

By Senators Saunders, Pruitt and Lee

25-2392-02

1 A bill to be entitled
2 An act relating to health care; providing
3 legislative findings and legislative intent
4 regarding health flex plans; defining terms;
5 providing for a pilot program for health flex
6 plans for certain uninsured persons; providing
7 criteria; authorizing the Agency for Health
8 Care Administration and the Department of
9 Insurance to adopt rules; exempting approved
10 health flex plans from certain licensing
11 requirements; providing criteria for
12 eligibility to enroll in a health flex plan;
13 requiring health flex plan providers to
14 maintain certain records; providing
15 requirements for denial, nonrenewal, or
16 cancellation of coverage; specifying that
17 coverage under an approved health flex plan is
18 not an entitlement; requiring a report with
19 specified evaluation elements; providing for
20 future repeal; establishing the Florida
21 Alzheimer's Center and Research Institute at
22 the University of South Florida; requiring the
23 State Board of Education to enter into an
24 agreement with a not-for-profit corporation for
25 the governance and operation of the institute;
26 providing that the corporation shall act as an
27 instrumentality of the state; authorizing the
28 creation of subsidiaries by the corporation;
29 providing powers of the corporation; providing
30 for a board of directors of the corporation and
31 the appointment and terms of its membership;

1 authorizing the State Board of Education to
2 secure and provide liability protection;
3 providing for an annual audit and report;
4 providing for assumption of certain
5 responsibilities of the corporation by the
6 State Board of Education under certain
7 circumstances; providing for administration of
8 the institute; providing for disbursal and use
9 of income; providing for reporting of
10 activities; requiring the appointment of a
11 council of scientific advisers; providing
12 responsibilities and terms of the council;
13 providing that the corporation and its
14 subsidiaries are not agencies within the
15 meaning of s. 20.03(11), F.S.; amending s.
16 408.7057, F.S.; redesignating a program title;
17 revising definitions; including preferred
18 provider organizations and health insurers in
19 the claim dispute resolution program;
20 specifying timeframes for submission of
21 supporting documentation necessary for dispute
22 resolution; providing consequences for failure
23 to comply; providing additional
24 responsibilities for the agency relating to
25 patterns of claim disputes; providing
26 timeframes for review by the resolution
27 organization; directing the agency to notify
28 appropriate licensure and certification
29 entities as part of violation of final orders;
30 amending s. 626.88, F.S.; redefining the term
31 "administrator," with respect to regulation of

1 insurance administrators; creating s. 627.6131,
2 F.S.; specifying payment-of-claims provisions
3 applicable to certain health insurers;
4 providing a definition; providing requirements
5 and procedures for paying, denying, or
6 contesting claims; providing criteria and
7 limitations; requiring payment within specified
8 periods; specifying rate of interest charged on
9 overdue payments; providing for electronic and
10 nonelectronic transmission of claims; providing
11 procedures for overpayment recovery; specifying
12 timeframes for adjudication of claims,
13 internally and externally; prohibiting action
14 to collect payment from an insured under
15 certain circumstances; providing applicability;
16 prohibiting contractual modification of
17 provisions of law; specifying circumstances for
18 retroactive claim denial; specifying claim
19 payment requirements; providing for billing
20 review procedures; specifying claim content
21 requirements; establishing a permissible error
22 ratio, specifying its applicability, and
23 providing for fines; providing specified
24 exceptions from notice and acknowledgment
25 requirements for pharmacy benefit manager
26 claims; amending s. 627.651, F.S.; conforming a
27 cross-reference; amending s. 627.662, F.S.;
28 specifying application of certain additional
29 provisions to group, blanket, and franchise
30 health insurance; amending s. 641.185, F.S.;
31 specifying that health maintenance organization

1 subscribers should receive prompt payment from
2 the organization; amending s. 641.234, F.S.;
3 specifying responsibility of a health
4 maintenance organization for certain violations
5 under certain circumstances; amending s.
6 641.30, F.S.; conforming a cross-reference;
7 amending s. 641.3154, F.S.; modifying the
8 circumstances under which a provider knows that
9 an organization is liable for service
10 reimbursement; amending s. 641.3155, F.S.;
11 revising payment of claims provisions
12 applicable to certain health maintenance
13 organizations; providing a definition;
14 providing requirements and procedures for
15 paying, denying, or contesting claims;
16 providing criteria and limitations; requiring
17 payment within specified periods; revising rate
18 of interest charged on overdue payments;
19 providing for electronic and nonelectronic
20 transmission of claims; providing procedures
21 for overpayment recovery; specifying timeframes
22 for adjudication of claims, internally and
23 externally; prohibiting action to collect
24 payment from a subscriber under certain
25 circumstances; prohibiting contractual
26 modification of provisions of law; specifying
27 circumstances for retroactive claim denial;
28 specifying claim payment requirements;
29 providing for billing review procedures;
30 specifying claim content requirements;
31 establishing a permissible error ratio,

1 specifying its applicability, and providing for
2 fines; providing specified exceptions from
3 notice and acknowledgment requirements for
4 pharmacy benefit manager claims; amending s.
5 641.51, F.S.; revising provisions governing
6 examinations by ophthalmologists; amending s.
7 456.053, F.S., the "Patient Self-Referral Act
8 of 1992"; redefining the term "referral" by
9 revising the list of practices that constitute
10 exceptions; amending s. 627.6699, F.S.;
11 allowing carriers to separate the experience of
12 small-employer groups having fewer than two
13 employees; restricting application of certain
14 laws to health plan policies under certain
15 circumstances; providing for construction of
16 laws enacted at the 2002 Regular Session in
17 relation to this act; providing effective
18 dates.

19
20 Be It Enacted by the Legislature of the State of Florida:

21
22 Section 1. Health flex plans.--
23 (1) INTENT.--The Legislature finds that a significant
24 proportion of the residents of this state are unable to obtain
25 affordable health insurance coverage. Therefore, it is the
26 intent of the Legislature to expand the availability of health
27 care options for low-income uninsured state residents by
28 encouraging health insurers, health maintenance organizations,
29 health-care-provider-sponsored organizations, local
30 governments, health care districts, or other public or private
31 community-based organizations to develop alternative

1 approaches to traditional health insurance which emphasize
2 coverage for basic and preventive health care services. To the
3 maximum extent possible, these options should be coordinated
4 with existing governmental or community-based health services
5 programs in a manner that is consistent with the objectives
6 and requirements of such programs.

7 (2) DEFINITIONS.--As used in this section, the term:

8 (a) "Agency" means the Agency for Health Care
9 Administration.

10 (b) "Department" means the Department of Insurance.

11 (c) "Enrollee" means an individual who has been
12 determined to be eligible for and is receiving health care
13 coverage under a health flex plan approved under this section.

14 (d) "Health care coverage" or "health flex plan
15 coverage" means health care services that are covered as
16 benefits under an approved health flex plan or that are
17 otherwise provided, either directly or through arrangements
18 with other persons, via a health flex plan on a prepaid
19 per-capita basis or on a prepaid aggregate fixed-sum basis.

20 (e) "Health flex plan" means a health plan approved
21 under subsection (3) which guarantees payment for specified
22 health care coverage provided to the enrollee.

23 (f) "Health flex plan entity" means a health insurer,
24 health maintenance organization, health care
25 provider-sponsored organization, local government, health care
26 district, or other public or private community-based
27 organization that develops and implements an approved health
28 flex plan and is responsible for administering the health flex
29 plan and paying all claims for health flex plan coverage by
30 enrollees of the health flex plan.

31

1 (3) PILOT PROGRAM.--The agency and the department
2 shall each approve or disapprove health flex plans that
3 provide health care coverage for eligible participants who
4 reside in the three areas of the state that have the highest
5 number of uninsured persons, as identified in the Florida
6 Health Insurance Study conducted by the agency and in Indian
7 River County. A health flex plan may limit or exclude benefits
8 otherwise required by law for insurers offering coverage in
9 this state, may cap the total amount of claims paid per year
10 per enrollee, may limit the number of enrollees, or may take
11 any combination of those actions.

12 (a) The agency shall develop guidelines for the review
13 of applications for health flex plans and shall disapprove or
14 withdraw approval of plans that do not meet or no longer meet
15 minimum standards for quality of care and access to care.

16 (b) The department shall develop guidelines for the
17 review of health flex plan applications and shall disapprove
18 or shall withdraw approval of plans that:

19 1. Contain any ambiguous, inconsistent, or misleading
20 provisions or any exceptions or conditions that deceptively
21 affect or limit the benefits purported to be assumed in the
22 general coverage provided by the health flex plan;

23 2. Provide benefits that are unreasonable in relation
24 to the premium charged or contain provisions that are unfair
25 or inequitable or contrary to the public policy of this state,
26 that encourage misrepresentation, or that result in unfair
27 discrimination in sales practices; or

28 3. Cannot demonstrate that the health flex plan is
29 financially sound and that the applicant is able to underwrite
30 or finance the health care coverage provided.

