By Representatives Diaz-Balart and Fasano

1 A bill to be entitled
2 An act relating to health care; providing
3 legislative findings and intent relating to
4 health flex plans; providing definitions;
5 providing for a pilot program for health flex
6 plans for certain uninsured persons; providing
7 criteria; authorizing the Agency for Health
8 Care Administration and the Department of
9 Insurance to adopt rules; exempting approved
10 health flex plans from certain licensing
11 requirements; providing criteria for
12 eligibility to enroll in a health flex plan;
13 requiring health flex plan providers to
14 maintain certain records; providing
15 requirements for denial, nonrenewal, or
16 cancellation of coverage; specifying that
17 coverage under an approved health flex plan is
18 not an entitlement; requiring a report;
19 providing for future repeal; establishing the
20 Florida Alzheimer's Center and Research
21 Institute at the University of South Florida;
22 requiring the State Board of Education to enter
23 into an agreement with a not-for-profit
24 corporation for the governance and operation of
25 the institute; providing that the corporation
26 shall act as an instrumentality of the state;
27 authorizing the creation of subsidiaries by the
28 corporation; providing powers of the
29 corporation; providing for a board of directors
30 of the corporation and the appointment and
31 terms of its membership; authorizing the State

1 Board of Education to secure and provide
2 liability protection; providing for an annual
3 audit and report; providing for assumption of
4 certain responsibilities of the corporation by
5 the State Board of Education under certain
6 circumstances; providing for administration of
7 the institute; providing for disbursal and use
8 of income; providing for reporting of
9 activities; requiring the appointment of a
10 council of scientific advisers; providing
11 responsibilities and terms of the council;
12 providing that the corporation and its
13 subsidiaries are not agencies within the
14 meaning of s. 20.03(11), F.S.; amending s.
15 408.7057, F.S.; redesignating a program title;
16 revising definitions; including preferred
17 provider organizations and health insurers in
18 the claim dispute resolution program;
19 specifying timeframes for submission of
20 supporting documentation necessary for dispute
21 resolution; providing consequences for failure
22 to comply; providing additional
23 responsibilities for the agency relating to
24 patterns of claim disputes; providing
25 timeframes for review by the resolution
26 organization; directing the agency to notify
27 appropriate licensure and certification
28 entities as part of violation of final orders;
29 amending s. 456.053, F.S.; revising a
30 definition; amending s. 626.88, F.S.;
31 redefining the term "administrator," with

1 respect to regulation of insurance
2 administrators; creating s. 627.6131, F.S.;
3 specifying payment-of-claims provisions
4 applicable to certain health insurers;
5 providing a definition; providing requirements
6 and procedures for paying, denying, or
7 contesting claims; providing criteria and
8 limitations; requiring payment within specified
9 periods; specifying rate of interest charged on
10 overdue payments; providing for electronic and
11 nonelectronic transmission of claims; providing
12 procedures for overpayment recovery; specifying
13 timeframes for adjudication of claims,
14 internally and externally; prohibiting action
15 to collect payment from an insured under
16 certain circumstances; providing applicability;
17 prohibiting contractual modification of
18 provisions of law; specifying circumstances for
19 retroactive claim denial; specifying claim
20 payment requirements; providing for billing
21 review procedures; specifying claim content
22 requirements; establishing a permissible error
23 ratio, specifying its applicability, and
24 providing for fines; providing specified
25 exceptions from notice and acknowledgment
26 requirements for pharmacy benefit manager
27 claims; amending s. 627.651, F.S.; conforming a
28 cross reference; amending s. 627.662, F.S.;
29 specifying application of certain additional
30 provisions to group, blanket, and franchise
31 health insurance; amending s. 627.6699, F.S.;

1 allowing carriers to separate the experience of
2 small employer groups having fewer than two
3 employees; restricting application of certain
4 laws to health plan policies under certain
5 circumstances; amending s. 641.185, F.S.;
6 specifying that health maintenance organization
7 subscribers should receive prompt payment from
8 the organization; amending s. 641.234, F.S.;
9 specifying responsibility of a health
10 maintenance organization for certain violations
11 under certain circumstances; amending s.
12 641.30, F.S.; conforming a cross reference;
13 amending s. 641.3154, F.S.; modifying the
14 circumstances under which a provider knows that
15 an organization is liable for service
16 reimbursement; amending s. 641.3155, F.S.;
17 revising payment of claims provisions
18 applicable to certain health maintenance
19 organizations; providing a definition;
20 providing requirements and procedures for
21 paying, denying, or contesting claims;
22 providing criteria and limitations; requiring
23 payment within specified periods; revising rate
24 of interest charged on overdue payments;
25 providing for electronic and nonelectronic
26 transmission of claims; providing procedures
27 for overpayment recovery; specifying timeframes
28 for adjudication of claims, internally and
29 externally; prohibiting action to collect
30 payment from a subscriber under certain
31 circumstances; prohibiting contractual

1 modification of provisions of law; specifying
2 circumstances for retroactive claim denial;
3 specifying claim payment requirements;
4 providing for billing review procedures;
5 specifying claim content requirements;
6 establishing a permissible error ratio,
7 specifying its applicability, and providing for
8 fines; providing specified exceptions from
9 notice and acknowledgment requirements for
10 pharmacy benefit manager claims; amending s.
11 641.51, F.S.; revising provisions governing
12 examinations by ophthalmologists; providing
13 construction; providing effective dates.
14
15 Be It Enacted by the Legislature of the State of Florida:
16
17 Section 1. Effective July 1, 2002:
18 Health flex plans.--
19 (1) INTENT.--The Legislature finds that a significant
20 proportion of the residents of this state are unable to obtain
21 affordable health insurance coverage. Therefore, it is the
22 intent of the Legislature to expand the availability of health
23 care options for low-income uninsured state residents by
24 encouraging health insurers, health maintenance organizations,
25 health care provider sponsored organizations, local
26 governments, health care districts, or other public or private
27 community-based organizations to develop alternative
28 approaches to traditional health insurance which emphasize
29 coverage for basic and preventive health care services. To the
30 maximum extent possible, these options should be coordinated
31 with existing governmental or community-based health services

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1 programs in a manner that is consistent with the objectives
2 and requirements of such programs.
3 (2) DEFINITIONS.--As used in this section, the term:
4 (a) "Agency" means the Agency for Health Care
5 Administration.
6 (b) "Department" means the Department of Insurance.
7 (c) "Enrollee" means an individual who has been
8 determined to be eligible for and is receiving health care
9 coverage under a health flex plan approved under this section.
10 (d) "Health care coverage" or "health flex plan
11 coverage" means health care services that are covered as
12 benefits under an approved health flex plan or that are
13 otherwise provided, either directly or through arrangements
14 with other persons, via a health flex plan on a prepaid per
15 capita basis or on a prepaid aggregate fixed-sum basis.
16 (e) "Health flex plan" means a health plan approved
17 under subsection (3) which guarantees payment for specified
18 health care coverage provided to the enrollee.
19 (f) "Health flex plan entity" means a health insurer,
20 health maintenance organization, health care
21 provider-sponsored organization, local government, health care
22 district, or other public or private community-based
23 organization that develops and implements an approved health
24 flex plan and is responsible for administering the health flex
25 plan and paying all claims for health flex plan coverage by
26 enrollees of the health flex plan.
27 (3) PILOT PROGRAM.--The agency and the department
28 shall each approve or disapprove health flex plans that
29 provide health care coverage for eligible participants who
30 reside in the three areas of the state that have the highest
31 number of uninsured persons, as identified in the Florida

