

Amendment No. (for drafter's use only)

	<u>Senate</u>	CHAMBER ACTION	<u>House</u>
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Representative(s) Wishner offered the following:

Amendment to Amendment (645115) (with title amendment)

Remove: everything after the enacting clause,

and insert:

Section 1. Paragraph (a) of subsection (1), paragraph (c) of subsection (2), and subsection (4) of section 408.7057, Florida Statutes, are amended, and paragraphs (e) and (f) are added to subsection (2) of that section, 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 major medical expense health insurance policy as defined in s. 627.643(2)(e) offered by a group or an individual health insurer licensed under chapter 624, including a preferred provider policy under s. 627.6471 and an

1 exclusive provider organization under s. 627.6472.

2 (2)

3 (c) Contracts entered into or renewed on or after
4 October 1, 2000, may require exhaustion of an internal
5 dispute-resolution process as a prerequisite to the submission
6 of a claim by a provider, or health maintenance organization,
7 or health insurer to the resolution organization ~~when the~~
8 ~~dispute-resolution program becomes effective.~~

9 (e) The resolution organization shall require the
10 managed care organization or provider submitting the claim
11 dispute to submit any supporting documentation to the
12 resolution organization within 15 days after receipt by the
13 managed care organization or provider of a request from the
14 resolution organization for documentation in support of the
15 claim dispute. Failure to submit the supporting documentation
16 within such time period shall result in the dismissal of the
17 submitted claim dispute.

18 (f) The resolution organization shall require the
19 respondent in the claim dispute to submit all documentation in
20 support of its position within 15 days after receiving a
21 request from the resolution organization for supporting
22 documentation. Failure to submit the supporting documentation
23 within such time period shall result in a default against the
24 managed care organization or provider. In the event of such a
25 default, the resolution organization shall issue its written
26 recommendation to the agency that a default be entered against
27 the defaulting entity. The written recommendation shall
28 include a recommendation to the agency that the defaulting
29 entity shall pay the entity submitting the claim dispute the
30 full amount of the claim dispute, plus all accrued interest.

31 (4) Within 30 days after receipt of the recommendation

1 of the resolution organization, the agency shall adopt the
2 recommendation as a final order. The agency may issue a final
3 order imposing fines or sanctions, including those contained
4 in s. 641.52. All fines collected under this subsection shall
5 be deposited into the Health Care Trust Fund.

6 Section 2. Subsection (1) of section 626.88, Florida
7 Statutes, is amended to read:

8 626.88 Definitions of "administrator" and "insurer".--

9 (1) For the purposes of this part, an "administrator"
10 is any person who directly or indirectly solicits or effects
11 coverage of, collects charges or premiums from, or adjusts or
12 settles claims on residents of this state in connection with
13 authorized commercial self-insurance funds or with insured or
14 self-insured programs which provide life or health insurance
15 coverage or coverage of any other expenses described in s.
16 624.33(1) or any person who provides billing and collection
17 services to health insurers and health maintenance
18 organizations on behalf of health care providers, other than
19 any of the following persons:

20 (a) An employer on behalf of such employer's employees
21 or the employees of one or more subsidiary or affiliated
22 corporations of such employer.

23 (b) A union on behalf of its members.

24 (c) An insurance company which is either authorized to
25 transact insurance in this state or is acting as an insurer
26 with respect to a policy lawfully issued and delivered by such
27 company in and pursuant to the laws of a state in which the
28 insurer was authorized to transact an insurance business.

29 (d) A health care services plan, health maintenance
30 organization, professional service plan corporation, or person
31 in the business of providing continuing care, possessing a

1 valid certificate of authority issued by the department, and
2 the sales representatives thereof, if the activities of such
3 entity are limited to the activities permitted under the
4 certificate of authority.

5 (e) An insurance agent licensed in this state whose
6 activities are limited exclusively to the sale of insurance.

7 (f) An adjuster licensed in this state whose
8 activities are limited to the adjustment of claims.

9 (g) A creditor on behalf of such creditor's debtors
10 with respect to insurance covering a debt between the creditor
11 and its debtors.

12 (h) A trust and its trustees, agents, and employees
13 acting pursuant to such trust established in conformity with
14 29 U.S.C. s. 186.

15 (i) A trust exempt from taxation under s. 501(a) of
16 the Internal Revenue Code, a trust satisfying the requirements
17 of ss. 624.438 and 624.439, or any governmental trust as
18 defined in s. 624.33(3), and the trustees and employees acting
19 pursuant to such trust, or a custodian and its agents and
20 employees, including individuals representing the trustees in
21 overseeing the activities of a service company or
22 administrator, acting pursuant to a custodial account which
23 meets the requirements of s. 401(f) of the Internal Revenue
24 Code.

25 (j) A financial institution which is subject to
26 supervision or examination by federal or state authorities or
27 a mortgage lender licensed under chapter 494 who collects and
28 remits premiums to licensed insurance agents or authorized
29 insurers concurrently or in connection with mortgage loan
30 payments.

31 (k) A credit card issuing company which advances for

1 and collects premiums or charges from its credit card holders
2 who have authorized such collection if such company does not
3 adjust or settle claims.

4 (l) A person who adjusts or settles claims in the
5 normal course of such person's practice or employment as an
6 attorney at law and who does not collect charges or premiums
7 in connection with life or health insurance coverage.

8 (m) A person approved by the Division of Workers'
9 Compensation of the Department of Labor and Employment
10 Security who administers only self-insured workers'
11 compensation plans.

12 (n) A service company or service agent and its
13 employees, authorized in accordance with ss. 626.895-626.899,
14 serving only a single employer plan, multiple-employer welfare
15 arrangements, or a combination thereof.

16
17 A person who provides billing and collection services to
18 health insurers and health maintenance organizations on behalf
19 of health care providers shall comply with the provisions of
20 ss. 627.6131, 641.3155, and 641.51(4).

21 Section 3. Section 627.613, Florida Statutes, is
22 amended to read:

23 627.613 Time of payment of claims.--

24 (1) The contract shall include the following
25 provision:

26
27 "Time of Payment of Claims: After receiving written
28 proof of loss, the insurer will pay monthly all benefits then
29 due for (type of benefit). Benefits for any other loss covered
30 by this policy will be paid as soon as the insurer receives
31 proper written proof."

1
2 (2) As used in this section, the term "claim" for a
3 noninstitutional provider means a paper or electronic billing
4 instrument submitted to the insurer's designated location
5 which consists of the HCFA 1500 data set, or its successor,
6 which has all mandatory entries for a physician licensed under
7 chapter 458, chapter 459, chapter 460, or chapter 461 or other
8 appropriate billing instrument that has all mandatory entries
9 for any other noninstitutional provider. For institutional
10 providers, "claim" means a paper or electronic billing
11 instrument submitted to the insurer's designated location
12 which consists of the UB-92 data set with entries stated as
13 mandatory by the National Uniform Billing Committee.~~Health~~
14 ~~insurers shall reimburse all claims or any portion of any~~
15 ~~claim from an insured or an insured's assignees, for payment~~
16 ~~under a health insurance policy, within 45 days after receipt~~
17 ~~of the claim by the health insurer. If a claim or a portion~~
18 ~~of a claim is contested by the health insurer, the insured or~~
19 ~~the insured's assignees shall be notified, in writing, that~~
20 ~~the claim is contested or denied, within 45 days after receipt~~
21 ~~of the claim by the health insurer. The notice that a claim~~
22 ~~is contested shall identify the contested portion of the claim~~
23 ~~and the reasons for contesting the claim.~~

24 (3) All claims for payment, whether electronic or
25 nonelectronic:

26 (a) Are considered received on the date the claim is
27 received by the insurer at its designated claims receipt
28 location.

