By Representative Benson

A bill to be entitled

An act relating to health insurance; amending s. 627.4235, F.S.; providing for payments of benefits under multiple health insurance policies regardless of certain timeframes; amending s. 627.613, F.S.; defining the term "clean claim" for purposes of health insurance claims made by a provider under contract with a health insurer; requiring payment within specified periods; requiring the payment of interest on overdue payments; providing payment procedures; requiring the Department of Insurance to adopt rules prescribing forms; requiring the use of standard code sets; creating s. 627.6135, F.S.; defining the term "emergency medical condition"; prohibiting a health insurer from placing certain requirements or limits on the provision of emergency services; providing for determining whether an emergency medical condition exists; providing requirements for providing emergency care and treatment; amending s. 641.19, F.S.; defining the term "emergency medical condition" for purposes of part I of ch. 641, F.S., relating to health maintenance organizations; amending s. 641.315, F.S.; providing that a contract is unenforceable to the extent that it conflicts with part I of ch. 641, F.S.; amending s. 641.3155, F.S.; providing procedures for the payment of claims; requiring payment within specified periods; requiring the

payment of interest on overdue payments; requiring the coordination of benefits; amending s. 641.3156, F.S.; specifying that certain authorizations for service are binding upon the health maintenance organization; amending s. 641.495, F.S.; providing requirements for issuing treatment authorizations; amending s. 408.7057, F.S.; redefining the term "managed care organization"; providing requirements for filing a claim dispute with a resolution organization; providing an effective date.

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

Section 1. Subsection (2) of section 627.4235, Florida Statutes, is amended to read:

627.4235 Coordination of benefits.--

(2) A hospital, medical, or surgical expense policy, health care services plan, or self-insurance plan that provides protection or insurance against hospital, medical, or surgical expenses issued in this state or issued for delivery in this state may contain a provision whereby the insurer may reduce or refuse to pay benefits otherwise payable thereunder solely on account of the existence of similar benefits provided under insurance policies issued by the same or another insurer, health care services plan, or self-insurance plan which provides protection or insurance against hospital, medical, or surgical expenses only if, as a condition of coordinating benefits with another insurer, the insurers together pay 100 percent of the total covered ~~reasonable~~

~~expenses actually incurred of the type of expense within the~~ benefits described in the policies and presented to the insurer for payment, regardless of any timeframes for payment or filing of claims established by any applicable contract.

Section 2. Section 627.613, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 627.613, F.S., for present text.)

627.613 Time of payment of claims.--

(1)(a) The term "clean claim" for a noninstitutional provider means a properly and accurately completed paper or electronic billing instrument that consists of the HCFA 1500 data set, or its successor, with entries stated as mandatory by the United States Secretary of Health and Human Services. Such claim does not involve coordination of benefits for third-party liability or subrogation, as evidenced by the information provided on the claim form related to coordination of benefits.

(b) The term "clean claim" for an institutional provider means a properly and accurately completed paper or electronic billing instrument that consists of the UB-92 data set, or its successor, with entries stated as mandatory by the National Uniform Billing Committee. It does not involve coordination of benefits for third-party liability or subrogation, as evidenced by the information provided on the claim form related to coordination of benefits.

(2)(a) A health insurer shall pay any clean claim or any portion of a clean claim made by a contract provider for services or goods provided under a contract with the health insurer, or a clean claim made by a noncontract provider which the insurer does not contest or deny, within 45 days after

receipt of the claim by the health insurer which is mailed or electronically transferred by the provider.

(b) A health insurer that denies or contests a provider's claim or any portion of a claim must notify the provider, in writing, within 45 days after the health insurer receives the claim 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, if contested, must include a request for additional information. If the provider submits additional information, the provider must, within 35 days after receipt of the request, mail or electronically transfer the information to the health insurer. The health insurer shall pay or deny the claim or portion of the claim within 45 days after receipt of the information.