1 Health Insurance Study conducted by the agency and in Indian
2 River County. A health flex plan may limit or exclude benefits
3 otherwise required by law for insurers offering coverage in
4 this state, may cap the total amount of claims paid per year
5 per enrollee, may limit the number of enrollees, or may take
6 any combination of those actions.
7 (a) The agency shall develop guidelines for the review
8 of applications for health flex plans and shall disapprove or
9 withdraw approval of plans that do not meet or no longer meet
10 minimum standards for quality of care and access to care.
11 (b) The department shall develop guidelines for the
12 review of health flex plan applications and shall disapprove
13 or shall withdraw approval of plans that:
14 1. Contain any ambiguous, inconsistent, or misleading
15 provisions or any exceptions or conditions that deceptively
16 affect or limit the benefits purported to be assumed in the
17 general coverage provided by the health flex plan;
18 2. Provide benefits that are unreasonable in relation
19 to the premium charged or contain provisions that are unfair
20 or inequitable or contrary to the public policy of this state,
21 that encourage misrepresentation, or that result in unfair
22 discrimination in sales practices; or
23 3. Cannot demonstrate that the health flex plan is
24 financially sound and that the applicant is able to underwrite
25 or finance the health care coverage provided.
26 (c) The agency and the department may adopt rules as
27 needed to administer this section.
28 (4) LICENSE NOT REQUIRED.--Neither the licensing
29 requirements of the Florida Insurance Code nor chapter 641,
30 Florida Statutes, relating to health maintenance
31 organizations, is applicable to a health flex plan approved

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1 under this section, unless expressly made applicable. However,
2 for the purpose of prohibiting unfair trade practices, health
3 flex plans are considered to be insurance subject to the
4 applicable provisions of part IX of chapter 626, Florida
5 Statutes, except as otherwise provided in this section.
6 (5) ELIGIBILITY.--Eligibility to enroll in an approved
7 health flex plan is limited to residents of this state who:
8 (a) Are 64 years of age or younger;
9 (b) Have a family income equal to or less than 200
10 percent of the federal poverty level;
11 (c) Are not covered by a private insurance policy and
12 are not eligible for coverage through a public health
13 insurance program, such as Medicare or Medicaid, or another
14 public health care program, such as KidCare, and have not been
15 covered at any time during the past 6 months; and
16 (d) Have applied for health care coverage through an
17 approved health flex plan and have agreed to make any payments
18 required for participation, including periodic payments or
19 payments due at the time health care services are provided.
20 (6) RECORDS.--Each health flex plan shall maintain
21 enrollment data and reasonable records of its losses,
22 expenses, and claims experience and shall make those records
23 reasonably available to enable the department to monitor and
24 determine the financial viability of the health flex plan, as
25 necessary. Provider networks and total enrollment by area
26 shall be reported to the agency biannually to enable the
27 agency to monitor access to care.
28 (7) NOTICE.--The denial of coverage by a health flex
29 plan, or the nonrenewal or cancellation of coverage, must be
30 accompanied by the specific reasons for denial, nonrenewal, or
31 cancellation. Notice of nonrenewal or cancellation must be

1 provided at least 45 days in advance of the nonrenewal or
2 cancellation, except that 10 days' written notice must be
3 given for cancellation due to nonpayment of premiums. If the
4 health flex plan fails to give the required notice, the health
5 flex plan coverage must remain in effect until notice is
6 appropriately given.
7 (8) NONENTITLEMENT.--Coverage under an approved health
8 flex plan is not an entitlement, and a cause of action does
9 not arise against the state, a local government entity, or any
10 other political subdivision of this state, or against the
11 agency, for failure to make coverage available to eligible
12 persons under this section.
13 (9) PROGRAM EVALUATION.--The agency and the department
14 shall evaluate the pilot program and its effect on the
15 entities that seek approval as health flex plans, on the
16 number of enrollees, and on the scope of the health care
17 coverage offered under a health flex plan; shall provide an
18 assessment of the health flex plans and their potential
19 applicability in other settings; and shall, by January 1,
20 2004, jointly submit a report to the Governor, the President
21 of the Senate, and the Speaker of the House of
22 Representatives.
23 (10) EXPIRATION.--This section expires July 1, 2004.
24 Section 2. Effective July 1, 2002:
25 Florida Alzheimer's Center and Research Institute.--
26 (1) The Florida Alzheimer's Center and Research
27 Institute is established at the University of South Florida.
28 (2)(a) The State Board of Education shall enter into
29 an agreement for the use of the facilities on the campus of
30 the University of South Florida to be known as the Florida
31 Alzheimer's Center and Research Institute, including all

1 furnishings, equipment, and other chattels used in the
2 operation of those facilities, with a Florida not-for-profit
3 corporation organized solely for the purpose of governing and
4 operating the Florida Alzheimer's Center and Research
5 Institute. This not-for-profit corporation, acting as an
6 instrumentality of the state, shall govern and operate the
7 Florida Alzheimer's Center and Research Institute in
8 accordance with the terms of the agreement between the State
9 Board of Education and the not-for-profit corporation. The
10 not-for-profit corporation may, with the prior approval of the
11 State Board of Education, create not-for-profit corporate
12 subsidiaries to fulfill its mission. The not-for-profit
13 corporation and its subsidiaries are authorized to receive,
14 hold, invest, and administer property and any moneys acquired
15 from private, local, state, and federal sources, as well as
16 technical and professional income generated or derived from
17 practice activities of the institute, for the benefit of the
18 institute and the fulfillment of its mission.
19 (b)1. The affairs of the not-for-profit corporation
20 shall be managed by a board of directors who shall serve
21 without compensation. The board of directors shall consist of
22 the President of the University of South Florida and the chair
23 of the State Board of Education, or their designees, 5
24 representatives of the state universities, and no fewer than 9
25 nor more than 14 representatives of the public who are neither
26 medical doctors nor state employees. Each director who is a
27 representative of a state university or of the public shall be
28 appointed to serve a term of 3 years. The chair of the board
29 of directors shall be selected by a majority vote of the
30 directors. Each director shall have only one vote.
31

1 2. The initial board of directors shall consist of the
2 President of the University of South Florida and the chair of
3 the State Board of Education, or their designees; the five
4 university representatives, of whom one is to be appointed by
5 the Governor, two by the President of the Senate, and two by
6 the Speaker of the House of Representatives; and nine public
7 representatives, of whom three are to be appointed by the
8 Governor, three by the President of the Senate, and three by
9 the Speaker of the House of Representatives. Upon the
10 expiration of the terms of the initial appointed directors,
11 all directors subject to 3-year terms of office under this
12 paragraph shall be appointed by a majority vote of the
13 directors, and the board may be expanded to include additional
14 public representative directors up to the maximum number
15 allowed. Any vacancy in office shall be filled for the
16 remainder of the term by majority vote of the directors. Any
17 director may be reappointed.
18 (3) The State Board of Education shall provide in the
19 agreement with the not-for-profit corporation for the
20 following:
21 (a) Approval by the State Board of Education of the
22 articles of incorporation of the not-for-profit corporation.
23 (b) Approval by the State Board of Education of the
24 articles of incorporation of any not-for-profit corporate
25 subsidiary created by the not-for-profit corporation.
26 (c) Use of hospital facilities and personnel by the
27 not-for-profit corporation and its subsidiaries for mutually
28 approved teaching and research programs conducted by the
29 University of South Florida or other accredited medical
30 schools or research institutes.
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1 (d) Preparation of an annual postaudit of the
2 not-for-profit corporation's financial accounts and the
3 financial accounts of any subsidiaries to be conducted by an
4 independent certified public accountant. The annual audit
5 report shall include management letters and shall be submitted
6 to the Auditor General and the State Board of Education for
7 review. The State Board of Education, the Auditor General,
8 and the Office of Program Policy Analysis and Government
9 Accountability shall have the authority to require and receive
10 from the not-for-profit corporation and any subsidiaries, or
11 from their independent auditor, any detail or supplemental
12 data relating to the operation of the not-for-profit
13 corporation or subsidiary.
14 (e) Provision by the not-for-profit corporation and
15 its subsidiaries of equal employment opportunities for all
16 persons regardless of race, color, religion, sex, age, or
17 national origin.
18 (4) The State Board of Education is authorized to
19 secure comprehensive general liability protection, including
20 professional liability protection, for the not-for-profit
21 corporation and its subsidiaries, pursuant to s. 240.213,
22 Florida Statutes.
23 (5) If the agreement between the not-for-profit
24 corporation and the State Board of Education is terminated for
25 any reason, the State Board of Education shall assume
26 governance and operation of the facilities.
27 (6) The institute shall be administered by a chief
28 executive officer, who shall be appointed by and serve at the
29 pleasure of the board of directors of the not-for-profit
30 corporation and who shall exercise the following powers and
31

