CHAPTER 2002-389

Senate Bill No. 46-E

An act relating to health care; providing legislative findings and legislative intent regarding health flex plans; defining terms; providing for a pilot program for health flex plans for certain uninsured persons; providing criteria; authorizing the Agency for Health Care Administration and the Department of Insurance to adopt rules; exempting approved health flex plans from certain licensing requirements; providing criteria for eligibility to enroll in a health flex plan; requiring health flex plan providers to maintain certain records; providing requirements for denial, nonrenewal, or cancellation of coverage; specifying that coverage under an approved health flex plan is not an entitlement; requiring a report with specified evaluation elements; providing for future repeal; establishing the Florida Alzheimer's Center and Research Institute at the University of South Florida; requiring the State Board of Education to enter into an agreement with a not-for-profit corporation for the governance and operation of the institute; providing that the corporation shall act as an instrumentality of the state; authorizing the creation of subsidiaries by the corporation; providing powers of the corporation; providing for a board of directors of the corporation and the appointment and terms of its membership; authorizing the State Board of Education to secure and provide liability protection; providing for an annual audit and report; providing for assumption of certain responsibilities of the corporation by the State Board of Education under certain circumstances; providing for administration of the institute; providing for disbursal and use of income; providing for reporting of activities; requiring the appointment of a council of scientific advisers; providing responsibilities and terms of the council; providing that the corporation and its subsidiaries are not agencies within the meaning of s. 20.03(11), F.S.; amending s. 408.7057, F.S.; redesignating a program title; revising definitions; including preferred provider organizations and health insurers in the claim dispute resolution program; specifying timeframes for submission of supporting documentation necessary for dispute resolution; providing consequences for failure to comply; providing additional responsibilities for the agency relating to patterns of claim disputes; providing timeframes for review by the resolution organization; directing the agency to notify appropriate licensure and certification entities as part of violation of final orders; amending s. 626.88, F.S.; redefining the term "administrator," with respect to regulation of insurance administrators; creating s. 627.6131, F.S.; specifying payment-of-claims provisions applicable to certain health insurers; providing a definition; providing requirements and procedures for paying, denying, or contesting claims; providing criteria and limitations; requiring payment within specified periods; specifying rate of interest charged on overdue payments; providing for electronic and nonelectronic transmission of claims; providing procedures for overpayment recovery; specifying timeframes for adjudication of claims, internally and externally; prohibiting action to collect payment from an

insured under certain circumstances; providing applicability; prohibiting contractual modification of provisions of law; specifying circumstances for retroactive claim denial; specifying claim payment requirements; providing for billing review procedures; specifying claim content requirements; establishing a permissible error ratio, specifying its applicability, and providing for fines; providing specified exceptions from notice and acknowledgment requirements for pharmacy benefit manager claims; amending s. 627.651, F.S.; conforming a cross-reference; amending s. 627.662, F.S.; specifying application of certain additional provisions to group, blanket, and franchise health insurance; amending s. 641.185, F.S.; specifying that health maintenance organization subscribers should receive prompt payment from the organization; amending s. 641.234, F.S.; specifying responsibility of a health maintenance organization for certain violations under certain circumstances; amending s. 641.30, F.S.; conforming a cross-reference; amending s. 641.3154, F.S.; modifying the circumstances under which a provider knows that an organization is liable for service reimbursement; amending s. 641.3155, F.S.; revising payment of claims provisions applicable to certain health maintenance organizations; providing a definition; providing requirements and procedures for paying, denying, or contesting claims; providing criteria and limitations; requiring payment within specified periods; revising rate of interest charged on overdue payments; providing for electronic and nonelectronic transmission of claims; providing procedures for overpayment recovery; specifying timeframes for adjudication of claims, internally and externally; prohibiting action to collect payment from a subscriber under certain circumstances; prohibiting contractual modification of provisions of law; specifying circumstances for retroactive claim denial; specifying claim payment requirements; providing for billing review procedures; specifying claim content requirements; establishing a permissible error ratio, specifying its applicability, and providing for fines; providing specified exceptions from notice and acknowledgment requirements for pharmacy benefit manager claims; amending s. 641.51, F.S.; revising provisions governing examinations by ophthalmologists; amending s. 456.053, F.S., the "Patient Self-Referral Act of 1992"; redefining the term "referral" by revising the list of practices that constitute exceptions; amending s. 627.6699, F.S.; allowing carriers to separate the experience of small-employer groups having fewer than two employees; restricting application of certain laws to health plan policies under certain circumstances; providing for construction of laws enacted at the 2002 Regular Session in relation to this act; providing effective dates.

