By Representative Byrd

A bill to be entitled

An act relating to health insurance; amending s. 636.003, F.S.; providing a definition; amending s. 636.009, F.S.; providing an additional condition upon issuance of a certificate of authority under certain circumstances; amending s. 636.016, F.S.; requiring the provision of certain information; amending s. 636.035, F.S.; clarifying limitations on certain provider arrangements; amending s. 636.038, F.S.; specifying procedures and requirements for grievance reporting and resolution; providing duties and responsibilities of the Department of Insurance; amending s. 627.638, F.S.; prohibiting refusal to pay certain benefits under certain circumstances; providing an effective date.

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

Section 1. Subsections (1)-(17) of section 636.003, Florida Statutes, are renumbered as subsections (2)-(18), and a new subsection (1) is added to said section, to read:

636.003 Definitions.--As used in this act, the term:

(1) "Adverse determination" means a coverage determination by a prepaid limited health service organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the organization's requirements for medical necessity, appropriateness, health

care setting, level of care, or effectiveness, and coverage for the requested service is therefore denied, reduced, or terminated, or an alternative benefit is applied.

Section 2. Paragraph (m) is added to subsection (1) of section 636.009, Florida Statutes, to read:

636.009 Issuance of certificate of authority; denial.--

(1) Following receipt of an application filed pursuant to s. 636.008, the department shall review such application and notify the applicant of any deficiencies contained therein. The department shall issue a certificate of authority to an applicant who has filed a completed application in conformity with s. 636.008, upon payment of the fees specified by s. 636.057 and upon the department being satisfied that the following conditions are met:

(m) In the case of a prepaid limited health services organization offering dental services, that a dental director, who is a dentist licensed under chapter 466, has been designated.

Section 3. Subsection (13) is added to section 636.016, Florida Statutes, to read:

636.016 Prepaid limited health service contracts.--For any entity licensed prior to October 1, 1993, all subscriber contracts in force at such time shall be in compliance with this section upon renewal of such contract.

(13) Each prepaid limited health service organization shall make available to each subscriber, upon request, a detailed description of the process the organization uses to authorize and refer services, determine whether services are medically necessary, determine when alternative services are applied, or examine the qualifications and credentials of

providers under contract with the organization. Such organization shall immediately report to the department any change by the organization in any such process or in the organization's definition of "medically necessary" or "alternative services."

Section 4. Subsections (2) and (3) of section 636.035, Florida Statutes, are amended to read:

636.035 Provider arrangements.--

(2) A ~~No~~ subscriber, who is in good standing, of a prepaid limited health service organization is not liable to any provider who has contracted with the prepaid limited ~~of~~ health service organization ~~care services~~ for any services covered by the prepaid limited health service organization with which the subscriber and provider have contracted.

(3) A ~~No~~ provider who has contracted with a ~~of~~ prepaid limited health care service organization ~~services~~ or any representative of such provider may not collect or attempt to collect from a subscriber, who is in good standing, any money for services covered by a prepaid limited health service organization with whom the provider has contracted, and no provider or representative of such provider may maintain any action against a subscriber of the ~~a~~ prepaid limited health service organization to collect money owed to such provider by the ~~a~~ prepaid limited health service organization.

Section 5. Section 636.038, Florida Statutes, is amended to read:

Substantial rewording of section. See s. 636.038, F.S., for present text.

636.038 Subscriber grievance reporting and resolution requirements.--

(1) For purposes of this section, organization means a prepaid limited health service organization. Each organization must have a grievance procedure available to its subscribers for the purpose of addressing complaints and grievances. Each organization must notify its subscribers that a subscriber must submit a grievance within 1 year after the date of occurrence of the action that initiated the grievance and may submit the grievance for review to the department after receiving a final disposition of the grievance through the organization's grievance process. An organization shall maintain records of all grievances and shall report annually to the department the total number of grievances handled, a categorization of the cases underlying the grievances, and the final disposition of the grievances.

(2) When an organization receives an initial complaint from a subscriber, the organization must respond to the complaint within a reasonable time after its submission. At the time of receipt of the initial complaint, the organization shall inform the subscriber that the subscriber has a right to file a written grievance at any time and that assistance in preparing the written grievance shall be provided by the organization.

(3) Each organization's grievance procedure, as required under subsection (1), must include, at a minimum:

(a) An explanation of how to pursue redress of a grievance.

