A bill to be entitled

An act relating to the provision of health care services; amending s. 627.6131, F.S.; prohibiting a health insurer from demanding repayment of an overpayment made due to error of the health insurer; reducing a period of time for a claim for overpayment; requiring a health insurer to pay, and prohibiting denial of, a claim for treatment under certain circumstances; providing exceptions; authorizing certain aggrieved persons to bring certain actions for certain violations; providing for recovery of amounts, interest, attorney's fees, and court costs; providing limits; requiring attorneys to submit affidavits for fees; providing for awards of fees or costs to become a part of the judgment and subject to execution; providing for application; amending s. 641.19, F.S.; clarifying a definition; amending s. 641.31, F.S.; prohibiting health maintenance contracts from prohibiting or restricting subscribers from assigning plan benefits to noncontract physicians for certain services; requiring recognition of the assignment and payment of services; providing requirements for certain physicians accepting such assignments; amending s. 641.315, F.S.; revising required contract termination provisions; amending s. 641.3155, F.S.; prohibiting a health maintenance organization from demanding repayment of an overpayment made due to error of the health maintenance organization; reducing a period of time for a claim for overpayment; authorizing certain aggrieved persons to bring certain actions for certain

violations; providing for recovery of amounts, interest, attorney's fees, and court costs; providing limits; requiring attorneys to submit affidavits for fees; providing for awards of fees or costs to become a part of the judgment and subject to execution; providing for application; amending s. 641.3156, F.S.; requiring a health maintenance organization to pay, and prohibiting denial of, a claim for treatment under certain circumstances; providing exceptions; amending s. 641.513, F.S.; revising provisions for reimbursement of noncontract providers; providing an effective date.

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

Section 1. Subsection (6) of section 627.6131, Florida Statutes, is amended, and subsections (18) and (19) are added to said section, to read:

627.6131 Payment of claims.--

(6) If a health insurer determines that it has made an overpayment to a provider for services rendered to an insured, the health insurer must make a claim for such overpayment to the provider's designated location. A health insurer may not demand repayment from the provider in any instance in which the overpayment is attributable to error of the health insurer. A health insurer that makes a claim for overpayment to a provider under this section shall give the provider a written or electronic statement specifying the basis for the retroactive denial or payment adjustment. The insurer must identify the

claim or claims, or overpayment claim portion thereof, for which a claim for overpayment is submitted.

(a) If an overpayment determination is the result of retroactive review or audit of coverage decisions or payment levels not related to fraud, a health insurer shall adhere to the following procedures:

1. All claims for overpayment must be submitted to a provider within 12 ~~30~~ months after the health insurer's payment of the claim. A provider must pay, deny, or contest the health insurer's claim for overpayment within 40 days after the receipt of the claim. All contested claims for overpayment must be paid or denied within 120 days after receipt of the claim. Failure to pay or deny overpayment and claim within 140 days after receipt creates an uncontestable obligation to pay the claim.

2. A provider that denies or contests a health insurer's claim for overpayment or any portion of a claim shall notify the health insurer, in writing, within 35 days after the provider receives the claim that the claim for overpayment is contested or denied. The notice that the claim for overpayment is denied or contested must identify the contested portion of the claim and the specific reason for contesting or denying the claim and, if contested, must include a request for additional information. If the health insurer submits additional information, the health insurer must, within 35 days after receipt of the request, mail or electronically transfer the information to the provider. The provider shall pay or deny the claim for overpayment within 45 days after receipt of the information. The notice is considered

made on the date the notice is mailed or electronically transferred by the provider.

3. The health insurer may not reduce payment to the provider for other services unless the provider agrees to the reduction in writing or fails to respond to the health insurer's overpayment claim as required by this paragraph.

4. Payment of an overpayment claim is considered made on the date the payment was mailed or electronically transferred. An overdue payment of a claim bears simple interest at the rate of 12 percent per year. Interest on an overdue payment for a claim for an overpayment begins to accrue when the claim should have been paid, denied, or contested.

(b) A claim for overpayment shall not be permitted beyond 12 ~~30~~ months after the health insurer's payment of a claim, except that claims for overpayment may be sought beyond that time from providers convicted of fraud pursuant to s. 817.234.

(18) A claim for treatment must be paid by a health insurer and may not be denied if a provider, whether or not under contract with the health insurer, follows the insurer's authorization procedures and receives authorization for a covered service for an eligible subscriber, unless the provider provided information to the health insurer with willful intent to misinform the health insurer. Emergency services are subject to the provisions of ss. 395.1041 and 401.45 and are not subject to the provisions of this subsection.

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

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

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

(c)1. In any civil action brought pursuant to this subsection, the prevailing party, after judgment in the trial court and after exhausting all appeals, if any, shall receive his or her attorney's fees and costs from the nonprevailing party.

2. If the provider is the prevailing party, such fees shall not exceed three times the amount in controversy or $10,000, whichever is greater.

3. If the health insurer is the prevailing party on any claim or defense for which the court finds that the insured or the insured's assignee knew or should have known that the claim or defense was not supported by the material facts necessary to establish the claim or defense, or would not be supported by the application of then-existing law as to those material facts, such fees shall not exceed two times the amount in controversy or $5,000, whichever is greater.