(3) Payment of a claim is considered made on the date the payment was received, electronically transferred, or otherwise delivered. Interest on an overdue payment for a clean claim, or for any uncontested portion of a clean claim, begins to accrue on the 45th day after the date the claim is received, according to the following schedule:

(a) For a claim that is paid between 45 days and 60 days after the date the claim was received by the health maintenance organization, interest accrues at a rate of 10 percent per year;

(b) For a claim that is paid between 61 days and 90 days after the date the claim was received by the health maintenance organization, interest accrues at a rate of 12 percent per year;

(c) For a claim that is paid between 91 days and 120 days after the date the claim was received by the health

maintenance organization, interest accrues at a rate of 15 percent per year; and

(d) For a claim that is paid more than 120 days after the date the claim was received by the health maintenance organization, interest accrues at a rate of 18 percent per year.

The interest must be included with the payment of the claim. Failure to include the interest with payment of the claim is a violation of s. 624.4211.

(4) A health insurer must pay or deny a claim not later than 120 days after receiving the claim. Failure to do so creates an uncontestable obligation for the health insurer to pay the claim to the provider.

(5) If, as a result of retroactive review of a coverage decision or payment level, a health insurer finds that it has made an overpayment to a provider for services rendered to a subscriber, the organization may not reduce payment to that provider for other services.

(6) If the claim has been electronically transmitted to the health insurer, a provider's claim for payment shall be considered received by the health insurer on the date receipt is verified electronically or, if the claim is mailed to the address disclosed by the organization, on the date indicated on the return receipt. A provider may not submit a duplicate claim until 45 days following receipt of a claim.

(7) A provider, or the provider's designee, who bills electronically must be provided with an electronic acknowledgment of the receipt of a claim within 72 hours.

(8) A health insurer may not retroactively deny a claim because of subscriber ineligibility more than 1 year after the date of payment of a clean claim.

(9) A health insurer may not delay payment on a claim from a physician, hospital, or other provider while waiting for the submission of a claim from another physician, hospital, or other provider for services provided during the same episode of illness. A health insurer may not deny or withhold payment on a claim because the insured has not paid a required deductible or copayment.

(10) The department shall adopt rules to establish claim forms that are consistent with federal claim-filing standards required by the United States Secretary of Health and Human Services. The department shall adopt rules to establish coding standards that are consistent with Medicare coding standards adopted by the United States Secretary of Health and Human Services. The coding standards shall apply to both electronic and paper claims.

(11) All providers and payers shall use the standard code sets defined for their area of operation by the United States Secretary of Health and Human Services. Unless otherwise defined by the secretary, the effective date for code changes shall be consistent with those adopted by the Medicare contractor, intermediary or carrier, and must include grace periods established by the contractor.

(12) A provision in a provider contract is void and unenforceable to the extent that it purports to waive or preclude the rights, remedies, or requirements set forth in this part.

Section 3. Section 627.6135, Florida Statutes, is created to read:

627.6135 Requirements for providing emergency services and care.--

(1) As used in this section, the term "emergency medical condition" means:

(a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, psychiatric disturbances, symptoms of substance abuse, 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.

(2) In providing for emergency services and care as a covered service, a health insurer may not:

(a) Require prior authorization for the receipt of prehospital transport or treatment or for emergency services and care.

(b) Indicate that emergencies are covered only if care is secured within a certain period of time.

(c) Use terms such as "life threatening" or "bona fide" to qualify the kind of emergency that is covered.

(d) Deny payment based on the subscriber's failure to notify the health insurer in advance of seeking treatment or within a certain period after the care is given.

(3) Prehospital and hospital-based trauma services and emergency services and care must be provided to an insured as required under ss. 395.1041, 395.4045, and 401.45.

(4)(a) When an insured is present at a hospital seeking emergency services and care, the determination as to whether an emergency medical condition exists shall be made, for the purposes of treatment, by a physician of the hospital or, to the extent permitted by applicable law, by other appropriate licensed professional hospital personnel under the supervision of the hospital physician. The physician or the appropriate personnel shall indicate in the patient's chart the results of the screening, examination, and evaluation. The health insurer shall compensate the provider for the screening, evaluation, and examination that is reasonably calculated to assist the health care provider in arriving at a determination as to whether the patient's condition is an emergency medical condition. The health insurer shall compensate the provider for emergency services and care. If a determination is made that an emergency medical condition does not exist, payment for services rendered subsequent to that determination is governed by the health insurance policy.

