

1 A bill to be entitled
2 An act relating to health services claims; amending s.
3 626.9541, F.S.; authorizing certain insurers to offer
4 voluntary wellness or health improvement programs that
5 provide certain rewards or incentives; providing for
6 medical verification for nonparticipation in such programs
7 for certain reasons; providing that such rewards or
8 incentives are not insurance benefits and do not
9 constitute a violation of unfair methods of competition
10 and unfair or deceptive acts or practice provisions;
11 providing construction; amending s. 627.6141, F.S.;
12 authorizing appeals from denials of certain claims for
13 certain services; requiring a health insurer to conduct a
14 retrospective review of the medical necessity of a service
15 under certain circumstances; requiring the health insurer
16 to submit a written justification for a determination that
17 a service was not medically necessary and provide a
18 process for appealing the determination; amending s.
19 627.6474, F.S.; prohibiting contracts between health
20 insurers and dentists from containing certain fee
21 requirements set by the insurer under certain
22 circumstances; providing a definition; providing
23 application; amending s. 636.035, F.S.; prohibiting
24 contracts between prepaid limited health service
25 organizations and dentists from containing certain fee
26 requirements set by the organization under certain
27 circumstances; providing a definition; providing
28 application; amending s. 641.315, F.S.; prohibiting

29 | contracts between health maintenance organizations and
 30 | dentists from containing certain fee requirements set by
 31 | the organization under certain circumstances; providing a
 32 | definition; providing application; amending s. 641.3156,
 33 | F.S.; authorizing appeals from denials of certain claims
 34 | for certain services; requiring a health maintenance
 35 | organization to conduct a retrospective review of the
 36 | medical necessity of a service under certain
 37 | circumstances; requiring the health maintenance
 38 | organization to submit a written justification for a
 39 | determination that a service was not medically necessary
 40 | and provide a process for appealing the determination;
 41 | providing an effective date.

42 |

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

44 |

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

47 | 626.9541 Unfair methods of competition and unfair or
 48 | deceptive acts or practices defined.—

49 | (3) WELLNESS PROGRAMS.—Notwithstanding subsection (1), an
 50 | insurer issuing a group or individual health benefit plan may
 51 | offer a voluntary wellness or health improvement program that
 52 | provides for rewards or incentives, including, but not limited
 53 | to, merchandise; gift cards; debit cards; premium discounts or
 54 | rebates; contributions towards a member's health savings
 55 | account; modifications to copayment, deductible, or coinsurance
 56 | amounts; or any combination of such rewards or incentives to

57 encourage or reward participation in the program. The health
 58 benefit plan member may be required to provide verification,
 59 including, but not limited to, a statement from the member's
 60 physician, that a medical condition makes it unreasonably
 61 difficult or medically inadvisable for the individual to
 62 participate in the wellness program. Any reward or incentive
 63 established under this subsection is not an insurance benefit
 64 and does not constitute a violation of this section. This
 65 subsection does not prohibit an insurer from offering incentives
 66 or rewards to members for adherence to wellness or health
 67 improvement programs if otherwise authorized by state or federal
 68 law.

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

71 627.6141 Denial of claims.—Each claimant, or hospital
 72 ~~provider~~ acting for a claimant, who has had a claim denied or a
 73 portion of a claim denied because the hospital failed to obtain
 74 the necessary authorization due to an unintentional act or error
 75 or omission ~~as not medically necessary~~ must be provided an
 76 opportunity for an appeal to the insurer's licensed physician
 77 who is responsible for the medical necessity reviews under the
 78 plan ~~or is a member of the plan's peer review group.~~ If the
 79 hospital appeals the denial, the health insurer shall conduct
 80 and complete a retrospective review of the medical necessity of
 81 the service within 30 business days after the submitted appeal.
 82 If the insurer determines upon review that the service was
 83 medically necessary, the insurer shall reverse the denial and
 84 pay the claim. If the insurer determines that the service was

85 not medically necessary, the insurer shall submit to the
 86 hospital specific written clinical justification for the
 87 determination. ~~The appeal may be by telephone, and the insurer's~~
 88 licensed physician must respond within a reasonable time, not to
 89 exceed 15 business days.