29 (b) Must not duplicate a claim previously submitted
30 unless it is determined that the original claim was not
31 received or is otherwise lost.~~A health insurer, upon receipt~~

1 ~~of the additional information requested from the insured or~~
2 ~~the insured's assignees shall pay or deny the contested claim~~
3 ~~or portion of the contested claim, within 60 days.~~

4 (c) For noninstitutional providers, all claims must be
5 mailed or electronically transferred to an insurer within 90
6 days after completion of the service and after the provider
7 has been furnished with the correct name and address of the
8 patient's insurer. For institutional providers, unless
9 otherwise agreed to through contract, all claims must be
10 mailed or electronically transferred to an insurer within 90
11 days after completion of the service and after the provider
12 has been furnished with the correct name and address of the
13 patient's health insurer.

14 (4)(a) For an electronically submitted claim, a health
15 insurer shall, within 24 hours after the beginning of the next
16 business day after receipt of the claim, provide electronic
17 acknowledgement of the receipt of the claim to the electronic
18 source submitting the claim.

19 (b) For an electronically submitted claim, a health
20 insurer shall, within 20 days after receipt of the claim, pay
21 the claim or notify a provider or designee if a claim is
22 denied or contested. Notice of the insurer's action on the
23 claim and payment of the claim is considered to be made on the
24 date the notice or payment is mailed or electronically
25 transferred.

26 (c)1. Notification of the health insurer's
27 determination of a contested claim must be accompanied by an
28 itemized list of additional information or documents the
29 insurer can reasonably determine are necessary to process the
30 claim.

31 2. A provider must submit the additional information

1 or documentation, as specified on the itemized list, within 35
2 days after receipt of the notification. Failure of a provider
3 to submit by mail or electronically the additional information
4 or documentation requested within 35 days after receipt of the
5 notification may result in denial of the claim.

6 3. A health insurer may not make more than one request
7 for documents under this paragraph in connection with a claim
8 unless the provider fails to submit all of the requested
9 documents to process the claim or the documents submitted by
10 the provider raise new, additional issues not included in the
11 original written itemization, in which case the health insurer
12 may provide the provider with one additional opportunity to
13 submit the additional documents needed to process the claim.
14 In no case may the health insurer request duplicate documents.

15 (d) For purposes of this subsection, electronic means
16 of transmission of claims, notices, documents, forms, and
17 payment shall be used to the greatest extent possible by the
18 health insurer and the provider.

19 (e) A claim must be paid or denied within 90 days
20 after receipt of the claim. Failure to pay or deny a claim
21 within 120 days after receipt of the claim creates an
22 uncontestable obligation to pay the claim.~~An insurer shall~~
23 ~~pay or deny any claim no later than 120 days after receiving~~
24 ~~the claim.~~

25 (5)(a) For all nonelectronically submitted claims, a
26 health insurer shall, effective November 1, 2003, provide to
27 the provider acknowledgement of receipt of the claim within 15
28 days after receipt of the claim or provide the provider,
29 within 15 days after receipt, with electronic access to the
30 status of a submitted claim.

31 (b) For all nonelectronically submitted claims, a

1 health insurer shall, within 40 days after receipt of the
2 claim, pay the claim or notify a provider or designee if a
3 claim is denied or contested. Notice of the insurer's action
4 on the claim and payment of the claim are considered to be
5 made on the date the notice or payment was mailed or
6 electronically transferred.

7 (c)1. Notification of the health insurer's
8 determination of a contested claim must be accompanied by an
9 itemized list of additional information or documents the
10 insurer can reasonably determine are necessary to process the
11 claim.

12 2. A provider must submit the additional information
13 or documentation, as specified on the itemized list, within 35
14 days after receipt of the notification. Failure of a provider
15 to submit by mail or electronically the additional information
16 or documentation requested within 35 days after receipt of the
17 notification may result in denial of the claim.

18 3. A health insurer may not make more than one request
19 for documents under this paragraph in connection with a claim
20 unless the provider fails to submit all of the requested
21 documents to process the claim or the documents submitted by
22 the provider raise new, additional issues not included in the
23 original written itemization, in which case the health insurer
24 may provide the provider with one additional opportunity to
25 submit the additional documents needed to process the claim.
26 In no case may the health insurer request duplicate documents.

27 (d) For purposes of this subsection, electronic means
28 of transmission of claims, notices, documents, forms, and
29 payment shall be used to the greatest extent possible by the
30 health insurer and the provider.

31 (e) A claim must be paid or denied within 120 days

1 after receipt of the claim. Failure to pay or deny a claim
2 within 140 days after receipt of the claim creates an
3 uncontestable obligation to pay the claim.~~Payment shall be~~
4 ~~treated as being made on the date a draft or other valid~~
5 ~~instrument which is equivalent to payment was placed in the~~
6 ~~United States mail in a properly addressed, postpaid envelope~~
7 ~~or, if not so posted, on the date of delivery.~~

8 (6) Payment of a claim is considered made on the date
9 the payment is mailed or electronically transferred. An
10 overdue payment of a claim bears simple interest of 12 percent
11 per year. Interest on an overdue payment for a claim or for
12 any portion of a claim begins to accrue when the claim should
13 have been paid, denied, or contested. The interest is payable
14 with the payment of the claim.~~All overdue payments shall bear~~
15 ~~simple interest at the rate of 10 percent per year.~~

16 (7) Upon written notification by an insured, an
17 insurer shall investigate any claim of improper billing by a
18 physician, hospital, or other health care provider. The
19 insurer shall determine if the insured was properly billed for
20 only those procedures and services that the insured actually
21 received. If the insurer determines that the insured has been
22 improperly billed, the insurer shall notify the insured and
23 the provider of its findings and shall reduce the amount of
24 payment to the provider by the amount determined to be
25 improperly billed. If a reduction is made due to such
26 notification by the insured, the insurer shall pay to the
27 insured 20 percent of the amount of the reduction up to \$500.

28 (8) A provider claim for payment shall be considered
29 received by the health insurer, if the claim has been
30 electronically transmitted to the health insurer, when receipt
31 is verified electronically or, if the claim is mailed to the

1 address disclosed by the health insurer, on the date indicated
2 on the return receipt. A provider must wait 35 days following
3 receipt of a claim before submitting a duplicate claim.

4 (9)(a) If, as a result of retroactive review of
5 coverage decisions or payment levels, a health insurer
6 determines that it has made an overpayment to a provider for
7 services rendered to an insured, the health insurer must make
8 a claim for such overpayment to the provider's designated
9 location. The health insurer may not reduce payment to that
10 provider for other services unless the provider agrees to the
11 reduction or fails to respond to the health insurer's claim as
12 required in this subsection.

13 (b) A provider shall pay a claim for an overpayment
14 made by a health insurer that the provider does not contest or
15 deny within 35 days after receipt of the claim that is mailed
16 or electronically transferred to the provider.

