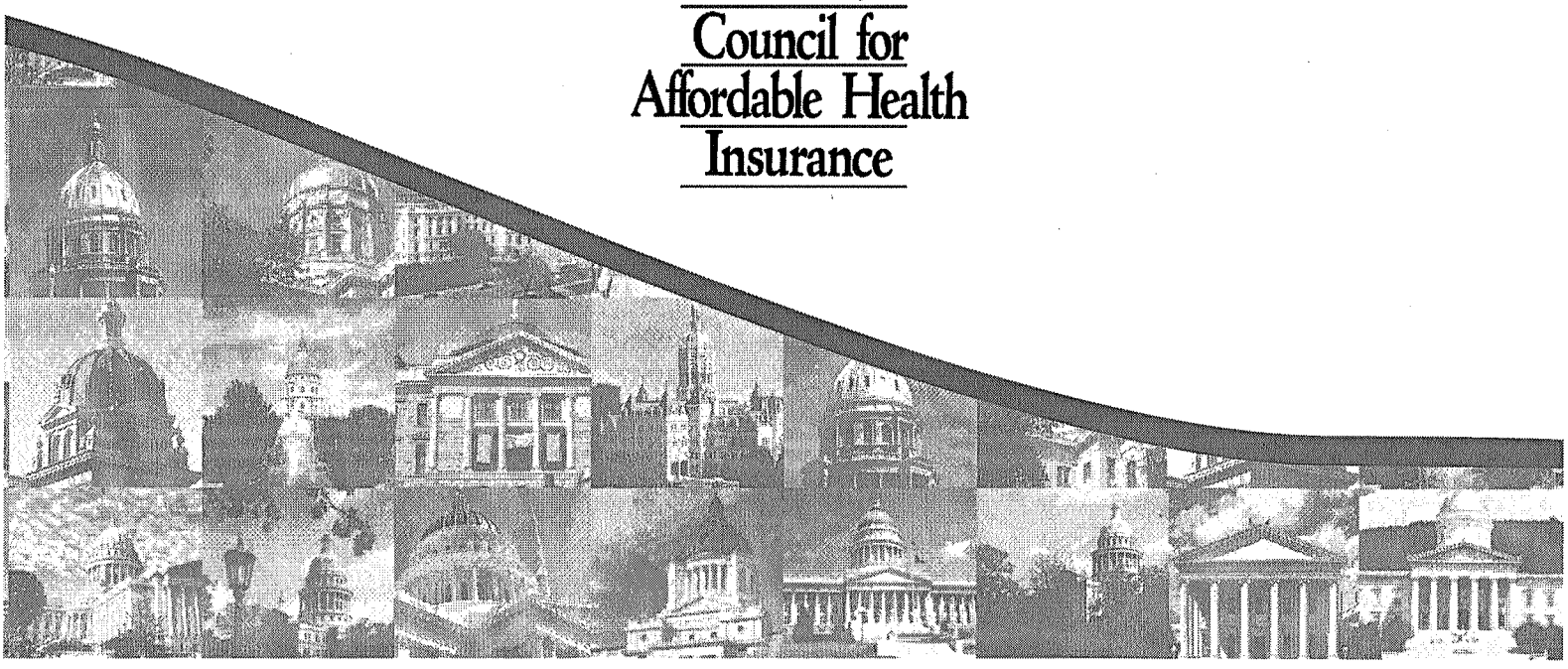
Council for
Affordable Health
Insurance



A State-by-State Breakdown of Health Insurance Mandates and Their Costs

A health insurance "mandate" is a requirement that an insurance company or health plan cover (or offer coverage for) common — but sometimes not so common — health care providers, benefits and patient populations. They include:

- Providers such as chiropractors and podiatrists, but also social workers and massage therapists;
- Benefits such as mammograms, well-child care and even drug and alcohol abuse treatment, but also acupuncture and hair prostheses (wigs); and,
- Populations such as adopted and non-custodial children.

For almost every health care product or service, there is someone who wants insurance to cover it so that those who sell the products and services get more business and those who use the products and services don't have to pay out of pocket for them.

