By Senator Saunders

25-864A-00

A bill to be entitled

An act relating to health care services; amending s. 641.19, F.S.; providing definitions; amending s. 641.315, F.S.; providing that authorization for a covered service provided by an HMO's physician, employee, or contractee is binding on the HMO and payment may not be denied; prohibiting denial of payments by an HMO for covered services provided by a hospital provider; amending s. 641.3155, F.S.; requiring HMOs to notify contract providers that a claim has been received within a specified time; providing conditions under which an HMO may contest a contract provider's claim; providing for reversion of overdue payments for claims; creating s. 641.3156, F.S.; providing for adoption of clean claims standards; amending s. 641.3903, F.S.; prohibiting specified false statements and unfair claim settlement practices; amending s. 641.3909, F.S.; authorizing the Department of Insurance to impose a monetary penalty for unfair methods of competition or unfair and deceptive acts or practices; amending s. 641.495, F.S.; providing an additional requirement for the issuance and maintenance of a health-care-provider certificate; amending s. 641.51, F.S.; requiring an HMO to ensure that only licensed physicians may render an adverse determination relating to a service provided by a licensed

physician; requiring the physician to submit to the provider and the subscriber facts and documentation relating to the HMO's adverse determination; providing an effective date.

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

Section 1. Section 641.19, Florida Statutes, is amended to read:

641.19 Definitions.--As used in this part, the term:

(1) "Affiliate" means any entity which exercises control over or is controlled by the health maintenance organization, directly or indirectly, through:

(a) Equity ownership of voting securities;

(b) Common managerial control; or

(c) Collusive participation by the management of the health maintenance organization and affiliate in the management of the health maintenance organization or the affiliate.

(2) "Agency" means the Agency for Health Care Administration.

(3) "Capitation" means the fixed amount paid by an HMO to a health care provider under contract with the health maintenance organization in exchange for the rendering of covered medical services.

(4) "Comprehensive health care services" means services, medical equipment, and supplies furnished by a provider, which may include, but which are not limited to, medical, surgical, and dental care; psychological, optometric, optic, chiropractic, podiatric, nursing, physical therapy, and pharmaceutical services; health education, preventive medical,

rehabilitative, and home health services; inpatient and outpatient hospital services; extended care; nursing home care; convalescent institutional care; technical and professional clinical pathology laboratory services; laboratory and ambulance services; appliances, drugs, medicines, and supplies; and any other care, service, or treatment of disease, or correction of defects for human beings.

(5) "Copayment" means a specific dollar amount, except as otherwise provided for by statute, that the subscriber must pay upon receipt of covered health care services. Copayments may not be established in an amount that will prevent a person from receiving a covered service or benefit as specified in the subscriber contract approved by the department.

(6) "Covered services" means health care services and supplies delivered by providers which are reimbursable under a subscriber's health maintenance contract.

(7)~~(6)~~ "Department" means the Department of Insurance.

(8)~~(7)~~ "Emergency medical condition" means:

(a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to the health of a patient, including a pregnant woman or a fetus.

2. Serious impairment to bodily functions.

3. Serious dysfunction of any bodily organ or part.

(b) With respect to a pregnant woman:

1. That there is inadequate time to effect safe transfer to another hospital prior to delivery;

2. That a transfer may pose a threat to the health and safety of the patient or fetus; or

3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

(9)~~(8)~~ "Emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital.

(10)~~(9)~~ "Entity" means any legal entity with continuing existence, including, but not limited to, a corporation, association, trust, or partnership.

(11)~~(10)~~ "Geographic area" means the county or counties, or any portion of a county or counties, within which the health maintenance organization provides or arranges for comprehensive health care services to be available to its subscribers.

(12)~~(11)~~ "Guaranteeing organization" is an organization which is domiciled in the United States; which has authorized service of process against it; and which has appointed the Insurance Commissioner and Treasurer as its agent for service of process issuing upon any cause of action arising in this state, based upon any guarantee entered into under this part.

(13)~~(12)~~ "Health maintenance contract" means any contract entered into by a health maintenance organization with a subscriber or group of subscribers to provide

comprehensive health care services in exchange for a prepaid per capita or prepaid aggregate fixed sum.