1 perform the following duties, subject to the approval of the
2 board of directors:
3 (a) The chief executive officer shall establish
4 programs that fulfill the mission of the institute in
5 research, education, treatment, prevention, and early
6 detection of Alzheimer's disease; however, the chief executive
7 officer may not establish academic programs for which academic
8 credit is awarded and which culminate in the conferring of a
9 degree, without prior approval of the State Board of
10 Education.
11 (b) The chief executive officer shall have control
12 over the budget and the dollars appropriated or donated to the
13 institute from private, local, state, and federal sources, as
14 well as technical and professional income generated or derived
15 from practice activities of the institute; however,
16 professional income generated by university faculty from
17 practice activities at the institute shall be shared between
18 the institute and the university as determined by the chief
19 executive officer and the appropriate university dean or vice
20 president.
21 (c) The chief executive officer shall appoint
22 representatives of the institute to carry out the research,
23 patient care, and educational activities of the institute and
24 establish the compensation, benefits, and terms of service of
25 such representatives. Representatives of the institute shall
26 be eligible to hold concurrent appointments at affiliated
27 academic institutions. University faculty shall be eligible
28 to hold concurrent appointments at the institute.
29 (d) The chief executive officer shall have control
30 over the use and assignment of space and equipment within the
31 facilities.

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(e) The chief executive officer shall have the power to create the administrative structure necessary to carry out the mission of the institute.

(f) The chief executive officer shall have a reporting relationship to the Commissioner of Education.

(g) The chief executive officer shall provide a copy of the institute's annual report to the Governor and Cabinet, the President of the Senate, the Speaker of the House of Representatives, and the chair of the State Board of Education.

(7) The board of directors of the not-for-profit corporation shall create a council of scientific advisers to the chief executive officer consisting of leading researchers, physicians, and scientists. The council shall review programs and recommend research priorities and initiatives to maximize the state's investment in the institute. The members of the council shall be appointed by the board of directors of the not-for-profit corporation, except for five members who shall be appointed by the State Board of Education. Each member of the council shall be appointed to serve a 2-year term and may be reappointed to the council.

(8) In carrying out the provisions of this section, the not-for-profit corporation and its subsidiaries are not agencies within the meaning of s. 20.03(11), Florida Statutes.

Section 3. Section 408.7057, Florida Statutes, is amended to read:

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

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

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

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(b)~~(a)~~ "Health plan ~~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 pursuant to chapter 624, including a preferred provider organization under s. 627.6471.

(c)~~(b)~~ "Resolution organization" means a qualified independent third-party claim-dispute-resolution entity selected by and contracted with the Agency for Health Care Administration.

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

(b) The resolution organization shall review claim disputes filed by contracted and noncontracted providers and health plans ~~managed care organizations~~ unless the disputed claim:

1. Is related to interest payment;

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2. Does not meet the jurisdictional amounts or the methods of aggregation established by agency rule, as provided in paragraph (a);

3. Is part of an internal grievance in a Medicare managed care organization or a reconsideration appeal through the Medicare appeals process;

4. Is related to a health plan that is not regulated by the state;

5. Is part of a Medicaid fair hearing pursued under 42 C.F.R. ss. 431.220 et seq.;

6. Is the basis for an action pending in state or federal court; or

7. Is subject to a binding claim-dispute-resolution process provided by contract entered into prior to October 1, 2000, between the provider and the managed care organization.

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

(d) A contracted or noncontracted provider or health plan ~~maintenance organization~~ may not file a claim dispute with the resolution organization more than 12 months after a final determination has been made on a claim by a health plan ~~maintenance organization~~.

(e) The resolution organization shall require the health plan or provider submitting the claim dispute to submit any supporting documentation to the resolution organization within 15 days after receipt by the health plan or provider of a request from the resolution organization for documentation

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1 in support of the claim dispute. The resolution organization
2 may extend the time if appropriate. Failure to submit the
3 supporting documentation within such time period shall result
4 in the dismissal of the submitted claim dispute.
5 (f) The resolution organization shall require the
6 respondent in the claim dispute to submit all documentation in
7 support of its position within 15 days after receiving a
8 request from the resolution organization for supporting
9 documentation. The resolution organization may extend the time
10 if appropriate. Failure to submit the supporting documentation
11 within such time period shall result in a default against the
12 health plan or provider. In the event of such a default, the
13 resolution organization shall issue its written recommendation
14 to the agency that a default be entered against the defaulting
15 entity. The written recommendation shall include a
16 recommendation to the agency that the defaulting entity shall
17 pay the entity submitting the claim dispute the full amount of
18 the claim dispute, plus all accrued interest, and shall be
19 considered a nonprevailing party for the purposes of this
20 section.
21 (g)1. If, on an ongoing basis during the preceding 12
22 months, the agency has reason to believe that a pattern of
23 noncompliance with ss. 627.6131 and 641.3155 exists on the
24 part of a particular health plan or provider, the agency shall
25 evaluate the information contained in these cases to determine
26 whether the information evidences a pattern and report its
27 findings, together with substantiating evidence, to the
28 appropriate licensure or certification entity for the health
29 plan or provider.
30 2. In addition, the agency shall prepare a report to
31 the Governor and the Legislature by February 1 of each year

1 enumerating claims dismissed, defaults issued, and failures to
2 comply with agency final orders issued under this section.
3 (3) The agency shall adopt rules to establish a
4 process to be used by the resolution organization in
5 considering claim disputes submitted by a provider or health
6 plan ~~managed care organization~~ which must include the issuance
7 by the resolution organization of a written recommendation,
8 supported by findings of fact, to the agency within 60 days
9 after the requested information is received by the resolution
10 organization within the timeframes specified by the resolution
11 organization. In no event shall the review time exceed 90 days
12 following receipt of the initial claim dispute submission by
13 the resolution organization ~~receipt of the claim dispute~~
14 ~~submission~~.
15 (4) Within 30 days after receipt of the recommendation
16 of the resolution organization, the agency shall adopt the
17 recommendation as a final order.
18 (5) The agency shall notify within 7 days the
19 appropriate licensure or certification entity whenever there
20 is a violation of a final order issued by the agency pursuant
21 to this section.
22 (6)~~(5)~~ The entity that does not prevail in the
23 agency's order must pay a review cost to the review
24 organization, as determined by agency rule. Such rule must
25 provide for an apportionment of the review fee in any case in
26 which both parties prevail in part. If the nonprevailing party
27 fails to pay the ordered review cost within 35 days after the
28 agency's order, the nonpaying party is subject to a penalty of
29 not more than $500 per day until the penalty is paid.
30 (7)~~(6)~~ The agency ~~for Health Care Administration~~ may
31 adopt rules to administer this section.

