

By Senator Campbell

33-614-99

1 A bill to be entitled
2 An act relating to health care; requiring
3 health maintenance organizations to provide for
4 the resolution of grievances brought by
5 subscribers; specifying the services to be
6 included in a grievance system; requiring
7 health maintenance organizations to establish
8 an informal appeal process; providing for a
9 formal internal appeal process; providing for
10 an external appeal when a subscriber is
11 dissatisfied with the results of a formal
12 appeal; providing for the grievance to be
13 reviewed by an independent utilization review
14 organization; providing for a party to appeal a
15 decision by the utilization review organization
16 to the Agency for Health Care Administration;
17 requiring that the Agency for Health Care
18 Administration enter into contracts with
19 utilization review organizations for the
20 purpose of reviewing appeals; authorizing the
21 agency to adopt rules; providing for the right
22 of a subscriber to maintain an action against a
23 health maintenance organization; providing
24 definitions; providing that a health
25 maintenance organization has the duty to
26 exercise ordinary care when making treatment
27 decisions; providing that a health maintenance
28 organization is liable for damages for harm
29 caused by failure to exercise ordinary care;
30 providing certain limitations on actions;
31 providing for a claim of liability to be

1 reviewed by an independent review organization;
2 providing for the statute of limitations to be
3 tolled under certain circumstances; requiring a
4 health maintenance organization to disclose
5 certain information to subscribers and
6 prospective subscribers; specifying additional
7 information that must be provided upon the
8 request of a subscriber or prospective
9 subscriber; requiring that a health maintenance
10 organization provide notice if a provider is
11 unavailable to render services; providing
12 requirements for the notice; requiring health
13 maintenance organizations to make certain
14 allowances in developing provider profiles and
15 measuring the performance of health care
16 providers; providing for such information to be
17 made available to the Department of Insurance,
18 the Agency for Health Care Administration, and
19 subscribers; prohibiting a health maintenance
20 organization from taking retaliatory action
21 against an employee for certain actions or
22 disclosures concerning improper patient care;
23 requiring that a health maintenance
24 organization refer a subscriber to an outside
25 provider in cases in which there is not a
26 provider within the organization's network to
27 provide a covered benefit; specifying
28 circumstances under which a health maintenance
29 organization must refer a subscriber to a
30 specialist; limiting the cost of services
31 provided by a nonparticipating provider;

1 providing for a standing referral to a
2 specialist under certain circumstances;
3 requiring that a health maintenance
4 organization provide a procedure to allow a
5 subscriber to obtain drugs that are not
6 included in the organization's drug formulary;
7 prohibiting a health maintenance organization
8 from arbitrarily interfering with certain
9 decisions of a health care provider;
10 prohibiting a health maintenance organization
11 from discriminating against a subscriber based
12 on race, national origin, and other factors;
13 requiring health maintenance organizations to
14 establish a policy governing the termination of
15 health care providers; providing requirements
16 for the policy; authorizing the Insurance
17 Commissioner to suspend or revoke a certificate
18 of authority upon finding certain violations by
19 a health maintenance organization; providing
20 for civil penalties; creating the "Access to
21 Emergency Medical Services Act"; providing
22 findings and purpose; requiring a health plan
23 that provides coverage for emergency services
24 to cover emergency services furnished to a
25 subscriber under specified circumstances;
26 requiring the health plan to promptly pay for
27 services; prohibiting a health plan from
28 imposing certain types of cost-sharing;
29 providing that a health plan may impose a
30 reasonable copayment; providing requirements
31 for a health plan with respect to providing

1 prior authorization; specifying circumstances
2 under which a health plan is deemed to have
3 approved a request for prior authorization for
4 certain services; prohibiting a health plan
5 from subsequently denying or reducing payment
6 for items or services; requiring that a health
7 plan include certain information in educational
8 materials; providing civil penalties; requiring
9 that the Director of Health Care Administration
10 take certain factors into consideration in
11 imposing a civil penalty; requiring the Agency
12 for Health Care Administration to adopt rules;
13 providing definitions; repealing s. 641.513,
14 F.S., relating to requirements for providing
15 emergency services and care; amending ss.
16 408.706, 627.419, F.S.; creating s. 641.3151,
17 F.S.; deleting provisions governing recruitment
18 and retention of health care providers in a
19 community health purchasing alliance district;
20 providing free choice to subscribers to certain
21 health care plans, and to persons covered under
22 certain health insurance policies or contracts,
23 in the selection of specified health care
24 providers; prohibiting coercion of provider
25 selection; specifying conditions under which
26 any health care provider must be permitted to
27 provide services under a health care plan or
28 health insurance policy or contract; amending
29 s. 627.6577, F.S.; creating ss. 636.0165,
30 641.3157, F.S.; providing for freedom of choice
31 for dental patients; providing limitations;

