By the Committee on Banking and Insurance; and Senators Saunders, Campbell, Peaden and Cowin

311-1784-02

A bill to be entitled

An act relating to health insurance; amending s. 408.7057, F.S.; redefining "managed care organization"; including preferred provider organization and health insurers in the claim dispute resolution program; specifying timeframes for submission of supporting documentation necessary for dispute resolution; providing consequences for failure to comply; authorizing the agency to impose fines and sanctions as part of final orders; amending s. 627.613, F.S.; revising time of payment of claims provisions; providing requirements and procedures for payment or denial of claims; providing criteria and limitations; revising rate of interest charged on overdue payments; providing for electronic transmission of claims; providing a penalty; providing for attorney's fees and costs; prohibiting contractual modification of provisions of law; creating s. 627.6142, F.S.; defining the term "authorization"; requiring health insurers to provide lists of medical care and health care services that require authorization; prohibiting denial of certain claims; providing procedural requirements for determination and issuance of authorizations of services; amending s. 627.638, F.S.; providing for direct payment for services in treatment of a psychological disorder or substance abuse; amending s. 627.651, F.S.; conforming a

cross-reference; amending s. 627.662, F.S.; specifying application of certain additional provisions to group, blanket, and franchise health insurance; amending s. 641.185, F.S.; entitling health maintenance organization subscribers to prompt payment when appropriate; amending s. 641.30, F.S.; conforming a cross-reference; amending s. 641.3155, F.S.; revising definitions; eliminating provisions that require the Department of Insurance to adopt rules consistent with federal claim-filing standards; providing requirements and procedures for payment of claims; requiring payment within specified periods; revising rate of interest charged on overdue payments; requiring employers to provide notice of changes in eligibility status within a specified time period; providing a penalty; entitling health maintenance organization subscribers to prompt payment by the organization for covered services by an out-of-network provider; requiring payment within specified periods; providing payment procedures; providing penalties; amending s. 641.3156, F.S.; defining the term "authorization"; requiring health maintenance organizations to provide lists of medical care and health care services that require authorization; prohibiting denial of certain claims; providing procedural requirements for determination and issuance of authorizations of

services; amending ss. 626.9541, 641.3903, F.S.; providing that untruthfully notifying a provider that a filed claim has not been received constitutes an unfair claim-settlement practice by insurers and health maintenance organizations; providing penalties; providing an effective date.

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

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, a preferred provider organization under s. 627.6471, or a health insurer licensed pursuant to chapter 627.

(2)

(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, or health insurer to the resolution organization ~~when the dispute-resolution program becomes effective~~.

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

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

(4) Within 30 days after receipt of the recommendation of the resolution organization, the agency shall adopt the recommendation as a final order. The agency may issue a final order imposing fines or sanctions, including those contained in s. 641.52. All fines collected under this subsection shall be deposited into the Health Care Trust Fund.

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

627.613 Time of payment of claims.--

(1) The contract shall include the following provision:

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

(2) Health insurers shall reimburse all claims or any portion of any claim from an insured or an insured's assignees, for payment under a health insurance policy, within 35 ~~45~~ days after receipt of the claim by the health insurer. If a claim or a portion of a claim is contested by the health insurer, the insured or the insured's assignees shall be notified, in writing, that the claim is contested or denied, within 35 ~~45~~ days after receipt of the claim by the health insurer. The notice that a claim is contested shall identify the contested portion of the claim, ~~and~~ the specific reasons for contesting the claim, and written itemization of any additional information or additional documents needed to process the claim or the contested portion of the claim. A health insurer may not make more than one request under this subsection in connection with a claim unless the provider fails to submit all of the requested information to process the claim or if information submitted by the provider raises new, additional issues not included in the original written itemization, in which case the health insurer may provide the health care provider with one additional opportunity to submit the additional information needed to process the claim. In no case may the health insurer request duplicate information.

(3) A health insurer, upon receipt of the additional information requested from the insured or the insured's assignees shall pay or deny the contested claim or portion of the contested claim, within 35 ~~60~~ days.

(4) A health ~~An~~ insurer shall pay or deny any claim no 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) Payment of a claim is considered ~~shall be treated as being~~ made on the date the payment was electronically transferred or otherwise delivered ~~a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery~~.

(6) All overdue payments shall bear simple interest at the rate of 12 ~~10~~ percent per year. Interest on a late payment of a claim or uncontested portion of a claim begins to accrue on the 36th day after the claim has been received. Interest due is payable with the payment of the claim.

