By the Committee on Banking and Insurance; and Senators Fasano and Gaetz

597-04880-10 20101232c1

A bill to be entitled

An act relating to health insurance; amending s. 626.9541, F.S.; authorizing an insurer offering a group or individual health benefit plan to offer a wellness program; authorizing rewards or incentives; providing that such rewards or incentives are not insurance benefits; providing for verification of a member's inability to participate for medical reasons; amending s. 627.6141, F.S.; authorizing appeals from denials of certain claims for certain services; requiring a health insurer to conduct a retrospective review of the medical necessity of a service under certain circumstances; requiring the health insurer to submit a written justification for a determination that a service was not medically necessary; amending s. 641.3156, F.S.; authorizing appeals from denials of certain claims for certain services; 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; providing an effective date.

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

Section 1. Subsection (3) is added to section 626.9541, Florida Statutes, to read:

626.9541 Unfair methods of competition and unfair or

deceptive acts or practices defined.—

(3) WELLNESS PROGRAMS.—An insurer issuing a group or individual health benefit plan may offer a voluntary wellness or health-improvement program that allows for rewards or incentives, including, but not limited to, merchandise, gift cards, debit cards, premium discounts or rebates, contributions towards a member's health savings account, modifications to copayment, deductible, or coinsurance amounts, or any combination of these incentives, to encourage participation or to reward for participation in the program. The health plan member may be required to provide verification, such as a statement from his or her physician, that a medical condition makes it unreasonably difficult or medically inadvisable for the individual to participate in the wellness program. Any reward or incentive established under this section is not an insurance benefit and does not violate this section. This subsection does not prohibit an insurer from offering incentives or rewards to members for adherence to wellness or health-improvement programs if otherwise allowed by state or federal law.

Section 2. Section 627.6141, Florida Statutes, is amended to read:

627.6141 Denial of claims.—

(1) Each claimant, or provider acting for a claimant, who has had a claim denied as not medically necessary 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. The appeal may be by telephone, and the insurer's licensed physician must respond within a reasonable time, not to exceed

15 business days.

(2) If a hospital claim or a portion of a hospital claim is denied because the hospital, due to an unintentional act of error or omission, failed to obtain the necessary authorization, the hospital may appeal the denial to the insurer's licensed physician who is responsible for medical necessity reviews. The health insurer shall conduct and complete a retrospective review of the medical necessity of the service within 30 business days after the submitted appeal. If the health insurer determines upon review that the service was medically necessary, the insurer shall reverse the denial and pay the claim. If the insurer determines that the service was not medically necessary, the insurer shall provide to the hospital specific written clinical justification for the determination.

Section 3. Present 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 claim or a portion of a hospital claim of a contracted provider is denied because the hospital, due to an unintentional act of error or omission, failed to obtain the necessary authorization, the hospital may appeal the denial to the health maintenance organization's licensed physician who is responsible for medical necessity reviews. The health maintenance organization shall conduct and complete a retrospective review of the medical necessity of the service within 30 business days after the submitted appeal. If the health maintenance organization determines upon review that the service was medically necessary, the health maintenance

organization shall reverse the denial and pay the claim. If the health maintenance organization determines that the service was not medically necessary, the health maintenance organization shall provide the hospital with specific written clinical justification for the determination.

Section 4. This act shall take effect July 1, 2010.