17 (c) A provider that denies or contests a health
18 insurer's claim for overpayment or any portion of a claim
19 shall notify the health insurer, in writing, within 35 days
20 after the provider receives the claim that the claim for
21 overpayment is contested or denied. The notice that the claim
22 for overpayment is contested or denied must identify the
23 contested portion of the claim and the specific reason for
24 contesting or denying the claim, and, if contested, must
25 include a request for additional information. The provider
26 shall pay or deny the claim for overpayment within 35 days
27 after receipt of the information.

28 (d) Payment of a claim for overpayment is considered
29 made on the date payment was electronically transferred or
30 otherwise delivered to the health insurer or on the date that
31 the provider receives a payment from the health insurer that

1 reduces or deducts the overpayment. An overdue payment of a
2 claim bears simple interest at the rate of 12 percent per
3 year. Interest on an overdue payment of a claim for
4 overpayment or for any uncontested portion of a claim for
5 overpayment begins to accrue on the 36th day after the claim
6 for overpayment has been received.

7 (e) A provider shall pay or deny any claim for
8 overpayment no later than 120 days after receiving the claim.
9 Failure to do so creates an uncontestable obligation for the
10 provider to pay the claim to the health insurer.

11 (f) A health insurer's claim for overpayment shall be
12 considered received by a provider, if the claim has been
13 electronically transmitted to the provider, when receipt is
14 verified electronically, or, if the claim is mailed to the
15 address disclosed by the provider, on the date indicated on
16 the return receipt. A health insurer must wait 35 days
17 following the provider's receipt of a claim for overpayment
18 before submitting a duplicate claim.

19 (10) Any retroactive reductions of payments or demands
20 for refund of previous overpayments that are due to
21 retroactive review of coverage decisions or payment levels
22 must be reconciled to specific claims. Any retroactive demands
23 by providers for payment due to underpayments or nonpayments
24 for covered services must be reconciled to specific claims.
25 The look-back or audit-review period shall not exceed 2 years
26 after the date the claim was paid by the health insurer,
27 unless fraud in billing is involved.

28 (11) A health insurer may not deny a claim because of
29 the insured's ineligibility if the provider can document
30 receipt of the insured's eligibility confirmation by the
31 health insurer prior to the date or time covered services were

1 provided. Any person who knowingly and willfully misinforms a
2 provider prior to receipt of services as to his or her
3 coverage eligibility commits insurance fraud, punishable as
4 provided in s. 817.50.

5 (12)(a) Without regard to any other remedy or relief
6 to which a person is entitled, or obligated to under contract,
7 anyone aggrieved by a violation of this section may bring an
8 action to obtain a declaratory judgment that an act or
9 practice violates this section and to enjoin a person who has
10 violated, is violating, or is otherwise likely to violate this
11 section.

12 (b) In any action brought by a person who has suffered
13 a loss as a result of a violation of this section, such person
14 may recover any amounts due the person under this section,
15 including accrued interest, plus attorney's fees and court
16 costs as provided in paragraph (c).

17 (c) In any civil litigation resulting from an act or
18 practice involving a violation of this section by a health
19 insurer in which the health insurer is found to have violated
20 this section, the provider, after judgment in the trial court
21 and after exhausting all appeals, if any, shall receive his or
22 her attorney's fees and costs from the insurer; however, such
23 fees shall not exceed three times the amount in controversy or
24 \$5,000, whichever is greater. In any such civil litigation, if
25 the insurer is found not to have violated this section, the
26 insurer, after judgment in the trial court and exhaustion of
27 all appeals, if any, may receive its reasonable attorney's
28 fees and costs from the provider on any claim or defense that
29 the court finds the provider knew or should have known was not
30 supported by the material facts necessary to establish the
31 claim or defense or would not be supported by the application

1 of then-existing law as to those material facts.

2 (d) The attorney for the prevailing party shall submit
3 a sworn affidavit of his or her time spent on the case and his
4 or her costs incurred for all the motions, hearings, and
5 appeals to the trial judge who presided over the civil case.

6 (e) Any award of attorney's fees or costs shall become
7 a part of the judgment and subject to execution as the law
8 allows.

9 (13) A permissive error ratio of 5 percent is
10 established for insurers claims payment violations of s.
11 627.613(4)(a), (b), (c), and (e) and (5)(a), (b), (c), and
12 (e). If the error ratio of a particular insurer does not
13 exceed the permissible error ratio of 5 percent for an audit
14 period, a fine may not be assessed for the noted claims
15 violations for the audit period. The error ratio shall be
16 determined by dividing the number of claims with violations
17 found on a statistically valid sample of claims for the audit
18 period, divided by the total number of claims in the sample.
19 If the error ratio exceeds the permissible error ratio of 5
20 percent, a fine may be assessed according to s. 624.4211 for
21 the claims payment violations that exceed the error ratio.
22 Notwithstanding the provisions of this section, the department
23 may fine a health insurer for claims payment violations of s.
24 627.613(4)(e) and (5)(e) which create an uncontestable
25 obligation to pay the claim. The department may not fine
26 insurers for violations that the department determines were
27 due to circumstances beyond the insurer's control.

28 (14) The provisions of this section may not be waived,
29 voided, or nullified by contracts.

30 (15) The amendments to this section by this act apply
31 only to a major medical expense health insurance policy as

1 defined in s. 627.643(2)(e) which is offered by a group or an
2 individual health insurer licensed under chapter 624,
3 including a preferred provider policy under s. 627.6417, an
4 exclusive provider organization under 627.6472, or a group or
5 individual insurance contract that provides payment for
6 enumerated dental services.

7 Section 4. Section 627.6142, Florida Statutes, is
8 created to read:

9 627.6142 Treatment authorization; payment of claims.--

10 (1) For purposes of this section, "authorization"
11 includes any requirement of a provider to notify an insurer in
12 advance of providing a covered service, regardless of whether
13 the actual terminology used by the insurer includes, but is
14 not limited to, preauthorization, precertification,
15 notification, or any other similar terminology.

16 (2) A health insurer that requires authorization for
17 medical care or health care services shall provide to each
18 provider with whom the health insurer has contracted pursuant
19 to s. 627.6471 or s. 627.6472 a list of the medical care and
20 health care services that require authorization and the
21 authorization procedures used by the health insurer at the
22 time a contract becomes effective. A health insurer that
23 requires authorization for medical care or health care
24 services shall provide to all other providers, not later than
25 10 working days after a request is made, a list of the medical
26 care and health care services that require authorization and
27 the authorization procedures established by the insurer. The
28 medical care or health care services that require
29 authorization and the authorization procedures used by the
30 insurer shall not be modified unless written notice is
31 provided at least 30 days in advance of any changes to all

1 affected insureds as well as to all contracted providers and
2 all other providers that had previously requested in writing a
3 list of medical care or health care services that require
4 authorization. An insurer that makes such list and procedures
5 accessible to providers and insureds electronically is in
6 compliance with this section so long as notice is provided at
7 least 30 days in advance of any changes in such list or
8 procedures to all insureds, contracted providers, and
9 noncontracted providers who had previously requested a list of
10 medical care or health care services that require
11 authorization.

12 (3)(a) Any claim for treatment may not be denied if a
13 provider follows the health insurer's published authorization
14 procedures and receives authorization, unless the provider
15 submits information to the health insurer with the willful
16 intention to misinform the health insurer.