The Impact of Mandates. While mandates make health insurance more comprehensive, they also make it more expensive because mandates require insurers to pay for care consumers previously funded out of their own pockets. We estimate that mandated benefits currently increase the cost of basic health coverage from a little less than 20% to more than 50%, depending on the state and its mandates. Mandating benefits is like saying to someone in the market for a new car, if you can't afford a Cadillac loaded with options, you have to walk. Having that Cadillac would be nice, as would having a health insurance policy that covers everything one might want. But drivers with less money can find many other affordable car options; whereas when the price of health insurance soars, few other options exist.

Why Is the Number of Mandates Growing? Elected representatives find it difficult to oppose any legislation that promises enhanced care to potentially motivated voters. The sponsors of mandates know this fact of political life. As a result, government interference in and control of the health care system is steadily increasing. So too is the cost of health insurance.

By the late 1960s, state legislatures had passed only a handful of mandated benefits; today, the Council for Affordable Health Insurance (CAHI) has identified 1,961 mandated benefits and providers. And more are on their way.

How do state legislators justify their actions? One way is to deny a mandate is a mandate. For example, legislators may claim that requiring health insurance to cover a type of provider — such as a chiropractor, podiatrist, midwife or naturopath — is not a mandate because they aren't requiring insurance to pay for a particular therapy. But that's a distinction without a difference; if insurance is required to cover the provider, it must pay for the service provided.

CAHI's Mandated Benefits and Providers Chart. The mandate chart is broken down on a state-by-state basis into three categories: benefits, providers and covered populations. Boxes with a "Y" indicate that the state has passed that particular mandate. Totals for each state and mandate are also included. Thus anyone can easily determine how many mandates and which ones each state has passed. (For a definition of each mandated benefit, please see http://www.cahi.org.)

How Is the Research Compiled? Since 1992, the Council for Affordable Health Insurance staff has tracked the introduction and passage of individual and small group market (i.e. not HMOs, PPOs, or the self-funded large group market) health insurance mandates in every state, but not until 2004 did we make this information available to the public. To corroborate our own findings, we survey every department of insurance and talk with other industry experts.

The question is sometimes raised why our mandate count may differ from other groups that identify state mandates. We do not currently differentiate between the individual and small group markets, especially since many states are blurring that traditional distinction by allowing "groups of one" (i.e., one person is considered a group) to be classified as a small group under federal law. Also, we do not differentiate between a benefit that is mandated and one that is only offered. Our actuaries advise us that the cost to provide that policy is the same: If the mandate is offered, it is essentially a mandated benefit because only those interested in the mandate will take advantage of it. In addition, states sometimes exempt either the individual or small group market from specific mandates, or may only apply that mandate to insurance companies that are domiciled in the state (e.g., a Blue Cross policy). Finally, states may pass a mandate in one legislative session only to come back in a later session and either expand or reduce the original bill's scope. That propensity to revise mandate legislation in subsequent years is one of the reasons why we don't include information on when the mandate originally passed.

Mandates and Standard Coverage. Just because we list something as a mandate doesn't necessarily mean it should be excluded from a standard health insurance policy. Many mandates listed here should be and often are included in comprehensive coverage. The purpose of this chart is to tabulate the number of benefits mandated by the states and assess their impact on the cost of insurance — not to make judgments about which mandates should or should not be included in a health insurance policy.

Assessing the Cost of Mandates. Besides listing the state mandated benefits, we provide a cost assessment of each one. CAHI's Actuarial Working Group on State Mandated Benefits analyzed company data and their experience and provided cost-range estimates — less than 1%, 1-3%, 3-5% and 5-10% — if the mandate were added to a policy that did not include the coverage. However, mandate legislation differs from bill to bill and from state to state. For example, one state may require insurance to cover a limited number of chiropractor visits per year, while another state may require chiropractors to be covered equally with medical doctors. The second will have a greater impact on the cost of a health insurance policy than the first. It would be impossible to make a detailed assessment of the cost of each state's mandates without evaluating each piece of legislation (more than 1,900 of them). Thus, the estimated cost level indicated in the chart is considered typical but may not apply to all variations of that mandate. Further, the additional cost of a mandate depends on the benefits of the policy to which it is attached. Example: A prescription drug mandate costs nothing if a policy already covers drugs, but can be very costly if added to a policy that doesn't cover drugs.

