A bill to be entitled

An act relating to health care management; amending s. 627.6044, F.S.; prohibiting certain insurers from engaging in actions that encourage insureds not to make payments before medical service is rendered; amending s. 627.6131, F.S.; providing additional circumstances in which a health insurer may not retroactively deny a claim; amending s. 627.6141, F.S.; requiring a claimant whose claim is denied for failure to obtain an authorization under certain circumstances to be provided an opportunity for an appeal; requiring that the insurer reverse a denial under certain circumstances; requiring the insurer to submit a written justification for a determination that a service was not medically necessary; amending ss. 627.6474 and 641.315, F.S.; prohibiting a health insurer or health maintenance organization from modifying a policy or procedure that would affect underlying contract terms without having a written mutual agreement; amending s. 641.3155, F.S.; providing additional circumstances in which a health maintenance organization may not retroactively deny a claim; amending s. 641.3156, F.S.; requiring a health maintenance organization to conduct a retrospective review of the medical necessity of a service under certain circumstances; requiring the health maintenance organization to submit a written justification for a determination that a service was not medically necessary and provide a process for appealing the determination; amending s. 641.54, F.S.; prohibiting a health maintenance

organization from engaging in certain actions that encourage subscribers not to make payments before medical service is rendered; creating a study group to evaluate increases in a patient's financial responsibility for hospital services; providing for membership; requiring the Office of Insurance Regulation, the Agency for Health Care Administration, and the organizations appointing members to the study group to provide organizational support; providing for the duties of the study group; providing for per diem and travel expenses for members; requiring the study group to present a final report to the Legislature; providing an effective date.

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

Section 1. Subsection (3) is added to section 627.6044, Florida Statutes, to read:

627.6044 Use of a specific methodology for payment of claims.--

(3) An insurer issuing a policy that provides for payment of claims based on a specific methodology may not take any action, such as providing a printed statement to an insured, that encourages the insured to refuse to pay a copayment, coinsurance, a portion of a deductible, or any other form of patient financial responsibility before a medical service is rendered or prior to receipt of an insurer's explanation of benefits.

Section 2. Subsection (11) of section 627.6131, Florida Statutes, is amended to read:

627.6131 Payment of claims.--

(11) A health insurer may not retroactively deny a claim because of insured ineligibility:

(a) More than 1 year after the date of payment of the claim;

(b) If the health insurer verified the eligibility of an insured at the time of treatment and provided an authorization number; or

(c) If, at the time of service, the health insurer provided the insured with a magnetic or smart identification as provided in s. 627.642 that identified the insured as eligible to receive services.

Section 3. Section 627.6141, Florida Statutes, is amended to read:

627.6141 Denial of claims.--Each claimant, or provider acting for a claimant, who has had a claim denied as not medically necessary or for failing to obtain authorization or obtaining only partial authorization due to an unintentional act or error or omission must be provided an opportunity for an appeal to the insurer's licensed physician who is responsible for the medical necessity reviews under the plan or is a member of the plan's peer review group. If the insurer determines upon review that the service was medically necessary, the insurer must reverse the denial and pay the claim. If the insurer determines that the service was not medically necessary, the insurer shall submit to the provider specific written clinical

justification for the determination. The appeal may be by telephone, and the insurer's licensed physician must respond within a reasonable time, not to exceed 15 business days.

Section 4. Section 627.6474, Florida Statutes, is amended to read:

627.6474 Provider contracts.--

(1) A health insurer shall not require a contracted health care practitioner as defined in s. 456.001(4) to accept the terms of other health care practitioner contracts with the insurer or any other insurer, or health maintenance organization, under common management and control with the insurer, including Medicare and Medicaid practitioner contracts and those authorized by s. 627.6471, s. 627.6472, or s. 641.315, except for a practitioner in a group practice as defined in s. 456.053 who must accept the terms of a contract negotiated for the practitioner by the group, as a condition of continuation or renewal of the contract. Any contract provision that violates this section is void. A violation of this section is not subject to the criminal penalty specified in s. 624.15.

(2) A health insurer may not modify, amend, or change any policy, procedure, or equivalent document adopted by reference in a contract in effect with a provider that would affect, directly or indirectly, the underlying contract terms without a mutual written agreement between the provider and the insurer. Written notice of any proposed change must be provided by the health insurer to the provider at least 45 days prior to the date the proposed change is implemented.