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

Section 1. Health flex plans.—

(1) INTENT.—The Legislature finds that a significant proportion of the residents of this state are unable to obtain affordable health insurance coverage. Therefore, it is the intent of the Legislature to expand the availability of health care options for low-income uninsured state residents by

encouraging health insurers, health maintenance organizations, health-care-provider-sponsored organizations, local governments, health care districts, or other public or private community-based organizations to develop alternative approaches to traditional health insurance which emphasize coverage for basic and preventive health care services. To the maximum extent possible, these options should be coordinated with existing governmental or community-based health services programs in a manner that is consistent with the objectives and requirements of such programs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Are 64 years of age or younger;

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

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

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

(6) RECORDS.—Each health flex plan shall maintain enrollment data and reasonable records of its losses, expenses, and claims experience and shall make those records reasonably available to enable the department to monitor and determine the financial viability of the health flex plan, as necessary. Provider networks and total enrollment by area shall be reported to the agency biannually to enable the agency to monitor access to care.

(7) NOTICE.—The denial of coverage by a health flex plan, or the nonrenewal or cancellation of coverage, must be accompanied by the specific reasons for denial, nonrenewal, or cancellation. Notice of nonrenewal or

cancellation must be provided at least 45 days in advance of the nonrenewal or cancellation, except that 10 days' written notice must be given for cancellation due to nonpayment of premiums. If the health flex plan fails to give the required notice, the health flex plan coverage must remain in effect until notice is appropriately given.

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

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

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

Section 2. Florida Alzheimer's Center and Research Institute.—

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

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

(b)1. The affairs of the not-for-profit corporation shall be managed by a board of directors who shall serve without compensation. The board of directors shall consist of the President of the University of South Florida and the chair of the State Board of Education, or their designees, 5 representatives of the state universities, and no fewer than 9 nor more than 14 representatives of the public who are neither medical doctors nor state employees. Each director who is a representative of a state university or of the public shall

be appointed to serve a term of 3 years. The chair of the board of directors shall be selected by a majority vote of the directors. Each director shall have only one vote.

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

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

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

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

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

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

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

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

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

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

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

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

(c) The chief executive officer shall appoint representatives of the institute to carry out the research, patient-care, and educational activities of the institute and establish the compensation, benefits, and terms of service of such representatives. Representatives of the institute shall be eligible to hold concurrent appointments at affiliated academic institutions. University faculty shall be eligible to hold concurrent appointments at the institute.

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

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

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

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

(7) The board of directors of the not-for-profit corporation shall create a council of scientific advisers to the chief executive officer consisting of leading researchers, physicians, and scientists. The council shall review programs and recommend research priorities and initiatives to maximize the state's investment in the institute. The members of the council shall be

appointed by the board of directors of the not-for-profit corporation, except for five members who shall be appointed by the State Board of Education. Each member of the council shall be appointed to serve a 2-year term and may be reappointed to the council.

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

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

408.7057 Statewide provider and health plan ~~managed care organization~~ claim dispute resolution program.—

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

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

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

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

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

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

1. Is related to interest payment;

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

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

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

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

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

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

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

(d) A contracted or noncontracted provider or health plan ~~maintenance organization~~ may not file a claim dispute with the resolution organization more than 12 months after a final determination has been made on a claim by a health plan or provider ~~maintenance organization~~.

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

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

(g)1. If on an ongoing basis during the preceding 12 months, the agency has reason to believe that a pattern of noncompliance with s. 627.6131 and s. 641.3155 exists on the part of a particular health plan or provider, the agency shall evaluate the information contained in these cases to determine whether the information evidences a pattern and report its findings, together with substantiating evidence, to the appropriate licensure or certification entity for the health plan or provider.