17 (b) Upon receipt of a request from a provider for
18 authorization, the health insurer shall issue a written
19 determination indicating whether the service or services are
20 authorized. If the request for an authorization is for an
21 inpatient admission, the determination shall be transmitted to
22 the provider making the request in writing no later than 24
23 hours after the request is made by the provider. If the health
24 insurer denies the request for authorization, the health
25 insurer shall notify the insured at the same time the insurer
26 notifies the provider requesting the authorization. A health
27 insurer that fails to respond to a request for an
28 authorization pursuant to this paragraph within 24 hours is
29 considered to have authorized the inpatient admission and
30 payment shall not be denied.

31 (4) If the proposed medical care or health care

1 service or services involve an inpatient admission and the
2 health insurer requires an authorization as a condition of
3 payment, the health insurer shall review and issue a written
4 or electronic authorization for the total estimated length of
5 stay for the admission, based on the recommendation of the
6 patient's physician. If the proposed medical care or health
7 care service or services are to be provided to an insured who
8 is an inpatient in a health care facility and authorization is
9 required, the health insurer shall issue a written
10 determination indicating whether the proposed services are
11 authorized or denied no later than 4 hours after the request
12 is made by the provider. A health insurer who fails to respond
13 to such request within 4 hours is considered to have
14 authorized the requested medical care or health care service
15 and payment shall not be denied.

16 (5) Authorization may not be required for emergency
17 services and care or emergency medical services as provided
18 pursuant to ss. 395.002, 395.1041, 401.45, and 401.252.

19 (6) The provisions of this section may not be waived,
20 voided, or nullified by contract.

21 Section 5. Subsection (3) is added to section 627.638,
22 Florida Statutes, to read:

23 627.638 Direct payment for hospital, medical
24 services.--

25 (3) Under any health insurance policy insuring against
26 loss or expense due to hospital confinement or to medical and
27 related services, payment of benefits shall be made directly
28 to any recognized hospital, doctor, or other person who
29 provided services for the treatment of a psychological
30 disorder or treatment for substance abuse, including drug and
31 alcohol abuse, when the treatment is in accordance with the

1 provisions of the policy and the insured specifically
2 authorizes direct payment of benefits. Payments shall be made
3 under this section, notwithstanding any contrary provisions in
4 the health insurance contract. This subsection applies to all
5 health insurance policies now or hereafter in force as of the
6 effective date of this act.

7 Section 6. Subsection (4) of section 627.651, Florida
8 Statutes, is amended to read:

9 627.651 Group contracts and plans of self-insurance
10 must meet group requirements.--

11 (4) This section does not apply to any plan which is
12 established or maintained by an individual employer in
13 accordance with the Employee Retirement Income Security Act of
14 1974, Pub. L. No. 93-406, or to a multiple-employer welfare
15 arrangement as defined in s. 624.437(1), except that a
16 multiple-employer welfare arrangement shall comply with ss.
17 627.419, 627.657, 627.6575, 627.6578, 627.6579, 627.6612,
18 627.66121, 627.66122, 627.6615, 627.6616, and 627.662~~(8)(6)~~.
19 This subsection does not allow an authorized insurer to issue
20 a group health insurance policy or certificate which does not
21 comply with this part.

22 Section 7. Section 627.662, Florida Statutes, is
23 amended to read:

24 627.662 Other provisions applicable.--The following
25 provisions apply to group health insurance, blanket health
26 insurance, and franchise health insurance:

27 (1) Section 627.569, relating to use of dividends,
28 refunds, rate reductions, commissions, and service fees.

29 (2) Section 627.602(1)(f) and (2), relating to
30 identification numbers and statement of deductible provisions.

31 (3) Section 627.635, relating to excess insurance.

1 (4) Section 627.638, relating to direct payment for
2 hospital or medical services.

3 (5) Section 627.640, relating to filing and
4 classification of rates.

5 (6) Section 627.6142, relating to treatment
6 authorizations.

7 ~~(7)(6)~~ Section 627.645(1), relating to denial of
8 claims.

9 ~~(8)(7)~~ Section 627.613, relating to time of payment of
10 claims.

11 ~~(9)(8)~~ Section 627.6471, relating to preferred
12 provider organizations.

13 ~~(10)(9)~~ Section 627.6472, relating to exclusive
14 provider organizations.

15 ~~(11)(10)~~ Section 627.6473, relating to combined
16 preferred provider and exclusive provider policies.

17 ~~(12)(11)~~ Section 627.6474, relating to provider
18 contracts.

19 Section 8. Paragraph (e) of subsection (1) of section
20 641.185, Florida Statutes, is amended to read:

21 641.185 Health maintenance organization subscriber
22 protections.--

23 (1) With respect to the provisions of this part and
24 part III, the principles expressed in the following statements
25 shall serve as standards to be followed by the Department of
26 Insurance and the Agency for Health Care Administration in
27 exercising their powers and duties, in exercising
28 administrative discretion, in administrative interpretations
29 of the law, in enforcing its provisions, and in adopting
30 rules:

31 (e) A health maintenance organization subscriber

1 should receive timely, concise information regarding the
2 health maintenance organization's reimbursement to providers
3 and services pursuant to ss. 641.31 and 641.31015 and is
4 entitled to prompt payment from the organization when
5 appropriate pursuant to s. 641.3155.

6 Section 9. Subsection (4) is added to section 641.234,
7 Florida Statutes, to read:

8 641.234 Administrative, provider, and management
9 contracts.--

10 (4)(a) If a health maintenance organization, through a
11 health care risk contract, transfers to any entity the
12 obligations to pay any provider for any claims arising from
13 services provided to or for the benefit of any subscriber of
14 the organization, the health maintenance organization shall
15 remain responsible for any violations of ss. 641,3155,
16 641.3156, and 641.51(4). The provisions of ss.
17 624.418-624.4211 and 641.52 shall apply to any such
18 violations.

19 (b) As used in this subsection:

20 1. The term "health care risk contract" means a
21 contract under which an entity receives compensation in
22 exchange for providing to the health maintenance organization
23 a provider network or other services, which may include
24 administrative services.

25 2. The term "entity" means a person licensed as an
26 administrator under s. 626.88 and does not include any
27 provider or group practice, as defined in s. 456.053,
28 providing services under the scope of the license of the
29 provider or the members of the group practice.

30 Section 10. Subsection (1) of section 641.30, Florida
31 Statutes, is amended to read:

1 641.30 Construction and relationship to other laws.--
2 (1) Every health maintenance organization shall accept
3 the ~~standard health~~ claim form prescribed pursuant to s.
4 641.3155 ~~627.647~~.

