By the Committees on General Government Appropriations; Banking and Insurance; and Senators Gaetz, Baker, Fasano, Posey, Oelrich, Bennett, Ring, Lynn and Storms

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A bill to be entitled

An act relating to health insurance; amending s. 624.443, F.S.; authorizing the Office of Insurance Regulation to waive the requirement that each multiple-employer welfare arrangement maintain its principal place of business in this state if the arrangement meets certain specified conditions and has a minimum specified fund balance at the time of licensure; amending s. 627.638, F.S.; authorizing the payment of health insurance policy benefits directly to a licensed ambulance provider; requiring that an insurer make payments directly to the preferred provider for the delivery of health care services; creating s. 627.64731, F.S.; providing requirements for the rent, lease, or granting of access to the health care services of a preferred provider or exclusive provider under a health care contract; amending s. 627.662, F.S.; applying the requirements for the rent, lease, or granting of access to the health care services of a preferred provider or exclusive provider under a health care contract to group health insurance, blanket health insurance, and franchise health insurance policies; amending s. 641.31; providing that a health maintenance contract may not prohibit and a claims form must provide an option for direct payment to specified providers; authorizing a health maintenance organization to require a provider to make available a written attestation of assignment of benefits; authorizing the attestation to be submitted to the health maintenance organization in electronic form; amending s. 641.3155, F.S.; decreasing the amount of time

in which a health maintenance organization may make a claim for overpayment against a provider; amending s. 627.6131, F.S.; reducing the period for a health insurer to submit a claim to a provider for overpayment; amending s. 627.6471, F.S.; requiring that a nonpreferred provider, upon request of the insured, provide to the insured the estimated range of charges for the services requested; specifying that the provider in not liable if the final charge exceeds the initial estimate; providing applicability; providing an effective date.

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

Section 1. Section 624.443, Florida Statutes, is amended to read:

624.443 Place of business; maintenance of records.--Each arrangement shall have and maintain its principal place of business in this state and shall therein make available to the office complete records of its assets, transactions, and affairs in accordance with such methods and systems as are customary for, or suitable to, the kind or kinds of business transacted. The office may waive this requirement if an arrangement has been operating in another state for at least 25 years, has been licensed in such state for at least 10 years, and has a minimum fund balance of $25 million at the time of licensure.

Section 2. Section 627.638, Florida Statutes, is amended to read:

627.638 Direct payment for hospital, medical services.--

(1) Any health insurance policy insuring against loss or

expense due to hospital confinement or to medical and related services may provide for payment of benefits directly to any recognized hospital, licensed ambulance provider, doctor, or other person who provided the services, in accordance with the provisions of the policy. To comply with this section, the words "or to the hospital, licensed ambulance provider, doctor, or person rendering services covered by this policy," or similar words appropriate to the terms of the policy, shall be added to applicable provisions of the policy.

(2) Whenever, in any health insurance claim form, an insured specifically authorizes payment of benefits directly to any recognized hospital, licensed ambulance provider, physician, or dentist, the insurer shall make such payment to the designated provider of such services, unless otherwise provided in the insurance contract. The insurance contract may not prohibit, and claims forms must provide an option for, the payment of benefits directly to a licensed hospital, licensed ambulance provider, physician, or dentist for care provided pursuant to s. 395.1041 or part III of chapter 401. The insurer may require written attestation of assignment of benefits. Payment to the provider from the insurer may not be more than the amount that the insurer would otherwise have paid without the assignment.

(3) Any insurer who has contracted with a preferred provider, as defined in s. 627.6471(1)(b), for the delivery of health care services to its insureds shall make payments directly to the preferred provider for such services.

Section 3. Section 627.64731, Florida Statutes, is created to read:

627.64731 Leasing, renting, or granting access to a

preferred provider or exclusive provider.--

(1) An insurer or administrator may not lease, rent, or otherwise grant access to the health care services of a preferred provider or an exclusive provider under a health care contract unless expressly authorized by the health care contract. At the time a health care contract is entered into with a preferred provider or exclusive provider, the insurer shall, to the extent possible, identify in the contract any third party to which the insurer or administrator has granted access to the health care services of the preferred provider or exclusive provider. A third party that is granted access must comply with all the applicable terms of the health care contract.