A Caution about Comparisons and Cost Estimates. Because mandates can drive up the cost of health insurance, it would be easy to assume that the states with the most mandates would also have the highest premiums. While that may be true in some states, it is not necessarily so. Some mandates have a much greater impact on the cost of health insurance than others. For example, mental health parity mandates, which require insurers to cover mental health care at the same levels as physical health care, have a much greater impact on the cost of premiums than would mandates for inexpensive procedures which few people need. In addition, mental health mandates often include mini-mandates within them, like coverage for autism diagnosis and treatment.

It may be tempting to think that since a particular mandate doesn't add much to the cost of a health insurance policy, there is no reason for legislators to oppose it. The result of this reasoning is that many states have 40, 50 or more mandates. Although most mandates only increase the cost of a policy by less than 1%, 40 such mandates will price many people out of the market. It is the accumulated impact of dozens of mandates, not just one, that makes health insurance unaffordable.

New Health Insurance Eligibility Categories. Over time, new trends emerge in health insurance coverage eligibility mandates. For example, in the past few legislative sessions we saw an increase in the "slacker mandate," in which health insurance coverage is extended to unmarried dependents or students up to the age of 30. Most recently, we have seen new categories for health insurance coverage eligibility emerge (e.g., "legal alien" and "elderly parent"). Maine has extended eligibility for health insurance coverage to include a person who is not yet a United States citizen but who is residing legally in this nation. Oregon added elderly parents who meet certain criteria. And at least four states — Maryland, Minnesota, New York and Texas — have extended eligibility for health insurance coverage to include a grandchild who is financially dependent on the grandparent. Finally, Illinois and Pennsylvania have added the military — U.S. armed services personnel can remain dependents for the amount of time they spent serving this country. (For more, please see CAHI's online publication "Trends in State Mandated Benefits" at http://www.cahi.org.)

Fortunately, there is evidence that some legislators are getting CAHI's message. At least 30 states now require that a mandate's cost be assessed before it is implemented. And at least 10 states provide for mandate-lite policies, which allow some individuals to purchase a policy with fewer mandates more tailored to their needs and financial situation.

The Rest of the Story. The mandates enumerated here don't tell the whole story. States have other ways of adversely affecting the cost of health insurance. For example, several states have adopted legislation that requires health insurers to accept anyone who applies, regardless of their health status, known as "guaranteed issue." Or they limit insurers' ability to price a policy to accurately reflect the risk an applicant brings to the pool, known as "community rating" or "modified community rating."

Both guaranteed issue and community rating can have a devastating impact on the price of health insurance, especially as younger and healthier people cancel their coverage, leaving the pool smaller and sicker. Thus, in the aggregate, mandates drive up the cost of health insurance. But determining the impact in a particular state requires careful analysis of each piece of mandatdate legislation, as well as other regulations that have been promulgate

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For more information on government mandates, guaranteed issue and community rating, please visit CAHI's website at www.cahi.org.