5 Section 11. Section 641.3155, Florida Statutes, is
6 amended to read:

7 641.3155 Payment of claims.--

8 (1)~~(a)~~ As used in this section, the term "~~clean~~ claim"
9 for a noninstitutional provider means a paper or electronic
10 billing instrument submitted to the health maintenance
11 organization's designated location which consists of the HCFA
12 1500 data set, or its successor, having all mandatory entries
13 completed for a physician licensed under chapter 458, chapter
14 459, chapter 460, or chapter 461 or other appropriate billing
15 instrument that has all mandatory entries for any other
16 noninstitutional provider. For institutional providers,
17 "claim" means a paper or electronic billing instrument
18 submitted to the insurer's designated location which consists
19 of the UB-92 data set with entries stated as mandatory by the
20 National Uniform Billing Committee.~~claim submitted on a HFCA~~
21 ~~1500 form which has no defect or impropriety, including lack~~
22 ~~of required substantiating documentation for noncontracted~~
23 ~~providers and suppliers, or particular circumstances requiring~~
24 ~~special treatment which prevent timely payment from being made~~
25 ~~on the claim. A claim may not be considered not clean solely~~
26 ~~because a health maintenance organization refers the claim to~~
27 ~~a medical specialist within the health maintenance~~
28 ~~organization for examination. If additional substantiating~~
29 ~~documentation, such as the medical record or encounter data,~~
30 ~~is required from a source outside the health maintenance~~
31 ~~organization, the claim is considered not clean. This~~

1 ~~definition of "clean claim" is repealed on the effective date~~
2 ~~of rules adopted by the department which define the term~~
3 ~~"clean claim."~~

4 ~~(b) Absent a written definition that is agreed upon~~
5 ~~through contract, the term "clean claim" for an institutional~~
6 ~~claim is a properly and accurately completed paper or~~
7 ~~electronic billing instrument that consists of the UB-92 data~~
8 ~~set or its successor with entries stated as mandatory by the~~
9 ~~National Uniform Billing Committee.~~

10 ~~(c) The department shall adopt rules to establish~~
11 ~~claim forms consistent with federal claim-filing standards for~~
12 ~~health maintenance organizations required by the federal~~
13 ~~Health Care Financing Administration. The department may adopt~~
14 ~~rules relating to coding standards consistent with Medicare~~
15 ~~coding standards adopted by the federal Health Care Financing~~
16 ~~Administration.~~

17 ~~(2) All claims for payment, whether electronic or~~
18 ~~nonelectronic:~~

19 ~~(a) Are considered received on the date the claim is~~
20 ~~received by the organization at its designated claims receipt~~
21 ~~location.~~

22 ~~(b) Must not duplicate a claim previously submitted~~
23 ~~unless it is determined that the original claim was not~~
24 ~~received or is otherwise lost.~~

25 ~~(a) A health maintenance organization shall pay any~~
26 ~~clean claim or any portion of a clean claim made by a contract~~
27 ~~provider for services or goods provided under a contract with~~
28 ~~the health maintenance organization or a clean claim made by a~~
29 ~~noncontract provider which the organization does not contest~~
30 ~~or deny within 35 days after receipt of the claim by the~~
31 ~~health maintenance organization which is mailed or~~

1 ~~electronically transferred by the provider.~~
2 ~~(b) A health maintenance organization that denies or~~
3 ~~contests a provider's claim or any portion of a claim shall~~
4 ~~notify the provider, in writing, within 35 days after the~~
5 ~~health maintenance organization receives the claim that the~~
6 ~~claim is contested or denied. The notice that the claim is~~
7 ~~denied or contested must identify the contested portion of the~~
8 ~~claim and the specific reason for contesting or denying the~~
9 ~~claim, and, if contested, must include a request for~~
10 ~~additional information. If the provider submits additional~~
11 ~~information, the provider must, within 35 days after receipt~~
12 ~~of the request, mail or electronically transfer the~~
13 ~~information to the health maintenance organization. The health~~
14 ~~maintenance organization shall pay or deny the claim or~~
15 ~~portion of the claim within 45 days after receipt of the~~
16 ~~information.~~
17 (c) For noninstitutional providers, all claims must be
18 mailed or electronically transferred to a health maintenance
19 organization within 90 days after completion of the service
20 and after the provider is furnished with the correct name and
21 address of the patient's health maintenance organization. For
22 institutional providers, unless otherwise agreed to through
23 contract, all claims must be mailed or electronically
24 transferred to a health maintenance organization within 90
25 days after completion of the service and after the provider is
26 furnished with the correct name and address of the patient's
27 health maintenance organization. Submission of a provider's
28 claim is considered made on the date it is electronically
29 transferred or mailed.
30 (3)(a) For an electronically submitted claim, a health
31 maintenance organization shall, within 24 hours after the

1 beginning of the next business day after receipt of the claim,
2 provide electronic acknowledgement of the receipt of the claim
3 to the electronic source submitting the claim.

4 (b) For an electronically submitted claim, a health
5 maintenance organization shall, within 20 days after receipt
6 of the claim, pay the claim or notify a provider if a claim is
7 denied or contested. Notice of the organization's action on
8 the claim and payment of the claim are considered to be made
9 on the date the notice or payment is mailed or electronically
10 transferred.

11 (c)1. Notification of the health maintenance
12 organization's determination of a contested claim must be
13 accompanied by an itemized list of additional information or
14 documents the organization can reasonably determine are
15 necessary to process the claim.

16 2. A provider must submit the additional information
17 or documentation, as specified on the itemized list, within 35
18 days after receipt of the notification. Failure of a provider
19 to submit by mail or electronically the additional information
20 or documentation requested within 35 days after receipt of the
21 notification may result in denial of the claim.

22 3. A health maintenance organization may not make more
23 than one request for documents under this paragraph in
24 connection with a claim unless the provider fails to submit
25 all of the requested documents to process the claim or the
26 documents submitted by the provider raise new, additional
27 issues not included in the original written itemization, in
28 which case the organization may provide the provider with one
29 additional opportunity to submit the additional documents
30 needed to process the claim. In no case may the organization
31 request duplicate documents.

1 (d) For purposes of this subsection, electronic means
2 of transmission of claims, notices, documents, forms, and
3 payment shall be used to the greatest extent possible by the
4 health maintenance organization and the provider.

5 (e) A claim must be paid or denied within 90 days
6 after receipt of the claim. Failure to pay or deny a claim
7 within 120 days after receipt of the claim creates an
8 uncontestable obligation to pay the claim.~~Payment of a claim~~
9 ~~is considered made on the date the payment was received or~~
10 ~~electronically transferred or otherwise delivered. An overdue~~
11 ~~payment of a claim bears simple interest at the rate of 10~~
12 ~~percent per year. Interest on an overdue payment for a clean~~
13 ~~claim or for any uncontested portion of a clean claim begins~~
14 ~~to accrue on the 36th day after the claim has been received.~~
15 ~~The interest is payable with the payment of the claim.~~

16 (4)(a) For all nonelectronically submitted claims, a
17 health maintenance organization shall, effective November 1,
18 2003, provide to the provider acknowledgement of receipt of
19 the claim within 15 days after receipt of the claim or provide
20 the provider, within 15 days after receipt, with electronic
21 access to the status of a submitted claim.

22 (b) For all nonelectronically submitted claims, a
23 health maintenance organization shall, within 40 days after
24 receipt of the claim, pay the claim or notify a provider if a
25 claim is denied or contested. Notice of the organization's
26 action on the claim and payment of the claim are considered to
27 be made on the date the notice or payment is mailed or
28 electronically transferred.

29 (c)1. Notification of the health maintenance
30 organization's determination of a contested claim must be
31 accompanied by an itemized list of additional information or

1 documents the organization can reasonably determine are
2 necessary to process the claim.

3 2. A provider must submit the additional information
4 or documentation, as specified on the itemized list, within 35
5 days after receipt of the notification. Failure of a provider
6 to submit by mail or electronically the additional information
7 or documentation requested within 35 days after receipt of the
8 notification may result in denial of the claim.

9 3. A health maintenance organization may not make more
10 than one request for documents under this paragraph in
11 connection with a claim unless the provider fails to submit
12 all of the requested documents to process the claim or the
13 documents submitted by the provider raise new, additional
14 issues not included in the original written itemization, in
15 which case the organization may provide the provider with one
16 additional opportunity to submit the additional documents
17 needed to process the claim. In no case may the health
18 maintenance organization request duplicate documents.