1 providing for civil penalties; providing
2 application; amending s. 641.28, F.S.; limiting
3 the parties that may recover attorney's fees
4 and court costs in an action to enforce the
5 terms of a health maintenance contract;
6 providing an effective date.
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8 Be It Enacted by the Legislature of the State of Florida:
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10 Section 1. Managed care bill of rights.--

11 (1) GENERAL PROVISIONS.--

12 (a) Each health maintenance organization shall
13 establish a system to provide for the presentation and
14 resolution of grievances brought by a subscriber or brought by
15 a representative or provider acting on behalf of a subscriber
16 and with the subscriber's consent. Such grievance may include,
17 but need not be limited to, complaints regarding referral to a
18 specialist, quality of care, choice and accessibility of
19 providers, network adequacy, termination of coverage, denial
20 of approval for coverage, or other limitations in the receipt
21 of health care services. Each system for resolving grievances
22 must be in writing, given to each subscriber and each
23 provider, and incorporated into the health maintenance
24 contract. Each grievance system must include:

25 1. The provision of the telephone numbers and business
26 addresses of each employee of the health maintenance
27 organization who is responsible for grievance resolution.

28 2. A system to record and document the status of all
29 grievances, which must be maintained for at least 3 years.

30 3. The services of a representative to assist
31 subscribers with grievance procedures upon request.

1 4. Establishment of a specified response time for the
2 resolution of grievances, which may not exceed the time limits
3 set forth in subsection (2) or subsection (3).

4 5. A detailed description of how grievances are
5 processed and resolved.

6 6. A requirement that the determination must set forth
7 the basis for any denial and include specific information
8 concerning appeal rights, procedures for an independent
9 external appeal, to whom and where to address any appeal, and
10 the applicable deadlines for appeal.

11 (b) If a health maintenance organization fails to
12 comply with any of the deadlines at any stage of the
13 organization's internal review process, or waives the
14 completion of the process, the subscriber, or the subscriber's
15 representative or provider, is relieved of the obligation to
16 complete the process and may proceed directly to the external
17 appeals process set forth in subsection (4).

18 (c) All time limits set forth in subsections (2), (3),
19 and (4) must include an additional 3 days for mailing
20 following the date of the postmark. A decision with respect to
21 urgent or emergency care must also be communicated by
22 telephone.

23 (2) INFORMAL APPEAL PROCESS.--

24 (a) Each health maintenance organization must
25 establish and maintain an informal internal appeal process
26 whereby any subscriber, or representative or provider acting
27 on behalf of a subscriber and with the subscriber's consent,
28 who has a grievance concerning any of the actions by the
29 health maintenance organization as described in paragraph
30 (1)(a) or related thereto, shall be given the opportunity to
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1 discuss and appeal that determination to the medical director
2 or the physician designee who rendered the determination.

3 (b) An informal appeal under this subsection must be
4 concluded as soon as possible in accordance with the medical
5 exigencies of the case. If the appeal is from a determination
6 regarding urgent or emergency care, the appeal must be
7 resolved within 72 hours after the initial contact by the
8 subscriber or the subscriber's representative or provider. In
9 the case of all other appeals, the appeal must be resolved
10 within 5 business days after the initial contact by the
11 subscriber or the subscriber's representative or provider. If
12 an appeal under this subsection is not resolved to the
13 satisfaction of the subscriber, the health maintenance
14 organization shall provide to the subscriber, the subscriber's
15 provider, and the subscriber's representative, if applicable,
16 a written explanation of the basis for the decision on the
17 grievance and notification of the right to proceed to a formal
18 appeals process under subsection (3). The notice must be
19 postmarked within the applicable time limits prescribed in
20 this paragraph.

21 (3) FORMAL INTERNAL APPEAL PROCESS.--

22 (a) Each health maintenance organization shall
23 establish and maintain a formal internal appeal process
24 whereby any subscriber, or representative or provider acting
25 on behalf of a subscriber and with the subscriber's consent,
26 who is dissatisfied with the results of the informal appeal
27 under subsection (2) may pursue the subscriber's appeal before
28 a panel of physicians selected by the health maintenance
29 organization who have not been involved in the determination
30 being appealed.