31

1 (c) The agency and the department may adopt rules as
2 needed to administer this section.

3 (4) LICENSE NOT REQUIRED.--Neither the licensing
4 requirements of the Florida Insurance Code nor chapter 641,
5 Florida Statutes, relating to health maintenance
6 organizations, is applicable to a health flex plan approved
7 under this section, unless expressly made applicable. However,
8 for the purpose of prohibiting unfair trade practices, health
9 flex plans are considered to be insurance subject to the
10 applicable provisions of part IX of chapter 626, Florida
11 Statutes, except as otherwise provided in this section.

12 (5) ELIGIBILITY.--Eligibility to enroll in an approved
13 health flex plan is limited to residents of this state who:

14 (a) Are 64 years of age or younger;

15 (b) Have a family income equal to or less than 200
16 percent of the federal poverty level;

17 (c) Are not covered by a private insurance policy and
18 are not eligible for coverage through a public health
19 insurance program, such as Medicare or Medicaid, or another
20 public health care program, such as KidCare, and have not been
21 covered at any time during the past 6 months; and

22 (d) Have applied for health care coverage through an
23 approved health flex plan and have agreed to make any payments
24 required for participation, including periodic payments or
25 payments due at the time health care services are provided.

26 (6) RECORDS.--Each health flex plan shall maintain
27 enrollment data and reasonable records of its losses,
28 expenses, and claims experience and shall make those records
29 reasonably available to enable the department to monitor and
30 determine the financial viability of the health flex plan, as
31 necessary. Provider networks and total enrollment by area

1 shall be reported to the agency biannually to enable the
2 agency to monitor access to care.

3 (7) NOTICE.--The denial of coverage by a health flex
4 plan, or the nonrenewal or cancellation of coverage, must be
5 accompanied by the specific reasons for denial, nonrenewal, or
6 cancellation. Notice of nonrenewal or cancellation must be
7 provided at least 45 days in advance of the nonrenewal or
8 cancellation, except that 10 days' written notice must be
9 given for cancellation due to nonpayment of premiums. If the
10 health flex plan fails to give the required notice, the health
11 flex plan coverage must remain in effect until notice is
12 appropriately given.

13 (8) NONENTITLEMENT.--Coverage under an approved health
14 flex plan is not an entitlement, and a cause of action does
15 not arise against the state, a local government entity, or any
16 other political subdivision of this state, or against the
17 agency, for failure to make coverage available to eligible
18 persons under this section.

19 (9) PROGRAM EVALUATION.--The agency and the department
20 shall evaluate the pilot program and its effect on the
21 entities that seek approval as health flex plans, on the
22 number of enrollees, and on the scope of the health care
23 coverage offered under a health flex plan; shall provide an
24 assessment of the health flex plans and their potential
25 applicability in other settings; and shall, by January 1,
26 2004, jointly submit a report to the Governor, the President
27 of the Senate, and the Speaker of the House of
28 Representatives.

29 (10) EXPIRATION.--This section expires July 1, 2004.

30 Section 2. Florida Alzheimer's Center and Research
31 Institute.--

1 (1) Effective July 1, 2002, the Florida Alzheimer's
2 Center and Research Institute is established at the University
3 of South Florida.

4 (2)(a) The State Board of Education shall enter into
5 an agreement for the use of the facilities on the campus of
6 the University of South Florida to be known as the Florida
7 Alzheimer's Center and Research Institute, including all
8 furnishings, equipment, and other chattels used in the
9 operation of those facilities, with a Florida not-for-profit
10 corporation organized solely for the purpose of governing and
11 operating the Florida Alzheimer's Center and Research
12 Institute. This not-for-profit corporation, acting as an
13 instrumentality of the state, shall govern and operate the
14 Florida Alzheimer's Center and Research Institute in
15 accordance with the terms of the agreement between the State
16 Board of Education and the not-for-profit corporation. The
17 not-for-profit corporation may, with the prior approval of the
18 State Board of Education, create not-for-profit corporate
19 subsidiaries to fulfill its mission. The not-for-profit
20 corporation and its subsidiaries are authorized to receive,
21 hold, invest, and administer property and any moneys acquired
22 from private, local, state, and federal sources, as well as
23 technical and professional income generated or derived from
24 practice activities of the institute, for the benefit of the
25 institute and the fulfillment of its mission.

26 (b)1. The affairs of the not-for-profit corporation
27 shall be managed by a board of directors who shall serve
28 without compensation. The board of directors shall consist of
29 the President of the University of South Florida and the chair
30 of the State Board of Education, or their designees, 5
31 representatives of the state universities, and no fewer than 9

1 nor more than 14 representatives of the public who are neither
2 medical doctors nor state employees. Each director who is a
3 representative of a state university or of the public shall be
4 appointed to serve a term of 3 years. The chair of the board
5 of directors shall be selected by a majority vote of the
6 directors. Each director shall have only one vote.

7 2. The initial board of directors shall consist of the
8 President of the University of South Florida and the chair of
9 the State Board of Education, or their designees; the five
10 university representatives, of whom one is to be appointed by
11 the Governor, two by the President of the Senate, and two by
12 the Speaker of the House of Representatives; and nine public
13 representatives, of whom three are to be appointed by the
14 Governor, three by the President of the Senate, and three by
15 the Speaker of the House of Representatives. Upon the
16 expiration of the terms of the initial appointed directors,
17 all directors subject to 3-year terms of office under this
18 paragraph shall be appointed by a majority vote of the
19 directors, and the board may be expanded to include additional
20 public representative directors up to the maximum number
21 allowed. Any vacancy in office shall be filled for the
22 remainder of the term by majority vote of the directors. Any
23 director may be reappointed.

24 (3) The State Board of Education shall provide in the
25 agreement with the not-for-profit corporation for the
26 following:

27 (a) Approval by the State Board of Education of the
28 articles of incorporation of the not-for-profit corporation.

29 (b) Approval by the State Board of Education of the
30 articles of incorporation of any not-for-profit corporate
31 subsidiary created by the not-for-profit corporation.

1 (c) Use of hospital facilities and personnel by the
2 not-for-profit corporation and its subsidiaries for mutually
3 approved teaching and research programs conducted by the
4 University of South Florida or other accredited medical
5 schools or research institutes.

6 (d) Preparation of an annual postaudit of the
7 not-for-profit corporation's financial accounts and the
8 financial accounts of any subsidiaries to be conducted by an
9 independent certified public accountant. The annual audit
10 report shall include management letters and shall be submitted
11 to the Auditor General and the State Board of Education for
12 review. The State Board of Education, the Auditor General,
13 and the Office of Program Policy Analysis and Government
14 Accountability shall have the authority to require and receive
15 from the not-for-profit corporation and any subsidiaries, or
16 from their independent auditor, any detail or supplemental
17 data relating to the operation of the not-for-profit
18 corporation or subsidiary.

19 (e) Provision by the not-for-profit corporation and
20 its subsidiaries of equal employment opportunities for all
21 persons regardless of race, color, religion, sex, age, or
22 national origin.

23 (4) The State Board of Education is authorized to
24 secure comprehensive general liability protection, including
25 professional liability protection, for the not-for-profit
26 corporation and its subsidiaries, pursuant to section 240.213,
27 Florida Statutes.

28 (5) If the agreement between the not-for-profit
29 corporation and the State Board of Education is terminated for
30 any reason, the State Board of Education shall assume
31 governance and operation of the facilities.

1 (6) The institute shall be administered by a chief
2 executive officer, who shall be appointed by and serve at the
3 pleasure of the board of directors of the not-for-profit
4 corporation and who shall exercise the following powers and
5 perform the following duties, subject to the approval of the
6 board of directors:

7 (a) The chief executive officer shall establish
8 programs that fulfill the mission of the institute in
9 research, education, treatment, prevention, and early
10 detection of Alzheimer's disease; however, the chief executive
11 officer may not establish academic programs for which academic
12 credit is awarded and which culminate in the conferring of a
13 degree, without prior approval of the State Board of
14 Education.

15 (b) The chief executive officer shall have control
16 over the budget and the dollars appropriated or donated to the
17 institute from private, local, state, and federal sources, as
18 well as technical and professional income generated or derived
19 from practice activities of the institute; however,
20 professional income generated by university faculty from
21 practice activities at the institute shall be shared between
22 the institute and the university as determined by the chief
23 executive officer and the appropriate university dean or vice
24 president.

25 (c) The chief executive officer shall appoint
26 representatives of the institute to carry out the research,
27 patient-care, and educational activities of the institute and
28 establish the compensation, benefits, and terms of service of
29 such representatives. Representatives of the institute shall
30 be eligible to hold concurrent appointments at affiliated
31

1 academic institutions. University faculty shall be eligible
2 to hold concurrent appointments at the institute.

