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; amending s. 627.6131, F.S.; requiring claims for overpayment and underpayment be submitted to the provider within a certain timeframe; providing exceptions; creating s. 627.64731, F.S.; providing definitions; providing requirements, limitations, and procedures for leasing, renting, or granting access to participating providers by third parties; providing exceptions; providing for arbitration; providing for application; amending s. 627.662, F.S.; expanding the list of sections applicable to certain types of insurance; amending s. 627.6699, F.S.; revising the definition of the term "small employer" with regard to the Employee Health Care Access Act; amending s. 641.31, F.S.; requiring health maintenance organizations to pay benefits directly to certain providers under certain circumstances; prohibiting health maintenance contracts from prohibiting and requiring claims forms to provide the option for payment of benefits directly to certain providers;

amending s. 641.3155, F.S.; providing time limitations for and prohibitions against submitting certain claims for overpayment and claims for underpayment; providing for 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. Subsections (18) and (19) are added to section 627.6131, Florida Statutes, to read:

627.6131 Payment of claims.--

(18) Notwithstanding the 30-month period provided in subsection (6), all claims for overpayment submitted to a provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 must be submitted to the provider within 12 months after the health insurer's payment of the claim. A claim for overpayment may not be permitted beyond 12 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.

(19) Notwithstanding any other provision of this section, all claims for underpayment from a provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 must be submitted to the insurer within 12 months after the health insurer's payment of the claim. A claim for underpayment may not be permitted beyond 12 months after the health insurer's payment of a claim.

Section 4. Section 627.64731, Florida Statutes, is created to read:

627.64731 Leasing, renting, or granting access to a participating provider.--

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

(a) "Contracting entity" means any person or entity that is engaged in the act of contracting with participating providers and has a direct contract with a participating provider for the delivery of health care services or the selling or assigning of physicians or physician panels to other health care entities.

(b) "Participating provider" means a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466, or a physician group practice that has a health care contract with a contracting entity and is entitled to reimbursement for health care services rendered to an enrollee under the health care contract and includes both preferred providers as defined in s. 627.6471 and exclusive providers as defined in s. 627.6472.

(2) A contracting entity may not sell, lease, rent, or

otherwise grant access to the health care services of a participating provider under a health care contract unless expressly authorized by the health care contract. The health care contract must specifically provide that it applies to network rental arrangements and state that one purpose of the contract is selling, renting, or giving the contracting entity rights to the services of the participating provider, including other preferred provider organizations. At the time a health care contract is entered into with a participating provider, the contracting entity shall, to the extent possible, identify any third party to which the contracting entity has granted access to the health care services of the participating provider. The contracting entity may sell, lease, rent, or otherwise grant access to the participating provider's services only to a third party that is:

(a) A payer or a third-party administrator or other entity responsible for administering claims on behalf of the payer;

(b) A preferred provider organization or preferred provider network that receives access to the participating provider's services pursuant to an arrangement with the preferred provider organization or preferred provider network in a contract with the participating provider and that is required to comply with all of the terms, conditions, and affirmative obligations to which the originally contracted primary participating provider network is bound under its contract with the participating provider, including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement; or

(c) An entity that is engaged in the business of providing electronic claims transport between the contracting entity and the payer or third-party administrator and that complies with all

of the applicable terms, conditions, and affirmative obligations of the contracting entity's contract with the participating provider including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement.

(3) Upon a request by a participating provider, a contracting entity must provide the identity of any third party that has been granted access to the health care services of the participating provider.

(4) A contracting entity that leases, rents, or otherwise grants access to the health care services of a participating provider must maintain an Internet website or a toll-free telephone number through which the provider may obtain a listing, updated at least every 90 days, of the third parties that have been granted access to the provider's health care services.

(5) A contracting entity that leases, rents, or otherwise grants access to a participating provider's health care services must ensure that an explanation of benefits or remittance advice furnished to the participating provider that delivers health care services under the health care contract identifies the contractual source of any applicable discount.

(6) Subject to applicable continuity-of-care laws, the right of a third party to exercise the rights and responsibilities of a contracting entity under a health care contract terminates on the day following the termination of the participating provider's contract with the contracting entity.