2. In addition, the agency shall prepare a report to the Governor and the Legislature by February 1 of each year, enumerating: claims dismissed;

defaults issued; and failures to comply with agency final orders issued under this section.

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

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

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

(6)~~(5)~~ The entity that does not prevail in the agency's order must pay a review cost to the review organization, as determined by agency rule. Such rule must provide for an apportionment of the review fee in any case in which both parties prevail in part. If the nonprevailing party fails to pay the ordered review cost within 35 days after the agency's order, the nonpaying party is subject to a penalty of not more than $500 per day until the penalty is paid.

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

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

626.88 Definitions of "administrator" and "insurer".—

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

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

(b) A union on behalf of its members.

(c) An insurance company which is either authorized to transact insurance in this state or is acting as an insurer with respect to a policy lawfully

issued and delivered by such company in and pursuant to the laws of a state in which the insurer was authorized to transact an insurance business.

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

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

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

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

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

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

(j) A financial institution which is subject to supervision or examination by federal or state authorities or a mortgage lender licensed under chapter 494 who collects and remits premiums to licensed insurance agents or authorized insurers concurrently or in connection with mortgage loan payments.

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

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

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

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

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

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

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

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

627.6131 Payment of claims.—

(1) The contract shall include the following provision:

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

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

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

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

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

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

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

All claims for payment, whether electronic or nonelectronic, must be mailed or electronically transferred to the secondary insurer within 90 days after

final determination by the primary insurer. A provider's claim is considered submitted on the date it is electronically transferred or mailed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) If a health insurer determines that it has made an overpayment to a provider for services rendered to an insured, the health insurer must make a claim for such overpayment to the provider's designated location. A health insurer 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 insurer 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 insurer shall adhere to the following procedures:

1. All claims for overpayment must be submitted to a provider within 30 months after the health insurer's payment of the claim. A provider must pay, deny, or contest the health insurer'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 insurer's claim for overpayment or any portion of a claim shall notify the health insurer, 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 health insurer submits additional information, the health insurer 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 insurer 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 insurer'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 begins to accrue when the claim should have been paid, denied, or contested.

(b) A claim for overpayment shall not be permitted beyond 30 months after the health insurer'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.

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

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

(9) A provider or any representative of a provider, regardless of whether the provider is under contract with the health insurer, may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency an insured for payment of covered services for which the health insurer contested or denied the provider's claim. This prohibition applies during the pendency of any claim for payment made by the provider to the health insurer for payment of the services or internal dispute resolution process to determine whether the health insurer is liable for the services. For a claim, this pendency applies from the date the claim or a portion of the claim is denied to the date of the completion of the health insurer's internal dispute resolution process, not to exceed 60 days. This subsection does not prohibit the collection by the provider of copayments, coinsurance, or deductible amounts due the provider.

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

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

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

(13) Upon written notification by an insured, an insurer shall investigate any claim of improper billing by a physician, hospital, or other health care provider. The insurer shall determine if the insured was properly billed for

only those procedures and services that the insured actually received. If the insurer determines that the insured has been improperly billed, the insurer shall notify the insured and the provider of its findings and shall reduce the amount of payment to the provider by the amount determined to be improperly billed. If a reduction is made due to such notification by the insured, the insurer shall pay to the insured 20 percent of the amount of the reduction up to $500.

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

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

(16) Notwithstanding paragraph (4)(b), where an electronic pharmacy claim is submitted to a pharmacy benefits manager acting on behalf of a health insurer the pharmacy benefits manager shall, within 30 days of receipt of the claim, pay the claim or notify a provider or designee if a claim is denied or contested. Notice of the insurer's action on the claim and payment of the claim is considered to be made on the date the notice or payment was mailed or electronically transferred.

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

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

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

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

Section 7. Section 627.662, Florida Statutes, is amended to read:

627.662 Other provisions applicable.—The following provisions apply to group health insurance, blanket health insurance, and franchise health insurance:

(1) Section 627.569, relating to use of dividends, refunds, rate reductions, commissions, and service fees.

(2) Section 627.602(1)(f) and (2), relating to identification numbers and statement of deductible provisions.