1 Section 4. Paragraph (o) of subsection (3) of section
2 456.053, Florida Statutes, is amended to read:
3 456.053 Financial arrangements between referring
4 health care providers and providers of health care services.--
5 (3) DEFINITIONS.--For the purpose of this section, the
6 word, phrase, or term:
7 (o) "Referral" means any referral of a patient by a
8 health care provider for health care services, including,
9 without limitation:
10 1. The forwarding of a patient by a health care
11 provider to another health care provider or to an entity which
12 provides or supplies designated health services or any other
13 health care item or service; or
14 2. The request or establishment of a plan of care by a
15 health care provider, which includes the provision of
16 designated health services or other health care item or
17 service.
18 3. The following orders, recommendations, or plans of
19 care shall not constitute a referral by a health care
20 provider:
21 a. By a radiologist for diagnostic-imaging services.
22 b. By a physician specializing in the provision of
23 radiation therapy services for such services.
24 c. By a medical oncologist for drugs and solutions to
25 be prepared and administered intravenously to such
26 oncologist's patient, as well as for the supplies and
27 equipment used in connection therewith to treat such patient
28 for cancer and the complications thereof.
29 d. By a cardiologist for cardiac catheterization
30 services.
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1 e. By a pathologist for diagnostic clinical laboratory
2 tests and pathological examination services, if furnished by
3 or under the supervision of such pathologist pursuant to a
4 consultation requested by another physician.
5 f. By a health care provider who is the sole provider
6 or member of a group practice for designated health services
7 or other health care items or services that are prescribed or
8 provided solely for such referring health care provider's or
9 group practice's own patients, and that are provided or
10 performed by or under the direct supervision of such referring
11 health care provider or group practice; provided, however,
12 that effective July 1, 1999, a physician licensed pursuant to
13 chapter 458, chapter 459, chapter 460, or chapter 461 may
14 refer a patient to a sole provider or group practice for
15 diagnostic imaging services, excluding radiation therapy
16 services, for which the sole provider or group practice billed
17 both the technical and the professional fee for or on behalf
18 of the patient, if the referring physician has no investment
19 interest in the practice. The diagnostic imaging service
20 referred to a group practice or sole provider must be a
21 diagnostic imaging service normally provided within the scope
22 of practice to the patients of the group practice or sole
23 provider. The group practice or sole provider may accept no
24 more that 15 percent of their patients receiving diagnostic
25 imaging services from outside referrals, excluding radiation
26 therapy services.
27 g. By a health care provider for services provided by
28 an ambulatory surgical center licensed under chapter 395.
29 ~~h. By a health care provider for diagnostic clinical~~
30 ~~laboratory services where such services are directly related~~
31 ~~to renal dialysis.~~

h.~~i.~~ By a urologist for lithotripsy services.

i.~~j.~~ By a dentist for dental services performed by an employee of or health care provider who is an independent contractor with the dentist or group practice of which the dentist is a member.

j.~~k.~~ By a physician for infusion therapy services to a patient of that physician or a member of that physician's group practice.

k.~~l.~~ By a nephrologist for renal dialysis services and supplies, except laboratory services.

l. By a health care provider whose principal professional practice consists of treating patients in their private residences for services to be rendered in such private residences, except for services rendered by a home health agency licensed under chapter 400. For purposes of this sub-subparagraph, the term "private residences" includes patients' private homes, independent living centers, and assisted living facilities, but does not include skilled nursing facilities.

Section 5. 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, through a health care risk contract as defined in s. 641.234 with an insurer or health

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1 maintenance organization, provides billing and collection
2 services to health insurers and health maintenance
3 organizations on behalf of health care providers, other than
4 any of the following persons:
5 (a) An employer on behalf of such employer's employees
6 or the employees of one or more subsidiary or affiliated
7 corporations of such employer.
8 (b) A union on behalf of its members.
9 (c) An insurance company which is either authorized to
10 transact insurance in this state or is acting as an insurer
11 with respect to a policy lawfully issued and delivered by such
12 company in and pursuant to the laws of a state in which the
13 insurer was authorized to transact an insurance business.
14 (d) A health care services plan, health maintenance
15 organization, professional service plan corporation, or person
16 in the business of providing continuing care, possessing a
17 valid certificate of authority issued by the department, and
18 the sales representatives thereof, if the activities of such
19 entity are limited to the activities permitted under the
20 certificate of authority.
21 (e) An insurance agent licensed in this state whose
22 activities are limited exclusively to the sale of insurance.
23 (f) An adjuster licensed in this state whose
24 activities are limited to the adjustment of claims.
25 (g) A creditor on behalf of such creditor's debtors
26 with respect to insurance covering a debt between the creditor
27 and its debtors.
28 (h) A trust and its trustees, agents, and employees
29 acting pursuant to such trust established in conformity with
30 29 U.S.C. s. 186.
31

1 (i) A trust exempt from taxation under s. 501(a) of
2 the Internal Revenue Code, a trust satisfying the requirements
3 of ss. 624.438 and 624.439, or any governmental trust as
4 defined in s. 624.33(3), and the trustees and employees acting
5 pursuant to such trust, or a custodian and its agents and
6 employees, including individuals representing the trustees in
7 overseeing the activities of a service company or
8 administrator, acting pursuant to a custodial account which
9 meets the requirements of s. 401(f) of the Internal Revenue
10 Code.
11 (j) A financial institution which is subject to
12 supervision or examination by federal or state authorities or
13 a mortgage lender licensed under chapter 494 who collects and
14 remits premiums to licensed insurance agents or authorized
15 insurers concurrently or in connection with mortgage loan
16 payments.
17 (k) A credit card issuing company which advances for
18 and collects premiums or charges from its credit card holders
19 who have authorized such collection if such company does not
20 adjust or settle claims.
21 (l) A person who adjusts or settles claims in the
22 normal course of such person's practice or employment as an
23 attorney at law and who does not collect charges or premiums
24 in connection with life or health insurance coverage.
25 (m) A person approved by the Division of Workers'
26 Compensation of the Department of Labor and Employment
27 Security who administers only self-insured workers'
28 compensation plans.
29 (n) A service company or service agent and its
30 employees, authorized in accordance with ss. 626.895-626.899,
31

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1 serving only a single employer plan, multiple-employer welfare
2 arrangements, or a combination thereof.
3 (o) Any provider or group practice, as defined in s.
4 456.053, providing services under the scope of the license of
5 the provider or the member of the group practice.
6 (p) Any hospital providing billing, claims, and
7 collection services solely on its own and its physicians'
8 behalf and providing services under the scope of its license.
9
10 A person who provides billing and collection services to
11 health insurers and health maintenance organizations on behalf
12 of health care providers shall comply with the provisions of
13 ss. 627.6131, 641.3155, and 641.51(4).
14 Section 6. Section 627.6131, Florida Statutes, is
15 created to read:
16 627.6131 Payment of claims.--
17 (1) The contract shall include the following
18 provision:
19
20 "Time of Payment of Claims: After receiving
21 written proof of loss, the insurer will pay
22 monthly all benefits then due for ...(type of
23 benefit).... Benefits for any other loss
24 covered by this policy will be paid as soon as
25 the insurer receives proper written proof."
26
27 (2) As used in this section, the term "claim" for a
28 noninstitutional provider means a paper or electronic billing
29 instrument submitted to the insurer's designated location that
30 consists of the HCFA 1500 data set, or its successor, that has
31 all mandatory entries for a physician licensed under chapter

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1 458, chapter 459, chapter 460, chapter 461, or chapter 463, or
2 psychologists licensed under chapter 490 or any appropriate
3 billing instrument that has all mandatory entries for any
4 other noninstitutional provider. For institutional providers,
5 "claim" means a paper or electronic billing instrument
6 submitted to the insurer's designated location that consists
7 of the UB-92 data set or its successor with entries stated as
8 mandatory by the National Uniform Billing Committee.
9 (3) All claims for payment or overpayment, whether
10 electronic or nonelectronic:
11 (a) Are considered received on the date the claim is
12 received by the insurer at its designated claims-receipt
13 location or the date the claim for overpayment is received by
14 the provider at its designated location.
15 (b) Must be mailed or electronically transferred to
16 the primary insurer within 6 months after the following have
17 occurred:
18 1. Discharge for inpatient services or the date of
19 service for outpatient services; and
20 2. The provider has been furnished with the correct
21 name and address of the patient's health insurer.
22
23 All claims for payment, whether electronic or nonelectronic,
24 must be mailed or electronically transferred to the secondary
25 insurer within 90 days after final determination by the
26 primary insurer. A provider's claim is considered submitted on
27 the date it is electronically transferred or mailed.
28 (c) Must not duplicate a claim previously submitted
29 unless it is determined that the original claim was not
30 received or is otherwise lost.
31

