CHAPTER 2016-222

Committee Substitute for Committee Substitute for Committee Substitute for House Bill No. 221

An act relating to health care services; amending s. 627.6686, F.S.; requiring a specified health insurance plan to provide specified coverage for treatment of Down syndrome; amending s. 641.31098, F.S.; requiring a specified health maintenance contract to provide specified health maintenance contract to provide specified coverage for treatment of Down syndrome; enacting s. 627.42392, F.S.; requiring a health insurer or a pharmacy benefits manager to only use a certain form; providing requirements for such form; providing legislative intent that the enactment of s. 627.42392(2), F.S., made by this act controls; amending s. 395.003, F.S.; requiring hospitals, ambulatory surgical centers, specialty hospitals, and urgent care centers to comply with certain provisions as a condition of licensure; amending s. 395.301, F.S.; requiring a hospital to post on its website certain information regarding health insurers, health maintenance organizations, health care practitioners, and practice groups that it contracts with, and a specified disclosure statement; amending s. 408.7057, F.S.; providing requirements for settlement offers between certain providers and health plans in a specified dispute resolution program; requiring the Agency for Health Care Administration to include in its rules additional requirements relating to a resolution organization's process in considering certain claim disputes; requiring a final order to be subject to judicial review; amending ss. 456.072, 458.331, and 459.015, F.S.; providing additional acts that constitute grounds for denial of a license or disciplinary action to which penalties apply; amending s. 626.9541, F.S.; specifying an additional unfair method of competition and unfair or deceptive act or practice; creating s. 627.64194, F.S.; defining terms; providing that an insurer is solely liable for payment of certain fees to a nonparticipating provider; providing limitations and requirements for reimbursements by an insurer to a nonparticipating provider; providing that certain disputes relating to reimbursement of a nonparticipating provider shall be resolved in a court of competent jurisdiction or through a specified voluntary dispute resolution process; amending s. 627.6471, F.S.; requiring an insurer that issues a policy including coverage for the services of a preferred provider to post on its website certain information about participating providers and physicians; requiring that specified notice be included in policies issued after a specified date which provide coverage for the services of a preferred provider; amending s. 627.662, F.S.; providing applicability of provisions relating to coverage for services and payment collection limitations to group health insurance, blanket health insurance, and franchise health insurance; providing effective dates.

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

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Section 1. Paragraph (b) of subsection (3) of section 627.6686, Florida Statutes, is amended to read:

627.6686 Coverage for individuals with autism spectrum disorder required; exception.—

(3) A health insurance plan issued or renewed on or after April 1, 2009, shall provide coverage to an eligible individual for:

(b) Treatment of autism spectrum disorder and Down syndrome through speech therapy, occupational therapy, physical therapy, and applied behavior analysis. Applied behavior analysis services shall be provided by an individual certified pursuant to s. 393.17 or an individual licensed under chapter 490 or chapter 491.

Section 2. Paragraph (b) of subsection (3) of section 641.31098, Florida Statutes, is amended to read:

641.31098 Coverage for individuals with developmental disabilities.—

(3) A health maintenance contract issued or renewed on or after April 1, 2009, shall provide coverage to an eligible individual for:

(b) Treatment of autism spectrum disorder and Down syndrome, through speech therapy, occupational therapy, physical therapy, and applied behavior analysis services. Applied behavior analysis services shall be provided by an individual certified pursuant to s. 393.17 or an individual licensed under chapter 490 or chapter 491.

Section 3. Notwithstanding the enactment of subsection (2) made to s. 627.42392, Florida Statutes, by HB 423, 1st Eng., 2016 Regular Session, subsection (2) of s. 627.42392, Florida Statutes, is enacted to read:

(2) Notwithstanding any other provision of law, effective January 1, 2017 or six (6) months after the effective date of the rule adopting the prior authorization form, whichever is later, a health insurer, or a pharmacy benefits manager on behalf of the health insurer, which does not provide an electronic prior authorization process for use by its contracted providers, shall only use the prior authorization form that has been approved by the Financial Services Commission for granting a prior authorization for a medical procedure, course of treatment, or prescription drug benefit. Such form may not exceed two pages in length, excluding any instructions or guiding documentation, and must include all clinical documentation necessary for health insurer to make a decision. At a minimum, the form must include: (1) sufficient patient information to identify the member, date of birth, full name, and Health Plan ID number; (2) Provider name, address and phone number; (3) the medical procedure, course of treatment, or prescription drug benefit being requested, including the medical reason therefor, and all services tried and failed; (4) any laboratory documentation required; and (5) an attestation that all information provided is true and accurate.

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Section 4. It is the intent of the Legislature that the enactment of s. 627.42392(2), Florida Statutes, made by this act shall control over the enactment of that subsection made by HB 423, 1st Eng., 2016 Regular Session, regardless of the order in which the bills are enacted.