	Total	Est. Cost	AK	AL	AR	AZ	CA	CO	CT	DC	DE	FL	GA	HI	IA	ID	IL	IN	KS	KY	LA	MA	MD
BENEFITS																							
Alcoholism	45	1% to 3%	Y	Y	Y		Y	Y	Y	Y		Y	Y	Y			Y	Y	Y	Y	Y	Y	Y
Alzheimer's	2	<1%																					Y
Ambulatory Surgery	12	1% to 3%			Y	Y						Y	Y	Y						Y	Y		
Ambulance Services	8	<1%							Y			Y									Y		
Anti-Psychotic Drugs	3	<1%																					
Autism	11	<1%						Y			Y		Y		Y			Y		Y			Y
Birthing Centers/Midwives	8	<1%						Y				Y											
Blood Lead Poisoning	7	<1%					Y				Y											Y	
Blood Products	2	<1%																					Y
Bone Marrow Transplants	11	<1%										Y	Y							Y	Y	Y	
Bone Mass Measurement	15	<1%					Y						Y				Y		Y	Y			Y
Breast Reconstruction	49	<1%	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y
Cancer Medications	3	<1%																			Y		
Cervical Cancer/HPV Screening	29	<1%	Y				Y	Y	Y	Y	Y		Y					Y			Y	Y	Y
Chemotherapy	4	<1%																					
Chlamydia	3	<1%											Y										Y
Cleft Palate	14	<1%						Y				Y				Y		Y			Y		Y
Clinical Trials	23	<1%				Y	Y		Y		Y		Y								Y	Y	Y
Colorectal Cancer Screening	28	<1%	Y	Y	Y				Y	Y	Y		Y				Y	Y			Y		Y
Congenital Bleeding Disorders	2	<1%																					
Contraceptives	31	1% to 3%	Y		Y	Y	Y		Y		Y		Y	Y	Y	Y	Y			Y		Y	Y
Dental Anesthesia	31	<1%	Y		Y		Y	Y	Y			Y	Y		Y		Y	Y	Y	Y	Y		Y
Diabetes Self-Management	27	<1%	Y		Y	Y	Y	Y		Y		Y	Y	Y	Y		Y	Y	Y	Y			Y
Diabetic Supplies	47	<1%	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y
Drug Abuse Treatment	34	<1%	Y	Y	Y		Y		Y	Y	Y	Y		Y					Y		Y		Y
Early Intervention Services	3	< 1%						Y															
Emergency Services	44	<1%			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Habilitative Services	2	<1%								Y							Y						
Hair Prostheses	10	<1%							Y			Y										Y	Y
Hearing Aid	10	<1%							Y											Y	Y		Y
HPV Vaccine	16	<1%						Y							Y		Y	Y					
Home Health Care	18	<1%				Y	Y	Y	Y											Y		Y	Y
Hospice Care	11	<1%			Y			Y						Y						Y			Y
In Vitro Fertilization	13	3% to 5%			Y		Y		Y					Y			Y					Y	Y
Kidney Disease	2	<1%																					
Long Term Care	4	1% to 3%								Y													Y
Lyme Disease	4	<1%							Y														
Mammogram	50	<1%	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mastectomy	24	<1%			Y		Y		Y			Y	Y				Y		Y	Y	Y	Y	
Mastectomy Stay	25	<1%			Y		Y		Y			Y	Y				Y		Y		Y		Y
Maternity	21	1% to 3%			Y		Y	Y	Y				Y	Y					Y			Y	Y
Maternity Stay	50	<1%	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mental Health General	39	1% to 3%		Y	Y		Y	Y	Y	Y		Y	Y	Y			Y		Y	Y	Y	Y	Y
Mental Health Parity	47	5% to 10%		Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Minimum Hysterectomy Stay	1	<1%																					
Minimum Testicular Cancer Stays	1	<1%																					Y
Morbid Obesity Treatment	4	1% to 3%											Y					Y					Y
Neurodevelopment Therapy	1	<1%																					
Newborn Hearing Screening	17	<1%	Y								Y	Y						Y				Y	Y
Newborn Sickle-Cell Testing	3	<1%																					
Off-Label Drug Use	36	<1%		Y	Y	Y	Y		Y		Y		Y				Y	Y	Y			Y	Y
Orthotics/Prosthetics	12	<1%					Y	Y	Y			Y										Y	Y
Ostomy Related Supplies	1	<1%							Y														
Other Infertility Services	8	<1%					Y										Y						
Ovarian Cancer Screening	3	<1%											Y				Y						
Psychotic Drugs	2	<1%																					
PKU/Formula	32	<1%	Y		Y	Y	Y	Y	Y			Y		Y				Y		Y	Y	Y	Y
Port-wine Stain Elimination	2	<1%																					
Prescription Drugs	2	5% to 10%																					
Prostate Cancer Screening	33	<1%		Y			Y	Y	Y	Y	Y		Y				Y	Y	Y		Y	Y	Y
Rehabilitation Services	8	1% to 3%							Y								Y				Y	Y	
Second Surgical Opinion	10	<1%					Y					Y						Y					Y
Smoking Cessation	2	1 % to 3%																					Y
TMJ Disorders	20	<1%			Y							Y	Y				Y			Y			Y
Well-Child Care	31	1% to 3%			Y		Y	Y	Y	Y		Y	Y	Y	Y				Y		Y	Y	Y

Legend: [Y] - Mandated ▒ - Not Mandated

ME	MI	MN	MO	MS	MT	NC	ND	NE	NH	NJ	NM	NV	NY	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VA	VT	WA	WI	WV	WY
Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
																						Y							
		Y	Y										Y		Y												Y		
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		Y				Y				Y		Y	Y		Y	Y					Y		Y		Y		Y	Y		Y
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		Y	Y	Y	Y	Y		Y		Y	Y		Y	Y	Y		Y	Y				Y	Y	Y			Y	Y	