19 (d) For purposes of this subsection, electronic means
20 of transmission of claims, notices, documents, forms, and
21 payment shall be used to the greatest extent possible by the
22 health maintenance organization and the provider.

23 (e) A claim must be paid or denied within 120 days
24 after receipt of the claim. Failure to pay or deny a claim
25 within 140 days after receipt of the claim creates an
26 uncontestable obligation to pay the claim.~~A health~~
27 ~~maintenance organization shall pay or deny any claim no later~~
28 ~~than 120 days after receiving the claim. Failure to do so~~
29 ~~creates an uncontestable obligation for the health maintenance~~
30 ~~organization to pay the claim to the provider.~~

31 (5) Payment of a claim is considered made on the date

1 the payment is mailed or electronically transferred. An
2 overdue payment of a claim bears simple interest of 12 percent
3 per year. Interest on an overdue payment for a claim or for
4 any portion of a claim begins to accrue when the claim should
5 have been paid, denied, or contested. The interest is payable
6 with the payment of the claim.

7 (6)(a)(5)(a) If, as a result of retroactive review of
8 coverage decisions or payment levels, a health maintenance
9 organization determines that it has made an overpayment to a
10 provider for services rendered to a subscriber, the
11 organization must make a claim for such overpayment to the
12 provider's designated location. The organization may not
13 reduce payment to that provider for other services unless the
14 provider agrees to the reduction in writing after receipt of
15 the claim for overpayment from the health maintenance
16 organization or fails to respond to the organization's claim
17 as required in this subsection.

18 (b) A provider shall pay a claim for an overpayment
19 made by a health maintenance organization which the provider
20 does not contest or deny within 35 days after receipt of the
21 claim that is mailed or electronically transferred to the
22 provider.

23 (c) A provider that denies or contests an
24 organization's claim for overpayment or any portion of a claim
25 shall notify the organization, in writing, within 35 days
26 after the provider receives the claim that the claim for
27 overpayment is contested or denied. The notice that the claim
28 for overpayment is denied or contested must identify the
29 contested portion of the claim and the specific reason for
30 contesting or denying the claim, and, if contested, must
31 include a request for additional information. If the

1 organization submits additional information, the organization
2 must, within 35 days after receipt of the request, mail or
3 electronically transfer the information to the provider. The
4 provider shall pay or deny the claim for overpayment within 45
5 days after receipt of the information.

6 (d) Payment of a claim for overpayment is considered
7 made on the date payment was received or electronically
8 transferred or otherwise delivered to the organization, or the
9 date that the provider receives a payment from the
10 organization that reduces or deducts the overpayment. An
11 overdue payment of a claim bears simple interest at the rate
12 of 12 ~~10~~ percent a year. Interest on an overdue payment of a
13 claim for overpayment or for any uncontested portion of a
14 claim for overpayment begins to accrue on the 36th day after
15 the claim for overpayment has been received.

16 (e) A provider shall pay or deny any claim for
17 overpayment no later than 120 days after receiving the claim.
18 Failure to do so creates an uncontestable obligation for the
19 provider to pay the claim to the organization.

20 ~~(7)(6)~~ Any retroactive reductions of payments or
21 demands for refund of previous overpayments which are due to
22 retroactive review-of-coverage decisions or payment levels
23 must be reconciled to specific claims unless the parties agree
24 to other reconciliation methods and terms. Any retroactive
25 demands by providers for payment due to underpayments or
26 nonpayments for covered services must be reconciled to
27 specific claims unless the parties agree to other
28 reconciliation methods and terms. The look-back or
29 audit-review period shall not exceed 2 years after the date
30 the claim was paid by the health maintenance organization,
31 unless fraud in billing is involved. ~~The look-back period may~~

1 ~~be specified by the terms of the contract.~~

2 (8)(a)(7)(a) A provider claim for payment shall be
3 considered received by the health maintenance organization, if
4 the claim has been electronically transmitted to the health
5 maintenance organization, when receipt is verified
6 electronically or, if the claim is mailed to the address
7 disclosed by the organization, on the date indicated on the
8 return receipt, or on the date the delivery receipt is signed
9 by the health maintenance organization if the claim is hand
10 delivered. A provider must wait 45 days following receipt of a
11 claim before submitting a duplicate claim.

12 (b) A health maintenance organization claim for
13 overpayment shall be considered received by a provider, if the
14 claim has been electronically transmitted to the provider,
15 when receipt is verified electronically or, if the claim is
16 mailed to the address disclosed by the provider, on the date
17 indicated on the return receipt. An organization must wait 45
18 days following the provider's receipt of a claim for
19 overpayment before submitting a duplicate claim.

20 (c) This section does not preclude the health
21 maintenance organization and provider from agreeing to other
22 methods of submission ~~transmission~~ and receipt of claims.

23 (9)(8) A provider, or the provider's designee, who
24 bills electronically is entitled to electronic acknowledgment
25 of the receipt of a claim within 72 hours.

26 (10)(9) A health maintenance organization may not
27 ~~retroactively~~ deny a claim because of subscriber ineligibility
28 if the provider can document receipt of subscriber eligibility
29 confirmation by the organization prior to the date or time
30 covered services were provided. Every health maintenance
31 organization contract with an employer shall include a

1 provision that requires the employer to notify the health
2 maintenance organization of changes in eligibility status
3 within 30 days more than 1 year after the date of payment of
4 the clean claim. Any person who knowingly misinforms a
5 provider prior to the receipt of services as to his or her
6 coverage eligibility commits insurance fraud punishable as
7 provided in s. 817.50.

8 (11)(10) A health maintenance organization shall pay a
9 contracted primary care or admitting physician, pursuant to
10 such physician's contract, for providing inpatient services in
11 a contracted hospital to a subscriber, if such services are
12 determined by the organization to be medically necessary and
13 covered services under the organization's contract with the
14 contract holder.

15 (12)(a) Without regard to any other remedy or relief
16 to which a person is entitled, or obligated to under contract,
17 anyone aggrieved by a violation of this section may bring an
18 action to obtain a declaratory judgment that an act or
19 practice violates this section and to enjoin a person who has
20 violated, is violating, or is otherwise likely to violate this
21 section.

22 (b) In any action brought by a person who has suffered
23 a loss as a result of a violation of this section, such person
24 may recover any amounts due the person under this section,
25 including accrued interest, plus attorney's fees and court
26 costs as provided in paragraph (c).

27 (c) In any civil litigation resulting from an act or
28 practice involving a violation of this section by a health
29 maintenance organization in which the organization is found to
30 have violated this section, the provider, after judgment in
31 the trial court and after exhausting all appeals, if any,

1 shall receive his or her attorney's fees and costs from the
2 organization; however, such fees shall not exceed three times
3 the amount in controversy or \$5,000, whichever is greater. In
4 any such civil litigation, if the organization is found not to
5 have violated this section, the organization, after judgment
6 in the trial court and exhaustion of all appeals, if any, may
7 receive its reasonable attorney's fees and costs from the
8 provider on any claim or defense that the court finds the
9 provider knew or should have known was not supported by the
10 material facts necessary to establish the claim or defense or
11 would not be supported by the application of then-existing law
12 as to those material facts.

13 (d) The attorney for the prevailing party shall submit
14 a sworn affidavit of his or her time spent on the case and his
15 or her costs incurred for all the motions, hearings, and
16 appeals to the trial judge who presided over the civil case.