Section 5. Paragraph (d) is added to subsection (5) of section 395.003, Florida Statutes, to read:

395.003 Licensure; denial, suspension, and revocation.—

(5)

(d) A hospital, an ambulatory surgical center, a specialty hospital, or an urgent care center shall comply with ss. 627.64194 and 641.513 as a condition of licensure.

Section 6. Subsection (13) is added to section 395.301, Florida Statutes, to read:

395.301 Itemized patient bill; form and content prescribed by the agency; patient admission status notification.—

(13) A hospital shall post on its website:

(a) The names and hyperlinks for direct access to the websites of all health insurers and health maintenance organizations for which the hospital contracts as a network provider or participating provider.

(b) A statement that:

1. Services may be provided in the hospital by the facility as well as by other health care practitioners who may separately bill the patient;

2. Health care practitioners who provide services in the hospital may or may not participate with the same health insurers or health maintenance organizations as the hospital; and

3. Prospective patients should contact the health care practitioner who will provide services in the hospital to determine which health insurers and health maintenance organizations the practitioner participates in as a network provider or preferred provider.

(c) As applicable, the names, mailing addresses, and telephone numbers of the health care practitioners and medical practice groups with which it contracts to provide services in the hospital, and instructions on how to contact the practitioners and groups to determine which health insurers and health maintenance organizations they participate in as network providers or preferred providers.

Section 7. Paragraph (h) is added to subsection (2) of section 408.7057, Florida Statutes, and subsections (3) and (4) of that section are amended, to read:

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408.7057 Statewide provider and health plan claim dispute resolution program.—

(2)

(h) Either the contracted or noncontracted provider or the health plan may make an offer to settle the claim dispute when it submits a request for a claim dispute and supporting documentation. The offer to settle the claim dispute must state its total amount, and the party to whom it is directed has 15 days to accept the offer once it is received. If the party receiving the offer does not accept the offer and the final order amount is more than 90 percent or less than 110 percent of the offer amount, the party receiving the offer must pay the final order amount to the offering party and is deemed a nonprevailing party for purposes of this section. The amount of an offer made by a contracted or noncontracted provider to settle an alleged underpayment by the health plan must be greater than 110 percent of the reimbursement amount the provider received. The amount of an offer made by a health plan to settle an alleged overpayment to the provider must be less than 90 percent of the alleged overpayment amount by the health plan. Both parties may agree to settle the disputed claim at any time, for any amount, regardless of whether an offer to settle was made or rejected.

(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 which must include:

(a) That the resolution organization review and consider all documentation submitted by both the health plan and the provider;

(b) That the resolution organization's recommendation make findings of fact;

(c) That either party may request that the resolution organization conduct an evidentiary hearing in which both sides can present evidence and examine witnesses, and for which the cost of the hearing is equally shared by the parties;

(d) That the resolution organization may not communicate ex parte with either the health plan or the provider during the dispute resolution;

(e) That the resolution organization's written recommendation, including findings of fact relating to the calculation under s. 641.513(5) for the recommended amount due for the disputed claim, include any evidence relied upon; and

(f) That ~~the issuance by~~ the resolution organization issue ~~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.

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(4) Within 30 days after receipt of the recommendation of the resolution organization, the agency shall adopt the recommendation as a final order. The final order is subject to judicial review pursuant to s. 120.68.

Section 8. Paragraph (oo) is added to subsection (1) of section 456.072, Florida Statutes, to read:

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(oo) Willfully failing to comply with s. 627.64194 or s. 641.513 with such frequency as to indicate a general business practice.

Section 9. Paragraph (tt) is added to subsection (1) of section 458.331, Florida Statutes, to read:

458.331 Grounds for disciplinary action; action by the board and department.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(tt) Willfully failing to comply with s. 627.64194 or s. 641.513 with such frequency as to indicate a general business practice.

Section 10. Paragraph (vv) is added to subsection (1) of section 459.015, Florida Statutes, to read:

459.015 Grounds for disciplinary action; action by the board and department.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(vv) Willfully failing to comply with s. 627.64194 or s. 641.513 with such frequency as to indicate a general business practice.

Section 11. Paragraph (gg) is added to subsection (1) of section 626.9541, Florida Statutes, to read:

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

(1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS.—The following are defined as unfair methods of competition and unfair or deceptive acts or practices:

(gg) *Out-of-network reimbursement.*—Willfully failing to comply with s. 627.64194 with such frequency as to indicate a general business practice.

Section 12. Section 627.64194, Florida Statutes, is created to read:

627.64194 Coverage requirements for services provided by nonparticipating providers; payment collection limitations.—

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

(a) "Emergency services" means emergency services and care, as defined in s. 641.47(8), which are provided in a facility.

(b) "Facility" means a licensed facility as defined in s. 395.002(16) and an urgent care center as defined in s. 395.002(30).

(c) "Insured" means a person who is covered under an individual or group health insurance policy delivered or issued for delivery in this state by an insurer authorized to transact business in this state.