	Total	Est. Cost	AK	AL	AR	AZ	CA	CO	CT	DC	DE	FL	GA	HI	IA	ID	IL	IN	KS	KY	LA	MA	MD
PROVIDERS																							
Acupuncturists	11	1% to 3%					Y					Y											
Chiropodist	4	<1%						Y															
Chiropractors	46	1% to 3%	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y		Y		Y	Y	Y	Y	Y	Y	Y
Dentists	35	3% to 5%	Y	Y	Y	Y	Y	Y	Y						Y			Y	Y		Y	Y	Y
Denturists	2	<1%																					
Dieticians	3	<1%																					
First Nurse Assistant	5	<1%											Y							Y	Y		
Lay Midwives	3	<1%																					
Licensed Health Professional	12	<1%			Y			Y									Y	Y					Y
Marriage Therapists	14	<1%						Y	Y			Y		Y									Y
Massage Therapists	4	<1%																					Y
Naturopaths	4	<1%	Y																				
Nurse Anesthetists	21	<1%		Y	Y	Y		Y										Y	Y			Y	Y
Nurse Midwives	30	<1%	Y			Y	Y	Y	Y		Y	Y										Y	Y
Nurse Practitioners	29	<1%	Y			Y	Y	Y	Y		Y				Y				Y				Y
Nurses	11	<1%						Y						Y	Y								
Occupational Therapists	11	1% to 3%	Y			Y	Y		Y			Y									Y		
Opticians	3	1% to 3%																					
Optometrists	43	1% to 3%	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y		Y		Y	Y	Y	Y	Y	Y	Y
Oral Surgeons	8	<1%						Y				Y					Y	Y	Y				
Osteopaths	22	1% to 3%	Y		Y			Y				Y					Y	Y	Y	Y			
Pain Management Specialist	3	1% to 3%						Y	Y										Y				
Pastoral Counselors	3	<1%																					
Pharmacists	5	<1%		Y															Y				
Physical Therapists	16	1% to 3%	Y						Y										Y		Y		Y
Physician Assistants	16	<1%	Y	Y							Y	Y			Y				Y	Y			Y
Podiatrists	35	<1%		Y	Y	Y	Y	Y			Y	Y					Y	Y	Y	Y	Y	Y	Y
Professional Counselors	16	<1%			Y		Y	Y				Y					Y					Y	
Psychiatric Nurse	16	<1%					Y	Y	Y			Y										Y	
Psychologists	44	1% to 3%	Y	Y	Y	Y	Y	Y	Y			Y	Y	Y			Y	Y	Y	Y	Y	Y	Y
Public or Other Facilities	25	<1%			Y	Y	Y		Y			Y				Y		Y			Y		Y
Social Workers	27	1% to 3%	Y				Y	Y	Y			Y					Y		Y		Y	Y	Y
Speech or Hearing Therapists	20	<1%	Y		Y	Y	Y									Y	Y				Y	Y	
COVERED PERSONS																							
Adopted Children	43	<1%	Y		Y	Y	Y	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y
Continuation/Dependents	44	<1%			Y	Y	Y	Y	Y		Y	Y	Y		Y		Y	Y	Y	Y	Y	Y	Y
Continuation/Employees	45	<1%			Y		Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Conversion to Non-Group	41	1% to 3%			Y	Y	Y	Y		Y		Y	Y		Y	Y	Y	Y	Y	Y	Y		Y
Dependent Students	30	<1%						Y	Y		Y	Y	Y			Y		Y			Y	Y	Y
Grandchildren	4	<1%																					Y
Handicapped Dependents	41	1% to 3%			Y	Y	Y	Y	Y			Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y
Newborns	51	1% to 3%	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Non-Custodial Children	11	<1%						Y	Y														
Domestic Partners	13	<1%					Y	Y	Y	Y					Y							Y	
Additional Mandates*	20				1		1					1	2										1
Total	1961		28	19	41	29	50	49	51	19	25	48	41	23	25	15	40	37	37	33	43	43	63

Legend: Y - Mandated - Not Mandated

* Additional mandates identified in sidebar on opposite page.

