A bill to be entitled

An act relating to health services claims; amending s. 626.9541, F.S.; authorizing certain insurers to offer voluntary wellness or health improvement programs that provide certain rewards or incentives; providing for medical verification for nonparticipation in such programs for certain reasons; providing that such rewards or incentives are not insurance benefits and do not constitute a violation of unfair methods of competition and unfair or deceptive acts or practice provisions; providing construction; amending s. 627.6141, F.S.; authorizing appeals from denials of certain claims for certain services; requiring a health insurer to conduct a retrospective review of the medical necessity of a service under certain circumstances; requiring the health insurer to submit a written justification for a determination that a service was not medically necessary and provide a process for appealing the determination; amending s. 627.6474, F.S.; prohibiting contracts between health insurers and dentists from containing certain fee requirements set by the insurer under certain circumstances; providing a definition; providing application; amending s. 636.035, F.S.; prohibiting contracts between prepaid limited health service organizations and dentists from containing certain fee requirements set by the organization under certain circumstances; providing a definition; providing application; amending s. 641.315, F.S.; prohibiting

contracts between health maintenance organizations and dentists from containing certain fee requirements set by the organization under certain circumstances; providing a definition; providing application; amending s. 641.3156, F.S.; authorizing appeals from denials of certain claims for certain services; requiring a health maintenance organization to conduct a retrospective review of the medical necessity of a service under certain circumstances; requiring the health maintenance organization to submit a written justification for a determination that a service was not medically necessary and provide a process for appealing the determination; providing an effective date.

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

Section 1. Subsection (3) is added to section 626.9541, Florida Statutes, to read:

626.9541 Unfair methods of competition and unfair or deceptive acts or practices defined.—

(3) WELLNESS PROGRAMS.—Notwithstanding subsection (1), an insurer issuing a group or individual health benefit plan may offer a voluntary wellness or health improvement program that provides for rewards or incentives, including, but not limited to, merchandise; gift cards; debit cards; premium discounts or rebates; contributions towards a member's health savings account; modifications to copayment, deductible, or coinsurance amounts; or any combination of such rewards or incentives to

encourage or reward participation in the program. The health benefit plan member may be required to provide verification, including, but not limited to, a statement from the member's physician, that a medical condition makes it unreasonably difficult or medically inadvisable for the individual to participate in the wellness program. Any reward or incentive established under this subsection is not an insurance benefit and does not constitute a violation of this section. This subsection does not prohibit an insurer from offering incentives or rewards to members for adherence to wellness or health improvement programs if otherwise authorized by state or federal law.

Section 2. Section 627.6141, Florida Statutes, is amended to read:

627.6141 Denial of claims.—Each claimant, or hospital ~~provider~~ acting for a claimant, who has had a claim denied or a portion of a claim denied because the hospital failed to obtain the necessary authorization due to an unintentional act or error or omission ~~as not medically necessary~~ must be provided an opportunity for an appeal to the insurer's licensed physician who is responsible for the medical necessity reviews under the plan ~~or is a member of the plan's peer review group~~. If the hospital appeals the denial, the health insurer shall conduct and complete a retrospective review of the medical necessity of the service within 30 business days after the submitted appeal. If the insurer determines upon review that the service was medically necessary, the insurer shall reverse the denial and pay the claim. If the insurer determines that the service was

not medically necessary, the insurer shall submit to the hospital specific written clinical justification for the determination. ~~The appeal may be by telephone, and the insurer's licensed physician must respond within a reasonable time, not to exceed 15 business days.~~

Section 3. Section 627.6474, Florida Statutes, is amended to read:

627.6474 Provider contracts.—

(1) A health insurer may ~~shall~~ not require a contracted health care practitioner as defined in s. 456.001(4) to accept the terms of other health care practitioner contracts with the insurer or any other insurer, or health maintenance organization, under common management and control with the insurer, including Medicare and Medicaid practitioner contracts and those authorized by s. 627.6471, s. 627.6472, s. 636.035, or s. 641.315, except for a practitioner in a group practice as defined in s. 456.053 who must accept the terms of a contract negotiated for the practitioner by the group, as a condition of continuation or renewal of the contract. Any contract provision that violates this section is void. A violation of this section is not subject to the criminal penalty specified in s. 624.15.

(2) A contract between a health insurer and a dentist licensed under chapter 466 for the provision of services to patients may not contain any provision that requires the dentist to provide services to the insured under such contract at a fee set by the health insurer unless such services are covered services under the applicable contract. As used in this subsection, the term "covered services" means services

reimbursable under the applicable contract, subject to such contractual limitations on benefits, such as deductibles, coinsurance, and copayments, as may apply. This subsection applies to all contracts entered into or renewed on or after July 1, 2010.

Section 4. Subsection (13) is added to section 636.035, Florida Statutes, to read:

636.035 Provider arrangements.—

(13) A contract between a prepaid limited health service organization and a dentist licensed under chapter 466 for the provision of services to subscribers of the prepaid limited health service organization may not contain any provision that requires the dentist to provide services to subscribers of the prepaid limited health service organization at a fee set by the prepaid limited health service organization unless such services are covered services under the applicable contract. As used in this subsection, the term "covered services" means services reimbursable under the applicable contract, subject to such contractual limitations on benefits, such as deductibles, coinsurance, and copayments, as may apply. This subsection applies to all contracts entered into or renewed on or after July 1, 2010.

Section 5. Subsection (11) is added to section 641.315, Florida Statutes, to read:

641.315 Provider contracts.—

(11) A contract between a health maintenance organization and a dentist licensed under chapter 466 for the provision of services to subscribers of the health maintenance organization

may not contain any provision that requires the dentist to provide services to subscribers of the health maintenance organization at a fee set by the health maintenance organization unless such services are covered services under the applicable contract. As used in this subsection, the term "covered services" means services reimbursable under the applicable contract, subject to such contractual limitations on subscriber benefits, such as deductibles, coinsurance, and copayments, as may apply. This subsection applies to all contracts entered into or renewed on or after July 1, 2010.

Section 6. Subsection (3) of section 641.3156, Florida Statutes, is renumbered as subsection (4), and a new subsection (3) is added to that section to read:

641.3156 Treatment authorization; payment of claims.—

(3) If a hospital claim or a portion of a hospital claim of a contracted hospital is denied because the hospital, due to an unintentional act of error or omission, failed to obtain the necessary authorization, the hospital may appeal the denial to the health maintenance organization's licensed physician who is responsible for medical necessity reviews. The health maintenance organization shall conduct and complete a retrospective review of the medical necessity of the service within 30 business days after the submitted appeal. If the health maintenance organization determines that the service is medically necessary, the health maintenance organization shall reverse the denial and pay the claim. If the health maintenance organization determines that the service is not medically necessary, the health maintenance organization shall provide the

hospital with specific written clinical justification for the determination.

Section 7. This act shall take effect July 1, 2010.