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. 626.88, F.S.; redefining the term "administrator," with respect to regulation of insurance administrators; 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; establishing a permissive error ratio and providing guidelines for applying the ratio; prohibiting contractual modification of provisions of law; providing applicability; 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. 641.234, F.S.; providing that health maintenance organizations remain liable for certain violations that occur after the transfer of certain financial obligations through health care risk contracts; 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; establishing a permissive error ratio and providing guidelines for applying the ratio; 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; amending s. 641.51, F.S.; revising provisions governing examinations by ophthalmologists; 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, 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 exclusive provider organization under s. 627.6472.

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

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

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

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

(b) A union on behalf of its members.

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

(d) A health care services plan, health maintenance organization, professional service plan corporation, or person in the business of providing continuing care, possessing a valid certificate of authority issued by the department, and the sales representatives thereof, if the activities of such entity are limited to the activities permitted under the certificate of authority.

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

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

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

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

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

meets the requirements of s. 401(f) of the Internal Revenue Code.

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

(k) A credit card issuing company which advances for and collects premiums or charges from its credit card holders who have authorized such collection if such company does not adjust or settle claims.

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

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

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

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

Section 3. 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) As used in this section, the term "claim" for a noninstitutional provider means a paper or electronic billing instrument submitted to the insurer's designated location which consists of the HCFA 1500 data set, or its successor, which has all mandatory entries for a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461 or other appropriate billing instrument that has all mandatory entries for any other noninstitutional provider. For institutional providers, "claim" means a paper or electronic billing instrument submitted to the insurer's designated location which consists of the UB-92 data set with entries stated as mandatory by the National Uniform Billing Committee.~~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 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 45 days after receipt of the claim by the health insurer. The notice that a claim~~

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

~~is contested shall identify the contested portion of the claim and the reasons for contesting the claim.~~

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

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

(b) Must not duplicate a claim previously submitted unless it is determined that the original claim was not received or is otherwise lost.~~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 60 days.~~

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

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

(b) For an electronically submitted claim, a health insurer shall, within 20 days after receipt of the claim, pay the claim or notify a provider or designee if a claim is

denied or contested. Notice of the insurer's action on the claim and payment of the claim is considered to be made on the date the notice or payment is mailed or electronically transferred.

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

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

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

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

(e) A claim must be paid or denied within 90 days after receipt of the claim. Failure to pay or deny a claim within 120 days after receipt of the claim creates an

uncontestable obligation to pay the claim.~~An insurer shall pay or deny any claim no later than 120 days after receiving the claim.~~

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

(b) For all nonelectronically submitted claims, a health insurer shall, within 40 days after receipt of the claim, pay the claim or notify a provider or designee if a claim is denied or contested. Notice of the insurer's action on the claim and payment of the claim are considered to be made on the date the notice or payment was mailed or electronically transferred.

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

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

3. A health insurer may not make more than one request for documents under this paragraph in connection with a claim unless the provider fails to submit all of the requested documents to process the claim or the documents submitted by

the provider raise new, additional issues not included in the original written itemization, in which case the health insurer may provide the provider with one additional opportunity to submit the additional documents needed to process the claim. In no case may the health insurer request duplicate documents.

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

(e) A claim must be paid or denied within 120 days after receipt of the claim. Failure to pay or deny a claim within 140 days after receipt of the claim creates an uncontestable obligation to pay the claim. ~~Payment shall be treated as being made on the date 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) Payment of a claim is considered made on the date the payment is mailed or electronically transferred. An overdue payment of a claim bears simple interest of 12 percent per year. Interest on an overdue payment for a claim or for any portion of a claim begins to accrue when the claim should have been paid, denied, or contested. The interest is payable with the payment of the claim. ~~All overdue payments shall bear simple interest at the rate of 10 percent per year.~~

(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 to the provider's designated location. 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 person is entitled, or obligated to under contract, anyone aggrieved by a violation of this section may bring an action to obtain a declaratory judgment that an act or practice violates this section and to enjoin a person who has violated, is violating, or is otherwise likely to violate this section.

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

(c) In any civil litigation resulting from an act or practice involving 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 attorney's fees and costs from the insurer; however, such fees shall not exceed three times the amount in controversy or $5,000, whichever is greater. In any such civil litigation, if the insurer is found not to have violated this section, the insurer, after judgment in the trial court and exhaustion of all appeals, if any, may receive its reasonable attorney's fees and costs from the provider on any claim or defense that the court finds the provider knew or should have known was not supported by the material facts necessary to establish the claim or defense or would not be supported by the application of then-existing law as to those material facts.

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

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

(13) A permissive error ratio of 5 percent is established for insurers claims payment violations of s. 627.613(4)(a), (b), (c), and (e) and (5)(a), (b), (c), and (e). If the error ratio of a particular insurer does not exceed the permissible error ratio of 5 percent for an audit period, a fine may not be assessed for the noted claims violations for the audit period. The error ratio shall be determined by dividing the number of claims with violations found on a statistically valid sample of claims for the audit period, divided by the total number of claims in the sample. If the error ratio exceeds the permissible error ratio of 5 percent, a fine may be assessed according to s. 624.4211 for the claims payment violations that exceed the error ratio.