1 (4)(a) For all electronically submitted claims, a
2 health insurer shall:
3 1. Within 24 hours after the beginning of the next
4 business day after receipt of the claim, provide electronic
5 acknowledgment of the receipt of the claim to the electronic
6 source submitting the claim.
7 2. Within 20 days after receipt of the claim, pay the
8 claim or notify a provider or designee if a claim is denied or
9 contested. Notice of the insurer's action on the claim and
10 payment of the claim is considered to be made on the date the
11 notice or payment was mailed or electronically transferred.
12 (b)1. Notification of the health insurer's
13 determination of a contested claim must be accompanied by an
14 itemized list of additional information or documents the
15 insurer can reasonably determine are necessary to process the
16 claim.
17 2. A provider must submit the additional information
18 or documentation, as specified on the itemized list, within 35
19 days after receipt of the notification. Additional information
20 is considered submitted on the date it is electronically
21 transferred or mailed. The health insurer may not request
22 duplicate documents.
23 (c) For purposes of this subsection, electronic means
24 of transmission of claims, notices, documents, forms, and
25 payments shall be used to the greatest extent possible by the
26 health insurer and the provider.
27 (d) A claim must be paid or denied within 90 days
28 after receipt of the claim. Failure to pay or deny a claim
29 within 120 days after receipt of the claim creates an
30 uncontestable obligation to pay the claim.
31

1 (5)(a) For all nonelectronically submitted claims, a
2 health insurer shall:
3 1. Effective November 1, 2003, provide acknowledgment
4 of receipt of the claim within 15 days after receipt of the
5 claim to the provider or provide a provider within 15 days
6 after receipt with electronic access to the status of a
7 submitted claim.
8 2. Within 40 days after receipt of the claim, pay the
9 claim or notify a provider or designee if a claim is denied or
10 contested. Notice of the insurer's action on the claim and
11 payment of the claim is considered to be made on the date the
12 notice or payment was mailed or electronically transferred.
13 (b)1. Notification of the health insurer's
14 determination of a contested claim must be accompanied by an
15 itemized list of additional information or documents the
16 insurer can reasonably determine are necessary to process the
17 claim.
18 2. A provider must submit the additional information
19 or documentation, as specified on the itemized list, within 35
20 days after receipt of the notification. Additional information
21 is considered submitted on the date it is electronically
22 transferred or mailed. The health insurer may not request
23 duplicate documents.
24 (c) For purposes of this subsection, electronic means
25 of transmission of claims, notices, documents, forms, and
26 payments shall be used to the greatest extent possible by the
27 health insurer and the provider.
28 (d) A claim must be paid or denied within 120 days
29 after receipt of the claim. Failure to pay or deny a claim
30 within 140 days after receipt of the claim creates an
31 uncontestable obligation to pay the claim.

1 (6) If a health insurer determines that it has made an
2 overpayment to a provider for services rendered to an insured,
3 the health insurer must make a claim for such overpayment to
4 the provider's designated location. A health insurer that
5 makes a claim for overpayment to a provider under this section
6 shall give the provider a written or electronic statement
7 specifying the basis for the retroactive denial or payment
8 adjustment. The insurer must identify the claim or claims, or
9 overpayment claim portion thereof, for which a claim for
10 overpayment is submitted.
11 (a) If an overpayment determination is the result of
12 retroactive review or audit of coverage decisions or payment
13 levels not related to fraud, a health insurer shall adhere to
14 the following procedures:
15 1. All claims for overpayment must be submitted to a
16 provider within 30 months after the health insurer's payment
17 of the claim. A provider must pay, deny, or contest the health
18 insurer's claim for overpayment within 40 days after the
19 receipt of the claim. All contested claims for overpayment
20 must be paid or denied within 120 days after receipt of the
21 claim. Failure to pay or deny overpayment and claim within 140
22 days after receipt creates an uncontestable obligation to pay
23 the claim.
24 2. A provider that denies or contests a health
25 insurer's claim for overpayment or any portion of a claim
26 shall notify the health insurer, in writing, within 35 days
27 after the provider receives the claim that the claim for
28 overpayment is contested or denied. The notice that the claim
29 for overpayment is denied or contested must identify the
30 contested portion of the claim and the specific reason for
31 contesting or denying the claim and, if contested, must

1 include a request for additional information. If the health
2 insurer submits additional information, the health insurer
3 must, within 35 days after receipt of the request, mail or
4 electronically transfer the information to the provider. The
5 provider shall pay or deny the claim for overpayment within 45
6 days after receipt of the information. The notice is
7 considered made on the date the notice is mailed or
8 electronically transferred by the provider.
9 3. The health insurer may not reduce payment to the
10 provider for other services unless the provider agrees to the
11 reduction in writing or fails to respond to the health
12 insurer's overpayment claim as required by this paragraph.
13 4. Payment of an overpayment claim is considered made
14 on the date the payment was mailed or electronically
15 transferred. An overdue payment of a claim bears simple
16 interest at the rate of 12 percent per year. Interest on an
17 overdue payment for a claim for an overpayment begins to
18 accrue when the claim should have been paid, denied, or
19 contested.
20 (b) A claim for overpayment shall not be permitted
21 beyond 30 months after the health insurer's payment of a
22 claim, except that claims for overpayment may be sought beyond
23 that time from providers convicted of fraud pursuant to s.
24 817.234.
25 (7) Payment of a claim is considered made on the date
26 the payment was mailed or electronically transferred. An
27 overdue payment of a claim bears simple interest of 12 percent
28 per year. Interest on an overdue payment for a claim or for
29 any portion of a claim begins to accrue when the claim should
30 have been paid, denied, or contested. The interest is payable
31 with the payment of the claim.

(8) For all contracts entered into or renewed on or after October 1, 2002, a health insurer's internal dispute resolution process related to a denied claim not under active review by a mediator, arbitrator, or third-party dispute entity must be finalized within 60 days after the receipt of the provider's request for review or appeal.

(9) A provider or any representative of a provider, regardless of whether the provider is under contract with the health insurer, may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency an insured for payment of covered services for which the health insurer contested or denied the provider's claim. This prohibition applies during the pendency of any claim for payment made by the provider to the health insurer for payment of the services or internal dispute resolution process to determine whether the health insurer is liable for the services. For a claim, this pendency applies from the date the claim or a portion of the claim is denied to the date of the completion of the health insurer's internal dispute resolution process, not to exceed 60 days. This subsection does not prohibit the collection by the provider of copayments, coinsurance, or deductible amounts due the provider.

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

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

(12) A health insurer shall pay a contracted primary care or admitting physician, pursuant to such physician's contract, for providing inpatient services in a contracted

1 hospital to an insured if such services are determined by the
2 health insurer to be medically necessary and covered services
3 under the health insurer's contract with the contract holder.
4 (13) Upon written notification by an insured, an
5 insurer shall investigate any claim of improper billing by a
6 physician, hospital, or other health care provider. The
7 insurer shall determine if the insured was properly billed for
8 only those procedures and services that the insured actually
9 received. If the insurer determines that the insured has been
10 improperly billed, the insurer shall notify the insured and
11 the provider of its findings and shall reduce the amount of
12 payment to the provider by the amount determined to be
13 improperly billed. If a reduction is made due to such
14 notification by the insured, the insurer shall pay to the
15 insured 20 percent of the amount of the reduction up to $500.
16 (14) A permissible error ratio of 5 percent is
17 established for insurer's claims payment violations of
18 paragraphs (4)(a), (b), and (d) and (5)(a), (b), and (d). If
19 the error ratio of a particular insurer does not exceed the
20 permissible error ratio of 5 percent for an audit period, no
21 fine shall be assessed for the noted claims violations for the
22 audit period. The error ratio shall be determined by dividing
23 the number of claims with violations found on a statistically
24 valid sample of claims for the audit period by the total
25 number of claims in the sample. If the error ratio exceeds
26 the permissible error ratio of 5 percent, a fine may be
27 assessed according to s. 624.4211 for those claims payment
28 violations which exceed the error ratio. Notwithstanding the
29 provisions of this section, the department may fine a health
30 insurer for claims payment violations of paragraphs (4)(d) and
31 (5)(d) which create an uncontestable obligation to pay the