3 (d) The chief executive officer shall have control
4 over the use and assignment of space and equipment within the
5 facilities.

6 (e) The chief executive officer shall have the power
7 to create the administrative structure necessary to carry out
8 the mission of the institute.

9 (f) The chief executive officer shall have a reporting
10 relationship to the Commissioner of Education.

11 (g) The chief executive officer shall provide a copy
12 of the institute's annual report to the Governor and Cabinet,
13 the President of the Senate, the Speaker of the House of
14 Representatives, and the chair of the State Board of
15 Education.

16 (7) The board of directors of the not-for-profit
17 corporation shall create a council of scientific advisers to
18 the chief executive officer consisting of leading researchers,
19 physicians, and scientists. The council shall review programs
20 and recommend research priorities and initiatives to maximize
21 the state's investment in the institute. The members of the
22 council shall be appointed by the board of directors of the
23 not-for-profit corporation, except for five members who shall
24 be appointed by the State Board of Education. Each member of
25 the council shall be appointed to serve a 2-year term and may
26 be reappointed to the council.

27 (8) In carrying out the provisions of this section,
28 the not-for-profit corporation and its subsidiaries are not
29 agencies within the meaning of section 20.03(11), Florida
30 Statutes.

31

1 Section 3. Section 408.7057, Florida Statutes, is
2 amended to read:

3 408.7057 Statewide provider and health plan ~~managed~~
4 ~~care organization~~ claim dispute resolution program.--

5 (1) As used in this section, the term:

6 (a) "Agency" means the Agency for Health Care
7 Administration.

8 (b)(a) "Health plan Managed care organization" means a
9 health maintenance organization or a prepaid health clinic
10 certified under chapter 641, a prepaid health plan authorized
11 under s. 409.912, ~~or~~ an exclusive provider organization
12 certified under s. 627.6472, or a major medical expense health
13 insurance policy, as defined in s. 627.643(2)(e), offered by a
14 group or an individual health insurer licensed pursuant to
15 chapter 624, including a preferred provider organization under
16 s. 627.6471.

17 (c)(b) "Resolution organization" means a qualified
18 independent third-party claim-dispute-resolution entity
19 selected by and contracted with the Agency for Health Care
20 Administration.

21 (2)(a) The agency ~~for Health Care Administration~~ shall
22 establish a program by January 1, 2001, to provide assistance
23 to contracted and noncontracted providers and health plans
24 ~~managed care organizations~~ for resolution of claim disputes
25 that are not resolved by the provider and the health plan
26 ~~managed care organization~~. The agency shall contract with a
27 resolution organization to timely review and consider claim
28 disputes submitted by providers and health plans ~~managed care~~
29 ~~organizations~~ and recommend to the agency an appropriate
30 resolution of those disputes. The agency shall establish by
31 rule jurisdictional amounts and methods of aggregation for

1 claim disputes that may be considered by the resolution
2 organization.

3 (b) The resolution organization shall review claim
4 disputes filed by contracted and noncontracted providers and
5 health plans ~~managed care organizations~~ unless the disputed
6 claim:

7 1. Is related to interest payment;

8 2. Does not meet the jurisdictional amounts or the
9 methods of aggregation established by agency rule, as provided
10 in paragraph (a);

11 3. Is part of an internal grievance in a Medicare
12 managed care organization or a reconsideration appeal through
13 the Medicare appeals process;

14 4. Is related to a health plan that is not regulated
15 by the state;

16 5. Is part of a Medicaid fair hearing pursued under 42
17 C.F.R. ss. 431.220 et seq.;

18 6. Is the basis for an action pending in state or
19 federal court; or

20 7. Is subject to a binding claim-dispute-resolution
21 process provided by contract entered into prior to October 1,
22 2000, between the provider and the managed care organization.

23 (c) Contracts entered into or renewed on or after
24 October 1, 2000, may require exhaustion of an internal
25 dispute-resolution process as a prerequisite to the submission
26 of a claim by a provider or a health plan maintenance
27 ~~organization~~ to the resolution organization ~~when the~~
28 ~~dispute-resolution program becomes effective.~~

29 (d) A contracted or noncontracted provider or health
30 plan maintenance organization may not file a claim dispute
31 with the resolution organization more than 12 months after a

1 final determination has been made on a claim by a health plan
2 or provider ~~maintenance organization~~.

3 (e) The resolution organization shall require the
4 health plan or provider submitting the claim dispute to submit
5 any supporting documentation to the resolution organization
6 within 15 days after receipt by the health plan or provider of
7 a request from the resolution organization for documentation
8 in support of the claim dispute. The resolution organization
9 may extend the time if appropriate. Failure to submit the
10 supporting documentation within such time period shall result
11 in the dismissal of the submitted claim dispute.

12 (f) The resolution organization shall require the
13 respondent in the claim dispute to submit all documentation in
14 support of its position within 15 days after receiving a
15 request from the resolution organization for supporting
16 documentation. The resolution organization may extend the time
17 if appropriate. Failure to submit the supporting documentation
18 within such time period shall result in a default against the
19 health plan or provider. In the event of such a default, the
20 resolution organization shall issue its written recommendation
21 to the agency that a default be entered against the defaulting
22 entity. The written recommendation shall include a
23 recommendation to the agency that the defaulting entity shall
24 pay the entity submitting the claim dispute the full amount of
25 the claim dispute, plus all accrued interest, and shall be
26 considered a nonprevailing party for the purposes of this
27 section.

28 (g)1. If on an ongoing basis during the preceding 12
29 months, the agency has reason to believe that a pattern of
30 noncompliance with s. 627.6131 and s. 641.3155 exists on the
31 part of a particular health plan or provider, the agency shall

1 evaluate the information contained in these cases to determine
2 whether the information evidences a pattern and report its
3 findings, together with substantiating evidence, to the
4 appropriate licensure or certification entity for the health
5 plan or provider.

6 2. In addition, the agency shall prepare a report to
7 the Governor and the Legislature by February 1 of each year,
8 enumerating: claims dismissed; defaults issued; and failures
9 to comply with agency final orders issued under this section.

10 (3) The agency shall adopt rules to establish a
11 process to be used by the resolution organization in
12 considering claim disputes submitted by a provider or health
13 plan ~~managed care organization~~ which must include the issuance
14 by the resolution organization of a written recommendation,
15 supported by findings of fact, to the agency within 60 days
16 after the requested information is received by the resolution
17 organization within the timeframes specified by the resolution
18 organization. In no event shall the review time exceed 90 days
19 following receipt of the initial claim dispute submission by
20 the resolution organization ~~receipt of the claim dispute~~
21 ~~submission.~~

22 (4) Within 30 days after receipt of the recommendation
23 of the resolution organization, the agency shall adopt the
24 recommendation as a final order.

25 (5) The agency shall notify within 7 days the
26 appropriate licensure or certification entity whenever there
27 is a violation of a final order issued by the agency pursuant
28 to this section.

29 ~~(6)~~(5) The entity that does not prevail in the
30 agency's order must pay a review cost to the review
31 organization, as determined by agency rule. Such rule must

1 provide for an apportionment of the review fee in any case in
2 which both parties prevail in part. If the nonprevailing party
3 fails to pay the ordered review cost within 35 days after the
4 agency's order, the nonpaying party is subject to a penalty of
5 not more than \$500 per day until the penalty is paid.

6 ~~(7)(6)~~ The agency for Health Care Administration may
7 adopt rules to administer this section.

8 Section 4. Subsection (1) of section 626.88, Florida
9 Statutes, is amended to read:

10 626.88 Definitions of "administrator" and "insurer".--

11 (1) For the purposes of this part, an "administrator"
12 is any person who directly or indirectly solicits or effects
13 coverage of, collects charges or premiums from, or adjusts or
14 settles claims on residents of this state in connection with
15 authorized commercial self-insurance funds or with insured or
16 self-insured programs which provide life or health insurance
17 coverage or coverage of any other expenses described in s.
18 624.33(1) or any person who, through a health care risk
19 contract as defined in s. 641.234 with an insurer or health
20 maintenance organization, provides billing and collection
21 services to health insurers and health maintenance
22 organizations on behalf of health care providers, other than
23 any of the following persons:

24 (a) An employer on behalf of such employer's employees
25 or the employees of one or more subsidiary or affiliated
26 corporations of such employer.

27 (b) A union on behalf of its members.

28 (c) An insurance company which is either authorized to
29 transact insurance in this state or is acting as an insurer
30 with respect to a policy lawfully issued and delivered by such
31

1 company in and pursuant to the laws of a state in which the
2 insurer was authorized to transact an insurance business.