Notwithstanding the provisions of this section, the department may fine a health insurer for claims payment violations of s. 627.613(4)(e) and (5)(e) which create an uncontestable obligation to pay the claim. The department may not fine insurers for violations that the department determines were due to circumstances beyond the insurer's control.

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

(15) The amendments to this section by this act apply only to a major medical expense health insurance policy as defined in s. 627.643(2)(e) which is offered by a group or an individual health insurer licensed under chapter 624, including a preferred provider policy under s. 627.6417, an exclusive provider organization under 627.6472, or a group or individual insurance contract that provides payment for enumerated dental services.

Section 4. 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)(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.

(4) 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.

(5) 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.

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

Section 5. 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 6. 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 7. 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 8. 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 9. Subsection (4) is added to section 641.234, Florida Statutes, to read:

641.234 Administrative, provider, and management contracts.--

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

(b) As used in this subsection:

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

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

Section 10. 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 11. 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 submitted to the health maintenance organization's designated location which consists of the HCFA 1500 data set, or its successor, having all mandatory entries completed for a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461 or other appropriate billing instrument that has all mandatory entries for any other noninstitutional provider. For institutional providers, "claim" means a paper or electronic billing instrument submitted to the insurer's designated location which consists

of the UB-92 data set with entries stated as mandatory by the National Uniform Billing Committee.~~claim submitted on a HFCA 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) All claims for payment, whether electronic or nonelectronic:

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

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

~~(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 mailed or electronically transferred by the provider.~~

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

(c) For noninstitutional providers, all claims must be mailed or electronically transferred to a health maintenance

organization within 90 days after completion of the service and after the provider is furnished with the correct name and address of the patient's health maintenance organization. For institutional providers, unless otherwise agreed to through contract, all claims must be mailed or electronically transferred to a health maintenance organization within 90 days after completion of the service and after the provider is furnished with the correct name and address of the patient's health maintenance organization. Submission of a provider's claim is considered made on the date it is electronically transferred or mailed.

(3)(a) For an electronically submitted claim, a health maintenance organization shall, within 24 hours after the beginning of the next business day after receipt of the claim, provide electronic acknowledgement of the receipt of the claim to the electronic source submitting the claim.

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

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

2. A provider must submit the additional information or documentation, as specified on the itemized list, within 35 days after receipt of the notification. Failure of a provider

to submit by mail or electronically the additional information or documentation requested within 35 days after receipt of the notification may result in denial of the claim.

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

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

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

(4)(a) For all nonelectronically submitted claims, a health maintenance organization shall, effective November 1, 2003, provide to the provider acknowledgement of receipt of

the claim within 15 days after receipt of the claim or provide the provider, within 15 days after receipt, with electronic access to the status of a submitted claim.

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

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

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

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

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

(e) A claim must be paid or denied within 120 days after receipt of the claim. Failure to pay or deny a claim within 140 days after receipt of the claim creates an uncontestable obligation to pay the claim.~~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) Payment of a claim is considered made on the date the payment is mailed or electronically transferred. An overdue payment of a claim bears simple interest of 12 percent per year. Interest on an overdue payment for a claim or for any portion of a claim begins to accrue when the claim should have been paid, denied, or contested. The interest is payable with the payment of the claim.

(6)(a)~~(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 to the provider's designated location. 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.

(7)~~(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.~~

(8)(a)~~(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.

(9)~~(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.

(10)~~(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.

(11)~~(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.

(12)(a) Without regard to any other remedy or relief to which a person is entitled, or obligated to under contract, anyone aggrieved by a violation of this section may bring an

action to obtain a declaratory judgment that an act or practice violates this section and to enjoin a person who has violated, is violating, or is otherwise likely to violate this section.

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

(c) In any civil litigation resulting from an act or practice involving a violation of this section by a health maintenance organization in which the organization 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 attorney's fees and costs from the organization; however, such fees shall not exceed three times the amount in controversy or $5,000, whichever is greater. In any such civil litigation, if the organization is found not to have violated this section, the organization, after judgment in the trial court and exhaustion of all appeals, if any, may receive its reasonable attorney's fees and costs from the provider on any claim or defense that the court finds the provider knew or should have known was not supported by the material facts necessary to establish the claim or defense or would not be supported by the application of then-existing law as to those material facts.

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

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

(13) 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.

(14) A permissive error ratio of 5 percent is established for organizations claims payment violations of s. 641.3155(3)(a), (b), (c), and (e) and (4)(a), (b), (c), and (e). If the error ratio of a particular organization does not exceed the permissible error ratio of 5 percent for an audit period, a fine may not be assessed for the noted claims violations for the audit period. The error ratio shall be determined by dividing the number of claims with violations found on a statistically valid sample of claims for the audit period divided by the total number of claims in the sample. If the error ratio exceeds the permissible error ratio of 5 percent, a fine may be assessed according to s. 624.4211 for

the claims payment violations that exceed the error ratio. Notwithstanding the provisions of this section, the department may fine a health maintenance organization for claims payment violations of s. 641.3155(3)(e) and (4)(e) which create an uncontestable obligation to pay the claim. The department may not fine organizations for violations that the department determines were due to circumstances beyond the organization's control.

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

Section 12. 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.~~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.~~

(3)(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.

(4) 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.

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

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

Section 13. 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 14. 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 15. Subsection (12) of section 641.51, Florida Statutes, is amended to read:

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

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

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