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

(8) A provider claim for payment shall be considered received by the health insurer, if the claim has been electronically transmitted to the health insurer, when receipt is verified electronically or, if the claim is mailed to the address disclosed by the health insurer, on the date indicated on the return receipt. A provider must wait 35 days following receipt of a claim before submitting a duplicate claim.

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

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

(c) A provider that denies or contests a health insurer's claim for overpayment or any portion of a claim shall notify the health insurer, in writing, within 35 days after the provider receives the claim that the claim for overpayment is contested or denied. The notice that the claim for overpayment is contested or denied 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. The provider shall pay or deny the claim for overpayment within 35 days after receipt of the information.

(d) Payment of a claim for overpayment is considered made on the date payment was electronically transferred or otherwise delivered to the health insurer or on the date that the provider receives a payment from the health insurer that reduces or deducts the overpayment. An overdue payment of a claim bears simple interest at the rate of 12 percent per year. Interest on an overdue payment of a claim for overpayment or for any uncontested portion of a claim for overpayment begins to accrue on the 36th day after the claim for overpayment has been received.

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

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

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

(11) A health insurer may not deny a claim because of the insured's ineligibility if the provider can document receipt of the insured's eligibility confirmation by the health insurer prior to the date or time covered services were provided. Any person who knowingly and willfully misinforms a provider prior to receipt of services as to his or her coverage eligibility commits insurance fraud, punishable as provided in s. 817.50.

(12)(a) Without regard to any other remedy or relief to which a provider is entitled, or obligated to under contract, any provider aggrieved by a violation of this section by a health insurer may bring an action to enjoin a person who has violated, or is violating, this section. In any such action, the provider who has suffered a loss as a result of the violation may recover any amounts due the provider by the health insurer, including accrued interest, plus attorney's fees and costs as provided in paragraph (b).

(b) In any action arising out of a violation of this section by a health insurer in which the health insurer is found to have violated this section, the provider, after judgment in the trial court and after exhausting all appeals, if any, shall receive his or her reasonable attorney's fees and costs from the health insurer.

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

Section 3. Section 627.6142, Florida Statutes, is created to read:

627.6142 Treatment authorization; payment of claims.--

(1) For purposes of this section, "authorization" includes any requirement of a provider to notify an insurer in advance of providing a covered service, regardless of whether

the actual terminology used by the insurer includes, but is not limited to, preauthorization, precertification, notification, or any other similar terminology.

(2) A health insurer that requires authorization for medical care or health care services shall provide to each provider with whom the health insurer has contracted pursuant to s. 627.6471 or s. 627.6472 a list of the medical care and health care services that require authorization and the authorization procedures used by the health insurer at the time a contract becomes effective. A health insurer that requires authorization for medical care or health care services shall provide to all other providers, not later than 10 working days after a request is made, a list of the medical care and health care services that require authorization and the authorization procedures established by the insurer. The medical care or health care services that require authorization and the authorization procedures used by the insurer shall not be modified unless written notice is provided at least 30 days in advance of any changes to all affected insureds as well as to all contracted providers and all other providers that had previously requested in writing a list of medical care or health care services that require authorization. An insurer that makes such list and procedures accessible to providers and insureds electronically is in compliance with this section so long as notice is provided at least 30 days in advance of any changes in such list or procedures to all insureds, contracted providers, and noncontracted providers who had previously requested a list of medical care or health care services that require authorization.

(3) Any claim for a covered service that does not require authorization that is ordered by a contracted physician and entered on the medical record may not be denied. If the health insurer determines that an overpayment has been made, then a claim for overpayment should be submitted to the provider pursuant to s. 627.613.

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

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

(5) If the proposed medical care or health care service or services involve an inpatient admission and the health insurer requires an authorization as a condition of payment, the health insurer shall review and issue a written or electronic authorization for the total estimated length of stay for the admission, based on the recommendation of the

patient's physician. If the proposed medical care or health care service or services are to be provided to an insured who is an inpatient in a health care facility and authorization is required, the health insurer shall issue a written determination indicating whether the proposed services are authorized or denied no later than 4 hours after the request is made by the provider. A health insurer who fails to respond to such request within 4 hours is considered to have authorized the requested medical care or health care service and payment shall not be denied.

(6) Authorization may not be required for emergency services and care or emergency medical services as provided pursuant to ss. 395.002, 395.1041, 401.45, and 401.252. Such emergency services and care shall extend through any inpatient admission required in order to provide for stabilization of an emergency medical condition pursuant to state and federal law.