17 (e) Any award of attorney's fees or costs shall become
18 a part of the judgment and subject to execution as the law
19 allows.

20 (13) A health maintenance organization subscriber is
21 entitled to prompt payment from the organization whenever a
22 subscriber pays an out-of-network provider for a covered
23 service and then submits a claim to the organization. The
24 organization shall pay the claim within 35 days after receipt
25 or the organization shall advise the subscriber of what
26 additional information is required to adjudicate the claim.
27 After receipt of the additional information, the organization
28 shall pay the claim within 10 days. If the organization fails
29 to pay claims submitted by subscribers within the time periods
30 specified in this subsection, the organization shall pay the
31 subscriber interest on the unpaid claim at the rate of 12

1 percent per year. Failure to pay claims and interest, if
2 applicable, within the time periods specified in this
3 subsection is a violation of the insurance code and each
4 occurrence shall be considered a separate violation.

5 (14) A permissive error ratio of 5 percent is
6 established for organizations claims payment violations of s.
7 641.3155(3)(a), (b), (c), and (e) and (4)(a), (b), (c), and
8 (e). If the error ratio of a particular organization does not
9 exceed the permissible error ratio of 5 percent for an audit
10 period, a fine may not be assessed for the noted claims
11 violations for the audit period. The error ratio shall be
12 determined by dividing the number of claims with violations
13 found on a statistically valid sample of claims for the audit
14 period divided by the total number of claims in the sample. If
15 the error ratio exceeds the permissible error ratio of 5
16 percent, a fine may be assessed according to s. 624.4211 for
17 the claims payment violations that exceed the error ratio.
18 Notwithstanding the provisions of this section, the department
19 may fine a health maintenance organization for claims payment
20 violations of s. 641.3155(3)(e) and (4)(e) which create an
21 uncontestable obligation to pay the claim. The department may
22 not fine organizations for violations that the department
23 determines were due to circumstances beyond the organization's
24 control.

25 (15) The provisions of this section may not be waived,
26 voided, or nullified by contract.

27 Section 12. Section 641.3156, Florida Statutes, is
28 amended to read:

29 641.3156 Treatment authorization; payment of claims.--

30 (1) For purposes of this section, "authorization"
31 includes any requirement of a provider to notify a health

1 maintenance organization in advance of providing a covered
2 service, regardless of whether the actual terminology used by
3 the organization includes, but is not limited to,
4 preauthorization, precertification, notification, or any other
5 similar terminology.

6 (2) A health maintenance organization that requires
7 authorization for medical care and health care services shall
8 provide to each contracted provider at the time a contract is
9 signed a list of the medical care and health care services
10 that require authorization and the authorization procedures
11 used by the organization. A health maintenance organization
12 that requires authorization for medical care and health care
13 services shall provide to each noncontracted provider, not
14 later than 10 working days after a request is made, a list of
15 the medical care and health care services that require
16 authorization and the authorization procedures used by the
17 organization. The list of medical care or health care services
18 that require authorization and the authorization procedures
19 used by the organization shall not be modified unless written
20 notice is provided at least 30 days in advance of any changes
21 to all subscribers, contracted providers, and noncontracted
22 providers who had previously requested a list of medical care
23 or health care services that require authorization. An
24 organization that makes such list and procedures accessible to
25 providers and subscribers electronically is in compliance with
26 this section so long as notice is provided at least 30 days in
27 advance of any changes in such list or procedures to all
28 subscribers, contracted providers, and noncontracted providers
29 who had previously requested a list of medical care or health
30 care services that require authorization.~~A health maintenance~~
31 ~~organization must pay any hospital-service or referral-service~~

1 ~~claim for treatment for an eligible subscriber which was~~
2 ~~authorized by a provider empowered by contract with the health~~
3 ~~maintenance organization to authorize or direct the patient's~~
4 ~~utilization of health care services and which was also~~
5 ~~authorized in accordance with the health maintenance~~
6 ~~organization's current and communicated procedures, unless the~~
7 ~~provider provided information to the health maintenance~~
8 ~~organization with the willful intention to misinform the~~
9 ~~health maintenance organization.~~

10 (3)(a)(2) A claim for treatment may not be denied if a
11 provider follows the health maintenance organization's
12 authorization procedures and receives authorization for a
13 covered service for an eligible subscriber, unless the
14 provider provided information to the health maintenance
15 organization with the willful intention to misinform the
16 health maintenance organization.

17 (b) On receipt of a request from a provider for
18 authorization pursuant to this section, the health maintenance
19 organization shall issue a written determination indicating
20 whether the service or services are authorized. If the request
21 for an authorization is for an inpatient admission, the
22 determination must be transmitted to the provider making the
23 request in writing no later than 24 hours after the request is
24 made by the provider. If the organization denies the request
25 for an authorization, the health maintenance organization must
26 notify the subscriber at the same time when notifying the
27 provider requesting the authorization. A health maintenance
28 organization that fails to respond to a request for an
29 authorization from a provider pursuant to this paragraph is
30 considered to have authorized the inpatient admission within
31 24 hours and payment may not be denied.

1 (4) If the proposed medical care or health care
2 service or services involve an inpatient admission and the
3 health maintenance organization requires authorization as a
4 condition of payment, the health maintenance organization
5 shall issue a written or electronic authorization for the
6 total estimated length of stay for the admission. If the
7 proposed medical care or health care service or services are
8 to be provided to a patient who is an inpatient in a health
9 care facility at the time the services are proposed and the
10 medical care or health care service requires an authorization,
11 the health maintenance organization shall issue a
12 determination indicating whether the proposed services are
13 authorized no later than 4 hours after the request by the
14 health care provider. A health maintenance organization that
15 fails to respond to such request within 4 hours is considered
16 to have authorized the requested medical care or health care
17 service and payment may not be denied.

18 ~~(5)(3)~~ Emergency services are subject to the
19 provisions of s. 641.513 and are not subject to the provisions
20 of this section.

21 (6) The provisions of this section may not be waived,
22 voided, or nullified by contract.

23 Section 13. Paragraph (i) of subsection (1) of section
24 626.9541, Florida Statutes, is amended to read:

25 626.9541 Unfair methods of competition and unfair or
26 deceptive acts or practices defined.--

27 (1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR
28 DECEPTIVE ACTS.--The following are defined as unfair methods
29 of competition and unfair or deceptive acts or practices:

30 (i) Unfair claim settlement practices.--

31 1. Attempting to settle claims on the basis of an

1 application, when serving as a binder or intended to become a
2 part of the policy, or any other material document which was
3 altered without notice to, or knowledge or consent of, the
4 insured;

5 2. A material misrepresentation made to an insured or
6 any other person having an interest in the proceeds payable
7 under such contract or policy, for the purpose and with the
8 intent of effecting settlement of such claims, loss, or damage
9 under such contract or policy on less favorable terms than
10 those provided in, and contemplated by, such contract or
11 policy; or

12 3. Committing or performing with such frequency as to
13 indicate a general business practice any of the following:

14 a. Failing to adopt and implement standards for the
15 proper investigation of claims;

16 b. Misrepresenting pertinent facts or insurance policy
17 provisions relating to coverages at issue;

18 c. Failing to acknowledge and act promptly upon
19 communications with respect to claims;

20 d. Denying claims without conducting reasonable
21 investigations based upon available information;

22 e. Failing to affirm or deny full or partial coverage
23 of claims, and, as to partial coverage, the dollar amount or
24 extent of coverage, or failing to provide a written statement
25 that the claim is being investigated, upon the written request
26 of the insured within 30 days after proof-of-loss statements
27 have been completed;

28 f. Failing to promptly provide a reasonable
29 explanation in writing to the insured of the basis in the
30 insurance policy, in relation to the facts or applicable law,
31 for denial of a claim or for the offer of a compromise

1 settlement;

2 g. Failing to promptly notify the insured of any
3 additional information necessary for the processing of a
4 claim; or

5 h. Failing to clearly explain the nature of the
6 requested information and the reasons why such information is
7 necessary; or-

8 (i) Notifying providers that claims filed under s.
9 627.613 have not been received when, in fact, the claims have
10 been received.