(3) Section 627.635, relating to excess insurance.

(4) Section 627.638, relating to direct payment for hospital or medical services.

(5) Section 627.640, relating to filing and classification of rates.

(6) Section 627.613, relating to timely payment of claims, or s. 627.6131, relating to payment of claims, whichever is applicable.

(7)~~(6)~~ Section 627.645(1), relating to denial of claims.

~~(7) Section 627.613, relating to time of payment of claims.~~

(8) Section 627.6471, relating to preferred provider organizations.

(9) Section 627.6472, relating to exclusive provider organizations.

(10) Section 627.6473, relating to combined preferred provider and exclusive provider policies.

(11) Section 627.6474, relating to provider contracts.

Section 8. Paragraph (e) of subsection (1) of section 641.185, Florida Statutes, is amended to read:

641.185 Health maintenance organization subscriber protections.—

(1) With respect to the provisions of this part and part III, the principles expressed in the following statements shall serve as standards to be followed by the Department of Insurance and the Agency for Health Care Administration in exercising their powers and duties, in exercising administrative

discretion, in administrative interpretations of the law, in enforcing its provisions, and in adopting rules:

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

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

641.234 Administrative, provider, and management contracts.—

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

(b) As used in this subsection:

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

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

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

641.30 Construction and relationship to other laws.—

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

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

641.3154 Organization liability; provider billing prohibited.—

(4) A provider or any representative of a provider, regardless of whether the provider is under contract with the health maintenance organization, may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency a subscriber of an organization for payment of services for which the organization is liable, if the provider in

good faith knows or should know that the organization is liable. This prohibition applies during the pendency of any claim for payment made by the provider to the organization for payment of the services and any legal proceedings or dispute resolution process to determine whether the organization is liable for the services if the provider is informed that such proceedings are taking place. It is presumed that a provider does not know and should not know that an organization is liable unless:

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

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

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

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

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

(Substantial rewording of section. See
s. 641.3155, F.S., for present text.)

641.3155 Prompt payment of claims.—

(1) As used in this section, the term "claim" for a noninstitutional provider means a paper or electronic billing instrument submitted to the health maintenance organization's designated location that consists of the HCFA 1500 data set, or its successor, that has all mandatory entries for a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 463, or psychologists licensed under chapter 490 or any appropriate billing instrument that has all mandatory entries for any other noninstitutional provider. For institutional providers, "claim" means a paper or electronic billing instrument submitted to the health maintenance organization's designated location that consists of the UB-92 data set or its successor with entries stated as mandatory by the National Uniform Billing Committee.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Within 40 days after receipt of the claim, pay the claim or notify a provider or designee if a claim is denied or contested. Notice of the health maintenance organization's action on the claim and payment of the claim is

considered to be made on the date the notice or payment was mailed or electronically transferred.

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

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

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

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

(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 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 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.

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

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

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

(8) A provider or any representative of a provider, regardless of whether the provider is under contract with the health maintenance organization, may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency a subscriber for payment of covered services for which the health maintenance organization contested or denied the provider's claim. This prohibition applies during the pendency of any claim for payment made by the provider to the health maintenance organization for payment of the services or internal dispute resolution process to determine whether the health maintenance organization is liable for the

services. For a claim, this pendency applies from the date the claim or a portion of the claim is denied to the date of the completion of the health maintenance organization's internal dispute resolution process, not to exceed 60 days. This subsection does not prohibit collection by the provider of copayments, coinsurance, or deductible amounts due the provider.

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

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

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

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

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

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

(15) Notwithstanding paragraph (4)(a), effective November 1, 2003, where a nonelectronic pharmacy claim is submitted to a pharmacy benefits

manager acting on behalf of a health maintenance organization the pharmacy benefits manager shall provide acknowledgment of receipt of the claim within 30 days after receipt of the claim to the provider or provide a provider within 30 days after receipt with electronic access to the status of a submitted claim.

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

641.51 Quality assurance program; second medical opinion requirement.—

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

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

456.053 Financial arrangements between referring health care providers and providers of health care services.—

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

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

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

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

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

a. By a radiologist for diagnostic-imaging services.