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1 (b) The members of the formal appeal panel must
2 include consultant practitioners who are trained in or who
3 practice in the same specialty that would typically manage the
4 case being appealed or must include other licensed health care
5 professionals who are mutually agreed upon by the parties. The
6 consulting practitioners or professionals may not have been
7 involved in the determination being appealed. The consulting
8 practitioners or professionals must participate in the panel's
9 review of the case at the request of the subscriber or the
10 subscriber's representative or provider.

11 (c) Within 10 business days after an appeal is filed
12 under this subsection, the health maintenance organization
13 must acknowledge in writing to the subscriber, or the
14 subscriber's representative or provider, receipt of the
15 appeal.

16 (d) A formal appeal under this subsection must be
17 concluded as soon as possible. If the appeal is from a
18 determination regarding urgent or emergency care, the appeal
19 must be resolved within 72 hours after the filing of the
20 formal appeal. In the case of all other appeals, the appeal
21 must be resolved within 5 business days after the filing of
22 the formal appeal.

23 (e) The health maintenance organization may extend the
24 review for up to an additional 20 days if it can demonstrate
25 reasonable cause for the delay which is beyond its control and
26 if the health maintenance organization provides a written
27 progress report and explanation for the delay to the Agency
28 for Health Care Administration. The health maintenance
29 organization must notify the subscriber, and where applicable
30 the subscriber's representative or provider, of the delay
31 prior to the end of the time limitation in paragraph (d).

1 (f) If a formal appeal under this subsection is
2 denied, the health maintenance organization must notify the
3 subscriber, and where applicable the subscriber's avocate or
4 provider, of the denial. The notice must be in writing, set
5 forth the basis for the denial, and include notice of the
6 subscriber's right to proceed to an independent external
7 appeal under subsection (4). The notice must include specific
8 instruction on how and where the subscriber may file for an
9 external appeal of the denial.

10 (4) EXTERNAL APPEAL PROCESS.--

11 (a) If a subscriber, or a subscriber's representative
12 or provider acting on behalf of a subscriber and with the
13 subscriber's consent, is dissatisfied with the results of a
14 formal internal appeal under subsection (3), the subscriber,
15 or the subscriber's representative or provider, may pursue an
16 appeal to the Agency for Health Care Administration for
17 referral to an independent utilization review organization.

18 (b) To initiate an external appeal, the subscriber, or
19 the subscriber's representative or provider, must file a
20 written request with the Agency for Health Care
21 Administration. The appeal must be filed within 30 business
22 days after receipt of the written decision of the formal
23 internal appeal under subsection (3). The agency may extend
24 for an additional 30 days the time for filing the appeal upon
25 a showing of good cause. A delay under this paragraph does not
26 affect a subscriber's right to proceed under any other
27 applicable state or federal law.

28 (c) Within 5 days after receiving a request for an
29 external appeal, the Agency for Health Care Administration
30 shall determine whether the procedural requirements described
31 in this section have been satisfied. If those requirements

1 have been satisfied, the agency shall assign the appeal to an
2 independent utilization review organization for review.

3 (d) The independent utilization review organization
4 shall assign the case for a full review within 5 days after
5 receiving an appeal under paragraph (c) and shall determine
6 whether, as a result of the health maintenance organization's
7 determination, the subscriber was deprived of any of the
8 rights described in paragraph (1)(a). The independent
9 utilization review organization shall consider all pertinent
10 medical records; reports submitted by the consulting physician
11 and other documents submitted by the parties; any applicable
12 and generally accepted practice guidelines developed by the
13 Federal Government, national or professional medical
14 societies, boards, or associations; and any applicable
15 clinical protocols or practice guidelines developed by the
16 health maintenance organization. The independent utilization
17 review organization shall refer all cases for review to a
18 consultant physician or other health care professional in the
19 same speciality or area of practice who manages the type of
20 treatment that is the subject of the appeal. All final
21 recommendations of the independent utilization review
22 organization are subject to approval by the medical director
23 of the independent utilization review organization or by an
24 alternate physician if the medical director has a conflict of
25 interest.

