By Senator Saunders

25-1161-99

A bill to be entitled

An act relating to health care; amending ss. 408.706, F.S., 627.419, F.S., and creating s. 641.3151, F.S.; allowing subscribers to certain health plans to select their physician; prohibiting the denial of payment to such health care providers selected; providing reimbursement criteria; providing penalties; amending s. 641.315, F.S.; limiting the liability for payment for HMO subscribers; amending s. 408.7056, F.S.; revising the membership of a statewide provider and subscriber assistance panel; amending s. 641.495, F.S.; providing responsibilities for health maintenance organization medical directors regarding adverse determinations with respect to subscribers; providing an effective date.

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

Section 1. Subsection (11) of section 408.706, Florida Statutes, is amended to read:

408.706 Community health purchasing alliances; accountable health partnerships.--

(11) Notwithstanding any other provision of law to the contrary, any subscriber to a health plan offered by or through a health maintenance organization, managed care organization, prepaid health plan, or accountable health partnership may select a physician of his or her choice who is licensed under chapter 458 or chapter 459. A health plan may

not contain any provision that requires or coerces a subscriber to use any physician other than one selected by the subscriber.

(a) A health maintenance organization, managed care organization, prepaid health plan, or accountable health partnership may not deny payment to a physician who has rendered covered services to a subscriber, based solely on the fact that the physician has not entered into a provider contract with the organization, plan, or partnership, if:

1. The physician meets the eligibility criteria of the organization, plan, or partnership; and

2. Under accepted medical standards, the services were medically necessary so that the organization, plan, or partnership would be required to pay for the services had they been performed by a contracted provider.

(b) Reimbursement for services by a physician who does not have a contract with the organization, plan, or partnership must be the lesser of:

1. Eighty percent of the physician's charges;

2. Eighty percent of the highest rate paid by the organization, plan, or partnership to contracted physicians for the procedure; or

3. The charge agreed to by the organization, plan, or partnership and the physician within 30 days after submittal of the claim.

The subscriber is liable for all physician charges not covered by the health maintenance organization under this paragraph.

(c) A health maintenance organization, managed care provider organization, prepaid health plan, or accountable

health partnership that violates this subsection is subject to a civil fine in the amount of:

1. Up to $25,000 for each violation; or

2. If the Director of the Agency for Health Care Administration determines that the entity has engaged in a pattern of violations, up to $100,000 for each violation.~~The ability to recruit and retain alliance district health care providers in its provider network. For provider networks initially formed in an alliance district after July 1, 1993, an accountable health partnership shall make offers as to provider participation in its provider network to relevant alliance district health care providers for at least 60 percent of the available provider positions. A provider who is made an offer may participate in an accountable health partnership as long as the provider abides by the terms and conditions of the provider network contract, provides services at a rate or price equal to the rate or price negotiated by the accountable health partnership, and meets all of the accountable health partnership's qualifications for participation in its provider networks including, but not limited to, network adequacy criteria. For purposes of this subsection, "alliance district health care provider" means a health care provider who is licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 464, or chapter 465 who has practiced in Florida for more than 1 year within the alliance district served by the accountable health partnership.~~

Section 2. Subsection (9) is added to section 627.419, Florida Statutes, 1998 Supplement, to read:

627.419 Construction of policies.--

(9)(a) Notwithstanding any other provision of law to the contrary, any person covered under any health insurance policy, health care services plan, or other contract that provides for payment for medical expense benefits or procedures may select a physician of his or her choice who is licensed under chapter 458 or chapter 459. A health plan may not contain any provision that requires or coerces a person covered by the plan to use any provider other than one selected by the subscriber. A health plan may not deny payment to a physician who has rendered covered services to an insured, based solely on the fact that the physician has not entered into a provider contract with the plan, if:

1. The physician meets the plan's eligibility criteria; and

2. Under accepted medical standards, the services were medically necessary so that the organization would be required to pay for the services had they been performed by a contracted physician.

(b) Reimbursement for services by a physician who does not have a contract with the health plan must be the lesser of:

1. Eighty percent of the physician's charges;

2. Eighty percent of the highest rate paid by the organization to contracted physicians for the procedure; or

3. The charge agreed to by the organization within 30 days after submittal of the claim.

The subscriber shall be liable for all physician charges not covered by the health plan under this paragraph.