(b)1. If a determination has been made that an emergency medical condition exists and the insured has notified the hospital, or the hospital emergency personnel otherwise have knowledge that the patient is insured under a health plan, the hospital must make a reasonable attempt to notify the subscriber's primary care physician, if known, or the health plan, if the health plan had previously requested

in writing that the notification be made directly to the health plan, of the existence of the emergency medical condition. If the primary care physician is not known, or has not been contacted, the hospital must:

a. Notify the health plan as soon as possible; or

b. Notify the health plan within 24 hours or on the next business day after admission of the subscriber as an inpatient to the hospital.

2. If notification required by this paragraph is not accomplished, the hospital must document its attempts to notify the health insurer of the circumstances that precluded attempts to notify the health insurer. A health insurer may not deny payment for emergency services and care based on a hospital's failure to comply with the notification requirements of this paragraph. This paragraph does not alter any contractual responsibility of an insured to make contact with a health insurer, subsequent to receiving treatment for the emergency medical condition.

(c) If the insured's primary care physician responds to the notification, the hospital physician and the primary care physician may discuss the appropriate care and treatment of the subscriber. The health insurer may have a member of the hospital staff with whom it has a contract participate in the treatment of the insured within the scope of the physician's hospital staff privileges. Notwithstanding any other state law, a hospital may request and collect insurance or financial information from a patient, in accordance with federal law, which is necessary to determine if the patient has health insurance, if emergency services and care are not thereby delayed.

Section 4. Paragraph (a) of subsection (7) of section 641.19, Florida Statutes, is amended to read:

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

(7) "Emergency medical condition" means:

(a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, psychiatric disturbances, symptoms of substance abuse, 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.

Section 5. Subsection (10) is added to section 641.315, Florida Statutes, to read:

641.315 Provider contracts.--

(10) A provision in a provider contract is void and unenforceable to the extent that it purports to waive or preclude the rights, remedies, or requirements set forth in this part.

Section 6. Subsections (1) and (3) of section 641.3155, Florida Statutes, are amended, and subsection (11) is added to that section, to read:

641.3155 Payment of claims.--

(1)(a) As used in this section, the term "clean claim" for a noninstitutional provider means a claim submitted on a HCFA 1500 for a physician licensed under chapter 458 or chapter 459 or other appropriate form for any other noninstitutional provider which has no defect or impropriety, including lack of required substantiating documentation for

noncontracted providers and suppliers, or particular circumstances requiring special treatment which prevent timely payment from being made on the claim. A claim may not be considered not clean solely because a health maintenance organization refers the claim to a medical specialist within the health maintenance organization for examination. If additional substantiating documentation, such as the medical record or encounter data, is required from a source outside the health maintenance organization, the claim is considered not clean. This definition of "clean claim" is repealed on the effective date of rules adopted by the department which define the term "clean claim."

(b) Absent a written definition that is agreed upon through contract, the term "clean claim" for an institutional claim is a properly and accurately completed paper or electronic billing instrument that consists of the UB-92 data set or its successor with entries stated as mandatory by the National Uniform Billing Committee. Such claim does not involve coordination of benefits for third-party liability or subrogation, as evidenced by the information provided on the claim form related to coordination of benefits.

(c) The department shall adopt rules to establish claim forms consistent with federal claim-filing standards for health maintenance organizations required by the United States Secretary of Health and Human Services ~~federal Health Care Financing Administration~~. The department may adopt rules relating to coding standards consistent with Medicare coding standards adopted by the United States Secretary of Health and Human Services ~~federal Health Care Financing Administration~~. The coding standards apply to both electronic and paper claims.

(d) All providers and payers shall use the standard code sets defined for their area of operation by the United States Secretary of Health and Human Services. Unless otherwise defined by the secretary, the effective date for code changes shall be consistent with those adopted by the Medicare contractor, intermediary or carrier, and include grace periods established by the contractor.

(3) 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.~~Interest on an overdue payment for a clean claim or for any uncontested portion of a clean claim begins to accrue on the 36th day after the claim has been received, according to the following schedule: ~~.~~

(a) For a claim that is paid between 36 days and 60 days after the date the claim was received by the health maintenance organization, interest accrues at a rate of 10 percent per year;

(b) For a claim that is paid between 61 days and 90 days after the date the claim was received by the health maintenance organization, interest accrues at a rate of 12 percent per year;

(c) For a claim that is paid between 91 days and 120 days after the date the claim was received by the health maintenance organization, interest accrues at a rate of 15 percent per year; and

(d) For a claim that is paid more than 120 days after the date the claim was received by the health maintenance organization, interest accrues at a rate of 18 percent per year.