11 Section 14. Subsection (5) of section 641.3903,
12 Florida Statutes, is amended to read:

13 641.3903 Unfair methods of competition and unfair or
14 deceptive acts or practices defined.--The following are
15 defined as unfair methods of competition and unfair or
16 deceptive acts or practices:

17 (5) UNFAIR CLAIM SETTLEMENT PRACTICES.--

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

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

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

29 1. Failing to adopt and implement standards for the
30 proper investigation of claims;

31 2. Misrepresenting pertinent facts or contract

- 1 provisions relating to coverage at issue;
- 2 3. Failing to acknowledge and act promptly upon
- 3 communications with respect to claims;
- 4 4. Denying of claims without conducting reasonable
- 5 investigations based upon available information;
- 6 5. Failing to affirm or deny coverage of claims upon
- 7 written request of the subscriber within a reasonable time not
- 8 to exceed 30 days after a claim or proof-of-loss statements
- 9 have been completed and documents pertinent to the claim have
- 10 been requested in a timely manner and received by the health
- 11 maintenance organization;
- 12 6. Failing to promptly provide a reasonable
- 13 explanation in writing to the subscriber of the basis in the
- 14 health maintenance contract in relation to the facts or
- 15 applicable law for denial of a claim or for the offer of a
- 16 compromise settlement;
- 17 7. Failing to provide, upon written request of a
- 18 subscriber, itemized statements verifying that services and
- 19 supplies were furnished, where such statement is necessary for
- 20 the submission of other insurance claims covered by individual
- 21 specified disease or limited benefit policies, provided that
- 22 the organization may receive from the subscriber a reasonable
- 23 administrative charge for the cost of preparing such
- 24 statement;
- 25 8. Failing to provide any subscriber with services,
- 26 care, or treatment contracted for pursuant to any health
- 27 maintenance contract without a reasonable basis to believe
- 28 that a legitimate defense exists for not providing such
- 29 services, care, or treatment. To the extent that a national
- 30 disaster, war, riot, civil insurrection, epidemic, or any
- 31 other emergency or similar event not within the control of the

1 health maintenance organization results in the inability of
2 the facilities, personnel, or financial resources of the
3 health maintenance organization to provide or arrange for
4 provision of a health service in accordance with requirements
5 of this part, the health maintenance organization is required
6 only to make a good faith effort to provide or arrange for
7 provision of the service, taking into account the impact of
8 the event. For the purposes of this paragraph, an event is
9 not within the control of the health maintenance organization
10 if the health maintenance organization cannot exercise
11 influence or dominion over its occurrence; or

12 9. Systematic downcoding with the intent to deny
13 reimbursement otherwise due; or-

14 10. Notifying providers that claims filed under s.
15 641.3155 have not been received when, in fact, the claims have
16 been received.

17 Section 15. Subsection (12) of section 641.51, Florida
18 Statutes, is amended to read:

19 641.51 Quality assurance program; second medical
20 opinion requirement.--

21 (12) If a contracted primary care physician, licensed
22 under chapter 458 or chapter 459, determines ~~and the~~
23 ~~organization determine~~ that a subscriber requires examination
24 by a licensed ophthalmologist for medically necessary,
25 contractually covered services, then the organization shall
26 authorize the contracted primary care physician to send the
27 subscriber to a contracted licensed ophthalmologist.

28 Section 16. This act shall take effect October 1,
29 2002.

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

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

2 And the title is amended as follows:

3 Remove: the entire title

4

5 and insert:

6 An act relating to health insurance; amending
7 s. 408.7057, F.S.; redefining "managed care
8 organization"; including preferred provider
9 organization and health insurers in the claim
10 dispute resolution program; specifying
11 timeframes for submission of supporting
12 documentation necessary for dispute resolution;
13 providing consequences for failure to comply;
14 authorizing the agency to impose fines and
15 sanctions as part of final orders; amending s.
16 626.88, F.S.; redefining the term
17 "administrator," with respect to regulation of
18 insurance administrators; amending s. 627.613,
19 F.S.; revising time of payment of claims
20 provisions; providing requirements and
21 procedures for payment or denial of claims;
22 providing criteria and limitations; revising
23 rate of interest charged on overdue payments;
24 providing for electronic transmission of
25 claims; providing a penalty; providing for
26 attorney's fees and costs; establishing a
27 permissive error ratio and providing guidelines
28 for applying the ratio; prohibiting contractual
29 modification of provisions of law; providing
30 applicability; creating s. 627.6142, F.S.;

31 defining the term "authorization"; requiring

1 health insurers to provide lists of medical
2 care and health care services that require
3 authorization; prohibiting denial of certain
4 claims; providing procedural requirements for
5 determination and issuance of authorizations of
6 services; amending s. 627.638, F.S.; providing
7 for direct payment for services in treatment of
8 a psychological disorder or substance abuse;
9 amending s. 627.651, F.S.; conforming a
10 cross-reference; amending s. 627.662, F.S.;
11 specifying application of certain additional
12 provisions to group, blanket, and franchise
13 health insurance; amending s. 641.185, F.S.;
14 entitling health maintenance organization
15 subscribers to prompt payment when appropriate;
16 amending s. 641.234, F.S.; providing that
17 health maintenance organizations remain liable
18 for certain violations that occur after the
19 transfer of certain financial obligations
20 through health care risk contracts; amending s.
21 641.30, F.S.; conforming a cross-reference;
22 amending s. 641.3155, F.S.; revising
23 definitions; eliminating provisions that
24 require the Department of Insurance to adopt
25 rules consistent with federal claim-filing
26 standards; providing requirements and
27 procedures for payment of claims; requiring
28 payment within specified periods; revising rate
29 of interest charged on overdue payments;
30 requiring employers to provide notice of
31 changes in eligibility status within a

1 specified time period; providing a penalty;
2 entitling health maintenance organization
3 subscribers to prompt payment by the
4 organization for covered services by an
5 out-of-network provider; requiring payment
6 within specified periods; providing payment
7 procedures; establishing a permissive error
8 ratio and providing guidelines for applying the
9 ratio; providing penalties; amending s.
10 641.3156, F.S.; defining the term
11 "authorization"; requiring health maintenance
12 organizations to provide lists of medical care
13 and health care services that require
14 authorization; prohibiting denial of certain
15 claims; providing procedural requirements for
16 determination and issuance of authorizations of
17 services; amending ss. 626.9541, 641.3903,
18 F.S.; providing that untruthfully notifying a
19 provider that a filed claim has not been
20 received constitutes an unfair claim-settlement
21 practice by insurers and health maintenance
22 organizations; providing penalties; amending s.
23 641.51, F.S.; revising provisions governing
24 examinations by ophthalmologists; providing an
25 effective date

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