1 claim. The department shall not fine insurers for violations
2 which the department determines were due to circumstances
3 beyond the insurer's control.
4 (15) This section is applicable only to a major
5 medical expense health insurance policy as defined in s.
6 627.643(2)(e) offered by a group or an individual health
7 insurer licensed pursuant to chapter 624, including a
8 preferred provider policy under s. 627.6471 and an exclusive
9 provider organization under s. 627.6472 or a group or
10 individual insurance contract that only provides direct
11 payments to dentists for enumerated dental services.
12 (16) Notwithstanding paragraph (4)(a)2., where an
13 electronic pharmacy claim is submitted to a pharmacy benefits
14 manager acting on behalf of a health insurer, the pharmacy
15 benefits manager shall, within 30 days after receipt of the
16 claim, pay the claim or notify a provider or designee if a
17 claim is denied or contested. Notice of the insurer's action
18 on the claim and payment of the claim is considered to be made
19 on the date the notice or payment was mailed or electronically
20 transferred.
21 (17) Notwithstanding paragraph (5)(a)1., effective
22 November 1, 2003, where a nonelectronic pharmacy claim is
23 submitted to a pharmacy benefits manager acting on behalf of a
24 health insurer, the pharmacy benefits manager shall provide
25 acknowledgment of receipt of the claim within 30 days after
26 receipt of the claim to the provider or provide a provider
27 within 30 days after receipt with electronic access to the
28 status of a submitted claim.
29 Section 7. Subsection (4) of section 627.651, Florida
30 Statutes, is amended to read:
31

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(7)~~(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 8. 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 627.613, relating to timely payment of claims, or s. 627.6131, relating to payment of claims.

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

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1 (8)~~(7)~~ Section 627.613, relating to time of payment of
2 claims.
3 (9)~~(8)~~ Section 627.6471, relating to preferred
4 provider organizations.
5 (10)~~(9)~~ Section 627.6472, relating to exclusive
6 provider organizations.
7 (11)~~(10)~~ Section 627.6473, relating to combined
8 preferred provider and exclusive provider policies.
9 (12)~~(11)~~ Section 627.6474, relating to provider
10 contracts.
11 Section 9. Paragraph (b) of subsection (6) and
12 paragraph (a) of subsection (15) of section 627.6699, Florida
13 Statutes, are amended to read:
14 627.6699 Employee Health Care Access Act.--
15 (6) RESTRICTIONS RELATING TO PREMIUM RATES.--
16 (b) For all small employer health benefit plans that
17 are subject to this section and are issued by small employer
18 carriers on or after January 1, 1994, premium rates for health
19 benefit plans subject to this section are subject to the
20 following:
21 1. Small employer carriers must use a modified
22 community rating methodology in which the premium for each
23 small employer must be determined solely on the basis of the
24 eligible employee's and eligible dependent's gender, age,
25 family composition, tobacco use, or geographic area as
26 determined under paragraph (5)(j) and in which the premium may
27 be adjusted as permitted by this paragraph ~~subparagraphs 5.~~
28 ~~and 6~~.
29 2. Rating factors related to age, gender, family
30 composition, tobacco use, or geographic location may be
31 developed by each carrier to reflect the carrier's experience.

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1 The factors used by carriers are subject to department review
2 and approval.
3 3. Small employer carriers may not modify the rate for
4 a small employer for 12 months from the initial issue date or
5 renewal date, unless the composition of the group changes or
6 benefits are changed. However, a small employer carrier may
7 modify the rate one time prior to 12 months after the initial
8 issue date for a small employer who enrolls under a previously
9 issued group policy that has a common anniversary date for all
10 employers covered under the policy if:
11 a. The carrier discloses to the employer in a clear
12 and conspicuous manner the date of the first renewal and the
13 fact that the premium may increase on or after that date.
14 b. The insurer demonstrates to the department that
15 efficiencies in administration are achieved and reflected in
16 the rates charged to small employers covered under the policy.
17 4. A carrier may issue a group health insurance policy
18 to a small employer health alliance or other group association
19 with rates that reflect a premium credit for expense savings
20 attributable to administrative activities being performed by
21 the alliance or group association if such expense savings are
22 specifically documented in the insurer's rate filing and are
23 approved by the department. Any such credit may not be based
24 on different morbidity assumptions or on any other factor
25 related to the health status or claims experience of any
26 person covered under the policy. Nothing in this subparagraph
27 exempts an alliance or group association from licensure for
28 any activities that require licensure under the insurance
29 code. A carrier issuing a group health insurance policy to a
30 small employer health alliance or other group association
31 shall allow any properly licensed and appointed agent of that

1 carrier to market and sell the small employer health alliance
2 or other group association policy. Such agent shall be paid
3 the usual and customary commission paid to any agent selling
4 the policy.
5 5. Any adjustments in rates for claims experience,
6 health status, or duration of coverage may not be charged to
7 individual employees or dependents. For a small employer's
8 policy, such adjustments may not result in a rate for the
9 small employer which deviates more than 15 percent from the
10 carrier's approved rate. Any such adjustment must be applied
11 uniformly to the rates charged for all employees and
12 dependents of the small employer. A small employer carrier may
13 make an adjustment to a small employer's renewal premium, not
14 to exceed 10 percent annually, due to the claims experience,
15 health status, or duration of coverage of the employees or
16 dependents of the small employer. Semiannually, small group
17 carriers shall report information on forms adopted by rule by
18 the department, to enable the department to monitor the
19 relationship of aggregate adjusted premiums actually charged
20 policyholders by each carrier to the premiums that would have
21 been charged by application of the carrier's approved modified
22 community rates. If the aggregate resulting from the
23 application of such adjustment exceeds the premium that would
24 have been charged by application of the approved modified
25 community rate by 5 percent for the current reporting period,
26 the carrier shall limit the application of such adjustments
27 only to minus adjustments beginning not more than 60 days
28 after the report is sent to the department. For any subsequent
29 reporting period, if the total aggregate adjusted premium
30 actually charged does not exceed the premium that would have
31 been charged by application of the approved modified community

1 rate by 5 percent, the carrier may apply both plus and minus
2 adjustments. A small employer carrier may provide a credit to
3 a small employer's premium based on administrative and
4 acquisition expense differences resulting from the size of the
5 group. Group size administrative and acquisition expense
6 factors may be developed by each carrier to reflect the
7 carrier's experience and are subject to department review and
8 approval.
9 6. A small employer carrier rating methodology may
10 include separate rating categories for one dependent child,
11 for two dependent children, and for three or more dependent
12 children for family coverage of employees having a spouse and
13 dependent children or employees having dependent children
14 only. A small employer carrier may have fewer, but not
15 greater, numbers of categories for dependent children than
16 those specified in this subparagraph.
17 7. Small employer carriers may not use a composite
18 rating methodology to rate a small employer with fewer than 10
19 employees. For the purposes of this subparagraph, a "composite
20 rating methodology" means a rating methodology that averages
21 the impact of the rating factors for age and gender in the
22 premiums charged to all of the employees of a small employer.
23 8.a. A carrier may separate the experience of small
24 employer groups with fewer than 2 eligible employees from the
25 experience of small employer groups with 2-50 eligible
26 employees for purposes of determining an alternative modified
27 community rating.
28 b. If a carrier separates the experience of small
29 employer groups as provided in sub-subparagraph a., the rate
30 to be charged to small employer groups of fewer than 2
31 eligible employees may not exceed 150 percent of the rate

1 determined for small employer groups of 2-50 eligible
2 employees. However, the carrier may charge excess losses of
3 the experience pool consisting of small employer groups with
4 fewer than 2 eligible employees to the experience pool
5 consisting of small employer groups with 2-50 eligible
6 employees so that all losses are allocated and the 150-percent
7 rate limit on the experience pool consisting of small employer
8 groups with fewer than 2 eligible employees is maintained.
9 Notwithstanding s. 627.411(1), the rate to be charged to a
10 small employer group of fewer than 2 eligible employees,
11 insured as of July 1, 2002, may be up to 125 percent of the
12 rate determined for small employer groups of 2-50 eligible
13 employees for the first annual renewal and 150 percent for
14 subsequent annual renewals.
15 (15) APPLICABILITY OF OTHER STATE LAWS.--
16 (a) Except as expressly provided in this section, a
17 law requiring coverage for a specific health care service or
18 benefit, or a law requiring reimbursement, utilization, or
19 consideration of a specific category of licensed health care
20 practitioner, does not apply to a standard or basic health
21 benefit plan policy or contract or a limited benefit policy or
22 contract offered or delivered to a small employer unless that
23 law is made expressly applicable to such policies or
24 contracts. A law restricting or limiting deductibles,
25 coinsurance, copayments, or annual or lifetime maximum
26 payments does not apply to any health plan policy, including a
27 standard or basic health benefit plan policy or contract,
28 offered or delivered to a small employer unless such law is
29 made expressly applicable to such policy or contract. However,
30 every small employer carrier must offer to eligible small
31 employers the standard benefit plan and the basic benefit