26 (e) The independent utilization review organization
27 shall issue its recommended decision to the Agency for Health
28 Care Administration and provide copies to the subscriber, the
29 subscriber's representative or provider if applicable, and the
30 health maintenance organization. The decision must be issued
31 as soon as possible in accordance with the medical exigencies

1 of the case which, except as provided in this paragraph, may
2 not exceed 30 business days after receipt of all documentation
3 necessary to complete the review. However, the independent
4 utilization review organization may extend its review for a
5 reasonable period due to circumstances beyond the control of
6 all parties to the action, and must advise the subscriber, the
7 subscriber's representative or provider if applicable, the
8 health maintenance organization, and the Agency for Health
9 Care Administration in a formal statement explaining the
10 delay. If any party fails to provide documentation sought by
11 the independent utilization review organization which is
12 within that party's control, the party waives its position
13 with respect to the review.

14 (f) If the independent utilization review organization
15 determines that the subscriber was deprived of medically
16 necessary covered services, the independent utilization review
17 organization shall, in its recommended decision, advise all
18 parties of the appropriate covered health care services the
19 subscriber is entitled to receive. In all cases, the
20 independent utilization review organization shall advise all
21 parties of the basis of its recommended decision.

22 (g) Any party may appeal the recommended decision to
23 the Agency for Health Care Administration, with a copy of the
24 appeal to all other parties, within 20 days after the date the
25 decision is issued. If a decision is appealed, any other party
26 may file with the Agency for Health Care Administration its
27 position on the issues raised in the appeal, with copies to
28 all other parties, within 20 days after receipt of the initial
29 appeal.

30 (h) The Agency for Health Care Administration shall
31 issue its decision within 30 days after completion of the

1 record in the case. The decision must include an explanation
2 of the basis supporting the decision. The final decision of
3 the Agency for Health Care Administration is binding on the
4 health maintenance organization.

5 (i) The Agency for Health Care Administration shall
6 issue a report 30 days after the end of each calendar quarter
7 which summarizes all appeals and final decisions. The report
8 must maintain the confidentiality of patient information and
9 shall be provided to the Governor, the Insurance Commissioner,
10 and the appropriate substantive committees of the Senate and
11 the House of Representatives. The quarterly reports shall be
12 available to the public.

13 (5) INDEPENDENT UTILIZATION REVIEW ORGANIZATIONS.--

14 (a) The Agency for Health Care Administration shall
15 enter into contracts with as many independent utilization
16 review organizations throughout the state as the agency deems
17 necessary to conduct external appeals under this section. Each
18 independent utilization review organization must be
19 independent of any insurance carrier, and a physician may not
20 be assigned to hear any appeal that would constitute a
21 conflict of interest. As part of its contract, each
22 independent utilization review organization shall submit to
23 the Agency for Health Care Administration a list of the
24 organization's physician reviewers and the health maintenance
25 organizations, health insurers, health providers, and other
26 health care providers with whom the organization has a
27 contractual or other business arrangement. Each organization
28 shall update the list of its business relationships as
29 changes, additions, or deletions occur.

30 (b) Upon any request for an external appeal, the
31 Agency for Health Care Administration shall assign the appeal

1 to an approved independent utilization review organization on
2 a random basis. The agency may deny an assignment if, in its
3 determination, the assignment would result in a conflict of
4 interest or would otherwise create the appearance of
5 impropriety.

6 (c) The Agency for Health Care Administration shall
7 adopt rules to administer this section.

8 Section 2. Right of subscribers to maintain an action
9 against a health maintenance organization.--

10 (1) DEFINITIONS.--As used in this section, the term:

11 (a) "Appropriate and medically necessary" means the
12 standard for health care services as determined by physicians
13 and health care providers in accordance with the prevailing
14 practices and standards of the medical profession and
15 community.

16 (b) "Health care treatment decision" means a
17 determination made when medical services are actually provided
18 by the health care plan and a decision that affects the
19 quality of the diagnosis, care, or treatment provided to the
20 plans subscribers.

21 (c) "Ordinary care" means, in the case of a health
22 maintenance organization, that degree of care that a health
23 maintenance organization of ordinary prudence would use under
24 the same or similar circumstances. In the case of a person who
25 is an employee, agent, or representative of a health
26 maintenance organization, the term "ordinary care" means that
27 degree of care that a person of ordinary prudence in the same
28 profession, specialty, or area of practice would use in the
29 same or similar circumstances.

30 (2) APPLICATION.--

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1 (a) A health maintenance organization has the duty to
2 exercise ordinary care when making health care treatment
3 decisions and is liable for damages for harm to a subscriber
4 which is proximately caused by its failure to exercise such
5 ordinary care.