(14)~~(13)~~ "Health maintenance organization" means any organization authorized under this part which:

(a) Provides emergency care, inpatient hospital services, physician care including care provided by physicians licensed under chapters 458, 459, 460, and 461, ambulatory diagnostic treatment, and preventive health care services;

(b) Provides, either directly or through arrangements with other persons, health care services to persons enrolled with such organization, on a prepaid per capita or prepaid aggregate fixed-sum basis;

(c) Provides, either directly or through arrangements with other persons, comprehensive health care services which subscribers are entitled to receive pursuant to a contract;

(d) Provides physician services, by physicians licensed under chapters 458, 459, 460, and 461, directly through physicians who are either employees or partners of such organization or under arrangements with a physician or any group of physicians; and

(e) If offering services through a managed care system, then the managed care system must be a system in which a primary physician licensed under chapter 458 or chapter 459 and chapters 460 and 461 is designated for each subscriber upon request of a subscriber requesting service by a physician licensed under any of those chapters, and is responsible for coordinating the health care of the subscriber of the respectively requested service and for referring the subscriber to other providers of the same discipline when necessary. Each female subscriber may select as her primary physician an obstetrician/gynecologist who has agreed to serve

as a primary physician and is in the health maintenance organization's provider network.

(15)~~(14)~~ "Insolvent" or "insolvency" means that all the statutory assets of the health maintenance organization, if made immediately available, would not be sufficient to discharge all of its liabilities or that the health maintenance organization is unable to pay its debts as they become due in the usual course of business. In the event that all the assets of the health maintenance organization, if made immediately available, would not be sufficient to discharge all of its liabilities, but the organization has a written guarantee of the type and subject to the same provisions as outlined in s. 641.225, the organization shall not be considered insolvent unless it is unable to pay its debts as they become due in the usual course of business.

(16) "Noncovered services" means health care services that are not covered services, including but not limited to those services the organization determines are not medically necessary or not a medical necessity.

(17)~~(15)~~ "Provider" means any physician, hospital, or other institution, organization, or person that furnishes health care services and is licensed or otherwise authorized to practice in the state.

(18)~~(16)~~ "Reporting period" means the annual accounting period or any part thereof or the fiscal year of the health maintenance organization.

(19)~~(17)~~ "Statutory accounting principles" means generally accepted accounting principles, except as modified by this part.

(20)~~(18)~~ "Subscriber" means an entity or individual who has contracted, or on whose behalf a contract has been

entered into, with a health maintenance organization for health care services or other persons who also receive health care services as a result of the contract.

(21) "Subscriber expenses" means any amounts due for health care services which are the subscriber's responsibility in accordance with the health maintenance contract, including copayments, coinsurance, and deductibles and expenses for those services determined by the organization to be noncovered services.

(22)~~(19)~~ "Surplus" means total statutory assets in excess of total liabilities, except that assets pledged to secure debts not reflected on the books of the health maintenance organization shall not be included in surplus. Surplus includes capital stock, capital in excess of par, other contributed capital, retained earnings, and surplus notes.

(23)~~(20)~~ "Surplus notes" means debt which has been guaranteed by the United States Government or its agencies, or debt which has been subordinated to all claims of subscribers and general creditors of the organization.

(24)~~(21)~~ "Uncovered expenditures" means the cost of health care services that are covered by a health maintenance organization, for which a subscriber would also be liable in the event of the insolvency of the organization.

Section 2. Section 641.315, Florida Statutes, is amended to read:

641.315 Provider contracts.--

(1) Whenever ~~a contract exists between~~ a health maintenance organization ~~and a provider and the organization~~ fails to meet its obligations to pay fees for authorized covered services already rendered to a subscriber, the health

maintenance organization shall be liable for such fee or fees rather than the subscriber~~; and the contract shall so state~~.

(2) Authorization for a covered service provided by a health maintenance organization's contracted physician or by a health maintenance organization's employee or by an entity contracting with or acting on behalf of the health maintenance organization is binding upon the health maintenance organization, and payment may not be denied.

(3)~~(2)~~ No subscriber of an HMO shall be liable to any provider of health care services for any services covered by the HMO.

(4)~~(3)~~ No provider of services or any representative of such provider shall collect or attempt to collect from an HMO subscriber any money for services covered by an HMO and no provider or representative of such provider may maintain any action at law against a subscriber of an HMO to collect money owed to such provider by an HMO.

(5)~~(4)~~ Every contract between an HMO and a provider of health care services shall be in writing and shall contain a provision that the subscriber shall not be liable to the provider for any services covered by the subscriber's contract with the HMO.

