

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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1 A bill to be entitled

2 An act relating to health insurance; amending s. 624.443,
3 F.S.; authorizing the Office of Insurance Regulation to
4 waive the requirement that each multiple-employer welfare
5 arrangement maintain its principal place of business in
6 this state if the arrangement meets certain specified
7 conditions and has a minimum specified fund balance at the
8 time of licensure; amending s. 627.638, F.S.; authorizing
9 the payment of health insurance policy benefits directly
10 to a licensed ambulance provider; requiring that an
11 insurer make payments directly to the preferred provider
12 for the delivery of health care services; creating s.
13 627.64731, F.S.; providing requirements for the rent,
14 lease, or granting of access to the health care services
15 of a preferred provider or exclusive provider under a
16 health care contract; amending s. 627.662, F.S.; applying
17 the requirements for the rent, lease, or granting of
18 access to the health care services of a preferred provider
19 or exclusive provider under a health care contract to
20 group health insurance, blanket health insurance, and
21 franchise health insurance policies; amending s. 641.31;
22 providing that a health maintenance contract may not
23 prohibit and a claims form must provide an option for
24 direct payment to specified providers; authorizing a
25 health maintenance organization to require a provider to
26 make available a written attestation of assignment of
27 benefits; authorizing the attestation to be submitted to
28 the health maintenance organization in electronic form;
29 amending s. 641.3155, F.S.; decreasing the amount of time

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30 in which a health maintenance organization may make a
31 claim for overpayment against a provider; amending s.
32 627.6131, F.S.; reducing the period for a health insurer
33 to submit a claim to a provider for overpayment; amending
34 s. 627.6471, F.S.; requiring that a nonpreferred provider,
35 upon request of the insured, provide to the insured the
36 estimated range of charges for the services requested;
37 specifying that the provider is not liable if the final
38 charge exceeds the initial estimate; providing
39 applicability; providing an effective date.

40
41 Be It Enacted by the Legislature of the State of Florida:

42
43 Section 1. Section 624.443, Florida Statutes, is amended to
44 read:

45 624.443 Place of business; maintenance of records.--Each
46 arrangement shall have and maintain its principal place of
47 business in this state and shall therein make available to the
48 office complete records of its assets, transactions, and affairs
49 in accordance with such methods and systems as are customary for,
50 or suitable to, the kind or kinds of business transacted. The
51 office may waive this requirement if an arrangement has been
52 operating in another state for at least 25 years, has been
53 licensed in such state for at least 10 years, and has a minimum
54 fund balance of \$25 million at the time of licensure.

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

57 627.638 Direct payment for hospital, medical services.--
58 (1) Any health insurance policy insuring against loss or

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

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

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

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

87 | 627.64731 Leasing, renting, or granting access to a

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88 preferred provider or exclusive provider.--

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

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

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

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

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

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

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

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

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

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

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

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

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146 (12), (13), and (14), respectively, and new subsection (11) is
147 added to that section, to read:

148 627.662 Other provisions applicable.--The following
149 provisions apply to group health insurance, blanket health
150 insurance, and franchise health insurance:

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

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

155 641.31 Health maintenance contracts.--

156 (41) A health maintenance organization contract may not
157 prohibit, and claims forms must provide an option for, the
158 payment of benefits directly to a licensed hospital, ambulance
159 transport and treatment provider pursuant to part III of chapter
160 401, physician, or dentist for covered services provided pursuant
161 to s. 395.1041. The health maintenance organization may require a
162 provider to retain and make available upon request a written
163 attestation of assignment of benefits. The attestation of
164 assignment of benefits may be submitted to the health maintenance
165 organization in electronic form.