(b) The names of the appropriate employees or a list of grievance departments that are responsible for implementing the organization's grievance procedure. The list must include the address and the toll-free telephone number of each

grievance department and the address of the department and its toll-free telephone hotline number.

(c) A description of the process through which a subscriber may, at any time, contact the toll-free telephone hotline of the department to inform it of the unresolved grievance, the toll-free telephone number of the department's consumer services hotline, and a description of how consumer services may assist in resolving the grievance.

(d) A process whereby the grievance manager acknowledges the grievance and investigates the grievance in order to notify the subscriber of a final decision in writing.

(e) A procedure for providing individuals who are unable to submit a written grievance with access to the grievance process, which shall include assistance by the organization in preparing the grievance and communicating back to the subscriber.

(4)(a) With respect to a grievance concerning an adverse determination, an organization shall make available to the subscriber a review of the grievance by an internal review panel; such review must be requested within 30 days after the organization's transmittal of the final determination notice of an adverse determination. A majority of the panel shall be persons who previously were not involved in the initial adverse determination. A person who previously was involved in the adverse determination may appear before the panel to present information or answer questions. The panel shall have the authority to bind the organization to the panel's decision.

(b) An organization shall ensure that a majority of the persons reviewing a grievance involving an adverse determination are providers who have appropriate expertise.

An organization shall issue a copy of the written decision of the review panel to the subscriber and to the provider, if any, who submits a grievance on behalf of a subscriber. In cases where there has been a denial of coverage of service, the reviewing provider shall not be a provider previously involved with the adverse determination.

(c) An organization shall establish written procedures for a review of an adverse determination. Review procedures shall be available to the subscriber and to a provider acting on behalf of a subscriber.

(d) In any case when the review process does not resolve a difference of opinion between the organization and the subscriber or the provider acting on behalf of the subscriber, the subscriber or the provider acting on behalf of the subscriber may submit a written grievance to the department.

(5) Except as provided in subsection (6), the organization shall resolve a grievance within 60 days after receipt of the grievance, or within a maximum of 90 days if the grievance involves the collection of information outside the service area. These time limitations are tolled if the organization has notified the subscriber, in writing, that additional information is required for proper review of the grievance and that such time limitations are tolled until such information is provided. After the organization receives the requested information, the time allowed for completion of the grievance process resumes.

(6) An organization shall establish written procedures for the expedited review of an urgent grievance. In an expedited review, an organization shall make a decision and notify the subscriber, or the provider acting on behalf of the

subscriber, as expeditiously as the subscriber's medical condition requires, but in no event more than 72 hours after receipt of the request for review. If the expedited review is a concurrent review determination, the service shall be continued without liability to the subscriber until the subscriber has been notified of the determination.

(7) The department shall investigate all reports of unresolved quality of care grievances received from review requests of subscribers whose grievances remain unresolved after the subscriber has followed the full grievance procedure of the organization.

(8)(a) The department shall advise subscribers with grievances to follow their organization's formal grievance process for resolution prior to review by the department. The subscriber may, however, submit a copy of the grievance to the department at any time during the process.

(b) Requiring completion of the organization's grievance process before the department's review does not preclude the department from investigating any complaint or grievance before the organization makes its final determination.

(9) Each organization must notify the subscriber in a final decision letter that the subscriber may request review of the organization's decision concerning the grievance by the department, if the grievance is not resolved to the satisfaction of the subscriber. The final decision letter must inform the subscriber that the request for review must be made within 365 days after receipt of the final decision letter, must explain how to initiate such a review, and must include the address and toll-free telephone number of the department.

(10) The department may impose administrative sanctions, in accordance with s. 636.048, against an organization for noncompliance with this section.

Section 6. Subsection (3) is added to section 627.638, Florida Statutes, to read:

627.638 Direct payment for hospital, medical services.--

(3) Any health insurer, preferred provider organization, exclusive provider organization, or other arrangement which authorizes treatment outside an exclusive list of providers and which provides payment of benefits to a hospital, doctor, or other person who renders covered services shall not refuse payment of benefits solely because the entity providing covered services was not a contracting provider.

Section 7. This act shall take effect October 1 of the year in which enacted.

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HOUSE SUMMARY

Requires prepaid limited health service organizations to provide descriptions of processes for authorizing and referring services, determining medical necessity, and determining application of alternative services. Specifies requirements and criteria for grievance reporting and resolution. Prohibits health care insurers or arrangements from refusing to pay benefits to noncontracting providers which provide covered services under specified circumstances. See bill for details.