(6)~~(5)~~ The provisions of this section shall not be construed to apply to the amount of any deductible or copayment which is not covered by the contract of the HMO.

(7)~~(6)~~(a) For all provider contracts executed after October 1, 1991, and within 180 days after October 1, 1991, for contracts in existence as of October 1, 1991:

1. The contracts must provide that the provider shall provide 60 days' advance written notice to the health maintenance organization and the department before canceling

the contract with the health maintenance organization for any reason; and

2. The contract must also provide that nonpayment for goods or services rendered by the provider to the health maintenance organization shall not be a valid reason for avoiding the 60-day advance notice of cancellation.

(b) For all provider contracts executed after October 1, 1996, and within 180 days after October 1, 1996, for contracts in existence as of October 1, 1996, the contracts must provide that the health maintenance organization will provide 60 days' advance written notice to the provider and the department before canceling, without cause, the contract with the provider, except in a case in which a patient's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action by the Board of Medicine or other governmental agency.

(8)~~(7)~~ Upon receipt by the health maintenance organization of a 60-day cancellation notice, the health maintenance organization may, if requested by the provider, terminate the contract in less than 60 days if the health maintenance organization is not financially impaired or insolvent.

(9)~~(8)~~ A contract between a health maintenance organization and a provider of health care services shall not contain any provision restricting the provider's ability to communicate information to the provider's patient regarding medical care or treatment options for the patient when the provider deems knowledge of such information by the patient to be in the best interest of the health of the patient.

(10)~~(9)~~ A contract between a health maintenance organization and a provider of health care services may not contain any provision that in any way prohibits or restricts:

(a) The health care provider from entering into a commercial contract with any other health maintenance organization; or

(b) The health maintenance organization from entering into a commercial contract with any other health care provider.

(11)~~(10)~~ A health maintenance organization or health care provider may not terminate a contract with a health care provider or health maintenance organization unless the party terminating the contract provides the terminated party with a written reason for the contract termination, which may include termination for business reasons of the terminating party. The reason provided in the notice required in this section or any other information relating to the reason for termination does not create any new administrative or civil action and may not be used as substantive evidence in any such action, but may be used for impeachment purposes. As used in this subsection, the term "health care provider" means a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461, or a dentist licensed under chapter 466.

(12) A health maintenance organization may not deny payment for covered services provided by a contracted hospital provider, or pay for a lower level of care than rendered, when such service is ordered by a contracted physician.

Section 3. Section 641.3155, Florida Statutes, is amended to read:

641.3155 Provider contracts; payment of claims.--

(1)(a) A health maintenance organization shall pay any claim or any portion of a claim made by a contract provider for services or goods provided under a contract with the health maintenance organization which the organization does not contest or deny within 35 days after receipt of the claim by the health maintenance organization which is mailed or electronically transferred by the provider.

(b) A health maintenance organization shall notify the provider that a claim has been received within 2 days, if the claim has been electronically transmitted to the health maintenance organization or its agent, or within 10 days if the claim was mailed or otherwise delivered. If receipt of a claim is not acknowledged within the applicable timeframe, the provider may resubmit the claim, and such resubmission will not constitute a fraudulent claim.

(c) A health maintenance organization shall notify the provider within 15 days after a claim has been received if the claim is incomplete, if the patient receiving the service is no longer an eligible subscriber, of if the service was not authorized.

(d)~~(b)~~ A health maintenance organization that denies or contests a provider's claim shall notify the contract provider, in writing, within 35 days after receipt of the claim by the health maintenance organization that the claim is contested or denied. The notice that the claim is denied or contested must identify the contested portion of the claim and the specific reason for contesting or denying the claim, and may include a request for additional information. If the health maintenance organization requests additional information, the provider shall, within 35 days after receipt of such request, mail or electronically transfer the

information to the health maintenance organization. The health maintenance organization shall acknowledge receiving the additional information within 5 days after its receipt. The health maintenance organization shall pay or deny the claim or portion of the claim within 45 days after receipt of the information.

(e) In order for a health maintenance organization to contest a portion of a provider's claim, the health maintenance organization must pay to the provider the uncontested portion of the claim within 35 days after receipt of claim by the health maintenance organization. The failure to pay the uncontested portion of a claim constitutes a waiver of the health maintenance organization's right to deny any part of the claim.