ME	MI	MN	MO	MS	MT	NC	ND	NE	NH	NJ	NM	NV	NY	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VA	VT	WA	WI	WV	WY
Y					Y						Y	Y				Y		Y				Y		Y		Y			
										Y														Y		Y			
Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y
Y	Y	Y	Y	Y	Y	Y		Y		Y	Y	Y	Y	Y	Y	Y	Y			Y	Y	Y		Y			Y		Y
					Y																					Y			
		Y																				Y							Y
Y																						Y							
Y											Y															Y			
		Y										Y								Y			Y			Y	Y		Y
Y		Y		Y		Y			Y			Y						Y				Y		Y					
									Y														Y		Y				
					Y																			Y	Y				
Y		Y		Y	Y	Y	Y				Y	Y					Y	Y		Y						Y			Y
Y	Y	Y		Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y		Y	Y		Y	Y			Y		Y		Y	
Y		Y	Y	Y	Y	Y	Y		Y		Y	Y				Y	Y	Y		Y	Y	Y				Y	Y	Y	Y
		Y				Y	Y			Y		Y	Y				Y									Y			
		Y										Y	Y																Y
		Y										Y												Y					
Y	Y	Y	Y	Y		Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y		Y	Y		Y	Y	Y
	Y								Y			Y																	
		Y						Y	Y		Y	Y		Y	Y		Y			Y		Y		Y		Y		Y	
Y						Y			Y																				
		Y				Y																		Y					
		Y			Y					Y	Y	Y	Y				Y					Y		Y		Y			Y
	Y				Y	Y						Y					Y					Y				Y			Y
	Y	Y	Y			Y		Y	Y		Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y		Y		Y		Y	Y
				Y	Y	Y	Y		Y									Y			Y	Y		Y					Y
Y		Y		Y		Y	Y					Y						Y	Y					Y				Y	Y
Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y		Y	Y		Y
Y	Y	Y		Y	Y	Y		Y						Y		Y		Y			Y	Y		Y		Y		Y	Y
Y	Y	Y		Y	Y	Y	Y		Y			Y	Y			Y					Y	Y		Y					Y
		Y	Y									Y	Y		Y		Y		Y		Y	Y		Y		Y			Y
		Y		Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Y	Y	Y	Y		Y	Y	Y	Y		Y	Y	Y	Y	Y		Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y
Y	Y	Y			Y		Y				Y					Y						Y		Y					Y
Y										Y	Y							Y						Y	Y			Y	
3										1		2	3			2						1					2		
53	26	64	39	29	40	47	34	32	39	42	51	52	55	26	36	36	38	47	29	31	40	54	23	55	27	53	34	38	32

ADDITIONAL MANDATES — We list these mandates separately because they only appear in very few states. They are included in the totals at the bottom of each state.			
AR	Athletic Trainer	1	<1%
CA	Asthma Education & Self Management	1	<1%
FL	Ambulatory Cancer Treatment	1	<1%
GA	Vision Care Services Telemedicine	2	1% to 3% <1%
MD	Testicular Cancer	1	<1%
ME	Breast Reduction Varicose Vein Removal Legal Non-Resident Living in USA	3	<1% <1% <1%
NJ	Wilm's Tumor	1	<1%
NV	Hormone Replacement Therapy Drug Abuse Counselor	2	<1% 1% to 3%
NY	Hormone Replacement Therapy Psychotropic Drugs Ambulatory Cancer Treatment	3	<1% <1% <1%
OR	Bilateral Cochlear implant Elderly parent	2	<1% <1%
TX	Brain injuries	1	<1%
WI	AIDS Vaccines Psychotropic Drugs	2	<1% <1%

Other CAHI state health reform publications available at www.cahi.org

"State Health Insurance Index 2006," by Merrill Matthews, Ph.D., Victoria Craig Bunce, JP Wieske

"2008 State Legislators' Guide to Health Insurance Solutions," by JP Wieske and Christie Raniszewski Herrera

"Trends in State Mandates, 2007," by Victoria Craig Bunce

"HSA State Implementation Report," by Victoria Craig Bunce

About the Council for Affordable Health Insurance

The Council for Affordable Health Insurance (CAHI) is a research and advocacy association of insurance carriers active in the individual, small group, HSA and senior markets. CAHI's membership includes health insurance companies, small businesses, physicians, actuaries and insurance brokers. Since 1992, CAHI has been an advocate for market-oriented solutions to the problems in America's health care system.

