A bill to be entitled

An act relating to health insurance claims payments; amending s. 627.638, F.S.; including licensed ambulance providers under provisions for direct payment for certain services; deleting an insurance contract limitation on payment of benefits directly to providers; authorizing attestations assigning benefits; providing for transfer of attestations electronically; requiring insurers to make payments directly to preferred providers under certain circumstances; providing an insurance contract prohibition and claims form requirement relating to payment of benefits directly to providers; providing a payment limitation; amending s. 627.6471, F.S.; prohibiting insurers and plan administrators from reimbursing preferred providers at an alternative or reduced rate for covered services under certain circumstances; providing exceptions; prohibiting preferred provider contract parties from selling, leasing, or transferring contract payment or reimbursement terms information under certain circumstances; amending s. 641.31, F.S.; requiring health maintenance organizations to pay benefits directly to certain providers under certain circumstances; prohibiting health maintenance contracts from prohibiting and requiring claims form to provide the option for payment of benefits directly to certain providers; amending s. 641.315, F.S.; prohibiting health maintenance organizations from selling, leasing, or transferring contract payment or reimbursement terms information under

certain circumstances; amending s. 641.3155, F.S.; decreasing the period of time authorized for overpayment claims of health maintenance organizations against providers; providing an effective date.

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

Section 1. Section 627.638, Florida Statutes, is amended to read:

627.638 Direct payment for hospital, ambulance, and medical services.--

(1) Any health insurance policy insuring against loss or expense due to hospital confinement or to medical and related services may provide for payment of benefits directly to any recognized hospital, licensed ambulance provider, doctor, or other person who provided the services, in accordance with the provisions of the policy. To comply with this section, the words "or to the hospital, licensed ambulance provider, doctor, or person rendering services covered by this policy," or similar words appropriate to the terms of the policy, shall be added to applicable provisions of the policy.

(2) Whenever, in any health insurance claim form, an insured specifically authorizes payment of benefits directly to any recognized hospital, licensed ambulance provider, physician, ~~or~~ dentist, or other person who provided the services, in accordance with the provisions of the policy, the insurer shall make such payment to the designated provider of such services~~, unless otherwise provided in the insurance contract~~. The

insurance contract may not prohibit, and claims forms must provide an option for, the payment of benefits directly to a licensed hospital, licensed ambulance provider, physician, ~~or~~ dentist, or other person who provided services for care provided pursuant to s. 395.1041 or part III of chapter 401. The insurer may require an ~~written~~ attestation assigning ~~of assignment of~~ benefits, which attestation may be in written or electronic form, at the discretion of the insured. If the attestation is in electronic form, the attestation may be transferred to the insurer electronically. An insurer may not require an attestation in both electronic and written form. Payment to the provider from the insurer may not be more than the amount that the insurer would otherwise have paid without the assignment.

(3) Whenever, in any health insurance claim form, an insured specifically authorizes payment of benefits directly to a preferred provider as defined in s. 627.6471(1)(b), the insurer shall make such payment to the preferred provider. The insurance contract may not prohibit, and claims forms must provide an option for, the payment of benefits directly to the preferred provider. An attestation assigning benefits may be transferred to the insurer in electronic form. Payment to the provider from the insurer may not be more than the amount that the insurer would otherwise have paid without the assignment.

(4) Notwithstanding the provisions of subsections (2) and (3), if an insured authorizes payment of benefits directly to a licensed hospital for health care services provided pursuant to s. 395.1041, the insurer shall make such payment to the designated provider of such services. The insurer shall accept a

provider's claim form that properly indicates that the insured has assigned payment of benefits directly to the hospital. Payment to the hospital from the insurer may not be more than the amount the insurer would otherwise have paid without the assignment.

Section 2. Subsection (7) is added to section 627.6471, Florida Statutes, to read:

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

(7)(a) An insurer or an administrator may not reimburse a preferred provider at an alternative or a reduced rate of payment for covered services that are provided to an insured unless:

1. The insurer or administrator has contracted with the preferred provider and has agreed to provide coverage for those health care services under the health insurance policy.

2. The preferred provider has agreed to the contract and to provide health care services under the terms of the contract.

(b) A party to a preferred provider contract may not sell, lease, or otherwise transfer information regarding the payment or reimbursement terms of the contract without the express authority of and prior adequate notification to the other contracting parties.

Section 3. Subsection (41) is added to section 641.31, Florida Statutes, to read:

641.31 Health maintenance contracts.--

(41) Whenever, in any health maintenance organization claim form, a subscriber specifically authorizes payment of

benefits directly to any hospital, ambulance provider, physician, or dentist, the health maintenance organization shall make such payment to the designated provider of such services, provided any benefits are due to the subscriber under the terms of the agreement between the subscriber and the health maintenance organization. The health maintenance organization contract may not prohibit, and claims forms must provide an option for, the payment of benefits directly to a licensed hospital, ambulance provider, physician, or dentist for covered services provided, for services provided pursuant to s. 395.1041, and for ambulance transport and treatment provided pursuant to part III of chapter 401. The attestation of assignment of benefits may be in written or electronic form. Payment to the provider from the health maintenance organization may not be more than the amount that the insurer would otherwise have paid without the assignment. Nothing in this subsection affects the applicability of ss. 641.3154 and 641.513 with respect to services provided and payment for such services provided pursuant to this subsection.

Section 4. Subsection (11) is added to section 641.315, Florida Statutes, to read:

641.315 Provider contracts.--

(11) A health maintenance organization may not sell, lease, or otherwise transfer information regarding the payment of reimbursement terms of a contract with a health care practitioner without the express authority of and prior adequate notification to the contracting parties.

Section 5. Subsection (5) of section 641.3155, Florida Statutes, is amended to read:

641.3155 Prompt payment of claims.--

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

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

1. All claims for overpayment must be submitted to a provider within 12 ~~30~~ months after the health maintenance organization's payment of the claim. A provider must pay, deny, or contest the health maintenance organization's claim for overpayment within 40 days after the receipt of the claim. All contested claims for overpayment must be paid or denied within 120 days after receipt of the claim. Failure to pay or deny overpayment and claim within 140 days after receipt creates an uncontestable obligation to pay the claim.

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

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

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

(b) A claim for overpayment shall not be permitted beyond 12 ~~30~~ months after the health maintenance organization's payment

of a claim, except that claims for overpayment may be sought beyond that time from providers convicted of fraud pursuant to s. 817.234.

Section 6. This act shall take effect July 1, 2008.