(2) Payment of a claim is considered made on the date the payment was received or electronically transferred ~~or otherwise delivered. An overdue payment of a claim bears simple interest at the rate of 10 percent per year~~. Overdue payments, either after 35 days for complete, uncontested claims, or after 120 days for all other claims, revert to the billed charges for facilities licensed under chapter 395 and to the usual and customary charges for other providers. Failure of a health maintenance organization to pay in a timely manner constitutes waiver of a discount contractually agreed to by the provider and the health maintenance organization.

(3) A health maintenance organization shall pay or deny any claim no later than 120 days after receiving the claim.

(4) Any retroactive reductions of payments or demands for refund of previous overpayments which are due to

retroactive review-of-coverage decisions or payment levels must be reconciled to specific claims unless the parties agree to other reconciliation methods and terms. Any retroactive demands by providers for payment due to underpayments or nonpayments for covered services must be reconciled to specific claims unless the parties agree to other reconciliation methods and terms. The look-back period may be specified by the terms of the contract.

(5) For the purposes of claims payment, a hospital's charges shall be determined to be the usual and customary charge.

Section 4. Section 641.3156, Florida Statutes, is created to read:

641.3156 Clean claims standards.--

(1)(a) As used in this section the term "clean claim" means either:

1. An institutional claim that is a properly completed billing instrument, paper or electronic, consisting of the UB-92 data set or its successor, and submitted on the designated paper or electronic format adopted by the National Uniform Billing Committee (NUBC) with entries designated as mandatory by the NUBC, together with any data required by the state uniform billing committee and included in the UB-92 manual that is in effect at the time of service; or

2. The definition established within an executed and current provider contract.

(b) The term "clean claim" as used in this section does not involve coordination of benefits for third-party liability or subrogation as evidenced by the information provided on the claim related to coordination of benefits.

(c) The definition prescribed in paragraph (a) is inapplicable to claims against a physician's practice. With respect to a physician's practice, the definition of the term "clean claim" must be agreed upon by contract.

(2) The Department of Insurance and the Agency for Health Care Administration shall require all health plans to adopt the standards developed by the National Uniform Billing Committee and the National Uniform Claims Committee, when adopted.

(3) All health plans and providers must meet the standards of the Health Insurance Portability and Accountability Act, as approved by the Health Care Financing Administration. The standards of the Health Insurance Portability and Accountability Act must be implemented by December 31, 2001, and must include the electronic processing of claims for all health plans. However, the Agency for Health Care Administration and the Department of Insurance may grant exceptions to this subsection for rural providers and solo practitioners.

(4) Failure to comply with the standards set forth in this section is an unfair method of competition under s. 641.3903.

Section 5. Subsections (4) and (5) of section 641.3903, Florida Statutes, are amended to read:

641.3903 Unfair methods of competition and unfair or deceptive acts or practices defined.--The following are defined as unfair methods of competition and unfair or deceptive acts or practices:

(4) FALSE STATEMENTS AND ENTRIES.--

(a) Knowingly:

1. Filing with any supervisory or other public official,

2. Making, publishing, disseminating, or circulating,

3. Delivering to any person,

4. Placing before the public, or

5. Causing, directly or indirectly, to be made, published, disseminated, circulated, or delivered to any person, or place before the public,

any material false statement.

(b) Knowingly making any false entry of a material fact in any book, report, or statement of any person.

(c) Denying a subscriber's or provider's claim for which an authorization has been obtained under s. 641.315(2).

(5) UNFAIR CLAIM SETTLEMENT PRACTICES.--

(a) Attempting to settle claims on the basis of an application or any other material document which was altered without notice to, or knowledge or consent of, a health maintenance organization, the subscriber or group of subscribers to a health maintenance organization, or the providers of the service;

(b) Making a material misrepresentation to the subscriber for the purpose and with the intent of effecting settlement of claims, loss, or damage under a health maintenance contract on less favorable terms than those provided in, and contemplated by, the contract; or

(c) Committing or performing against a subscriber or provider with such frequency as to indicate a general business practice any of the following:

1. Failing to adopt and implement claims standards defined in this chapter for the proper processing, payment, and investigation of claims;

2. Misrepresenting pertinent facts or contract provisions relating to coverage at issue;

3. Failing to acknowledge and act promptly upon any communications from a subscriber or provider with respect to claims;

4. Denying of a subscriber's or provider's claims or portions of claims without conducting reasonable investigations based upon available information;