Section 5. Subsection (11) is added to section 641.315, Florida Statutes, to read:

641.315 Provider contracts.--

(11) A health maintenance organization may not modify, amend, or change any policy, procedure, or equivalent document adopted by reference in a contract in effect with a provider that would affect, directly or indirectly, the underlying contract terms without a mutual written agreement between the provider and the organization. Written notice of any proposed change must be provided by the health maintenance organization to the provider at least 45 days prior to the date the proposed change is implemented.

Section 6. Subsection (10) of section 641.3155, Florida Statutes, is amended to read:

641.3155 Prompt payment of claims.--

(10) A health maintenance organization may not retroactively deny a claim because of subscriber ineligibility:

(a) More than 1 year after the date of payment of the claim;

(b) If the health maintenance organization verified the eligibility of a subscriber at the time of treatment and provided an authorization number; or

(c) If, at the time of service, the health maintenance organization provided the subscriber with a magnetic or smart identification as provided in s. 627.642 that identified the subscriber as eligible to receive services.

Section 7. Subsection (3) of section 641.3156, Florida Statutes, is renumbered as subsection (4), and a new subsection (3) is added to that section to read:

641.3156 Treatment authorization; payment of claims.--

(3) If a hospital-service or referral-service claim is denied because the provider, due to an unintentional act of error or omission, failed to obtain authorization or obtained only partial authorization, the provider may appeal the denial and the health maintenance organization must conduct and complete within 30 days after the submitted appeal a retrospective review of the medical necessity of the service. If the health maintenance organization determines that the service is medically necessary, the health maintenance organization must reverse the denial and pay the claim. If the health maintenance organization determines that the service is not medically necessary, the health maintenance organization shall provide the provider with specific written clinical justification for the determination.

Section 8. Subsection (8) is added to section 641.54, Florida Statutes, to read:

641.54 Information disclosure.--

(8) A health maintenance organization may not take any action, such as issuing a printed statement to a subscriber, that encourages a subscriber to refuse to pay a copayment, a coinsurance percentage, a deductible, or any other portion of a patient's financial responsibility before a medical service is rendered or prior to receipt of the health maintenance organization's explanation of benefits.

Section 9. (1) A 12-person study group is created for the purpose of evaluating increases in patient financial responsibility for hospital services and the resulting impact on the affordability and accessibility of private, employer-sponsored health insurance. A representative of an employer who purchases health insurance for its employees, appointed by the Florida Chamber of Commerce, and an employer who provides health insurance through a self-insured plan, appointed by Associated Industries of Florida, shall act as co-chairs of the study group. The remaining 10 members of the study group shall be appointed as follows:

(a) Two members appointed by the Florida Hospital Association.

(b) Two members appointed by the Florida Chamber of Commerce representing purchasers of health insurance.

(c) Two members appointed by Associated Industries of Florida representing purchasers of health insurance.

(d) One member of the Florida Senate appointed by the President.

(e) One member of the House of Representatives appointed by the Speaker of the House of Representatives.

(f) Two representatives of health insurance plans appointed by the Chief Financial Officer.

(2) Organizational support for the study group shall be provided by the Office of Insurance Regulation, the Agency for Health Care Administration, and the organizations appointing members to the study group.

(3) The study group shall evaluate and develop findings

and recommendations regarding the following:

(a) Changes in patient financial responsibility associated with hospital services in the form of copayments, coinsurance, and deductibles over the last several years as data is available.

(b) The effect of patient payment requirements on access to hospital services.

(c) The effect of financial disincentives regarding the inappropriate use of hospital emergency rooms and ways to strengthen such incentives.

(d) The effect of patient payment requirements on the cost of employer-sponsored health insurance.

(e) Methods to ensure that patient financial requirements are met.

(f) Impediments to collections from patients at the point of service.

(g) Methods to improve accurate collections from patients at the point of service.

(4) Members of the study group shall serve without compensation. The organizations appointing members shall pay per diem and travel expenses for their respective members for the meetings of the study group. All meetings shall be held in Tallahassee.

(5) The members of the study group shall be appointed by July 30, 2009, and shall hold their first meeting by September 1, 2009. The final report of the study group shall be presented to the President of the Senate and the Speaker of the House of Representatives no later than January 29, 2010.

Section 10. This act shall take effect July 1, 2009.