COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED __ (Y/N)

ADOPTED AS AMENDED __ (Y/N)

ADOPTED W/O OBJECTION __ (Y/N)

FAILED TO ADOPT __ (Y/N)

WITHDRAWN __ (Y/N)

OTHER ______

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1 Committee/Subcommittee hearing bill: Appropriations Committee
2 Representative Hager offered the following:
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4 **Amendment**
5 Remove everything after the enacting clause and insert:
6 Section 1. Subsection (11) of section 627.6131, Florida
7 Statutes, is amended to read:
8 627.6131 Payment of claims.—
9 (11)(a) A health insurer may not retroactively deny a
10 claim because of insured ineligibility more than 1 year after
11 the date of payment of the claim.
12 (b) For purposes of this section, “grace period” means the
13 time period set forth in s. 627.608, Florida Statutes.
14 (c) For care provided during the grace period, when a
15 health care provider or a representative of the health care
16 provider seeks information regarding eligibility, performs a

17 benefit inquiry, or submits a request for a related claim
18 status, or for one or more related claims in the remittance
19 advice, the health insurer shall clearly identify, at the same
20 time that it responds to the underlying request, that the
21 insured is in the grace period and that payment by the health
22 insurer is uncertain. The information provided by the health
23 insurer about the insured's grace period status is binding on
24 the health insurer. If the health insurer informs the health
25 care provider that the insured is in the grace period and the
26 provider elects to provide services to the insured, the health
27 insurer may later refuse payment or seek to recoup payment from
28 the health care provider if the grace period expires without the
29 overdue premium being paid. If the health insurer informs the
30 health care provider or a representative of the health care
31 provider that the insured is eligible for services, and does not
32 inform the health care provider that the insured is in the grace
33 period, that determination shall be binding on the health
34 insurer, and the claim(s) for services rendered shall be paid by
35 the health insurer. This binding determination shall further
36 preclude the health insurer from seeking to recoup payment from
37 the health care provider.
38 (d) Notwithstanding any other provision of law, if the
39 health insurer notifies the physician that it intends to pend
40 claims during the grace period, or intends to recoup monies paid
41 to the physician during the grace period, the physician may

42 elect to postpone the provision of non-emergency medical care
43 until the insured is no longer in the grace period. A contract
44 between a health insurer and a health care provider shall not
45 prohibit the health care provider from postponing non-emergency
46 care for an insured while the insured is in the grace period.
47 (e) Notwithstanding subsection (a), when the insured is
48 not in the grace period at the time of treatment, a health
49 insurer that has verified the eligibility of an insured at the
50 time of treatment or has provided an authorization number may
51 not retroactively deny a claim because of insured ineligibility
52 at any time.
53 (f) Paragraphs (b), (c), (d) and (e) apply to policies
54 entered into or renewed on or after January 1, 2019.
55 Section 2. Subsection (10) of section 641.3155, Florida
56 Statutes, is amended to read:
57 641.3155 Prompt payment of claims.-
58 (10)(a) A health maintenance organization may not
59 retroactively deny a claim because of subscriber ineligibility
60 more than 1 year after the date of payment of the claim.
61 (b) For purposes of this section, "grace period" means the
62 time period set forth s. 641.31(15)(a), Florida Statutes.
63 (c) For care provided to a subscriber during the grace
64 period, when a health care provider or a representative of the
65 health care provider seeks information regarding eligibility,
66 performs a benefit inquiry, or submits a request for a related

67 claim status, or for one or more related claims in the
68 remittance advice, the health maintenance organization shall
69 clearly identify, at the same time that it responds to the
70 underlying request, that the subscriber is in the grace period
71 and that payment by the health maintenance organization is
72 uncertain. The information provided by the health maintenance
73 organization about the subscriber's grace period status is
74 binding on the health maintenance organization. If the health
75 maintenance organization informs the health care provider that
76 the subscriber is in the grace period, the health maintenance
77 organization may retroactively deny the claim and refuse payment
78 or seek to recoup payment from the health care provider. If the
79 health maintenance organization informs the health care provider
80 or a representative of the health care provider that the
81 subscriber is eligible for services and does not inform the
82 health care provider that the enrollee is in the grace period,
83 that determination shall be binding on the health maintenance
84 organization, and the claim(s) for services rendered shall be
85 paid by the health maintenance organization. This binding
86 determination shall further preclude the health maintenance
87 organization from seeking to recoup payment from the health care
88 provider.
89 (d) Notwithstanding any other provision of law, if the
90 health maintenance organization notifies the physician that it
91 intends to pend claims during the grace period, or intends to

92 recoup monies paid to the physician during the grace period, the
93 physician may elect to postpone the provision of non-emergency
94 medical care until the subscriber is no longer in the grace
95 period. A contract between a health maintenance organization and
96 a health care provider shall not prohibit the health care
97 provider from postponing non-emergency care for a subscriber
98 while the subscriber is in the grace period.
99 (e) Notwithstanding subsection (a), when the subscriber is
100 not in the grace period at the time of treatment, a health
101 maintenance organization that has verified the eligibility of a
102 subscriber at the time of treatment or has provided an
103 authorization number may not retroactively deny a claim because
104 of subscriber ineligibility at any time.
105 (f) Paragraphs (b), (c), (d) and (e) do not apply to
106 Medicaid managed care plans pursuant to part IV of chapter 409,
107 and only apply to contracts entered into or renewed on or after
108 January 1, 2019.
109 Section 3. This act shall take effect on July 1, 2018.