1 plan, as required by subsection (5), as such plans have been
2 approved by the department pursuant to subsection (12).
3 Section 10. Paragraph (e) of subsection (1) of section
4 641.185, Florida Statutes, is amended to read:
5 641.185 Health maintenance organization subscriber
6 protections.--
7 (1) With respect to the provisions of this part and
8 part III, the principles expressed in the following statements
9 shall serve as standards to be followed by the Department of
10 Insurance and the Agency for Health Care Administration in
11 exercising their powers and duties, in exercising
12 administrative discretion, in administrative interpretations
13 of the law, in enforcing its provisions, and in adopting
14 rules:
15 (e) A health maintenance organization subscriber
16 should receive timely, concise information regarding the
17 health maintenance organization's reimbursement to providers
18 and services pursuant to ss. 641.31 and 641.31015 and should
19 receive prompt payment from the organization pursuant to s.
20 641.3155.
21 Section 11. Subsection (4) is added to section
22 641.234, Florida Statutes, to read:
23 641.234 Administrative, provider, and management
24 contracts.--
25 (4)(a) If a health maintenance organization, through a
26 health care risk contract, transfers to any entity the
27 obligations to pay any provider for any claims arising from
28 services provided to or for the benefit of any subscriber of
29 the organization, the health maintenance organization shall
30 remain responsible for any violations of ss. 641.3155,
31 641.3156, 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. The term does not include a hospital providing billing, claims, and collection services solely on its own and its physicians' behalf and providing services under the scope of its license.

Section 12. 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 13. Subsection (4) of section 641.3154, Florida Statutes, is amended to read:

641.3154 Organization liability; provider billing prohibited.--

(4) A provider or any representative of a provider, regardless of whether the provider is under contract with the health maintenance organization, may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency a subscriber of an organization for

1 payment of services for which the organization is liable, if
2 the provider in good faith knows or should know that the
3 organization is liable. This prohibition applies during the
4 pendency of any claim for payment made by the provider to the
5 organization for payment of the services and any legal
6 proceedings or dispute resolution process to determine whether
7 the organization is liable for the services if the provider is
8 informed that such proceedings are taking place. It is
9 presumed that a provider does not know and should not know
10 that an organization is liable unless:
11 (a) The provider is informed by the organization that
12 it accepts liability;
13 (b) A court of competent jurisdiction determines that
14 the organization is liable; ~~or~~
15 (c) The department or agency makes a final
16 determination that the organization is required to pay for
17 such services subsequent to a recommendation made by the
18 Statewide Provider and Subscriber Assistance Panel pursuant to
19 s. 408.7056; or
20 (d) The agency issues a final order that the
21 organization is required to pay for such services subsequent
22 to a recommendation made by a resolution organization pursuant
23 to s. 408.7057.
24 Section 14. Section 641.3155, Florida Statutes, is
25 amended to read:
26 (Substantial rewording of section. See
27 s. 641.3155, F.S., for present text.)
28 641.3155 Prompt payment of claims.--
29 (1) As used in this section, the term "claim" for a
30 noninstitutional provider means a paper or electronic billing
31 instrument submitted to the health maintenance organization's

1 designated location that consists of the HCFA 1500 data set,
2 or its successor, that has all mandatory entries for a
3 physician licensed under chapter 458, chapter 459, chapter
4 460, chapter 461, or chapter 463, or psychologists licensed
5 under chapter 490 or any appropriate billing instrument that
6 has all mandatory entries for any other noninstitutional
7 provider. For institutional providers, "claim" means a paper
8 or electronic billing instrument submitted to the health
9 maintenance organization's designated location that consists
10 of the UB-92 data set or its successor with entries stated as
11 mandatory by the National Uniform Billing Committee.
12 (2) All claims for payment or overpayment, whether
13 electronic or nonelectronic:
14 (a) Are considered received on the date the claim is
15 received by the organization at its designated claims-receipt
16 location or the date a claim for overpayment is received by
17 the provider at its designated location.
18 (b) Must be mailed or electronically transferred to
19 the primary organization within 6 months after the following
20 have occurred:
21 1. Discharge for inpatient services or the date of
22 service for outpatient services; and
23 2. The provider has been furnished with the correct
24 name and address of the patient's health maintenance
25 organization.
26
27 All claims for payment, whether electronic or nonelectronic,
28 must be mailed or electronically transferred to the secondary
29 organization within 90 days after final determination by the
30 primary organization. A provider's claim is considered
31

1 submitted on the date it is electronically transferred or
2 mailed.
3 (c) Must not duplicate a claim previously submitted
4 unless it is determined that the original claim was not
5 received or is otherwise lost.
6 (3)(a) For all electronically submitted claims, a
7 health maintenance organization shall:
8 1. Within 24 hours after the beginning of the next
9 business day after receipt of the claim, provide electronic
10 acknowledgment of the receipt of the claim to the electronic
11 source submitting the claim.
12 2. Within 20 days after receipt of the claim, pay the
13 claim or notify a provider or designee if a claim is denied or
14 contested. Notice of the organization's action on the claim
15 and payment of the claim is considered to be made on the date
16 the notice or payment was mailed or electronically
17 transferred.
18 (b)1. Notification of the health maintenance
19 organization's determination of a contested claim must be
20 accompanied by an itemized list of additional information or
21 documents the insurer can reasonably determine are necessary
22 to process the claim.
23 2. A provider must submit the additional information
24 or documentation, as specified on the itemized list, within 35
25 days after receipt of the notification. Additional information
26 is considered submitted on the date it is electronically
27 transferred or mailed. The health maintenance organization may
28 not request duplicate documents.
29 (c) For purposes of this subsection, electronic means
30 of transmission of claims, notices, documents, forms, and
31

1 payment shall be used to the greatest extent possible by the
2 health maintenance organization and the provider.
3 (d) A claim must be paid or denied within 90 days
4 after receipt of the claim. Failure to pay or deny a claim
5 within 120 days after receipt of the claim creates an
6 uncontestable obligation to pay the claim.
7 (4)(a) For all nonelectronically submitted claims, a
8 health maintenance organization shall:
9 1. Effective November 1, 2003, provide acknowledgement
10 of receipt of the claim within 15 days after receipt of the
11 claim to the provider or designee or provide a provider or
12 designee within 15 days after receipt with electronic access
13 to the status of a submitted claim.
14 2. Within 40 days after receipt of the claim, pay the
15 claim or notify a provider or designee if a claim is denied or
16 contested. Notice of the health maintenance organization's
17 action on the claim and payment of the claim is considered to
18 be made on the date the notice or payment was mailed or
19 electronically transferred.
20 (b)1. Notification of the health maintenance
21 organization's determination of a contested claim must be
22 accompanied by an itemized list of additional information or
23 documents the organization can reasonably determine are
24 necessary to process the claim.
25 2. A provider must submit the additional information
26 or documentation, as specified on the itemized list, within 35
27 days after receipt of the notification. Additional information
28 is considered submitted on the date it is electronically
29 transferred or mailed. The health maintenance organization may
30 not request duplicate documents.
31