3 (d) A health care services plan, health maintenance
4 organization, professional service plan corporation, or person
5 in the business of providing continuing care, possessing a
6 valid certificate of authority issued by the department, and
7 the sales representatives thereof, if the activities of such
8 entity are limited to the activities permitted under the
9 certificate of authority.

10 (e) An insurance agent licensed in this state whose
11 activities are limited exclusively to the sale of insurance.

12 (f) An adjuster licensed in this state whose
13 activities are limited to the adjustment of claims.

14 (g) A creditor on behalf of such creditor's debtors
15 with respect to insurance covering a debt between the creditor
16 and its debtors.

17 (h) A trust and its trustees, agents, and employees
18 acting pursuant to such trust established in conformity with
19 29 U.S.C. s. 186.

20 (i) A trust exempt from taxation under s. 501(a) of
21 the Internal Revenue Code, a trust satisfying the requirements
22 of ss. 624.438 and 624.439, or any governmental trust as
23 defined in s. 624.33(3), and the trustees and employees acting
24 pursuant to such trust, or a custodian and its agents and
25 employees, including individuals representing the trustees in
26 overseeing the activities of a service company or
27 administrator, acting pursuant to a custodial account which
28 meets the requirements of s. 401(f) of the Internal Revenue
29 Code.

30 (j) A financial institution which is subject to
31 supervision or examination by federal or state authorities or

1 a mortgage lender licensed under chapter 494 who collects and
2 remits premiums to licensed insurance agents or authorized
3 insurers concurrently or in connection with mortgage loan
4 payments.

5 (k) A credit card issuing company which advances for
6 and collects premiums or charges from its credit card holders
7 who have authorized such collection if such company does not
8 adjust or settle claims.

9 (l) A person who adjusts or settles claims in the
10 normal course of such person's practice or employment as an
11 attorney at law and who does not collect charges or premiums
12 in connection with life or health insurance coverage.

13 (m) A person approved by the Division of Workers'
14 Compensation of the Department of Labor and Employment
15 Security who administers only self-insured workers'
16 compensation plans.

17 (n) A service company or service agent and its
18 employees, authorized in accordance with ss. 626.895-626.899,
19 serving only a single employer plan, multiple-employer welfare
20 arrangements, or a combination thereof.

21 (o) Any provider or group practice, as defined in s.
22 456.053, providing services under the scope of the license of
23 the provider or the member of the group practice.

24 (p) Any hospital providing billing, claims, and
25 collection services solely on its own and its physicians'
26 behalf and providing services under the scope of its license.

27
28 A person who provides billing and collection services to
29 health insurers and health maintenance organizations on behalf
30 of health care providers shall comply with the provisions of
31 ss. 627.6131, 641.3155, and 641.51(4).

1 Section 5. Section 627.6131, Florida Statutes, is
2 created to read:

3 627.6131 Payment of claims.--

4 (1) The contract shall include the following
5 provision:

6
7 "Time of Payment of Claims: After receiving
8 written proof of loss, the insurer will pay
9 monthly all benefits then due for ...(type of
10 benefit).... Benefits for any other loss
11 covered by this policy will be paid as soon as
12 the insurer receives proper written proof."

13
14 (2) As used in this section, the term "claim" for a
15 noninstitutional provider means a paper or electronic billing
16 instrument submitted to the insurer's designated location that
17 consists of the HCFA 1500 data set, or its successor, that has
18 all mandatory entries for a physician licensed under chapter
19 458, chapter 459, chapter 460, chapter 461, or chapter 463, or
20 psychologists licensed under chapter 490 or any appropriate
21 billing instrument that has all mandatory entries for any
22 other noninstitutional provider. For institutional providers,
23 "claim" means a paper or electronic billing instrument
24 submitted to the insurer's designated location that consists
25 of the UB-92 data set or its successor with entries stated as
26 mandatory by the National Uniform Billing Committee.

27 (3) All claims for payment or overpayment, whether
28 electronic or nonelectronic:

29 (a) Are considered received on the date the claim is
30 received by the insurer at its designated claims-receipt
31

1 location or the date the claim for overpayment is received by
2 the provider at its designated location.

3 (b) Must be mailed or electronically transferred to
4 the primary insurer within 6 months after the following have
5 occurred:

6 1. Discharge for inpatient services or the date of
7 service for outpatient services; and

8 2. The provider has been furnished with the correct
9 name and address of the patient's health insurer.

10
11 All claims for payment, whether electronic or nonelectronic,
12 must be mailed or electronically transferred to the secondary
13 insurer within 90 days after final determination by the
14 primary insurer. A provider's claim is considered submitted on
15 the date it is electronically transferred or mailed.

16 (c) Must not duplicate a claim previously submitted
17 unless it is determined that the original claim was not
18 received or is otherwise lost.

19 (4) For all electronically submitted claims, a health
20 insurer shall:

21 (a) Within 24 hours after the beginning of the next
22 business day after receipt of the claim, provide electronic
23 acknowledgment of the receipt of the claim to the electronic
24 source submitting the claim.

25 (b) Within 20 days after receipt of the claim, pay the
26 claim or notify a provider or designee if a claim is denied or
27 contested. Notice of the insurer's action on the claim and
28 payment of the claim is considered to be made on the date the
29 notice or payment was mailed or electronically transferred.

30 (c)1. Notification of the health insurer's
31 determination of a contested claim must be accompanied by an

1 itemized list of additional information or documents the
2 insurer can reasonably determine are necessary to process the
3 claim.

4 2. A provider must submit the additional information
5 or documentation, as specified on the itemized list, within 35
6 days after receipt of the notification. Additional information
7 is considered submitted on the date it is electronically
8 transferred or mailed. The health insurer may not request
9 duplicate documents.

10 (d) For purposes of this subsection, electronic means
11 of transmission of claims, notices, documents, forms, and
12 payments shall be used to the greatest extent possible by the
13 health insurer and the provider.

14 (e) A claim must be paid or denied within 90 days
15 after receipt of the claim. Failure to pay or deny a claim
16 within 120 days after receipt of the claim creates an
17 uncontestable obligation to pay the claim.

18 (5) For all nonelectronically submitted claims, a
19 health insurer shall:

20 (a) Effective November 1, 2003, provide acknowledgment
21 of receipt of the claim within 15 days after receipt of the
22 claim to the provider or provide a provider within 15 days
23 after receipt with electronic access to the status of a
24 submitted claim.

25 (b) Within 40 days after receipt of the claim, pay the
26 claim or notify a provider or designee if a claim is denied or
27 contested. Notice of the insurer's action on the claim and
28 payment of the claim is considered to be made on the date the
29 notice or payment was mailed or electronically transferred.

30 (c)1. Notification of the health insurer's
31 determination of a contested claim must be accompanied by an

1 itemized list of additional information or documents the
2 insurer can reasonably determine are necessary to process the
3 claim.

4 2. A provider must submit the additional information
5 or documentation, as specified on the itemized list, within 35
6 days after receipt of the notification. Additional information
7 is considered submitted on the date it is electronically
8 transferred or mailed. The health insurer may not request
9 duplicate documents.

10 (d) For purposes of this subsection, electronic means
11 of transmission of claims, notices, documents, forms, and
12 payments shall be used to the greatest extent possible by the
13 health insurer and the provider.

14 (e) A claim must be paid or denied within 120 days
15 after receipt of the claim. Failure to pay or deny a claim
16 within 140 days after receipt of the claim creates an
17 uncontestable obligation to pay the claim.

18 (6) If a health insurer determines that it has made an
19 overpayment to a provider for services rendered to an insured,
20 the health insurer must make a claim for such overpayment to
21 the provider's designated location. A health insurer that
22 makes a claim for overpayment to a provider under this section
23 shall give the provider a written or electronic statement
24 specifying the basis for the retroactive denial or payment
25 adjustment. The insurer must identify the claim or claims, or
26 overpayment claim portion thereof, for which a claim for
27 overpayment is submitted.

28 (a) If an overpayment determination is the result of
29 retroactive review or audit of coverage decisions or payment
30 levels not related to fraud, a health insurer shall adhere to
31 the following procedures:

1 1. All claims for overpayment must be submitted to a
2 provider within 30 months after the health insurer's payment
3 of the claim. A provider must pay, deny, or contest the health
4 insurer's claim for overpayment within 40 days after the
5 receipt of the claim. All contested claims for overpayment
6 must be paid or denied within 120 days after receipt of the
7 claim. Failure to pay or deny overpayment and claim within 140
8 days after receipt creates an uncontestable obligation to pay
9 the claim.