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

Section 4. Subsection (3) is added to section 627.638, Florida Statutes, to read:

627.638 Direct payment for hospital, medical services.--

(3) Under any health insurance policy insuring against loss or expense due to hospital confinement or to medical and related services, payment of benefits shall be made directly to any recognized hospital, doctor, or other person who provided services for the treatment of a psychological disorder or treatment for substance abuse, including drug and alcohol abuse, when the treatment is in accordance with the provisions of the policy and the insured specifically authorizes direct payment of benefits. Payments shall be made

under this section, notwithstanding any contrary provisions in the health insurance contract. This subsection applies to all health insurance policies now or hereafter in force as of the effective date of this act.

Section 5. Subsection (4) of section 627.651, Florida Statutes, is amended to read:

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

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

Section 6. Section 627.662, Florida Statutes, is amended to read:

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

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

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

(3) Section 627.635, relating to excess insurance.

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

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

(6) Section 627.6142, relating to treatment authorizations.

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

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

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

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

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

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

Section 7. Paragraph (e) of subsection (1) of section 641.185, Florida Statutes, is amended to read:

641.185 Health maintenance organization subscriber protections.--

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

(e) A health maintenance organization subscriber should receive timely, concise information regarding the health maintenance organization's reimbursement to providers

and services pursuant to ss. 641.31 and 641.31015 and is entitled to prompt payment from the organization when appropriate pursuant to s. 641.3155.

Section 8. Subsection (1) of section 641.30, Florida Statutes, is amended to read:

641.30 Construction and relationship to other laws.--

(1) Every health maintenance organization shall accept the ~~standard health~~ claim form prescribed pursuant to s. 641.3155 ~~627.647~~.

Section 9. Section 641.3155, Florida Statutes, is amended to read:

641.3155 Payment of claims.--

(1)~~(a)~~ As used in this section, the term "~~clean~~ claim" for a noninstitutional provider means a paper or electronic billing instrument that consists of the HCFA 1500 data set that has all mandatory entries for a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 490 or other appropriate form for any other noninstitutional provider, or its successor. For institutional providers, "claim" means a paper or electronic billing instrument that consists of the UB-92 data set or its successor that has all mandatory entries.~~claim submitted on a HCFA 1500 form 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.~~

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

(2)(a) A health maintenance organization 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 maintenance organization or a ~~clean~~ claim made by a noncontract provider which the organization does not contest or deny within 35 days after receipt of the claim by the health maintenance organization which is submitted ~~mailed or electronically transferred~~ by the provider, either electronically or using hand delivery, the United States mail, or a reputable overnight delivery service.

(b) A health maintenance organization that denies or contests a provider's claim or any portion of a claim shall notify the provider, in writing, within 35 days after the health maintenance organization 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 give the provider a written itemization of any ~~include a request for~~ additional information or additional documents needed to process the claim or any portion of the claim that is not being paid. 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 maintenance organization. The health maintenance organization shall pay or deny the claim or portion of the claim within 35 ~~45~~ days after receipt of the information. A health maintenance organization may not make more than one request under this paragraph in connection with a claim, unless the provider fails to submit all of the requested information to process the claim or if information submitted by the provider raises new, additional issues not included in the original written itemization, in which case the health maintenance organization may provide the health care provider with one additional opportunity to submit the additional information needed to process the claim. In no case may the health insurer request duplicate information.

(c) A health maintenance organization shall not deny or withhold payment on a claim because the insured has not paid a required deductible or copayment.

(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 12 ~~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. The interest is payable with the payment of the claim.

(4) A health maintenance organization shall pay or deny any claim no later than 120 days after receiving the claim. Failure to do so creates an uncontestable obligation for the health maintenance organization to pay the claim to the provider.

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

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

(c) A provider that denies or contests an organization's claim for overpayment or any portion of a claim shall notify the organization, in writing, within 35 days after the provider receives the claim that the claim for overpayment is contested or denied. The notice that the claim for overpayment is denied or contested must identify the contested portion of the claim and the specific reason for contesting or denying the claim, and, if contested, must

include a request for additional information. If the organization submits additional information, the organization must, within 35 days after receipt of the request, mail or electronically transfer the information to the provider. The provider shall pay or deny the claim for overpayment within 45 days after receipt of the information.