(c) The provider of any health insurance policy, health care services plan, or other contract that violates this subsection is subject to a civil fine in the amount of:

1. Up to $25,000 for each violation; or

2. If the Director of the Agency for Health Care Administration determines that the entity has engaged in a pattern of violations, up to $100,000 for each violation.

Section 3. Section 641.3151, Florida Statutes, is created to read:

641.3151 Subscriber freedom of choice.--

(1) Notwithstanding any other provision of law to the contrary, any subscriber to a health plan offered by or through a health maintenance organization or managed care organization may select a physician of his or her choice who is licensed under chapter 458 or chapter 459. A health plan may not contain any provision that requires or coerces a subscriber to use any physician other than one selected by the subscriber. A health maintenance organization or managed care organization may not deny payment to a physician who has rendered covered services to a subscriber, based solely on the fact that the physician has not entered into a provider contract with the organization, if:

(a) The physician meets the organization's eligibility criteria; and

(b) Under accepted medical standards, the services were medically necessary so that the organization would be required to pay for the services had they been performed by a contracted physician.

(2) Reimbursement for services by a physician who does not have a contract with the health maintenance organization or managed care organization must be the lesser of:

(a) Eighty percent of the physician's charges;

(b) Eighty percent of the highest rate paid by the organization to contracted physicians for the procedure; or

(c) The charge agreed to by the organization within 30 days after submittal of the claim.

The subscriber shall be liable for all physician charges not covered by the health maintenance organization under this subsection.

(3) A health maintenance organization or managed care provider organization that violates this section is subject to a civil fine in the amount of:

(a) Up to $25,000 for each violation; or

(b) If the Director of the Agency for Health Care Administration determines that the entity has engaged in a pattern of violations, up to $100,000 for each violation.

Section 4. Subsections (2) and (3) of section 641.315, Florida Statutes, are amended to read:

641.315 Provider contracts.--

(2) No subscriber of an HMO shall be liable to any contracted provider of health care services of that HMO for any services covered by the HMO.

(3) No contracted provider of services of an HMO or any representative of such provider shall collect or attempt to collect from an HMO subscriber any money for services covered by an HMO and no contracted provider or representative of such provider may maintain any action at law against a subscriber of an HMO to collect money owed to such provider by an HMO.

Section 5. Subsection (11) of section 408.7056, Florida Statutes, 1998 Supplement, is amended to read:

408.7056 Statewide Provider and Subscriber Assistance Program.--

(11) The panel shall consist of members employed by the agency and members employed by the department, chosen by their respective agencies. In addition, at least one-third of the panel must be comprised of physicians licensed under chapter 458 or chapter 459. If the grievance involves an adverse determination, as defined in s. 641.47, at least one of the physicians on the panel must be in the same specialty as that forming the subject of the grievance or must have training and experience in the procedure in question. The agency may contract with a medical director and a primary care physician who shall provide additional technical expertise to the panel. The medical director shall be selected from a health maintenance organization with a current certificate of authority to operate in Florida.

Section 6. Subsection (11) of section 641.495, Florida Statutes, 1998 Supplement, is amended to read:

641.495 Requirements for issuance and maintenance of certificate.--

(11) The organization shall designate a medical director who is a physician licensed under chapter 458 or chapter 459. For every adverse determination made by the HMO regarding any subscriber, the medical director must document and sign the subscriber's medical records setting forth the facts regarding the HMO's adverse determination and the rationale for that determination. The rendering of an adverse determination by a medical director constitutes the practice of medicine as defined in s. 458.305.

Section 7. This act shall take effect July 1, 1999.

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SENATE SUMMARY

Revises provisions related to health services plans. Allows subscribers to select their physicians. Prohibits the denial of payment to such providers and provides criteria for reimbursement. Provides penalties. Limits the liability of HMO subscribers for payments to providers. Revises the membership of the statewide provider and assistance panels. Provides responsibilities for HMO medical directors regarding adverse determinations. (See bill for details.)