10 2. A provider that denies or contests a health
11 insurer's claim for overpayment or any portion of a claim
12 shall notify the health insurer, in writing, within 35 days
13 after the provider receives the claim that the claim for
14 overpayment is contested or denied. The notice that the claim
15 for overpayment is denied or contested must identify the
16 contested portion of the claim and the specific reason for
17 contesting or denying the claim and, if contested, must
18 include a request for additional information. If the health
19 insurer submits additional information, the health insurer
20 must, within 35 days after receipt of the request, mail or
21 electronically transfer the information to the provider. The
22 provider shall pay or deny the claim for overpayment within 45
23 days after receipt of the information. The notice is
24 considered made on the date the notice is mailed or
25 electronically transferred by the provider.

26 3. The health insurer may not reduce payment to the
27 provider for other services unless the provider agrees to the
28 reduction in writing or fails to respond to the health
29 insurer's overpayment claim as required by this paragraph.

30 4. Payment of an overpayment claim is considered made
31 on the date the payment was mailed or electronically

1 transferred. An overdue payment of a claim bears simple
2 interest at the rate of 12 percent per year. Interest on an
3 overdue payment for a claim for an overpayment begins to
4 accrue when the claim should have been paid, denied, or
5 contested.

6 (b) A claim for overpayment shall not be permitted
7 beyond 30 months after the health insurer's payment of a
8 claim, except that claims for overpayment may be sought beyond
9 that time from providers convicted of fraud pursuant to s.
10 817.234.

11 (7) Payment of a claim is considered made on the date
12 the payment was mailed or electronically transferred. An
13 overdue payment of a claim bears simple interest of 12 percent
14 per year. Interest on an overdue payment for a claim or for
15 any portion of a claim begins to accrue when the claim should
16 have been paid, denied, or contested. The interest is payable
17 with the payment of the claim.

18 (8) For all contracts entered into or renewed on or
19 after October 1, 2002, a health insurer's internal dispute
20 resolution process related to a denied claim not under active
21 review by a mediator, arbitrator, or third-party dispute
22 entity must be finalized within 60 days after the receipt of
23 the provider's request for review or appeal.

24 (9) A provider or any representative of a provider,
25 regardless of whether the provider is under contract with the
26 health insurer, may not collect or attempt to collect money
27 from, maintain any action at law against, or report to a
28 credit agency an insured for payment of covered services for
29 which the health insurer contested or denied the provider's
30 claim. This prohibition applies during the pendency of any
31 claim for payment made by the provider to the health insurer

1 for payment of the services or internal dispute resolution
2 process to determine whether the health insurer is liable for
3 the services. For a claim, this pendency applies from the
4 date the claim or a portion of the claim is denied to the date
5 of the completion of the health insurer's internal dispute
6 resolution process, not to exceed 60 days. This subsection
7 does not prohibit the collection by the provider of
8 copayments, coinsurance, or deductible amounts due the
9 provider.

10 (10) The provisions of this section may not be waived,
11 voided, or nullified by contract.

12 (11) A health insurer may not retroactively deny a
13 claim because of insured ineligibility more than 1 year after
14 the date of payment of the claim.

15 (12) A health insurer shall pay a contracted primary
16 care or admitting physician, pursuant to such physician's
17 contract, for providing inpatient services in a contracted
18 hospital to an insured if such services are determined by the
19 health insurer to be medically necessary and covered services
20 under the health insurer's contract with the contract holder.

21 (13) Upon written notification by an insured, an
22 insurer shall investigate any claim of improper billing by a
23 physician, hospital, or other health care provider. The
24 insurer shall determine if the insured was properly billed for
25 only those procedures and services that the insured actually
26 received. If the insurer determines that the insured has been
27 improperly billed, the insurer shall notify the insured and
28 the provider of its findings and shall reduce the amount of
29 payment to the provider by the amount determined to be
30 improperly billed. If a reduction is made due to such

31

1 notification by the insured, the insurer shall pay to the
2 insured 20 percent of the amount of the reduction up to \$500.

3 (14) A permissible error ratio of 5 percent is
4 established for insurer's claims payment violations of
5 paragraphs (4)(a), (b), (c), and (e) and (5)(a), (b), (c), and
6 (e). If the error ratio of a particular insurer does not
7 exceed the permissible error ratio of 5 percent for an audit
8 period, no fine shall be assessed for the noted claims
9 violations for the audit period. The error ratio shall be
10 determined by dividing the number of claims with violations
11 found on a statistically valid sample of claims for the audit
12 period by the total number of claims in the sample. If the
13 error ratio exceeds the permissible error ratio of 5 percent,
14 a fine may be assessed according to s. 624.4211 for those
15 claims payment violations which exceed the error ratio.
16 Notwithstanding the provisions of this section, the department
17 may fine a health insurer for claims payment violations of
18 paragraphs (4)(e) and (5)(e) which create an uncontestable
19 obligation to pay the claim. The department shall not fine
20 insurers for violations which the department determines were
21 due to circumstances beyond the insurer's control.

22 (15) This section is applicable only to a major
23 medical expense health insurance policy as defined in s.
24 627.643(2)(e) offered by a group or an individual health
25 insurer licensed pursuant to chapter 624, including a
26 preferred provider policy under s. 627.6471 and an exclusive
27 provider organization under s. 627.6472 or a group or
28 individual insurance contract that only provides direct
29 payments to dentists for enumerated dental services.

30 (16) Notwithstanding paragraph (4)(b), where an
31 electronic pharmacy claim is submitted to a pharmacy benefits

1 manager acting on behalf of a health insurer the pharmacy
2 benefits manager shall, within 30 days of receipt of the
3 claim, pay the claim or notify a provider or designee if a
4 claim is denied or contested. Notice of the insurer's action
5 on the claim and payment of the claim is considered to be made
6 on the date the notice or payment was mailed or electronically
7 transferred.

8 (17) Notwithstanding paragraph (5)(a), effective
9 November 1, 2003, where a nonelectronic pharmacy claim is
10 submitted to a pharmacy benefits manager acting on behalf of a
11 health insurer the pharmacy benefits manager shall provide
12 acknowledgment of receipt of the claim within 30 days after
13 receipt of the claim to the provider or provide a provider
14 within 30 days after receipt with electronic access to the
15 status of a submitted claim.

16 Section 6. Subsection (4) of section 627.651, Florida
17 Statutes, is amended to read:

18 627.651 Group contracts and plans of self-insurance
19 must meet group requirements.--

20 (4) This section does not apply to any plan which is
21 established or maintained by an individual employer in
22 accordance with the Employee Retirement Income Security Act of
23 1974, Pub. L. No. 93-406, or to a multiple-employer welfare
24 arrangement as defined in s. 624.437(1), except that a
25 multiple-employer welfare arrangement shall comply with ss.
26 627.419, 627.657, 627.6575, 627.6578, 627.6579, 627.6612,
27 627.66121, 627.66122, 627.6615, 627.6616, and 627.662~~(7)(6)~~.
28 This subsection does not allow an authorized insurer to issue
29 a group health insurance policy or certificate which does not
30 comply with this part.

31

1 Section 7. Section 627.662, Florida Statutes, is
2 amended to read:
3 627.662 Other provisions applicable.--The following
4 provisions apply to group health insurance, blanket health
5 insurance, and franchise health insurance:
6 (1) Section 627.569, relating to use of dividends,
7 refunds, rate reductions, commissions, and service fees.
8 (2) Section 627.602(1)(f) and (2), relating to
9 identification numbers and statement of deductible provisions.
10 (3) Section 627.635, relating to excess insurance.
11 (4) Section 627.638, relating to direct payment for
12 hospital or medical services.
13 (5) Section 627.640, relating to filing and
14 classification of rates.
15 (6) Section 627.613, relating to timely payment of
16 claims, or s. 627.6131, relating to payment of claims,
17 whichever is applicable.
18 ~~(7)(6)~~ Section 627.645(1), relating to denial of
19 claims.
20 ~~(7) Section 627.613, relating to time of payment of~~
21 ~~claims.~~
22 (8) Section 627.6471, relating to preferred provider
23 organizations.
24 (9) Section 627.6472, relating to exclusive provider
25 organizations.
26 (10) Section 627.6473, relating to combined preferred
27 provider and exclusive provider policies.
28 (11) Section 627.6474, relating to provider contracts.
29 Section 8. Paragraph (e) of subsection (1) of section
30 641.185, Florida Statutes, is amended to read:
31

1 641.185 Health maintenance organization subscriber
2 protections.--

3 (1) With respect to the provisions of this part and
4 part III, the principles expressed in the following statements
5 shall serve as standards to be followed by the Department of
6 Insurance and the Agency for Health Care Administration in
7 exercising their powers and duties, in exercising
8 administrative discretion, in administrative interpretations
9 of the law, in enforcing its provisions, and in adopting
10 rules:

11 (e) A health maintenance organization subscriber
12 should receive timely, concise information regarding the
13 health maintenance organization's reimbursement to providers
14 and services pursuant to ss. 641.31 and 641.31015 and should
15 receive prompt payment from the organization pursuant to s.
16 641.3155.