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

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

(6) Any retroactive reductions of payments or demands for refund of previous overpayments which are due to retroactive review-of-coverage decisions or payment levels must be reconciled to specific claims unless the parties agree to other reconciliation methods and terms. Any retroactive demands by providers for payment due to underpayments or nonpayments for covered services must be reconciled to specific claims unless the parties agree to other reconciliation methods and terms. The look-back or audit-review period shall not exceed 2 years after the date the claim was paid by the health maintenance organization,

unless fraud in billing is involved.~~The look-back period may be specified by the terms of the contract.~~

(7)(a) A provider claim for payment shall be considered received by the health maintenance organization, if the claim has been electronically transmitted to the health maintenance organization, when 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, or on the date the delivery receipt is signed by the health maintenance organization if the claim is hand delivered. A provider must wait 45 days following receipt of a claim before submitting a duplicate claim.

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

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

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

(9) A health maintenance organization may not ~~retroactively~~ deny a claim because of subscriber ineligibility if the provider can document receipt of subscriber eligibility confirmation by the organization prior to the date or time covered services were provided. Every health maintenance

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

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

(11)(a) Without regard to any other remedy or relief to which a provider is entitled, or obligated to under contract, any provider aggrieved by a violation of this section by a health insurer may bring an action to enjoin a person who has violated, or is violating, this section. In any such action, the provider who has suffered a loss as a result of the violation may recover any amounts due the provider by the health insurer, including accrued interest, plus attorney's fees and costs as provided in paragraph (b).

(b) In any action arising out of a violation of this section by a health insurer in which the health insurer is found to have violated this section, the provider, after judgment in the trial court and after exhausting all appeals, if any, shall receive his or her reasonable attorney's fees and costs from the health insurer.

(12) A health maintenance organization subscriber is entitled to prompt payment from the organization whenever a subscriber pays an out-of-network provider for a covered service and then submits a claim to the organization. The organization shall pay the claim within 35 days after receipt or the organization shall advise the subscriber of what additional information is required to adjudicate the claim. After receipt of the additional information, the organization shall pay the claim within 10 days. If the organization fails to pay claims submitted by subscribers within the time periods specified in this subsection, the organization shall pay the subscriber interest on the unpaid claim at the rate of 12 percent per year. Failure to pay claims and interest, if applicable, within the time periods specified in this subsection is a violation of the insurance code and each occurrence shall be considered a separate violation.

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

Section 10. Section 641.3156, Florida Statutes, is amended to read:

641.3156 Treatment authorization; payment of claims.--

(1) For purposes of this section, "authorization" includes any requirement of a provider to notify a health maintenance organization in advance of providing a covered service, regardless of whether the actual terminology used by the organization includes, but is not limited to, preauthorization, precertification, notification, or any other similar terminology.

(2) A health maintenance organization that requires authorization for medical care and health care services shall provide to each contracted provider at the time a contract is

signed a list of the medical care and health care services that require authorization and the authorization procedures used by the organization. A health maintenance organization that requires authorization for medical care and health care services shall provide to each noncontracted provider, not later than 10 working days after a request is made, a list of the medical care and health care services that require authorization and the authorization procedures used by the organization. The list of medical care or health care services that require authorization and the authorization procedures used by the organization shall not be modified unless written notice is provided at least 30 days in advance of any changes to all subscribers, contracted providers, and noncontracted providers who had previously requested a list of medical care or health care services that require authorization. An organization that makes such list and procedures accessible to providers and subscribers electronically is in compliance with this section so long as notice is provided at least 30 days in advance of any changes in such list or procedures to all subscribers, contracted providers, and noncontracted providers who had previously requested a list of medical care or health care services that require authorization.

(3) Any claim for a covered service that does not require an authorization that is ordered by a contracted physician may not be denied. If an organization determines that an overpayment has been made, then a claim for overpayment should be submitted pursuant to s. 641.3155.~~A health maintenance organization must pay any hospital-service or referral-service claim for treatment for an eligible subscriber which was authorized by a provider empowered by contract with the health maintenance organization to authorize~~

~~or direct the patient's utilization of health care services and which was also authorized in accordance with the health maintenance organization's current and communicated procedures, unless the provider provided information to the health maintenance organization with the willful intention to misinform the health maintenance organization.~~

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

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

(5) If the proposed medical care or health care service or services involve an inpatient admission and the health maintenance organization requires authorization as a

condition of payment, the health maintenance organization shall issue a written or electronic authorization for the total estimated length of stay for the admission. If the proposed medical care or health care service or services are to be provided to a patient who is an inpatient in a health care facility at the time the services are proposed and the medical care or health care service requires an authorization, the health maintenance organization shall issue a determination indicating whether the proposed services are authorized no later than 4 hours after the request by the health care provider. A health maintenance organization that fails to respond to such request within 4 hours is considered to have authorized the requested medical care or health care service and payment may not be denied.