1 (c) For purposes of this subsection, electronic means
2 of transmission of claims, notices, documents, forms, and
3 payments shall be used to the greatest extent possible by the
4 health maintenance organization and the provider.
5 (d) A claim must be paid or denied within 120 days
6 after receipt of the claim. Failure to pay or deny a claim
7 within 140 days after receipt of the claim creates an
8 uncontestable obligation to pay the claim.
9 (5) If a health maintenance organization determines
10 that it has made an overpayment to a provider for services
11 rendered to a subscriber, the health maintenance organization
12 must make a claim for such overpayment to the provider's
13 designated location. A health maintenance organization that
14 makes a claim for overpayment to a provider under this section
15 shall give the provider a written or electronic statement
16 specifying the basis for the retroactive denial or payment
17 adjustment. The health maintenance organization must identify
18 the claim or claims, or overpayment claim portion thereof, for
19 which a claim for overpayment is submitted.
20 (a) If an overpayment determination is the result of
21 retroactive review or audit of coverage decisions or payment
22 levels not related to fraud, a health maintenance organization
23 shall adhere to the following procedures:
24 1. All claims for overpayment must be submitted to a
25 provider within 30 months after the health maintenance
26 organization's payment of the claim. A provider must pay,
27 deny, or contest the health maintenance organization's claim
28 for overpayment within 40 days after the receipt of the claim.
29 All contested claims for overpayment must be paid or denied
30 within 120 days after receipt of the claim. Failure to pay or
31

1 deny overpayment and claim within 140 days after receipt
2 creates an uncontestable obligation to pay the claim.
3 2. A provider that denies or contests a health
4 maintenance organization's claim for overpayment or any
5 portion of a claim shall notify the organization, in writing,
6 within 35 days after the provider receives the claim that the
7 claim for overpayment is contested or denied. The notice that
8 the claim for overpayment is denied or contested must identify
9 the contested portion of the claim and the specific reason for
10 contesting or denying the claim and, if contested, must
11 include a request for additional information. If the
12 organization submits additional information, the organization
13 must, within 35 days after receipt of the request, mail or
14 electronically transfer the information to the provider. The
15 provider shall pay or deny the claim for overpayment within 45
16 days after receipt of the information. The notice is
17 considered made on the date the notice is mailed or
18 electronically transferred by the provider.
19 3. The health maintenance organization may not reduce
20 payment to the provider for other services unless the provider
21 agrees to the reduction in writing or fails to respond to the
22 health maintenance organization's overpayment claim as
23 required by this paragraph.
24 4. Payment of an overpayment claim is considered made
25 on the date the payment was mailed or electronically
26 transferred. An overdue payment of a claim bears simple
27 interest at the rate of 12 percent per year. Interest on an
28 overdue payment for a claim for an overpayment payment begins
29 to accrue when the claim should have been paid, denied, or
30 contested.
31

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

1 (b) A claim for overpayment shall not be permitted
2 beyond 30 months after the health maintenance organization's
3 payment of a claim, except that claims for overpayment may be
4 sought beyond that time from providers convicted of fraud
5 pursuant to s. 817.234.
6 (6) Payment of a claim is considered made on the date
7 the payment was mailed or electronically transferred. An
8 overdue payment of a claim bears simple interest of 12 percent
9 per year. Interest on an overdue payment for a claim or for
10 any portion of a claim begins to accrue when the claim should
11 have been paid, denied, or contested. The interest is payable
12 with the payment of the claim.
13 (7)(a) For all contracts entered into or renewed on or
14 after October 1, 2002, a health maintenance organization's
15 internal dispute resolution process related to a denied claim
16 not under active review by a mediator, arbitrator, or
17 third-party dispute entity must be finalized within 60 days
18 after the receipt of the provider's request for review or
19 appeal.
20 (b) All claims to a health maintenance organization
21 begun after October 1, 2000, not under active review by a
22 mediator, arbitrator, or third-party dispute entity shall
23 result in a final decision on the claim by the health
24 maintenance organization by January 2, 2003, for the purpose
25 of the statewide provider and health plan claim dispute
26 resolution program pursuant to s. 408.7057.
27 (8) A provider or any representative of a provider,
28 regardless of whether the provider is under contract with the
29 health maintenance organization, may not collect or attempt to
30 collect money from, maintain any action at law against, or
31 report to a credit agency a subscriber for payment of covered

1 services for which the health maintenance organization
2 contested or denied the provider's claim. This prohibition
3 applies during the pendency of any claim for payment made by
4 the provider to the health maintenance organization for
5 payment of the services or internal dispute resolution process
6 to determine whether the health maintenance organization is
7 liable for the services. For a claim, this pendency applies
8 from the date the claim or a portion of the claim is denied to
9 the date of the completion of the health maintenance
10 organization's internal dispute resolution process, not to
11 exceed 60 days. This subsection does not prohibit collection
12 by the provider of copayments, coinsurance, or deductible
13 amounts due the provider.
14 (9) The provisions of this section may not be waived,
15 voided, or nullified by contract.
16 (10) A health maintenance organization may not
17 retroactively deny a claim because of subscriber ineligibility
18 more than 1 year after the date of payment of the claim.
19 (11) A health maintenance organization shall pay a
20 contracted primary care or admitting physician, pursuant to
21 such physician's contract, for providing inpatient services in
22 a contracted hospital to a subscriber if such services are
23 determined by the health maintenance organization to be
24 medically necessary and covered services under the health
25 maintenance organization's contract with the contract holder.
26 (12) A permissible error ratio of 5 percent is
27 established for health maintenance organizations' claims
28 payment violations of paragraphs (3)(a), (b), and (d) and
29 (4)(a), (b), and (d). If the error ratio of a particular
30 insurer does not exceed the permissible error ratio of 5
31 percent for an audit period, no fine shall be assessed for the

1 noted claims violations for the audit period. The error ratio
2 shall be determined by dividing the number of claims with
3 violations found on a statistically valid sample of claims for
4 the audit period by the total number of claims in the sample.
5 If the error ratio exceeds the permissible error ratio of 5
6 percent, a fine may be assessed according to s. 624.4211 for
7 those claims payment violations which exceed the error ratio.
8 Notwithstanding the provisions of this section, the department
9 may fine a health maintenance organization for claims payment
10 violations of paragraphs (3)(d) and (4)(d) which create an
11 uncontestable obligation to pay the claim. The department
12 shall not fine organizations for violations which the
13 department determines were due to circumstances beyond the
14 organization's control.
15 (13) This section shall apply to all claims or any
16 portion of a claim submitted by a health maintenance
17 organization subscriber under a health maintenance
18 organization subscriber contract to the organization for
19 payment.
20 (14) Notwithstanding paragraph (3)(a)2., where an
21 electronic pharmacy claim is submitted to a pharmacy benefits
22 manager acting on behalf of a health maintenance organization
23 the pharmacy benefits manager shall, within 30 days after
24 receipt of the claim, pay the claim or notify a provider or
25 designee if a claim is denied or contested. Notice of the
26 organization's action on the claim and payment of the claim is
27 considered to be made on the date the notice or payment was
28 mailed or electronically transferred.
29 (15) Notwithstanding paragraph (4)(a)1., effective
30 November 1, 2003, where a nonelectronic pharmacy claim is
31 submitted to a pharmacy benefits manager acting on behalf of a

health maintenance organization, the pharmacy benefits manager shall provide acknowledgment of receipt of the claim within 30 days after receipt of the claim to the provider or provide a provider within 30 days after receipt with electronic access to the status of a submitted claim.

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. Effective upon this act becoming a law:

If any law amended by this act was also amended by a law enacted during the 2002 Regular Session of the Legislature, such laws shall be construed to have been enacted during the same session of the Legislature and full effect shall be given to each if possible.

Section 17. Except as otherwise provided herein, this act shall take effect October 1, 2002.

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2 HOUSE SUMMARY

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Provides for a pilot program for health flex plans for uninsured persons, exempts approved health flex plans from licensing requirements, provides for eligibility to enroll in a health flex plan, provides requirements for health flex plans, and provides for civil actions against health plan entities by the Agency for Health Care Administration. Establishes the Florida Alzheimer's Center and Research Institute at the University of South Florida and provides for the governance, operation, and administration of the institute by a corporation through the State Board of Education. Requires the appointment of a council of scientific advisers. Revises provisions of the claim dispute resolution program. Specifies payment-of-claims provisions applicable to health insurers and health maintenance organizations and provides requirements and procedures for paying, denying, or contesting claims. See bill for details.

4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

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