(2) An insurer or administrator must notify a preferred provider or exclusive provider, in writing, within 5 business days of the identity of any third party that has been granted access to the health care services of the provider by the insurer or administrator. The provider may opt out of participating in a third party's health care plan by providing written notice to the insurer or administrator within 30 days after receiving notice pursuant to this subsection.

(3) An insurer or administrator that leases, rents, or otherwise grants access to the health care services of a preferred provider or exclusive provider must maintain an Internet website or a toll-free telephone number through which the provider may obtain a listing, updated at least biannually, of the third parties that have been granted access to the provider's health care services.

(4) An insurer or administrator that leases, rents, or otherwise grants access to a provider's health care services must

ensure that an explanation of benefits or remittance advice furnished to the preferred provider or exclusive provider that delivers health care services under the health care contract identifies the contractual source of any applicable discount.

(5) The right of a third party to exercise the rights and responsibilities of an insurer or administrator under a health care contract terminates on the date that the preferred provider's or exclusive provider's contract with the insurer or administrator is terminated.

(6) The provisions of this section do not apply if the third party that is granted access to a preferred provider's or exclusive provider's health care services under a health care contract is:

(a) An employer or other entity providing coverage for health care services to the employer's employees or the entity's members and the employer or entity has a contract with the insurer or administrator or the insurer's or administrator's affiliate for the administration or processing of claims for payment or services provided under the health care contract;

(b) An affiliate or a subsidiary of the insurer or administrator; or

(c) An entity providing administrative services to, or receiving administrative services from, the insurer or administrator or the insurer's or administrators' affiliate or subsidiary.

(7) A health care contract may provide for arbitration of disputes arising under this section.

Section 4. Present subsections (11), (12), and (13) of section 627.662, Florida Statutes, are renumbered as subsections

(12), (13), and (14), respectively, and new subsection (11) is added to that section, to read:

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

(11) Section 627.64731, relating to leasing, renting, or granting access to a preferred provider or exclusive provider.

Section 5. Subsection (41) is added to section 641.31, Florida Statutes, to read:

641.31 Health maintenance contracts.--

(41) A health maintenance organization contract may not prohibit, and claims forms must provide an option for, the payment of benefits directly to a licensed hospital, ambulance transport and treatment provider pursuant to part III of chapter 401, physician, or dentist for covered services provided pursuant to s. 395.1041. The health maintenance organization may require a provider to retain and make available upon request a written attestation of assignment of benefits. The attestation of assignment of benefits may be submitted to the health maintenance organization in electronic form.

Section 6. Subsection (5) of section 641.3155, Florida Statutes, is amended 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. 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 may ~~shall~~ not be made ~~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.

Section 7. Subsection (6) of section 627.6131, Florida Statutes, is amended 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 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.

Section 8. Subsection (7) is added to section 627.6471, Florida Statutes, to read:

627.6471 Contracts for reduced rates of payment; limitations; coinsurance and deductibles.--

(7) For care other than for ambulance transport or treatment under to part III of chapter 401 or services provided under s. 395.1041, if an insured under this section is requesting services from a nonpreferred provider and requests information from the insurer or the provider in order to determine patient financial responsibility:

(a) The nonpreferred provider shall provide the insured with an estimated average charge for the service and a statement notifying the insured that the final charge may exceed the estimated charge.

(b) The insurer shall provide the insured and the nonpreferred provider with an estimate of the payment to the provider and a statement notifying the insured that the final charge may exceed the estimated allowable payment amount.

The nonpreferred provider and the insurer are not liable if the total charges of the provider or the insurer's actual payment differs from the estimate.

Section 9. This act shall take effect July 1, 2008, and shall apply to contracts entered into, issued, or renewed on or after that date.