(6)~~(3)~~ Emergency services are subject to the provisions of s. 641.513 and are not subject to the provisions of this section. Such emergency services and care shall extend through any inpatient admission required in order to provide for stabilization of an emergency medical condition pursuant to state and federal law.

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

Section 11. Paragraph (i) of subsection (1) of section 626.9541, Florida Statutes, is amended to read:

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

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

(i) Unfair claim settlement practices.--

1. Attempting to settle claims on the basis of an application, when serving as a binder or intended to become a part of the policy, or any other material document which was altered without notice to, or knowledge or consent of, the insured;

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

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

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

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

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

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

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

f. Failing to promptly provide a reasonable explanation in writing to the insured of the basis in the insurance policy, in relation to the facts or applicable law,

for denial of a claim or for the offer of a compromise settlement;

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

h. Failing to clearly explain the nature of the requested information and the reasons why such information is necessary; or~~.~~

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

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

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

(5) UNFAIR CLAIM SETTLEMENT PRACTICES.--

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

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

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

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

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

3. Failing to acknowledge and act promptly upon communications with respect to claims;

4. Denying of claims without conducting reasonable investigations based upon available information;

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

6. Failing to promptly provide a reasonable explanation in writing to the subscriber of the basis in the health maintenance contract in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement;

7. Failing to provide, upon written request of a subscriber, itemized statements verifying that services and supplies were furnished, where such statement is necessary for the submission of other insurance claims covered by individual specified disease or limited benefit policies, provided that the organization may receive from the subscriber a reasonable administrative charge for the cost of preparing such statement;

8. Failing to provide any subscriber with services, care, or treatment contracted for pursuant to any health maintenance contract without a reasonable basis to believe that a legitimate defense exists for not providing such services, care, or treatment. To the extent that a national disaster, war, riot, civil insurrection, epidemic, or any

other emergency or similar event not within the control of the health maintenance organization results in the inability of the facilities, personnel, or financial resources of the health maintenance organization to provide or arrange for provision of a health service in accordance with requirements of this part, the health maintenance organization is required only to make a good faith effort to provide or arrange for provision of the service, taking into account the impact of the event. For the purposes of this paragraph, an event is not within the control of the health maintenance organization if the health maintenance organization cannot exercise influence or dominion over its occurrence; or

9. Systematic downcoding with the intent to deny reimbursement otherwise due; or~~.~~

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

Section 13. This act shall take effect October 1, 2002.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN COMMITTEE SUBSTITUTE FOR Senate Bill 362

Standardizes all time periods for health insurers and HMOs to pay, deny, or contest any claim, or portion of a claim, to 35 days.

Reduces interest rate penalties for overdue payments of claims from 18 to 12 percent a year.

Deletes coordination of benefits and removes the requirement that the Department of Insurance adopt rules to establish claim forms consistent with federal claim-filing and code set standards.

Adds health insurers to provisions of statewide dispute resolution program and specifies time frames for submission of supporting documentation necessary for dispute resolution; provides consequences for failure to comply and authorizes the Agency for Health Care Administration to impose fines or sanctions.

Allows insurers and HMOs to make one request for additional information from a provider if information previously submitted by the provider raises new or additional issues.

Expands the time frame for requests for HMO or health insurer authorizations from 8 to 24 hours for inpatient admissions and from 1 to 4 hours for inpatients in a health care facility.

Increases the review period from 1 to 2 years for "look-back" or audit reviews and provides an exception for fraud.

Provides that an HMO or health insurer may not deny a claim for subscriber ineligibility under certain circumstances.

Mandates that any health insurance policy insuring against loss or expense due to hospital confinement or to medical services, provide that payment of benefits must be made directly to any hospital, doctor, or other person who provides treatment of a psychological disorder for substance abuse, including drug and alcohol abuse, when such treatment is in accordance with provisions of such policy and the insured authorizes direct payment of benefits. Payments must be made under this provision, notwithstanding contrary provisions in health insurance contracts.

Provides that untruthfully notifying a provider that a filed claim has not been received constitutes an unfair trade practice for insurers and HMOs.