(d)1. In any civil action brought by a health insurer pursuant to this subsection, the prevailing party, after judgment in the trial court and after exhausting all appeals, if

any, shall receive his or her attorney's fees and costs from the nonprevailing party.

2. If the health insurer is the prevailing party on any claim or defense for which the court finds that the insured or the insured's assignee knew or should have known that the claim or defense was not supported by the material facts necessary to establish the claim or defense, or would not be supported by the application of then-existing law as to those material facts, such fees shall not exceed two times the amount in controversy or $5,000, whichever is greater.

3. If the insured or the insured's assignee is the prevailing party, such fees shall not exceed three times the amount in controversy or $10,000, whichever is greater.

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

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

(g) This subsection shall apply in any proceeding in which the provider alleges that the health insurer has failed to comply with its contractual obligations.

Section 2. Subsection (16) of section 641.19, Florida Statutes, is amended to read:

641.19 Definitions.--As used in this part, the term:

(16) "Schedule of reimbursements" means a schedule of fees to be paid by a health maintenance organization to a physician

provider for reimbursement for specific services pursuant to the terms of a contract. The physician provider's net reimbursement may vary after consideration of other factors, including, but not limited to, bundling codes together into another code, modifiers used, and member cost-sharing responsibility, as long as these factors are disclosed and included in the terms of the contract between the health maintenance organization and provider. The reimbursement schedule may be stated as:

(a) A percentage of the current Medicare fee schedule and rules for specific relative-value services;

(b) A listing of the reimbursements to be paid by Current Procedural Terminology codes for physicians that pertain to each physician's practice; or

(c) Any other method agreed upon by the parties.

Specific nonrelative-value services shall be stated separately from relative-value services, and reimbursement for unclassified services shall be on a reasonable basis.

Section 3. Subsection (41) is added to section 641.31, Florida Statutes, to read:

641.31 Health maintenance contracts.--

(41)(a) A health maintenance organization contract may not prohibit or restrict a subscriber from assigning plan benefits to physicians not under contract with the organization for covered health care services rendered by the physician to the subscriber.

(b) Any assignment by a subscriber of plan benefits that designates that the subscriber has been accepted by a physician

not under contract with the organization must be recognized by the organization and paid pursuant to s. 641.3155.

(c) Except for physicians providing services pursuant to s. 641.513, any physician who accepts an assignment pursuant to this subsection agrees, by submitting the claim to the health maintenance organization, to accept the amount paid by the health maintenance organization as payment in full for the health care services provided and to not collect any balance from the subscriber.

Section 4. Subsections (1) and (2) of section 641.315, Florida Statutes, are amended to read:

641.315 Provider contracts.--

(1) Each contract between a health maintenance organization and a provider of health care services must be in writing and must contain a provision that, except as otherwise provided, the subscriber is not liable to the provider for any services for which the health maintenance organization is liable as specified in s. 641.3154.

(2)(a) Each contract between a health maintenance organization and a provider of health care services ~~For all provider contracts executed after October 1, 1991, and within 180 days after October 1, 1991, for contracts in existence as of October 1, 1991:~~

~~1. The contracts~~ must provide that ~~require~~ the provider may terminate the contract, without cause, by giving 90 ~~to give 60~~ days' advance written notice to the health maintenance organization and the office. ~~before canceling the contract with the health maintenance organization for any reason; and~~

~~2.~~ The contract must also provide that nonpayment for goods or services rendered by the provider to the health maintenance organization is not a valid reason for avoiding the 90-day ~~60-day~~ advance notice of cancellation.

(b) Each contract between a health maintenance organization and a provider of health care services ~~All provider contracts~~ must contain a provision providing ~~provide~~ that the health maintenance organization may terminate the contract, without cause, by giving 90 ~~will provide~~ ~~60~~ days' advance written notice to the provider and the office before canceling, without cause, the contract with the provider, except in a case in which a patient's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action by the Board of Medicine or other governmental agency.

Section 5. Subsection (5) of section 641.3155, Florida Statutes, is amended, and subsection (16) is added to said section, to read:

641.3155 Prompt payment of claims.--

(5) If a health maintenance organization determines that it has made an overpayment to a provider for services rendered to a subscriber, the health maintenance organization must make a claim for such overpayment to the provider's designated location. The health maintenance organization may not demand repayment from the provider in any instance in which the overpayment is attributable to error of the health maintenance organization. A health maintenance organization that makes a claim for overpayment to a provider under this section shall

give the provider a written or electronic statement specifying the basis for the retroactive denial or payment adjustment. The health maintenance organization must identify the claim or claims, or overpayment claim portion thereof, for which a claim for overpayment is submitted.

(a) If an overpayment determination is the result of retroactive review or audit of coverage decisions or payment levels not related to fraud, a health maintenance organization shall adhere to the following procedures:

1. All claims for overpayment must be submitted to a provider within 12 ~~30~~ months after the health maintenance organization's payment of the claim. A provider must pay, deny, or contest the health maintenance organization's claim for overpayment within 40 days after the receipt of the claim. All contested claims for overpayment must be paid or denied within 120 days after receipt of the claim. Failure to pay or deny overpayment and claim within 140 days after receipt creates an uncontestable obligation to pay the claim.

