A bill to be entitled

An act relating to health care coverage; amending ss. 627.6471 and 627.6472, F.S.; providing reimbursement rates applicable to payments by insurers for covered health care services provided in a hospital by physicians who are not members of a preferred provider network or exclusive provider network; providing requirements and limitations with respect to the collection of fees or payments for such services; defining the term "hospital-based physician" or "physician"; requiring an insurer to report certain violations to the Department of Health; amending s. 641.31, F.S.; providing applicability; amending s. 641.513, F.S.; providing reimbursement rates applicable to payments by health maintenance organizations for covered health care services provided in a hospital setting by physicians who do not have a contract with the health maintenance organization; providing requirements and limitations with respect to the collection of fees or payments for such services; defining the term "hospital-based physician" or "physician"; requiring a health maintenance organization to report certain violations to the Department of Health; providing an effective date.

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

Section 1. Subsection (7) is added to section 627.6471, Florida Statutes, to read:

627.6471 Contracts for reduced rates of payment; limitations; coinsurance and deductibles.—

(7) When a hospital is a member of an insurer's preferred provider network, and the hospital-based physicians that provide covered services at that hospital are not members of the insurer's preferred provider network, the following apply:

(a) Reimbursement by the insurer for covered services rendered to covered persons by the physician shall be the same as the percentage rate that is paid to preferred providers, and that reimbursement rate must be applied to the lesser of the following amounts:

1. The physician's charges;

2. The usual and customary amount accepted by physicians for similar services in the community where the services were provided; or

3. The amount mutually agreed to by the physician and the insurer.

(b) If the insurer is liable for services rendered by the hospital-based physician, the insurer is liable for payment of the fees to the physician, and the covered persons are not liable for payment of fees to the physician, except for co-insurance or other cost sharing applicable pursuant to the covered persons insurance contract. A physician or any representative of the physician may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency a covered person for payment of

services for which the insurer is liable, if the physician in good faith knows or should know that the insurer is liable. This prohibition applies during the pendency of any claim for payment made by the physician to the insurer for payment of the services and any legal proceedings or dispute resolution process to determine whether the insurer is liable for the services if the physician is informed that such proceedings are taking place. It is presumed that a physician does not know and should not know that the insurer is liable unless:

1. The physician is informed by the insurer that it accepts liability;

2. A court of competent jurisdiction determines that the insurer is liable; or

3. The office makes a final determination that the insurer is required to pay for such services.

(c) For purposes of this subsection, the term "hospital-based physician" or "physician" means any physician, including, but not limited to, radiologists, anesthesiologists, pathologists, emergency room physicians, or group of physicians, that have entered into a contract with a hospital that:

1. Allows a physician to provide medical services for inpatient and outpatient treatment through the hospital without being specifically chosen by the patient;

2. Precludes similar-specialty physicians from providing medical treatment for inpatient and outpatient treatment through the hospital; or

3. Fosters the opportunity for a physician to provide medical services for inpatient and outpatient treatment through

the hospital.

(d) The insurer shall report any suspected violation of this subsection to the Department of Health, which shall take appropriate action as authorized by law.

Section 2. Subsection (19) is added to section 627.6472, Florida Statutes, to read:

627.6472 Exclusive provider organizations.—

(19) When a hospital is a member of an insurer's exclusive provider network, and the hospital-based physicians that provide covered services at that hospital are not members of the insurer's exclusive provider network, the following apply:

(a) Reimbursement by the insurer for covered services rendered to covered persons by the physician shall be the same as the percentage rate that is paid to exclusive providers, and that reimbursement rate must be applied to the lesser of the following amounts:

1. The physician's charges;

2. The usual and customary amount accepted by physicians for similar services in the community where the services were provided; or

3. The amount mutually agreed to by the physician and the insurer.

(b) If the insurer is liable for services rendered by the hospital-based physician, the insurer is liable for payment of the fees to the physician, and the covered persons are not liable for payment of fees to the physician, except for co-insurance or other cost sharing applicable pursuant to the covered persons insurance contract. A physician or any

representative of the physician may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency a covered person for payment of services for which the insurer is liable, if the physician in good faith knows or should know that the insurer is liable. This prohibition applies during the pendency of any claim for payment made by the physician to the insurer for payment of the services and any legal proceedings or dispute resolution process to determine whether the insurer is liable for the services if the physician is informed that such proceedings are taking place. It is presumed that a physician does not know and should not know that the insurer is liable unless:

1. The physician is informed by the insurer that it accepts liability;

2. A court of competent jurisdiction determines that the insurer is liable; or

3. The office makes a final determination that the insurer is required to pay for such services.

(c) For purposes of this subsection, the term "hospital-based physician" or "physician" means any physician, including, but not limited to, radiologists, anesthesiologists, pathologists, emergency room physicians, or group of physicians, that have entered into a contract with a hospital that:

1. Allows a physician to provide medical services for inpatient and outpatient treatment through the hospital without being specifically chosen by the patient;

2. Precludes similar-specialty physicians from providing medical treatment for inpatient and outpatient treatment through

the hospital; or

3. Fosters the opportunity for a physician to provide medical services for inpatient and outpatient treatment through the hospital.

(d) The insurer shall report any suspected violation of this subsection to the Department of Health, which shall take appropriate action as authorized by law.

Section 3. Paragraph (d) of subsection (38) of section 641.31, Florida Statutes, is amended to read:

641.31 Health maintenance contracts.—

(38)

(d) Notwithstanding the limitations of deductibles and copayment provisions in this part, a point-of-service rider may require the subscriber to pay a reasonable copayment for each visit for services provided by a noncontracted provider chosen at the time of the service. The copayment by the subscriber may either be a specific dollar amount or a percentage of the reimbursable provider charges covered by the contract and must be paid by the subscriber to the noncontracted provider upon receipt of covered services. The point-of-service rider may require that a reasonable annual deductible for the expenses associated with the point-of-service rider be met and may include a lifetime maximum benefit amount. The rider must include the language required by s. 627.6044 and must comply with copayment limits described in s. 627.6471. Section 641.3154 does not apply to a point-of-service rider authorized under this subsection, unless the health care services are rendered in an emergency setting or in a hospital or by hospital-based

physicians as described in s. 641.513.

Section 4. Subsection (5) of section 641.513, Florida Statutes, is amended to read:

641.513 Requirements for providing emergency services and care.—

(5)(a) Reimbursement for services pursuant to this section by a provider, including those services rendered in an emergency setting in a hospital or by a hospital-based physician, who does not have a contract with the health maintenance organization shall be the lesser of:

1.~~(a)~~ The provider's charges;

2.~~(b)~~ The usual and customary provider charges for similar services in the community where the services were provided; or

3.~~(c)~~ The charge mutually agreed to by the health maintenance organization and the provider within 60 days of the submittal of the claim.

(b) If the health maintenance organization is liable for services rendered by the hospital-based physician, the health maintenance organization is liable for payment of the fees to the physician, and the subscriber is not liable for payment of fees to the physician, except for copayment or other cost sharing applicable pursuant to the subscriber's health maintenance organization contract. A physician or any representative of the physician may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency a subscriber for payment of services for which the health maintenance organization is liable, if the physician in good faith knows or should know that the health

maintenance organization is liable. This prohibition applies during the pendency of any claim for payment made by the physician to the health maintenance organization for payment of the services and any legal proceedings or dispute resolution process to determine whether the health maintenance organization is liable for the services if the physician is informed that such proceedings are taking place. It is presumed that a physician does not know and should not know that the health maintenance organization is liable unless:

1. The physician is informed by the health maintenance organization that it accepts liability;

2. A court of competent jurisdiction determines that the health maintenance organization is liable; or

3. The office makes a final determination that the health maintenance organization is required to pay for such services.

(c) For purposes of this subsection, the term "hospital-based physician" or "physician" means any physician, including, but not limited to, radiologists, anesthesiologists, pathologists, emergency room physicians, or group of physicians, that have entered into a contract with a hospital that:

1. Allows a physician to provide medical services for inpatient and outpatient treatment through the hospital without being specifically chosen by the patient;

2. Precludes similar-specialty physicians from providing medical treatment for inpatient and outpatient treatment through the hospital; or

3. Fosters the opportunity for a physician to provide medical services for inpatient and outpatient treatment through

the hospital.

(d) The health maintenance organization shall report any suspected violation of this subsection to the Department of Health, which shall take appropriate action as authorized by law.

Such reimbursement shall be net of any applicable copayment authorized pursuant to subsection (4).

Section 5. This act shall take effect July 1, 2013.