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

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

d. By a cardiologist for cardiac catheterization services.

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

f. By a health care provider who is the sole provider or member of a group practice for designated health services or other health care items or services that are prescribed or provided solely for such referring health care provider's or group practice's own patients, and that are provided or performed by or under the direct supervision of such referring health care provider or group practice; provided, however, that effective July 1, 1999, a physician licensed pursuant to chapter 458, chapter 459, chapter 460, or chapter 461 may refer a patient to a sole provider or group practice for diagnostic imaging services, excluding radiation therapy services, for which the sole provider or group practice billed both the technical and the professional fee for or on behalf of the patient, if the referring physician has no investment interest in the practice. The diagnostic imaging service referred to a group practice or sole provider must be a diagnostic imaging service normally provided within the scope of practice to the patients of the group practice or sole provider. The group practice or sole provider may accept no more that 15 percent of their patients receiving diagnostic imaging services from outside referrals, excluding radiation therapy services.

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

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

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

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

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

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

l. By a health care provider whose principal professional practice consists of treating patients in their private residences for services to be rendered in such private residences, except for services rendered by a home health agency licensed under chapter 400. For purposes of this sub-subparagraph, the term "private residences" includes patient's private homes, independent living centers, and assisted living facilities, but does not include skilled nursing facilities.

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

627.6699 Employee Health Care Access Act.—

(6) RESTRICTIONS RELATING TO PREMIUM RATES.—

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

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

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

3. Small employer carriers may not modify the rate for a small employer for 12 months from the initial issue date or renewal date, unless the composition of the group changes or benefits are changed. However, a small employer carrier may modify the rate one time prior to 12 months after the initial issue date for a small employer who enrolls under a previously issued group policy that has a common anniversary date for all employers covered under the policy if:

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

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

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

5. Any adjustments in rates for claims experience, health status, or duration of coverage may not be charged to individual employees or dependents.

For a small employer's policy, such adjustments may not result in a rate for the small employer which deviates more than 15 percent from the carrier's approved rate. Any such adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer. A small employer carrier may make an adjustment to a small employer's renewal premium, not to exceed 10 percent annually, due to the claims experience, health status, or duration of coverage of the employees or dependents of the small employer. Semiannually, small group carriers shall report information on forms adopted by rule by the department, to enable the department to monitor the relationship of aggregate adjusted premiums actually charged policyholders by each carrier to the premiums that would have been charged by application of the carrier's approved modified community rates. If the aggregate resulting from the application of such adjustment exceeds the premium that would have been charged by application of the approved modified community rate by 5 percent for the current reporting period, the carrier shall limit the application of such adjustments only to minus adjustments beginning not more than 60 days after the report is sent to the department. For any subsequent reporting period, if the total aggregate adjusted premium actually charged does not exceed the premium that would have been charged by application of the approved modified community rate by 5 percent, the carrier may apply both plus and minus adjustments. A small employer carrier may provide a credit to a small employer's premium based on administrative and acquisition expense differences resulting from the size of the group. Group size administrative and acquisition expense factors may be developed by each carrier to reflect the carrier's experience and are subject to department review and approval.

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

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

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

b. If a carrier separates the experience of small employer groups as provided in sub-subparagraph a., the rate to be charged to small employer groups of less than 2 eligible employees may not exceed 150 percent of the rate determined for small employer groups of 2-50 eligible employees. However, the carrier may charge excess losses of the experience pool consisting of small employer groups with less than 2 eligible employees to the experience pool consisting of small employer groups with 2-50 eligible employees

so that all losses are allocated and the 150-percent rate limit on the experience pool consisting of small employer groups with less than 2 eligible employees is maintained. Notwithstanding s. 627.411(1), the rate to be charged to a small employer group of fewer than 2 eligible employees, insured as of July 1, 2002, may be up to 125 percent of the rate determined for small employer groups of 2-50 eligible employees for the first annual renewal and 150 percent for subsequent annual renewals.

(15) APPLICABILITY OF OTHER STATE LAWS.—

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

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

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

Approved by the Governor May 24, 2002.

Filed in Office Secretary of State May 24, 2002.