1 A bill to be entitled
2 An act relating to health insurance claims payments;
3 amending s. 624.443, F.S.; authorizing the Office of
4 Insurance Regulation to waive certain principal place of
5 business and records availability requirements for certain
6 multiple-employer welfare arrangements under specified
7 circumstances; amending s. 627.638, F.S.; including
8 licensed ambulance providers under provisions for direct
9 payment for certain services; deleting an insurance
10 contract limitation on payment of benefits directly to
11 providers; authorizing attestations assigning benefits;
12 providing for transfer of attestations electronically;
13 requiring insurers to make payments directly to preferred
14 providers under certain circumstances; providing an
15 insurance contract prohibition and claims form requirement
16 relating to payment of benefits directly to providers;
17 providing a payment limitation; amending s. 627.6471,
18 F.S.; prohibiting insurers and plan administrators from
19 reimbursing preferred providers at an alternative or
20 reduced rate for covered services under certain
21 circumstances; providing exceptions; prohibiting preferred
22 provider contract parties from selling, leasing, or
23 transferring contract payment or reimbursement terms
24 information under certain circumstances; amending s.
25 641.31, F.S.; requiring health maintenance organizations
26 to pay benefits directly to certain providers under
27 certain circumstances; prohibiting health maintenance
28 contracts from prohibiting and requiring claims form to

29 provide the option for payment of benefits directly to
30 certain providers; amending s. 641.315, F.S.; prohibiting
31 health maintenance organizations from selling, leasing, or
32 transferring contract payment or reimbursement terms
33 information under certain circumstances; amending s.
34 641.3155, F.S.; decreasing the period of time authorized
35 for overpayment claims of health maintenance organizations
36 against providers; providing an effective date.
37
38 Be It Enacted by the Legislature of the State of Florida:
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40 Section 1. Section 624.443, Florida Statutes, is amended
41 to read:
42 624.443 Place of business; maintenance of records.--Each
43 arrangement shall have and maintain its principal place of
44 business in this state and shall therein make available to the
45 office complete records of its assets, transactions, and affairs
46 in accordance with such methods and systems as are customary
47 for, or suitable to, the kind or kinds of business transacted.
48 The office may waive this requirement if an arrangement has been
49 operating in another state for at least 25 years, has been
50 licensed in such state for at least 10 years, and has a minimum
51 fund balance of $25 million at the time of licensure.
52 Section 2. Section 627.638, Florida Statutes, is amended
53 to read:
54 627.638 Direct payment for hospital, ambulance, and
55 medical services.--
56 (1) Any health insurance policy insuring against loss or

57 expense due to hospital confinement or to medical and related
58 services may provide for payment of benefits directly to any
59 recognized hospital, licensed ambulance provider, doctor, or
60 other person who provided the services, in accordance with the
61 provisions of the policy. To comply with this section, the words
62 "or to the hospital, licensed ambulance provider, doctor, or
63 person rendering services covered by this policy," or similar
64 words appropriate to the terms of the policy, shall be added to
65 applicable provisions of the policy.
66 (2) Whenever, in any health insurance claim form, an
67 insured specifically authorizes payment of benefits directly to
68 any recognized hospital, licensed ambulance provider, physician,
69 ~~or~~ dentist, or other person who provided the services, in
70 accordance with the provisions of the policy, the insurer shall
71 make such payment to the designated provider of such services~~,~~
72 ~~unless otherwise provided in the insurance contract~~. The
73 insurance contract may not prohibit, and claims forms must
74 provide an option for, the payment of benefits directly to a
75 licensed hospital, licensed ambulance provider, physician, ~~or~~
76 dentist, or other person who provided services for care provided
77 pursuant to s. 395.1041 or part III of chapter 401. The insurer
78 may require an ~~written~~ attestation assigning ~~of assignment of~~
79 benefits, which attestation may be in written or electronic
80 form, at the discretion of the insured. If the attestation is in
81 electronic form, the attestation may be transferred to the
82 insurer electronically. An insurer may not require an
83 attestation in both electronic and written form. Payment to the
84 provider from the insurer may not be more than the amount that