17 Section 9. Subsection (4) is added to section 641.234,
18 Florida Statutes, to read:

19 641.234 Administrative, provider, and management
20 contracts.--

21 (4)(a) If a health maintenance organization, through a
22 health care risk contract, transfers to any entity the
23 obligations to pay any provider for any claims arising from
24 services provided to or for the benefit of any subscriber of
25 the organization, the health maintenance organization shall
26 remain responsible for any violations of ss. 641,3155,
27 641.3156, and 641.51(4). The provisions of ss.
28 624.418-624.4211 and 641.52 shall apply to any such
29 violations.

30 (b) As used in this subsection:
31

1 1. The term "health care risk contract" means a
2 contract under which an entity receives compensation in
3 exchange for providing to the health maintenance organization
4 a provider network or other services, which may include
5 administrative services.

6 2. The term "entity" means a person licensed as an
7 administrator under s. 626.88 and does not include any
8 provider or group practice, as defined in s. 456.053,
9 providing services under the scope of the license of the
10 provider or the members of the group practice. The term does
11 not include a hospital providing billing, claims, and
12 collection services solely on its own and its physicians'
13 behalf and providing services under the scope of its license.

14 Section 10. Subsection (1) of section 641.30, Florida
15 Statutes, is amended to read:

16 641.30 Construction and relationship to other laws.--

17 (1) Every health maintenance organization shall accept
18 the ~~standard health~~ claim form prescribed pursuant to s.
19 641.3155 ~~627.647~~.

20 Section 11. Subsection (4) of section 641.3154,
21 Florida Statutes, is amended to read:

22 641.3154 Organization liability; provider billing
23 prohibited.--

24 (4) A provider or any representative of a provider,
25 regardless of whether the provider is under contract with the
26 health maintenance organization, may not collect or attempt to
27 collect money from, maintain any action at law against, or
28 report to a credit agency a subscriber of an organization for
29 payment of services for which the organization is liable, if
30 the provider in good faith knows or should know that the
31 organization is liable. This prohibition applies during the

1 pendency of any claim for payment made by the provider to the
2 organization for payment of the services and any legal
3 proceedings or dispute resolution process to determine whether
4 the organization is liable for the services if the provider is
5 informed that such proceedings are taking place. It is
6 presumed that a provider does not know and should not know
7 that an organization is liable unless:

8 (a) The provider is informed by the organization that
9 it accepts liability;

10 (b) A court of competent jurisdiction determines that
11 the organization is liable; ~~or~~

12 (c) The department or agency makes a final
13 determination that the organization is required to pay for
14 such services subsequent to a recommendation made by the
15 Statewide Provider and Subscriber Assistance Panel pursuant to
16 s. 408.7056; or

17 (d) The agency issues a final order that the
18 organization is required to pay for such services subsequent
19 to a recommendation made by a resolution organization pursuant
20 to s. 408.7057.

21 Section 12. Section 641.3155, Florida Statutes, is
22 amended to read:

23 (Substantial rewording of section. See
24 s. 641.3155, F.S., for present text.)
25 641.3155 Prompt payment of claims.--

26 (1) As used in this section, the term "claim" for a
27 noninstitutional provider means a paper or electronic billing
28 instrument submitted to the health maintenance organization's
29 designated location that consists of the HCFA 1500 data set,
30 or its successor, that has all mandatory entries for a
31 physician licensed under chapter 458, chapter 459, chapter

1 460, chapter 461, or chapter 463, or psychologists licensed
2 under chapter 490 or any appropriate billing instrument that
3 has all mandatory entries for any other noninstitutional
4 provider. For institutional providers, "claim" means a paper
5 or electronic billing instrument submitted to the health
6 maintenance organization's designated location that consists
7 of the UB-92 data set or its successor with entries stated as
8 mandatory by the National Uniform Billing Committee.

9 (2) All claims for payment or overpayment, whether
10 electronic or nonelectronic:

11 (a) Are considered received on the date the claim is
12 received by the organization at its designated claims-receipt
13 location or the date a claim for overpayment is received by
14 the provider at its designated location.

15 (b) Must be mailed or electronically transferred to
16 the primary organization within 6 months after the following
17 have occurred:

18 1. Discharge for inpatient services or the date of
19 service for outpatient services; and

20 2. The provider has been furnished with the correct
21 name and address of the patient's health maintenance
22 organization.

23
24 All claims for payment, whether electronic or nonelectronic,
25 must be mailed or electronically transferred to the secondary
26 organization within 90 days after final determination by the
27 primary organization. A provider's claim is considered
28 submitted on the date it is electronically transferred or
29 mailed.

30
31

1 (c) Must not duplicate a claim previously submitted
2 unless it is determined that the original claim was not
3 received or is otherwise lost.

4 (3) For all electronically submitted claims, a health
5 maintenance organization shall:

6 (a) Within 24 hours after the beginning of the next
7 business day after receipt of the claim, provide electronic
8 acknowledgment of the receipt of the claim to the electronic
9 source submitting the claim.

10 (b) Within 20 days after receipt of the claim, pay the
11 claim or notify a provider or designee if a claim is denied or
12 contested. Notice of the organization's action on the claim
13 and payment of the claim is considered to be made on the date
14 the notice or payment was mailed or electronically
15 transferred.

16 (c)1. Notification of the health maintenance
17 organization's determination of a contested claim must be
18 accompanied by an itemized list of additional information or
19 documents the insurer can reasonably determine are necessary
20 to process the claim.

21 2. A provider must submit the additional information
22 or documentation, as specified on the itemized list, within 35
23 days after receipt of the notification. Additional information
24 is considered submitted on the date it is electronically
25 transferred or mailed. The health maintenance organization may
26 not request duplicate documents.

27 (d) For purposes of this subsection, electronic means
28 of transmission of claims, notices, documents, forms, and
29 payment shall be used to the greatest extent possible by the
30 health maintenance organization and the provider.

31

1 (e) A claim must be paid or denied within 90 days
2 after receipt of the claim. Failure to pay or deny a claim
3 within 120 days after receipt of the claim creates an
4 uncontestable obligation to pay the claim.

5 (4) For all nonelectronically submitted claims, a
6 health maintenance organization shall:

7 (a) Effective November 1, 2003, provide
8 acknowledgement of receipt of the claim within 15 days after
9 receipt of the claim to the provider or designee or provide a
10 provider or designee within 15 days after receipt with
11 electronic access to the status of a submitted claim.

12 (b) Within 40 days after receipt of the claim, pay the
13 claim or notify a provider or designee if a claim is denied or
14 contested. Notice of the health maintenance organization's
15 action on the claim and payment of the claim is considered to
16 be made on the date the notice or payment was mailed or
17 electronically transferred.

18 (c)1. Notification of the health maintenance
19 organization's determination of a contested claim must be
20 accompanied by an itemized list of additional information or
21 documents the organization can reasonably determine are
22 necessary to process the claim.

23 2. A provider must submit the additional information
24 or documentation, as specified on the itemized list, within 35
25 days after receipt of the notification. Additional information
26 is considered submitted on the date it is electronically
27 transferred or mailed. The health maintenance organization may
28 not request duplicate documents.

29 (d) For purposes of this subsection, electronic means
30 of transmission of claims, notices, documents, forms, and
31

1 payments shall be used to the greatest extent possible by the
2 health maintenance organization and the provider.

3 (e) A claim must be paid or denied within 120 days
4 after receipt of the claim. Failure to pay or deny a claim
5 within 140 days after receipt of the claim creates an
6 uncontestable obligation to pay the claim.

7 (5) If a health maintenance organization determines
8 that it has made an overpayment to a provider for services
9 rendered to a subscriber, the health maintenance organization
10 must make a claim for such overpayment to the provider's
11 designated location. A health maintenance organization that
12 makes a claim for overpayment to a provider under this section
13 shall give the provider a written or electronic statement
14 specifying the basis for the retroactive denial or payment
15 adjustment. The health maintenance organization must identify
16 the claim or claims, or overpayment claim portion thereof, for
17 which a claim for overpayment is submitted.

18 (a) If an overpayment determination is the result of
19 retroactive review or audit of coverage decisions or payment
20 levels not related to fraud, a health maintenance organization
21 shall adhere to the following procedures:

22 1. All claims for overpayment must be submitted to a
23 provider within 30 months after the health maintenance
24 organization's payment of the claim. A provider must pay,
25 deny, or contest the health maintenance organization's claim
26 for overpayment within 40 days after the receipt of the claim.
27 All contested claims for overpayment must be paid or denied
28 within 120 days after receipt of the claim. Failure to pay or
29 deny overpayment and claim within 140 days after receipt
30 creates an uncontestable obligation to pay the claim.