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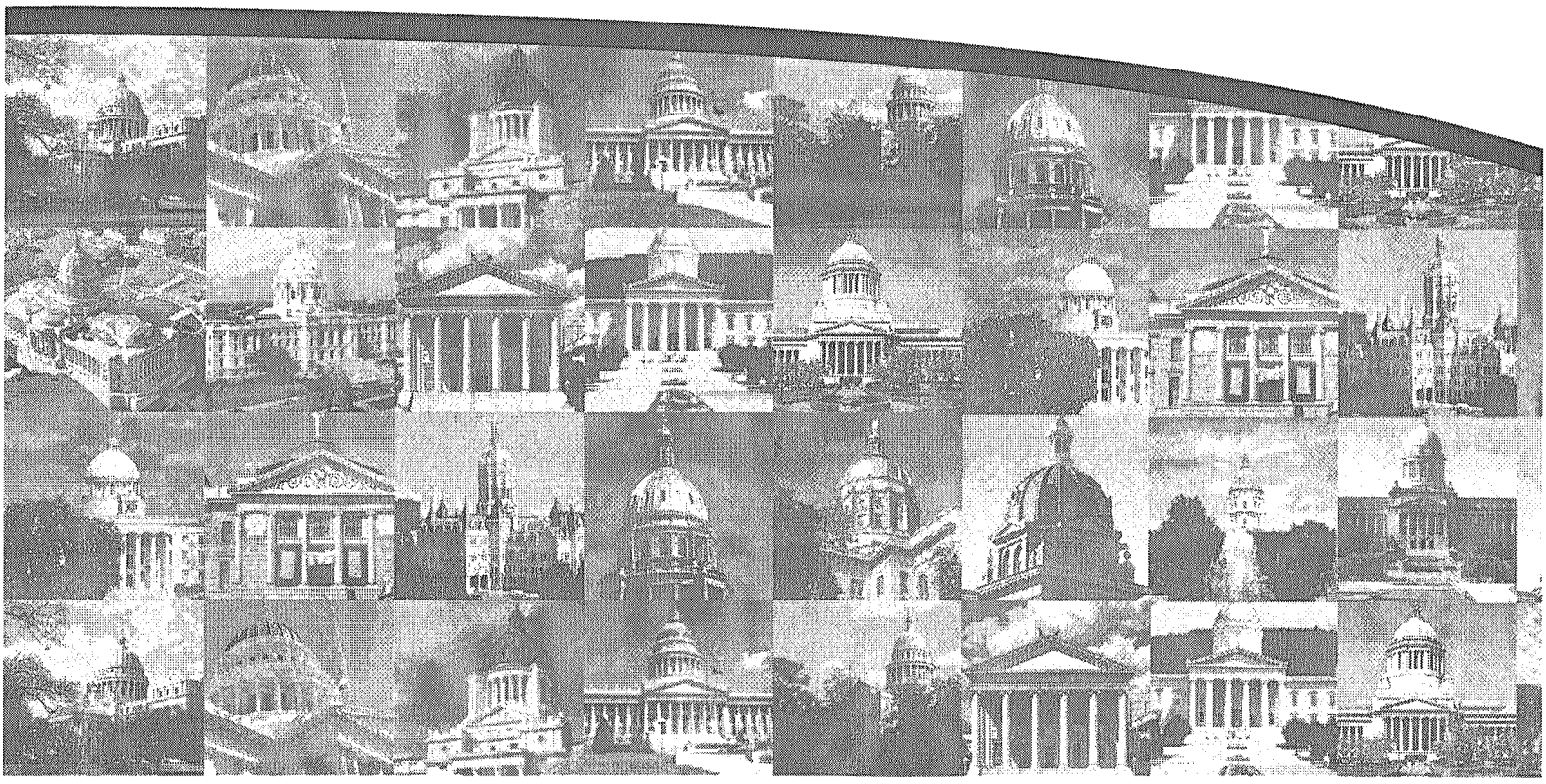

THE WALL STREET JOURNAL. ONLINE

February 8, 2008

OPINION

Mandate Update

By VICTORIA C. BUNCE and J.P. WIESKE
February 8, 2008; Page A17

To hear some of the presidential candidates, you'd think that health-insurance companies are the driving force behind the growing cost of health insurance. The more likely culprits are our politicians and the laws they pass.