5. Failing to affirm or deny coverage of claims upon written request of the subscriber or provider within a reasonable time not to exceed 30 days after a claim or proof-of-loss statements have been completed and documents pertinent to the claim have been requested in a timely manner and received by the health maintenance organization;

6. Failing to promptly provide a reasonable explanation in writing to the subscriber of the basis in the health maintenance contract in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement, or failing to promptly provide a reasonable explanation in writing to the provider of the basis in the health maintenance contract in relation to the facts or applicable law, or in the case of a contracted provider the basis in the provision of the provider's contract for denial of a claim or partial payment of a claim;

7. Failing to provide, upon written request of a subscriber, itemized statements verifying that services and supplies were furnished, where such statement is necessary for the submission of other insurance claims covered by individual

specified disease or limited benefit policies, provided that the organization may receive from the subscriber a reasonable administrative charge for the cost of preparing such statement; or

8. Failing to provide any subscriber with services, care, or treatment contracted for pursuant to any health maintenance contract without a reasonable basis to believe that a legitimate defense exists for not providing such services, care, or treatment. To the extent that a national disaster, war, riot, civil insurrection, epidemic, or any other emergency or similar event not within the control of the health maintenance organization results in the inability of the facilities, personnel, or financial resources of the health maintenance organization to provide or arrange for provision of a health service in accordance with requirements of this part, the health maintenance organization is required only to make a good faith effort to provide or arrange for provision of the service, taking into account the impact of the event. For the purposes of this paragraph, an event is not within the control of the health maintenance organization if the health maintenance organization cannot exercise influence or dominion over its occurrence.

Section 6. Subsection (3) is added to section 641.3909, to read:

641.3909 Cease and desist and penalty orders.--After the hearing provided in s. 641.3907, the department shall enter a final order in accordance with s. 120.569. If it is determined that the person, entity, or health maintenance organization charged has engaged in an unfair or deceptive act or practice or the unlawful operation of a health maintenance organization without a subsisting certificate of authority,

the department shall also issue an order requiring the violator to cease and desist from engaging in such method of competition, act, or practice or unlawful operation of a health maintenance organization. Further, if the act or practice constitutes a violation of s. 641.3901 or s. 641.3903, the department may, at its discretion, order any one or more of the following:

(3) A monetary penalty of not more than $50,000 per violation of s. 641.3901 or s. 641.3903. Monetary penalties assessed by the department under this subsection must be allocated one-half to the department for the specific purpose of monitoring and enforcing the provisions of ss. 641.3901 and 641.3903, and one-half to the Agency for Health Care Administration, Bureau of Managed Care.

Section 7. Section 641.495, Florida Statutes, is amended to read:

641.495 Requirements for issuance and maintenance of certificate.--

(1) The agency shall issue a health care provider certificate to an applicant filing a completed application in conformity with ss. 641.48 and 641.49, upon payment of the prescribed fee, and upon the agency's being satisfied that the applicant has the ability to provide quality of care consistent with the prevailing professional standards of care and which applicant otherwise meets the requirements of this part.

(2) A certificate, unless sooner suspended or revoked, shall automatically expire 2 years from the date of issuance, or at any time accreditation is withdrawn, unless renewed by the organization. The certificate shall be renewed upon application for renewal and payment of a renewal fee of

$1,000, provided that the organization is in compliance with the requirements of this part and all rules adopted under this part. An application for renewal of a certificate shall be made 90 days prior to expiration of the certificate, on forms provided by the agency. The renewal application shall not require the resubmission of any documents previously filed with the agency if such documents have remained valid and unchanged since their original filing.

(3) The organization shall demonstrate its capability to provide health care services in the geographic area that it proposes to service. In addition, each health maintenance organization shall notify the agency of its intent to expand its geographic area at least 60 days prior to the date it plans to begin providing health care services in the new area. Prior to the date the health maintenance organization begins enrolling members in the new area, it must submit a notarized affidavit, signed by two officers of the organization who have the authority to legally bind the organization, to the agency describing and affirming its existing and projected capability to provide health care services to its projected number of subscribers in the new area. The notarized affidavit shall further assure that, 15 days prior to providing health care services in the new area, the health maintenance organization shall be able, through documentation or otherwise, to demonstrate that it shall be capable of providing services to its projected subscribers for at least the first 60 days of operation. If the agency determines that the organization is not capable of providing health care services to its projected number of subscribers in the new area, the agency may issue an order as required under chapter 120 prohibiting the organization from expanding into the new area. In any

proceeding under chapter 120, the agency shall have the burden of establishing that the organization is not capable of providing health care services to its projected number of subscribers in the new area.