90 Section 3. Section 627.6474, Florida Statutes, is amended
 91 to read:

92 627.6474 Provider contracts.—

93 (1) A health insurer may ~~shall~~ not require a contracted
 94 health care practitioner as defined in s. 456.001(4) to accept
 95 the terms of other health care practitioner contracts with the
 96 insurer or any other insurer, or health maintenance
 97 organization, under common management and control with the
 98 insurer, including Medicare and Medicaid practitioner contracts
 99 and those authorized by s. 627.6471, s. 627.6472, s. 636.035, or
 100 s. 641.315, except for a practitioner in a group practice as
 101 defined in s. 456.053 who must accept the terms of a contract
 102 negotiated for the practitioner by the group, as a condition of
 103 continuation or renewal of the contract. Any contract provision
 104 that violates this section is void. A violation of this section
 105 is not subject to the criminal penalty specified in s. 624.15.

106 (2) A contract between a health insurer and a dentist
 107 licensed under chapter 466 for the provision of services to
 108 patients may not contain any provision that requires the dentist
 109 to provide services to the insured under such contract at a fee
 110 set by the health insurer unless such services are covered
 111 services under the applicable contract. As used in this
 112 subsection, the term "covered services" means services

CS/HB 715

2010

113 reimbursable under the applicable contract, subject to such
114 contractual limitations on benefits, such as deductibles,
115 coinsurance, and copayments, as may apply. This subsection
116 applies to all contracts entered into or renewed on or after
117 July 1, 2010.

118 Section 4. Subsection (13) is added to section 636.035,
119 Florida Statutes, to read:

120 636.035 Provider arrangements.—

121 (13) A contract between a prepaid limited health service
122 organization and a dentist licensed under chapter 466 for the
123 provision of services to subscribers of the prepaid limited
124 health service organization may not contain any provision that
125 requires the dentist to provide services to subscribers of the
126 prepaid limited health service organization at a fee set by the
127 prepaid limited health service organization unless such services
128 are covered services under the applicable contract. As used in
129 this subsection, the term "covered services" means services
130 reimbursable under the applicable contract, subject to such
131 contractual limitations on benefits, such as deductibles,
132 coinsurance, and copayments, as may apply. This subsection
133 applies to all contracts entered into or renewed on or after
134 July 1, 2010.

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

137 641.315 Provider contracts.—

138 (11) A contract between a health maintenance organization
139 and a dentist licensed under chapter 466 for the provision of
140 services to subscribers of the health maintenance organization

141 may not contain any provision that requires the dentist to
142 provide services to subscribers of the health maintenance
143 organization at a fee set by the health maintenance organization
144 unless such services are covered services under the applicable
145 contract. As used in this subsection, the term "covered
146 services" means services reimbursable under the applicable
147 contract, subject to such contractual limitations on subscriber
148 benefits, such as deductibles, coinsurance, and copayments, as
149 may apply. This subsection applies to all contracts entered into
150 or renewed on or after July 1, 2010.

151 Section 6. Subsection (3) of section 641.3156, Florida
152 Statutes, is renumbered as subsection (4), and a new subsection
153 (3) is added to that section to read:

154 641.3156 Treatment authorization; payment of claims.—

155 (3) If a hospital claim or a portion of a hospital claim
156 of a contracted hospital is denied because the hospital, due to
157 an unintentional act of error or omission, failed to obtain the
158 necessary authorization, the hospital may appeal the denial to
159 the health maintenance organization's licensed physician who is
160 responsible for medical necessity reviews. The health
161 maintenance organization shall conduct and complete a
162 retrospective review of the medical necessity of the service
163 within 30 business days after the submitted appeal. If the
164 health maintenance organization determines that the service is
165 medically necessary, the health maintenance organization shall
166 reverse the denial and pay the claim. If the health maintenance
167 organization determines that the service is not medically
168 necessary, the health maintenance organization shall provide the

CS/HB 715

2010

169 | hospital with specific written clinical justification for the
170 | determination.

171 | Section 7. This act shall take effect July 1, 2010.