85 the insurer would otherwise have paid without the assignment.
86 (3) Whenever, in any health insurance claim form, an
87 insured specifically authorizes payment of benefits directly to
88 a preferred provider as defined in s. 627.6471(1)(b), the
89 insurer shall make such payment to the preferred provider. The
90 insurance contract may not prohibit, and claims forms must
91 provide an option for, the payment of benefits directly to the
92 preferred provider. An attestation assigning benefits may be
93 transferred to the insurer in electronic form. Payment to the
94 provider from the insurer may not be more than the amount that
95 the insurer would otherwise have paid without the assignment.
96 (4) Notwithstanding the provisions of subsections (2) and
97 (3), if an insured authorizes payment of benefits directly to a
98 licensed hospital for health care services provided pursuant to
99 s. 395.1041, the insurer shall make such payment to the
100 designated provider of such services. The insurer shall accept a
101 provider's claim form that properly indicates that the insured
102 has assigned payment of benefits directly to the hospital.
103 Payment to the hospital from the insurer may not be more than
104 the amount the insurer would otherwise have paid without the
105 assignment.
106 Section 3. Subsection (7) is added to section 627.6471,
107 Florida Statutes, to read:
108 627.6471 Contracts for reduced rates of payment;
109 limitations; coinsurance and deductibles.--
110 (7)(a) An insurer or an administrator may not reimburse a
111 preferred provider at an alternative or a reduced rate of
112 payment for covered services that are provided to an insured

113 unless:
114 1. The insurer or administrator has contracted with the
115 preferred provider and has agreed to provide coverage for those
116 health care services under the health insurance policy.
117 2. The preferred provider has agreed to the contract and
118 to provide health care services under the terms of the contract.
119 (b) A party to a preferred provider contract may not sell,
120 lease, or otherwise transfer information regarding the payment
121 or reimbursement terms of the contract without the express
122 authority of and prior adequate notification to the other
123 contracting parties.
124 Section 4. Subsection (41) is added to section 641.31,
125 Florida Statutes, to read:
126 641.31 Health maintenance contracts.--
127 (41) Whenever, in any health maintenance organization
128 claim form, a subscriber specifically authorizes payment of
129 benefits directly to any contracted hospital, ambulance
130 provider, physician, dentist, or other person who provided
131 services, the health maintenance organization shall make such
132 payment to the designated provider of such services, provided
133 any benefits are due to the subscriber under the terms of the
134 agreement between the subscriber and the health maintenance
135 organization. The health maintenance organization contract may
136 not prohibit, and claims forms must provide an option for, the
137 payment of benefits directly to a licensed hospital, ambulance
138 provider, physician, or dentist for covered services provided,
139 for services provided pursuant to s. 395.1041, and for ambulance
140 transport and treatment provided pursuant to part III of chapter

141 401. The attestation of assignment of benefits may be in written
142 or electronic form. Payment to the provider from the health
143 maintenance organization may not be more than the amount that
144 the insurer would otherwise have paid without the assignment.
145 Nothing in this subsection affects the applicability of ss.
146 641.3154 and 641.513 with respect to services provided and
147 payment for such services provided pursuant to this subsection.
148 Section 5. Subsection (11) is added to section 641.315,
149 Florida Statutes, to read:
150 641.315 Provider contracts.--
151 (11) A health maintenance organization may not sell,
152 lease, or otherwise transfer information regarding the payment
153 of reimbursement terms of a contract with a health care
154 practitioner without the express authority of and prior adequate
155 notification to the contracting parties.
156 Section 6. Subsection (5) of section 641.3155, Florida
157 Statutes, is amended to read:
158 641.3155 Prompt payment of claims.--
159 (5) If a health maintenance organization determines that
160 it has made an overpayment to a provider for services rendered
161 to a subscriber, the health maintenance organization must make a
162 claim for such overpayment to the provider's designated
163 location. A health maintenance organization that makes a claim
164 for overpayment to a provider under this section shall give the
165 provider a written or electronic statement specifying the basis
166 for the retroactive denial or payment adjustment. The health
167 maintenance organization must identify the claim or claims, or

168 overpayment claim portion thereof, for which a claim for
169 overpayment is submitted.
170 (a) If an overpayment determination is the result of
171 retroactive review or audit of coverage decisions or payment
172 levels not related to fraud, a health maintenance organization
173 shall adhere to the following procedures:
174 1. All claims for overpayment must be submitted to a
175 provider within 12 ~~30~~ months after the health maintenance
176 organization's payment of the claim. A provider must pay, deny,
177 or contest the health maintenance organization's claim for
178 overpayment within 40 days after the receipt of the claim. All
179 contested claims for overpayment must be paid or denied within
180 120 days after receipt of the claim. Failure to pay or deny
181 overpayment and claim within 140 days after receipt creates an
182 uncontestable obligation to pay the claim.
183 2. A provider that denies or contests a health maintenance
184 organization's claim for overpayment or any portion of a claim
185 shall notify the organization, in writing, within 35 days after
186 the provider receives the claim that the claim for overpayment
187 is contested or denied. The notice that the claim for
188 overpayment is denied or contested must identify the contested
189 portion of the claim and the specific reason for contesting or
190 denying the claim and, if contested, must include a request for
191 additional information. If the organization submits additional
192 information, the organization must, within 35 days after receipt
193 of the request, mail or electronically transfer the information
194 to the provider. The provider shall pay or deny the claim for
195 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 7. This act shall take effect July 1, 2008.