(4) The organization shall ensure that the health care services it provides to subscribers, including physician services as required by s. 641.19(13)(d) and (e), are accessible to the subscribers, with reasonable promptness, with respect to geographic location, hours of operation, provision of after-hours service, and staffing patterns within generally accepted industry norms for meeting the projected subscriber needs.

(5) Each organization shall maintain on-line and telephone services 24 hours a day, 7 days a week, for purposes of providers confirming subscriber eligibility and authorization for services. Each organization shall make available communications to a live person for authorizations and information on the coverage status. In no circumstance may an organization give a provider a pending authorization.

(6)~~(5)~~ The organization shall exercise reasonable care in assuring that delivered health care services are performed by appropriately licensed providers.

(7)~~(6)~~ The organization shall have a system for verification and examination of the credentials of each of its providers. The organization shall maintain in a central file the credentials, including a copy of the current Florida license, of each of its physicians.

(8)~~(7)~~ Every organization shall establish standards and procedures reasonably necessary to provide for the maintenance of a readily accessible medical records system which is adequate to accommodate necessary information

including an accurate documentation of all services provided for every enrolled subscriber.

(9)~~(8)~~ Each organization's contracts, certificates, and subscriber handbooks shall contain a provision, if applicable, disclosing that, for certain types of described medical procedures, services may be provided by physician assistants, nurse practitioners, or other individuals who are not licensed physicians.

(10)~~(9)~~ Every organization shall have a subscriber grievance procedure, including, as appropriate, a procedure for disenrolling for cause, which is outlined in all master group and individual contracts as well as in any certificate or handbook provided to subscribers.

(11)~~(10)~~ The organization shall provide, through contract or otherwise, for periodic review of its medical facilities and services, as required under s. 641.512.

(12)~~(11)~~ The organization shall designate a medical director who is a physician licensed under chapter 458 or chapter 459.

(13)~~(12)~~ The provisions of part I of chapter 395 do not apply to a health maintenance organization that, on or before January 1, 1991, provides not more than 10 outpatient holding beds for short-term and hospice-type patients in an ambulatory care facility for its members, provided that such health maintenance organization maintains current accreditation by the Joint Commission on Accreditation of Health Care Organizations, the Accreditation Association for Ambulatory Health Care, or the National Committee for Quality Assurance.

Section 8. Present subsections (4), (5), (6), (7), (8), (9), and (10) of section 641.51, Florida Statutes, are

redesignated as subsections (5), (6), (7), (8), (9), (10), and (11), respectively, and a new subsection (4) is added to that section to read:

641.51 Quality assurance program; second medical opinion requirement.--

(4) The organization shall ensure that only a physician licensed under chapter 458 or chapter 459 may render an adverse determination regarding a service provided by a physician licensed under chapter 458 or chapter 459 and shall require the physician to submit to the provider and the subscriber the facts and documentation regarding the organization's adverse determination within 2 working days after the subscriber or provider is notified of the adverse determination. The facts and documentation must be written, include the utilization-review criteria or benefits provisions used in the adverse determination, and be signed by the physician rendering the adverse determination. The organization must include with the notification of an adverse determination information concerning the appeal process for adverse determinations.

Section 9. This act shall take effect July 1, 2000.

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SENATE SUMMARY

Provides definitions applicable to the Health Maintenance Organization Act. Provides that authorization for a covered service provided by an HMO's physician, employee, or contractee is binding on the HMO, and that payment may not be denied. Prohibits the denial of payments by an HMO for covered services provided by a hospital provider. Requires an HMO to notify contract providers that a claim has been received within a specified time. Provides conditions under which an HMO may contest a contract provider's claim. Provides for a reversion to charges for facilities and providers of overdue payments for claims. Provides for the adoption of claims standards. Prohibits specified false statements and unfair claim settlement practices. Authorizes the Department of Insurance to impose a monetary penalty for unfair methods of competition or unfair and deceptive acts or practices. Provides an additional requirement for the issuance and maintenance of a health care provider certificate. Requires an HMO to ensure that only licensed physicians may render an adverse determination relating to service provided by a licensed physician. Requires the physician to submit to the provider and the subscriber facts and documentation relating to the HMO's adverse determination.