166 Section 6. Subsection (5) of section 641.3155, Florida
167 Statutes, is amended to read:

168 641.3155 Prompt payment of claims.--

169 (5) If a health maintenance organization determines that it
170 has made an overpayment to a provider for services rendered to a
171 subscriber, the health maintenance organization must make a claim
172 for such overpayment to the provider's designated location. A
173 health maintenance organization that makes a claim for
174 overpayment to a provider under this section shall give the

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

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

184 1. All claims for overpayment must be submitted to a
185 provider within 12 ~~30~~ months after the health maintenance
186 organization's payment of the claim. A provider must pay, deny,
187 or contest the ~~health maintenance organization's~~ claim for
188 overpayment within 40 days after the receipt of the claim. All
189 contested claims for overpayment must be paid or denied within
190 120 days after receipt of the claim. Failure to pay or deny
191 overpayment and claim within 140 days after receipt creates an
192 uncontestable obligation to pay the claim.

193 2. A provider that denies or contests a health maintenance
194 organization's claim for overpayment or any portion of a claim
195 shall notify the organization, in writing, within 35 days after
196 the provider receives the claim ~~that the claim for overpayment is~~
197 ~~contested or denied~~. The notice that the claim for overpayment is
198 denied or contested must identify the contested portion of the
199 claim and the specific reason for contesting or denying the claim
200 and, if contested, must include a request for additional
201 information. If the organization submits additional information,
202 the organization must, within 35 days after receipt of the
203 request, mail or electronically transfer the information to the

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204 provider. The provider shall pay or deny the claim for
205 overpayment within 45 days after receipt of the information. The
206 notice is considered made on the date the notice is mailed or
207 electronically transferred by the provider.

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

213 4. Payment of an overpayment claim is considered made on
214 the date the payment was mailed or electronically transferred. An
215 overdue payment of a claim bears simple interest at the rate of
216 12 percent per year. Interest on an overdue payment for a claim
217 ~~for an overpayment payment~~ begins to accrue when the claim should
218 have been paid, denied, or contested.

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

224 Section 7. Subsection (6) of section 627.6131, Florida
225 Statutes, is amended to read:

226 627.6131 Payment of claims.--

227 (6) If a health insurer determines that it has made an
228 overpayment to a provider for services rendered to an insured,
229 the health insurer must make a claim for such overpayment to the
230 provider's designated location. A health insurer that makes a
231 claim for overpayment to a provider under this section shall give
232 the provider a written or electronic statement specifying the

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233 basis for the retroactive denial or payment adjustment. The
234 insurer must identify the claim or claims, or overpayment claim
235 portion thereof, for which a claim for overpayment is submitted.

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

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

248 2. A provider that denies or contests a health insurer's
249 claim for overpayment or any portion of a claim shall notify the
250 health insurer, in writing, within 35 days after the provider
251 receives the claim that the claim for overpayment is contested or
252 denied. The notice that the claim for overpayment is denied or
253 contested must identify the contested portion of the claim and
254 the specific reason for contesting or denying the claim and, if
255 contested, must include a request for additional information. If
256 the health insurer submits additional information, the health
257 insurer must, within 35 days after receipt of the request, mail
258 or electronically transfer the information to the provider. The
259 provider shall pay or deny the claim for overpayment within 45
260 days after receipt of the information. The notice is considered
261 made on the date the notice is mailed or electronically

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262 transferred by the provider.

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

267 4. Payment of an overpayment claim is considered made on
268 the date the payment was mailed or electronically transferred. An
269 overdue payment of a claim bears simple interest at the rate of
270 12 percent per year. Interest on an overdue payment for a claim
271 for an overpayment begins to accrue when the claim should have
272 been paid, denied, or contested.

273 (b) A claim for overpayment shall not be permitted beyond
274 12 ~~30~~ months after the health insurer's payment of a claim,
275 except that claims for overpayment may be sought beyond that time
276 from providers convicted of fraud pursuant to s. 817.234.

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

279 627.6471 Contracts for reduced rates of payment;
280 limitations; coinsurance and deductibles.--

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

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

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

295
296 The nonpreferred provider and the insurer are not liable if the
297 total charges of the provider or the insurer's actual payment
298 differs from the estimate.

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