31

1 2. A provider that denies or contests a health
2 maintenance organization's claim for overpayment or any
3 portion of a claim shall notify the organization, in writing,
4 within 35 days after the provider receives the claim that the
5 claim for overpayment is contested or denied. The notice that
6 the claim for overpayment is denied or contested must identify
7 the contested portion of the claim and the specific reason for
8 contesting or denying the claim and, if contested, must
9 include a request for additional information. If the
10 organization submits additional information, the organization
11 must, within 35 days after receipt of the request, mail or
12 electronically transfer the information to the provider. The
13 provider shall pay or deny the claim for overpayment within 45
14 days after receipt of the information. The notice is
15 considered made on the date the notice is mailed or
16 electronically transferred by the provider.

17 3. The health maintenance organization may not reduce
18 payment to the provider for other services unless the provider
19 agrees to the reduction in writing or fails to respond to the
20 health maintenance organization's overpayment claim as
21 required by this paragraph.

22 4. Payment of an overpayment claim is considered made
23 on the date the payment was mailed or electronically
24 transferred. An overdue payment of a claim bears simple
25 interest at the rate of 12 percent per year. Interest on an
26 overdue payment for a claim for an overpayment payment begins
27 to accrue when the claim should have been paid, denied, or
28 contested.

29 (b) A claim for overpayment shall not be permitted
30 beyond 30 months after the health maintenance organization's
31 payment of a claim, except that claims for overpayment may be

1 sought beyond that time from providers convicted of fraud
2 pursuant to s. 817.234.

3 (6) Payment of a claim is considered made on the date
4 the payment was mailed or electronically transferred. An
5 overdue payment of a claim bears simple interest of 12 percent
6 per year. Interest on an overdue payment for a claim or for
7 any portion of a claim begins to accrue when the claim should
8 have been paid, denied, or contested. The interest is payable
9 with the payment of the claim.

10 (7)(a) For all contracts entered into or renewed on or
11 after October 1, 2002, a health maintenance organization's
12 internal dispute resolution process related to a denied claim
13 not under active review by a mediator, arbitrator, or
14 third-party dispute entity must be finalized within 60 days
15 after the receipt of the provider's request for review or
16 appeal.

17 (b) All claims to a health maintenance organization
18 begun after October 1, 2000, not under active review by a
19 mediator, arbitrator, or third-party dispute entity, shall
20 result in a final decision on the claim by the health
21 maintenance organization by January 2, 2003, for the purpose
22 of the statewide provider and health plan claim dispute
23 resolution program pursuant to s. 408.7057.

24 (8) A provider or any representative of a provider,
25 regardless of whether the provider is under contract with the
26 health maintenance organization, may not collect or attempt to
27 collect money from, maintain any action at law against, or
28 report to a credit agency a subscriber for payment of covered
29 services for which the health maintenance organization
30 contested or denied the provider's claim. This prohibition
31 applies during the pendency of any claim for payment made by

1 the provider to the health maintenance organization for
2 payment of the services or internal dispute resolution process
3 to determine whether the health maintenance organization is
4 liable for the services. For a claim, this pendency applies
5 from the date the claim or a portion of the claim is denied to
6 the date of the completion of the health maintenance
7 organization's internal dispute resolution process, not to
8 exceed 60 days. This subsection does not prohibit collection
9 by the provider of copayments, coinsurance, or deductible
10 amounts due the provider.

11 (9) The provisions of this section may not be waived,
12 voided, or nullified by contract.

13 (10) A health maintenance organization may not
14 retroactively deny a claim because of subscriber ineligibility
15 more than 1 year after the date of payment of the claim.

16 (11) A health maintenance organization shall pay a
17 contracted primary care or admitting physician, pursuant to
18 such physician's contract, for providing inpatient services in
19 a contracted hospital to a subscriber if such services are
20 determined by the health maintenance organization to be
21 medically necessary and covered services under the health
22 maintenance organization's contract with the contract holder.

23 (12) A permissible error ratio of 5 percent is
24 established for health maintenance organizations' claims
25 payment violations of paragraphs (3)(a), (b), (c), and (e) and
26 (4)(a), (b), (c), and (e). If the error ratio of a particular
27 insurer does not exceed the permissible error ratio of 5
28 percent for an audit period, no fine shall be assessed for the
29 noted claims violations for the audit period. The error ratio
30 shall be determined by dividing the number of claims with
31 violations found on a statistically valid sample of claims for

1 the audit period by the total number of claims in the sample.
2 If the error ratio exceeds the permissible error ratio of 5
3 percent, a fine may be assessed according to s. 624.4211 for
4 those claims payment violations which exceed the error ratio.
5 Notwithstanding the provisions of this section, the department
6 may fine a health maintenance organization for claims payment
7 violations of paragraphs (3)(e) and (4)(e) which create an
8 uncontestable obligation to pay the claim. The department
9 shall not fine organizations for violations which the
10 department determines were due to circumstances beyond the
11 organization's control.

12 (13) This section shall apply to all claims or any
13 portion of a claim submitted by a health maintenance
14 organization subscriber under a health maintenance
15 organization subscriber contract to the organization for
16 payment.

17 (14) Notwithstanding paragraph (3)(b), where an
18 electronic pharmacy claim is submitted to a pharmacy benefits
19 manager acting on behalf of a health maintenance organization
20 the pharmacy benefits manager shall, within 30 days of receipt
21 of the claim, pay the claim or notify a provider or designee
22 if a claim is denied or contested. Notice of the
23 organization's action on the claim and payment of the claim is
24 considered to be made on the date the notice or payment was
25 mailed or electronically transferred.

26 (15) Notwithstanding paragraph (4)(a), effective
27 November 1, 2003, where a nonelectronic pharmacy claim is
28 submitted to a pharmacy benefits manager acting on behalf of a
29 health maintenance organization the pharmacy benefits manager
30 shall provide acknowledgment of receipt of the claim within 30
31 days after receipt of the claim to the provider or provide a

1 provider within 30 days after receipt with electronic access
2 to the status of a submitted claim.

3 Section 13. Subsection (12) of section 641.51, Florida
4 Statutes, is amended to read:

5 641.51 Quality assurance program; second medical
6 opinion requirement.--

7 (12) If a contracted primary care physician, licensed
8 under chapter 458 or chapter 459, determines ~~and the~~
9 ~~organization determine~~ that a subscriber requires examination
10 by a licensed ophthalmologist for medically necessary,
11 contractually covered services, then the organization shall
12 authorize the contracted primary care physician to send the
13 subscriber to a contracted licensed ophthalmologist.

14 Section 14. Paragraph (o) of subsection (3) of section
15 456.053, Florida Statutes, is amended to read:

16 456.053 Financial arrangements between referring
17 health care providers and providers of health care services.--

18 (3) DEFINITIONS.--For the purpose of this section, the
19 word, phrase, or term:

20 (o) "Referral" means any referral of a patient by a
21 health care provider for health care services, including,
22 without limitation:

23 1. The forwarding of a patient by a health care
24 provider to another health care provider or to an entity which
25 provides or supplies designated health services or any other
26 health care item or service; or

27 2. The request or establishment of a plan of care by a
28 health care provider, which includes the provision of
29 designated health services or other health care item or
30 service.

31

1 3. The following orders, recommendations, or plans of
2 care shall not constitute a referral by a health care
3 provider:

4 a. By a radiologist for diagnostic-imaging services.

5 b. By a physician specializing in the provision of
6 radiation therapy services for such services.

7 c. By a medical oncologist for drugs and solutions to
8 be prepared and administered intravenously to such
9 oncologist's patient, as well as for the supplies and
10 equipment used in connection therewith to treat such patient
11 for cancer and the complications thereof.

12 d. By a cardiologist for cardiac catheterization
13 services.

14 e. By a pathologist for diagnostic clinical laboratory
15 tests and pathological examination services, if furnished by
16 or under the supervision of such pathologist pursuant to a
17 consultation requested by another physician.

18 f. By a health care provider who is the sole provider
19 or member of a group practice for designated health services
20 or other health care items or services that are prescribed or
21 provided solely for such referring health care provider's or
22 group practice's own patients, and that are provided or
23 performed by or under the direct supervision of such referring
24 health care provider or group practice; provided, however,
25 that effective July 1, 1999, a physician licensed pursuant to
26 chapter 458, chapter 459, chapter 460, or chapter 461 may
27 refer a patient to a sole provider or group practice for
28 diagnostic imaging services, excluding radiation therapy
29 services, for which the sole provider or group practice billed
30 both the technical and the professional fee for or on behalf
31 of the patient, if the referring physician has no investment

1 interest in the practice. The diagnostic imaging service
2 referred to a group practice or sole provider must be a
3 diagnostic imaging service normally provided within the scope
4 of practice to the patients of the group practice or sole
5 provider. The group practice or sole provider may accept no
6 more than 15 percent of their patients receiving diagnostic
7 imaging services from outside referrals, excluding radiation
8 therapy services.