2. A provider that denies or contests a health maintenance organization's claim for overpayment or any portion of a claim shall notify the organization, in writing, within 35 days after the provider receives the claim that the claim for overpayment is contested or denied. The notice that the claim for overpayment is denied or contested must identify the contested portion of the claim and the specific reason for contesting or denying the claim and, if contested, must include a request for additional information. If the organization submits additional information, the organization must, within 35 days after receipt

of the request, mail or electronically transfer the information to the provider. The provider shall pay or deny the claim for overpayment within 45 days after receipt of the information. The notice is considered made on the date the notice is mailed or electronically transferred by the provider.

3. The health maintenance organization may not reduce payment to the provider for other services unless the provider agrees to the reduction in writing or fails to respond to the health maintenance organization's overpayment claim as required by this paragraph.

4. Payment of an overpayment claim is considered made on the date the payment was mailed or electronically transferred. An overdue payment of a claim bears simple interest at the rate of 12 percent per year. Interest on an overdue payment for a claim for an overpayment payment begins to accrue when the claim should have been paid, denied, or contested.

(b) A claim for overpayment shall not be permitted beyond 12 ~~30~~ months after the health maintenance organization's payment of a claim, except that claims for overpayment may be sought beyond that time from providers convicted of fraud pursuant to s. 817.234.

(16)(a) Without regard to any other remedy or relief to which a person is entitled, or obligated to under contract, anyone aggrieved by a violation of this section, s. 641.3156, or s. 641.513 may bring an action for damages or to obtain a declaratory judgment that an act or practice violates this section, s. 641.3156, or s. 641.513 and to enjoin a person who

has violated, is violating, or is otherwise likely to violate this section.

(b) In any action brought by a person who has suffered damages as a result of a violation of this section, s. 641.3156, or s. 641.513, such person may recover any amounts due the person, including accrued interest, plus attorney's fees and court costs as provided in paragraphs (c) and (d).

(c)1. In any civil action brought pursuant to this subsection, the prevailing party, after judgment in the trial court and after exhausting all appeals, if any, shall receive his or her attorney's fees and costs from the nonprevailing party.

2. If the provider is the prevailing party, such fees shall not exceed three times the amount in controversy or $10,000, whichever is greater.

3. If the health maintenance organization is the prevailing party on any claim or defense for which the court finds that the provider knew or should have known that the claim or defense was not supported by the material facts necessary to establish the claim or defense, or would not be supported by the application of then-existing law as to those material facts, such fees shall not exceed two times the amount in controversy or $5,000, whichever is greater.

(d)1. In any civil action brought by a health maintenance organization pursuant to this subsection, the prevailing party, after judgment in the trial court and after exhausting all appeals, if any, shall receive his or her attorney's fees and costs from the nonprevailing party.

2. If the health maintenance organization is the prevailing party on any claim or defense for which the court finds that the provider knew or should have known that the claim or defense was not supported by the material facts necessary to establish the claim or defense, or would not be supported by the application of then-existing law as to those material facts, such fees shall not exceed two times the amount in controversy or $5,000, whichever is greater.

3. If the provider is the prevailing party, such fees shall not exceed three times the amount in controversy or $10,000, whichever is greater.

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

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

(g) This subsection shall apply in any proceeding in which the provider alleges that the health maintenance organization has failed to comply with its contractual obligations.

Section 6. Subsection (2) of section 641.3156, Florida Statutes, is amended to read:

641.3156 Treatment authorization; payment of claims.--

(2) A claim for treatment must be paid by a health maintenance organization and may not be denied if a provider, whether or not under contract with a health maintenance organization, follows the health maintenance organization's

authorization procedures and receives authorization for a covered service for an eligible subscriber, unless the provider provided information to the health maintenance organization with the willful intention to misinform the health maintenance organization. Emergency services are subject to the provisions of ss. 395.1041 and 401.45 and are not subject to the provisions of this subsection.

Section 7. Subsection (5) of section 641.513, Florida Statutes, is amended 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, or 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. For physicians only, the usual and customary charge shall be the average gross charge for that service in the county where the service is provided; or

(c) The charge mutually agreed to by the health maintenance organization and the provider within 30 ~~60~~ days after ~~of~~ the submittal of the claim.

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

Section 8. Subsection (5) of section 641.513, Florida Statutes, as created by section 9 of chapter 96-223, Laws of Florida, is amended to read:

641.513 Requirements for providing emergency services and care.--

(5) Reimbursement for services pursuant to ~~under~~ this section by a provider who does not have a contract with the health maintenance organization, or 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. For physicians only, the usual and customary charge shall be the average gross charge for that service in the county where the service is provided; or

(c) The charge mutually agreed to by the health maintenance organization and the provider within 30 ~~60~~ days after the submittal of the claim.

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

Section 9. This act shall take effect October 1, 2005.