(7) The provisions of this section do not apply if the third party that is granted access to a participating 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 contracting entity or the contracting entity's affiliate for the administration or processing of claims for payment or services provided under the health care contract;

(b) An entity providing administrative services to, or receiving administrative services from, the contracting entity or the contracting entity's affiliate or subsidiary; or

(c) An affiliate or a subsidiary of a contracting entity, or other entity if operating under the same brand licensee program as the contracting entity.

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

(9) A contracting entity shall ensure that all third parties to which the contracting entity has sold, rented, assigned, or otherwise given access to the participating provider's discounted rate comply with the physician contract, including all requirements to encourage access to the participating provider, and pay the provider pursuant to the rates of payment and methodology set forth in that contract, unless otherwise agreed to by a participating provider.

(10) A contracting entity is deemed in compliance with this section when the insured's identification card provides information, written or electronically, which identifies the preferred provider network or networks to be used to reimburse the provider for covered services.

(11) This section does not apply to a contract between a contracting entity and a discount medical plan organization

licensed or exempt under part II of chapter 636.

Section 5. Subsections (11), (12), and (13) of section 627.662, Florida Statutes, are renumbered as subsections (12), (13), and (14), respectively, and a 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 participating provider.

Section 6. Paragraph (v) of subsection (3) of section 627.6699, Florida Statutes, is amended to read:

627.6699 Employee Health Care Access Act.--

(3) DEFINITIONS.--As used in this section, the term:

(v) "Small employer" means, in connection with a health benefit plan with respect to a calendar year and a plan year, any person, sole proprietor, self-employed individual, independent contractor, firm, corporation, partnership, or association that is actively engaged in business, has its principal place of business in this state, employed an average of at least 1 but not more than 50 eligible employees on business days during the preceding calendar year the majority of whom were employed in this state, ~~and~~ employs at least 1 employee on the first day of the plan year, and is not formed primarily for purposes of purchasing insurance. In determining the number of eligible employees, companies that are an affiliated group as defined in s. 1504(a) of the Internal Revenue Code of 1986, as amended, are considered a single employer. For purposes of this section, a sole proprietor, an independent contractor, or a self-employed

individual is considered a small employer only if all of the conditions and criteria established in this section are met.

Section 7. Subsection (41) is added to section 641.31, Florida Statutes, to read:

641.31 Health maintenance contracts.--

(41) Whenever, in any health maintenance organization claim form, a subscriber specifically authorizes payment of benefits directly to any contracted hospital, ambulance provider, physician, or dentist, the health maintenance organization shall make such payment to the designated provider of such services if any benefits are due to the subscriber under the terms of the agreement between the subscriber and the health maintenance organization. The 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 provider, physician, or dentist for covered services provided, for services provided pursuant to s. 395.1041, and for ambulance transport and treatment provided pursuant to part III of chapter 401. The attestation of assignment of benefits may be in written or electronic form. Payment to the provider from the health maintenance organization may not be more than the amount that the insurer would otherwise have paid without the assignment. This subsection does not affect the applicability of ss. 641.3154 and 641.513 with respect to services provided and payment for such services provided pursuant to the subsection.

Section 8. Subsections (16) and (17) are added to section 641.3155, Florida Statutes, to read:

641.3155 Prompt payment of claims.--

(16) Notwithstanding the 30-month period provided in

subsection (5), all claims for overpayment submitted to a provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 must be submitted to the provider within 12 months after the health maintenance organization's payment of the claim. A claim for overpayment may not be permitted beyond 12 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.

(17) Notwithstanding any other provision of this section, all claims for underpayment from a provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 must be submitted to the health maintenance organization within 12 months after the health maintenance organization's payment of the claim. A claim for underpayment may not be permitted beyond 12 months after the health maintenance organization's payment of a claim.

Section 9. This act shall take effect November 1, 2008, and applies to contracts entered into, issued, or renewed on or after that date, and the amendments made by this act to ss. 627.6131 and 641.3155, Florida Statutes, apply to claims payments made on or after November 1, 2008.