A bill to be entitled

An act relating to charges for health care services; amending s. 641.513, F.S.; providing that the rate for emergency care charged to a health maintenance organization by a health care provider who does not have a contract with the health maintenance organization may not exceed the Medicare rate; providing maximum charges for certain followup services; amending s. 627.6131, F.S.; providing that certain unlawful actions with regard to bill collecting by health care providers also constitutes a violation of the Florida Deceptive and Unfair Trade Practices Act; amending s. 641.3155, F.S.; providing that certain unlawful actions with regard to bill collecting by health care providers also constitutes a violation of the Florida Deceptive and Unfair Trade Practices Act; amending s. 395.301, F.S.; requiring that certain charges and changes in charges for health care services must be made available to the public; requiring certain health care facilities to make records available to patients and those paying on behalf of patients for the purpose of verifying the accuracy of billings; amending s. 395.10973, F.S.; requiring the Agency for Health Care Administration to audit certain billings; establishing a permissible error ratio for such billings; providing fines for facilities that exceed the error ratio; providing an effective date.

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

Section 1. Subsection (5) of section 641.513, Florida Statutes, is amended and subsection (7) is added to said section, to read:

641.513 Requirements for providing emergency services and care.--

(5) Reimbursement for services pursuant to this section by a provider who does not have a contract with the health maintenance organization shall be the lesser of:

(a) The provider's charges;

(b) The usual and customary provider charges for similar services in the community where the services were provided; ~~or~~

(c) The charge mutually agreed to by the health maintenance organization and the provider within 60 days <u>after</u> ~~of~~ the submittal of the claim<u>; or</u>

<u>(d) The Medicare payment rate for the services in accordance with the prevailing Medicare allowable fee schedule</u>.

Such reimbursement shall be net of any applicable copayment authorized pursuant to subsection (4).

<u>(7) Reimbursement for any medically necessary followup services provided to subscribers who are not Medicaid recipients by a provider for whom no contract exists between the provider and the health maintenance organization shall be the lesser of:

(a) The provider's charges;

(b) The usual and customary provider charges for similar services in the community where the services were provided;

(c) The charge mutually agreed to by the health maintenance organization and the provider within 60 days after the submittal of the claim; or</u>

(d) The Medicare payment rate for the services in accordance with the prevailing Medicare allowable fee schedule.

Section 2. Subsection (9) of section 627.6131, Florida Statutes, is amended to read:

627.6131 Payment of claims.--

(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. The failure of the provider to observe the requirements of this subsection which constitute a violation of this subsection also constitutes a deceptive and unfair trade practice for the purposes of ss. 501.201-501.213, and administrative rules adopted thereunder. This subsection does not prohibit the collection by the provider of copayments, coinsurance, or deductible amounts due the provider.

Section 3. Subsection (8) of section 641.3155, Florida Statutes, is amended to read:

641.3155 Prompt payment of claims.--

(8) 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 for payment of covered services for which the health maintenance organization 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 maintenance organization for payment of the services or internal dispute resolution process to determine whether the health maintenance organization 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 maintenance organization's internal dispute resolution process, not to exceed 60 days. The failure of the provider to observe the requirements of this subsection which constitute a violation of this subsection also constitutes a deceptive and unfair trade practice for the purposes of ss. 501.201-501.213, and administrative rules adopted thereunder. This subsection does not prohibit collection by the provider of copayments, coinsurance, or deductible amounts due the provider.

Section 4. Subsections (7) and (8) are added to section 395.301, Florida Statutes, to read:

395.301 Itemized patient bill; form and content prescribed by the agency.--

(7) A licensed facility not operated by the state must make available to the public on its internet website or by other electronic means and in its reception areas open to the public a listing of all of its charges or charge master and its average length of stay associated with established diagnostic groups. The facility’s list of charges, codes, and description of services must be consistent with federal electronic transmission

uniform standards under the Health Insurance Portability and Accountability Act. The facility must provide 30 days public notice at all required posting areas, including by electronic means, prior to implementing any changes to its list of charges or charge master. The notice must separately identify the amount and percent by which a charge is being reduced or increased. The facility must include on such notice an explanation developed by the agency as to how the public may use the information in the selection of a health care facility.

(8) A licensed facility not operated by the state must make available to a patient or a payor acting on behalf of the patient records necessary for verification of the accuracy of the patient's bill or payor's claim related to such patient's bill within a reasonable time after the request for such records. The verification information must be made available in the facility's offices. Such records shall be available to the patient or payor prior to and after payment of the bill or claim. The facility may not charge the patient or payor for making such verification records available, except that the facility may charge its usual charge for providing copies of records as specified in s. 395.3025.

Section 5. Subsection (9) is added to section 395.10973, Florida Statutes, to read:

395.10973 Powers and duties of the agency.--It is the function of the agency to:

(9) Develop a program to audit the accuracy of patient bills and payor claims for provider charges of $20,000 or more. The audit shall establish a facility's error ratio for bill or claim errors. An error ratio of up to 5 percent is permissible. The error ratio shall be determined by dividing the number of

claims and bills with violations found on a statistically valid sample of claims and bills for provider charges of $20,000 or more for the audit period by the total number of claims and bills in the sample. If the error ratio exceeds the permissible error ratio of 5 percent, a fine may be assessed for those claims and bill errors which exceed the error ratio in the amount of $500 per error, but not to exceed $100,000 for the noted audit period.

Section 6. This act shall take effect upon becoming a law.