The interest is payable with the payment of the claim.

(11)(a) Each policy issued by a health maintenance organization must contain a provision for coordinating benefits under the policy with any similar benefits provided by any other health maintenance organization, group hospital, medical, or surgical expense policy; any group health care services plan; any auto medical policy; any governmental medical expense policy; or any group-type self-insurance plan that provides protection or insurance against hospital, medical, or surgical expenses for the same loss.

(b) A policy issued by a health maintenance organization may contain a provision whereby the health maintenance organization may reduce or refuse to pay benefits otherwise payable under the policy solely due to the existence of similar benefits provided under insurance policies issued by the same or another health maintenance organization, insurer, health care services plan, or self-insurance plan if the similar benefits provide protection or insurance against hospital, medical, or surgical expenses only if, as a condition of coordinating benefits with another insurer, 100 percent of the total covered benefits described in the policies and presented for payment are paid, regardless of any timeframes for payment or filing of claims established by any applicable contract.

Section 7. Subsection (4) is added to section 641.3156, Florida Statutes, to read:

641.3156 Treatment authorization; payment of claims.--

(4) Authorization for a covered service provided by a health maintenance organization's contracted physician for an eligible subscriber is binding upon the health maintenance

organization, and the health maintenance organization may not deny payment.

Section 8. Subsection (4) of section 641.495, Florida Statutes, is amended to read:

641.495 Requirements for issuance and maintenance of certificate.--

(4)(a) 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. ~~The health maintenance organization must provide treatment authorization 24 hours a day, 7 days a week. Requests for treatment authorization may not be held pending unless the requesting provider contractually agrees to take a pending or tracking number.~~

(b) The organization shall ensure that treatment authorizations are provided 24 hours a day, 7 days a week. A request for treatment authorization must be responded to within 2 hours. Failure to respond within 2 hours waives the right of the health maintenance organization to deny the claim for lack of authorization. A request for treatment authorization may not be held pending unless the requesting provider contractually agrees to take a pending or tracking number.

Section 9. Paragraph (a) of subsection (1) and paragraphs (a) and (c) of subsection (2) of section 408.7057, Florida Statutes, are amended to read:

408.7057 Statewide provider and managed care organization claim dispute resolution program.--

(1) As used in this section, the term:

(a) "Managed care organization" means a health maintenance organization or a prepaid health clinic certified under chapter 641, a prepaid health plan authorized under s. 409.912, ~~or~~ an exclusive provider organization certified under s. 627.6472, or a preferred provider organization.

(2)(a) The Agency for Health Care Administration shall establish a program by January 1, 2001, to provide assistance to contracted and noncontracted providers and managed care organizations for resolution of claim disputes that are not resolved by the provider and the managed care organization. The agency shall contract with ~~a~~ resolution organizations ~~organization~~ to timely review and consider claim disputes submitted by providers and managed care organizations and recommend to the agency an appropriate resolution of those disputes. The agency shall establish by rule jurisdictional amounts and methods of aggregation for claim disputes that may be considered by the resolution organizations ~~organization~~.

(c) Contracts entered into or renewed on or after October 1, 2000, may require exhaustion of an internal dispute-resolution process as a prerequisite to the submission of a claim by a provider or health maintenance organization to the resolution organization when the dispute-resolution program becomes effective. However, if the internal dispute-resolution process is not completed within 60 days after the filing of the claim dispute with the health maintenance organization, the provider may file a claim dispute with a resolution organization.

Section 10. This act shall take effect July 1, 2001.

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SENATE SUMMARY

Revises various provisions governing the payment of claims by health insurers and health maintenance organizations. Revises requirements for paying benefits under multiple health insurance policies. Defines the term "clean claim." Requires that a claim be paid within a specified period. Requires payment of interest on overdue payments. Defines the term "emergency medical condition." Prohibits certain limits on the provision of emergency services. Revises requirements for health maintenance organization with respect to treatment authorizations. See bill for details.