Since the early 1990s, the Council for Affordable Health Insurance (CAHI) has tracked state health-insurance mandate legislation in all 50 states, and our actuarial team estimates the impact of those mandated benefits on the cost of a policy.

A health-insurance "mandate" is a legislative requirement that an insurance company or health plan cover (or offer coverage for) common -- but sometimes not so common -- health- care providers, benefits and patient populations. They include:

- Providers such as chiropractors (mandated in 46 states) and podiatrists (35 states), but also massage therapists (four states) and naturopaths (four states);

- Benefits such as mammograms (50 states) and drug abuse treatment (34 states), but also morbid obesity treatment (four states) and wigs for cancer patients (10 states);

- Populations such as dependent students (30 states), but also grandchildren (four states).

Although there were only a handful of state mandates in the 1960s, CAHI's just released "Health Insurance Mandates in the States, 2008" has identified 1,961 nationwide -- up from 1,901 a year ago.

For almost every health-care product or service, there are at least two groups that want insurance to cover it: those who sell the products and services so they can get more business, and those who use the products and services to lower their out-of-pocket costs. Both of these highly motivated groups push state legislators -- and increasingly members of Congress -- to require insurance to cover the care. As a result, government interference in and control of the health-care system is steadily increasing -- and so is the cost of health insurance.

Mandate proponents often claim that covering a particular medical product or service actually lowers health-care costs, because either the proposed coverage costs less than the standard of care (for example, a chiropractor or podiatrist usually charges less than a medical doctor), or the service will reduce or avoid future medical costs.

To be sure, some health-care services such as vaccines and mammograms can be very cost effective, especially when targeting certain at-risk groups and individuals. And many of the mandates we identify would normally be included in a comprehensive health-insurance policy.

But the fact is that mandates almost always raise the cost of health insurance. That's because mandates require insurers to pay for care that consumers previously funded out of their own pockets, if they purchased it at all.

Although most mandates will have a relatively small impact when taken individually, it's the cumulative effect that drives up the cost of coverage. It's like telling people they must have a "Cadillac plan" loaded with options. Cadillacs are nice, but not everyone can afford one. And when people can't afford coverage, they join the ranks of the uninsured.

Mandates also limit choices. Why should an older couple nearing retirement pay for maternity coverage, or a teetotaler pay for drug and alcohol abuse counseling?

One of the things you notice when tracking mandates over time is that some mandate legislation catches on. For example, over the past several years we have seen a steady increase in the cervical cancer/human papillomavirus (HPV) vaccine mandate. In the last state legislative session, at least 41 states introduced legislation to mandate coverage for this vaccine, and 24 states introduced legislation to mandate the HPV vaccine as part of the school entrance vaccine list.

Another trend is the "eligibility" mandates. Health insurance typically allows dependents to stay on a policy during their college years. But some states are increasing dependent eligibility up to age 30, regardless of student status. As a result, some commonly refer to this mandate as the "slacker mandate."

In addition, we are seeing new eligibility categories emerging, such as "domestic partner," "legal alien," "elderly parent," "grandchild" and "U.S. armed services personnel." All of these are attempts to force insurers to cover people under someone else's existing policy.

Such micromanaging of benefits is unique to health insurance. State legislators aren't nearly as aggressive in controlling life, property and casualty, and even auto insurance. As a result, those insurance markets function better and provide consumers with more choices.

Fortunately, a few states are recognizing that mandates make health insurance more expensive. At least 10 states now permit mandate-lite policies, which allow individuals to purchase a policy with fewer mandates and so are more tailored to their needs and financial situation. And there are now at least 30 states that require a mandate's cost to be assessed before it is implemented.

Mandates aren't the only things driving up the cost of health insurance. States that require insurers to accept any individual who applies, regardless of their health status, are imposing costly burdens on health insurance. And those costs get passed on to consumers -- if they decide to keep their coverage.

Before politicians jump on the anti-health-insurance bandwagon, they should look at the role they are playing in driving up costs. Making health insurance more affordable would be a lot easier if they would stop legislating what it has to cover.

Ms. Bunce is research and policy director at the Council for Affordable Health Insurance.

Mr. Wieske is director of state affairs at CAHI.

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