9 g. By a health care provider for services provided by
10 an ambulatory surgical center licensed under chapter 395.

11 ~~h. By a health care provider for diagnostic clinical~~
12 ~~laboratory services where such services are directly related~~
13 ~~to renal dialysis.~~

14 ~~h.i.~~ By a urologist for lithotripsy services.

15 ~~i.j.~~ By a dentist for dental services performed by an
16 employee of or health care provider who is an independent
17 contractor with the dentist or group practice of which the
18 dentist is a member.

19 ~~j.k.~~ By a physician for infusion therapy services to a
20 patient of that physician or a member of that physician's
21 group practice.

22 ~~k.l.~~ By a nephrologist for renal dialysis services and
23 supplies, except laboratory services.

24 l. By a health care provider whose principal
25 professional practice consists of treating patients in their
26 private residences for services to be rendered in such private
27 residences, except for services rendered by a home health
28 agency licensed under chapter 400. For purposes of this
29 sub-subparagraph, the term "private residences" includes
30 patient's private homes, independent living centers, and

31

1 assisted living facilities, but does not include skilled
2 nursing facilities.

3 Section 15. Paragraph (b) of subsection (6) and
4 paragraph (a) of subsection (15) of section 627.6699, Florida
5 Statutes, are amended to read:

6 627.6699 Employee Health Care Access Act.--

7 (6) RESTRICTIONS RELATING TO PREMIUM RATES.--

8 (b) For all small employer health benefit plans that
9 are subject to this section and are issued by small employer
10 carriers on or after January 1, 1994, premium rates for health
11 benefit plans subject to this section are subject to the
12 following:

13 1. Small employer carriers must use a modified
14 community rating methodology in which the premium for each
15 small employer must be determined solely on the basis of the
16 eligible employee's and eligible dependent's gender, age,
17 family composition, tobacco use, or geographic area as
18 determined under paragraph (5)(j) and in which the premium may
19 be adjusted as permitted by this paragraph ~~subparagraphs 5.~~
20 ~~and 6.~~

21 2. Rating factors related to age, gender, family
22 composition, tobacco use, or geographic location may be
23 developed by each carrier to reflect the carrier's experience.
24 The factors used by carriers are subject to department review
25 and approval.

26 3. Small employer carriers may not modify the rate for
27 a small employer for 12 months from the initial issue date or
28 renewal date, unless the composition of the group changes or
29 benefits are changed. However, a small employer carrier may
30 modify the rate one time prior to 12 months after the initial
31 issue date for a small employer who enrolls under a previously

1 issued group policy that has a common anniversary date for all
2 employers covered under the policy if:

3 a. The carrier discloses to the employer in a clear
4 and conspicuous manner the date of the first renewal and the
5 fact that the premium may increase on or after that date.

6 b. The insurer demonstrates to the department that
7 efficiencies in administration are achieved and reflected in
8 the rates charged to small employers covered under the policy.

9 4. A carrier may issue a group health insurance policy
10 to a small employer health alliance or other group association
11 with rates that reflect a premium credit for expense savings
12 attributable to administrative activities being performed by
13 the alliance or group association if such expense savings are
14 specifically documented in the insurer's rate filing and are
15 approved by the department. Any such credit may not be based
16 on different morbidity assumptions or on any other factor
17 related to the health status or claims experience of any
18 person covered under the policy. Nothing in this subparagraph
19 exempts an alliance or group association from licensure for
20 any activities that require licensure under the insurance
21 code. A carrier issuing a group health insurance policy to a
22 small employer health alliance or other group association
23 shall allow any properly licensed and appointed agent of that
24 carrier to market and sell the small employer health alliance
25 or other group association policy. Such agent shall be paid
26 the usual and customary commission paid to any agent selling
27 the policy.

28 5. Any adjustments in rates for claims experience,
29 health status, or duration of coverage may not be charged to
30 individual employees or dependents. For a small employer's
31 policy, such adjustments may not result in a rate for the

1 small employer which deviates more than 15 percent from the
2 carrier's approved rate. Any such adjustment must be applied
3 uniformly to the rates charged for all employees and
4 dependents of the small employer. A small employer carrier may
5 make an adjustment to a small employer's renewal premium, not
6 to exceed 10 percent annually, due to the claims experience,
7 health status, or duration of coverage of the employees or
8 dependents of the small employer. Semiannually, small group
9 carriers shall report information on forms adopted by rule by
10 the department, to enable the department to monitor the
11 relationship of aggregate adjusted premiums actually charged
12 policyholders by each carrier to the premiums that would have
13 been charged by application of the carrier's approved modified
14 community rates. If the aggregate resulting from the
15 application of such adjustment exceeds the premium that would
16 have been charged by application of the approved modified
17 community rate by 5 percent for the current reporting period,
18 the carrier shall limit the application of such adjustments
19 only to minus adjustments beginning not more than 60 days
20 after the report is sent to the department. For any subsequent
21 reporting period, if the total aggregate adjusted premium
22 actually charged does not exceed the premium that would have
23 been charged by application of the approved modified community
24 rate by 5 percent, the carrier may apply both plus and minus
25 adjustments. A small employer carrier may provide a credit to
26 a small employer's premium based on administrative and
27 acquisition expense differences resulting from the size of the
28 group. Group size administrative and acquisition expense
29 factors may be developed by each carrier to reflect the
30 carrier's experience and are subject to department review and
31 approval.

1 6. A small employer carrier rating methodology may
2 include separate rating categories for one dependent child,
3 for two dependent children, and for three or more dependent
4 children for family coverage of employees having a spouse and
5 dependent children or employees having dependent children
6 only. A small employer carrier may have fewer, but not
7 greater, numbers of categories for dependent children than
8 those specified in this subparagraph.

9 7. Small employer carriers may not use a composite
10 rating methodology to rate a small employer with fewer than 10
11 employees. For the purposes of this subparagraph, a "composite
12 rating methodology" means a rating methodology that averages
13 the impact of the rating factors for age and gender in the
14 premiums charged to all of the employees of a small employer.

15 8.a. A carrier may separate the experience of small
16 employer groups with less than 2 eligible employees from the
17 experience of small employer groups with 2-50 eligible
18 employees for purposes of determining an alternative modified
19 community rating.

20 b. If a carrier separates the experience of small
21 employer groups as provided in sub-subparagraph a., the rate
22 to be charged to small employer groups of less than 2 eligible
23 employees may not exceed 150 percent of the rate determined
24 for small employer groups of 2-50 eligible employees. However,
25 the carrier may charge excess losses of the experience pool
26 consisting of small employer groups with less than 2 eligible
27 employees to the experience pool consisting of small employer
28 groups with 2-50 eligible employees so that all losses are
29 allocated and the 150-percent rate limit on the experience
30 pool consisting of small employer groups with less than 2
31 eligible employees is maintained. Notwithstanding s.

1 627.411(1), the rate to be charged to a small employer group
2 of fewer than 2 eligible employees, insured as of July 1,
3 2002, may be up to 125 percent of the rate determined for
4 small employer groups of 2-50 eligible employees for the first
5 annual renewal and 150 percent for subsequent annual renewals.

6 (15) APPLICABILITY OF OTHER STATE LAWS.--

7 (a) Except as expressly provided in this section, a
8 law requiring coverage for a specific health care service or
9 benefit, or a law requiring reimbursement, utilization, or
10 consideration of a specific category of licensed health care
11 practitioner, does not apply to a standard or basic health
12 benefit plan policy or contract or a limited benefit policy or
13 contract offered or delivered to a small employer unless that
14 law is made expressly applicable to such policies or
15 contracts. A law restricting or limiting deductibles,
16 coinsurance, copayments, or annual or lifetime maximum
17 payments does not apply to any health plan policy, including a
18 standard or basic health benefit plan policy or contract,
19 offered or delivered to a small employer unless such law is
20 made expressly applicable to such policy or contract. However,
21 every small employer carrier must offer to eligible small
22 employers the standard benefit plan and the basic benefit
23 plan, as required by subsection (5), as such plans have been
24 approved by the department pursuant to subsection (12).

25 Section 16. If any law that is amended by this act was
26 also amended by a law enacted at the 2002 Regular Session of
27 the Legislature, such laws shall be construed as if they had
28 been enacted at the same session of the Legislature, and full
29 effect should be given to each if that is possible.

30
31

1 Section 17. This act shall take effect October 1,
2 2002, except that this section and sections 1, 2, and 16 of
3 this act shall take effect July 1, 2002.

4
5 *****

6 SENATE SUMMARY

7 Revises and creates provisions relating to a wide variety
8 of subjects relating to health care, health care
9 providers, and health care delivery. (See bill for
10 details.)
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31