(d) "Nonemergency services" means the services and care that are not emergency services.

(e) "Nonparticipating provider" means a provider who is not a preferred provider as defined in s. 627.6471 or a provider who is not an exclusive provider as defined in s. 627.6472. For purposes of covered emergency services under this section, a facility licensed under chapter 395 or an urgent care center defined in s. 395.002(30) is a nonparticipating provider if the facility has not contracted with an insurer to provide emergency services to its insureds at a specified rate.

(f) "Participating provider" means, for purposes of this section, a preferred provider as defined in s. 627.6471 or an exclusive provider as defined in s. 627.6472.

(2) An insurer is solely liable for payment of fees to a nonparticipating provider of covered emergency services provided to an insured in accordance with the coverage terms of the health insurance policy, and such insured is not liable for payment of fees for covered services to a nonparticipating provider of emergency services, other than applicable copayments, coinsurance, and deductibles. An insurer must provide coverage for emergency services that:

(a) May not require prior authorization.

(b) Must be provided regardless of whether the services are furnished by a participating provider or a nonparticipating provider.

(c) May impose a coinsurance amount, copayment, or limitation of benefits requirement for a nonparticipating provider only if the same requirement applies to a participating provider.

The provisions of s. 627.638 apply to this subsection.

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(3) An insurer is solely liable for payment of fees to a nonparticipating provider of covered nonemergency services provided to an insured in accordance with the coverage terms of the health insurance policy, and such insured is not liable for payment of fees to a nonparticipating provider, other than applicable copayments, coinsurance, and deductibles, for covered nonemergency services that are:

(a) Provided in a facility that has a contract for the nonemergency services with the insurer which the facility would be otherwise obligated to provide under contract with the insurer; and

(b) Provided when the insured does not have the ability and opportunity to choose a participating provider at the facility who is available to treat the insured.

The provisions of s. 627.638 apply to this subsection.

(4) An insurer must reimburse a nonparticipating provider of services under subsections (2) and (3) as specified in s. 641.513(5), reduced only by insured cost share responsibilities as specified in the health insurance policy, within the applicable timeframe provided in s. 627.6131.

(5) A nonparticipating provider of emergency services as provided in subsection (2) or a nonparticipating provider of nonemergency services as provided in subsection (3) may not be reimbursed an amount greater than the amount provided in subsection (4) and may not collect or attempt to collect from the insured, directly or indirectly, any excess amount, other than copayments, coinsurance, and deductibles. This section does not prohibit a nonparticipating provider from collecting or attempting to collect from the insured an amount due for the provision of noncovered services.

(6) Any dispute with regard to the reimbursement to the nonparticipating provider of emergency or nonemergency services as provided in subsection (4) shall be resolved in a court of competent jurisdiction or through the voluntary dispute resolution process in s. 408.7057.

Section 13. Subsection (2) of section 627.6471, Florida Statutes, is amended to read:

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

(2) Any insurer issuing a policy of health insurance in this state, which insurance includes coverage for the services of a preferred provider, must provide each policyholder and certificateholder with a current list of preferred providers and must make the list available on its website. The list must include, when applicable and reported, a listing by specialty of the names, addresses, and telephone numbers of all participating providers, including facilities, and, in the case of physicians, must also include board certifications, languages spoken, and any affiliations with participating hospitals. Information posted on the insurer's website must be updated on at

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least a calendar-month basis with additions or terminations of providers from the insurer's network or reported changes in physicians' hospital affiliations ~~for public inspection during regular business hours at the principal office of the insurer within the state~~.

Section 14. Effective upon this act becoming a law, subsection (7) is added to section 627.6471, Florida Statutes, to read:

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

(7) Any policy issued under this section after January 1, 2017, must include the following disclosure: "WARNING: LIMITED BENEFITS WILL BE PAID WHEN NONPARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a nonparticipating provider for a covered nonemergency service, benefit payments to the provider are not based upon the amount the provider charges. The basis of the payment will be determined according to your policy's out-of-network reimbursement benefit. Nonparticipating providers may bill insureds for any difference in the amount. YOU MAY BE REQUIRED TO PAY MORE THAN THE COINSURANCE OR COPAYMENT AMOUNT. Participating providers have agreed to accept discounted payments for services with no additional billing to you other than coinsurance, copayment, and deductible amounts. You may obtain further information about the providers who have contracted with your insurance plan by consulting your insurer's website or contacting your insurer or agent directly."

Section 15. Subsection (15) is added to section 627.662, Florida Statutes, to read:

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

(15) Section 627.64194, relating to coverage requirements for services provided by nonparticipating providers and payment collection limitations.

Section 16. Except as otherwise expressly provided in this act and except for this section, which shall take effect upon this act becoming a law, this act shall take effect July 1, 2016.

Approved by the Governor April 14, 2016.

Filed in Office Secretary of State April 14, 2016.

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