6 (b) A health maintenance organization is also liable
7 for damages for harm to a subscriber which are proximately
8 caused by the health care treatment decisions made by its:

- 9 1. Employees;
10 2. Agents; or
11 3. Representatives,

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13 who act on behalf of the health maintenance organization and
14 over whom it has the right to exercise influence or control,
15 whose actions or failure to act result in the failure to
16 exercise ordinary care.

17 (c) It is a defense to any action asserted against a
18 health maintenance organization that:

19 1. Neither the health maintenance organization or any
20 employee, agent, or representative for whose conduct such
21 health maintenance organization is liable under paragraph (b)
22 controlled, influenced, or participated in the health care
23 treatment decision; and

24 2. The health maintenance organization did not deny or
25 delay payment for any treatment prescribed or recommended by a
26 health care provider to the subscriber.

27 (d) The standards in paragraphs (a) and (b) do not
28 create an obligation on the part of the health maintenance
29 organization to provide treatment to a subscriber which is not
30 covered by the health care plan.

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1 (e) This section does not create any liability on the
2 part of an employer, an employer group-purchasing
3 organization, or a pharmacy licensed by the Board of Pharmacy
4 which purchases coverage or assumes risk on behalf of its
5 employees.

6 (f) A health maintenance organization may not remove a
7 physician or health care provider from its plan or refuse to
8 renew the physician or health care provider with its plan for
9 advocating on behalf of a subscriber for appropriate and
10 medically necessary health care for the subscriber.

11 (g) A health maintenance organization may not enter
12 into a contract with a physician, hospital, or other health
13 care provider or pharmaceutical company which includes an
14 indemnification or hold-harmless clause for the acts or
15 conduct of the health maintenance organization. Any such
16 indemnification or hold-harmless clause in an existing
17 contract is void.

18 (h) Any law of this state prohibiting a health
19 maintenance organization from practicing medicine or being
20 licensed to practice medicine may not be asserted as a defense
21 by a health maintenance organization in an action brought
22 against it pursuant to this section or any other law.

23 (i) In an action against a health maintenance
24 organization, a finding that a physician or other health care
25 provider is an employee, agent, or representative of such
26 health maintenance organization may not be based solely on
27 proof that such person's name appears in a listing of approved
28 physicians or health care providers made available to
29 subscribers under a health care plan.

30 (j) This section does not apply to workers'
31 compensation insurance coverage.

1 (3) LIMITATIONS ON ACTIONS.--
2 (a) A person may not maintain an action under this
3 section against a health maintenance organization that is
4 required to comply with the appeal process provided under
5 section 1 of this act unless the subscriber, or the
6 subscriber's representative:
7 1. Has exhausted the appeals and review applicable
8 under the appeal process; or
9 2. Before instituting the action:
10 a. Gives written notice of the claim as provided by
11 paragraph (b); and
12 b. Agrees to submit the claim to a review by an
13 independent review organization as required by paragraph (c).
14 (b) Notice of intent to maintain an action must be
15 delivered or mailed to the health maintenance organization
16 against whom the action is made not later than the 30th day
17 before the date the claim is filed.
18 (c) The subscriber, or the subscriber's
19 representative, must submit the claim to a review by an
20 independent review organization if the health maintenance
21 organization against whom the claim is made requests the
22 review not later than the 14th day after the date notice under
23 paragraph (b) is received by the health maintenance
24 organization. If the health maintenance organization does not
25 request the review within the period specified by this
26 paragraph, the subscriber, or the subscriber's representative,
27 is not required to submit the claim to independent review
28 before maintaining the action.
29 (d) Subject to paragraph (e), if the subscriber has
30 not complied with paragraph (a), an action under this section
31 may not be dismissed by the court, but the court may, in its

1 discretion, order the parties to submit to an independent
2 review or mediation or other nonbinding alternative dispute
3 resolution and may abate the action for a period not to exceed
4 30 days for such purposes. Such orders of the court are the
5 sole remedies available to a party complaining of a
6 subscriber's failure to comply with paragraph (a).

7 (e) The subscriber is not required to comply with
8 paragraph (c) and an order of abatement or other order
9 pursuant to paragraph (d) for failure to comply may not be
10 imposed if the subscriber has filed a pleading alleging in
11 substance that:

12 1. Harm to the subscriber has already occurred because
13 of the conduct of the health maintenance organization or
14 because of an act or omission of an employee, agent, or
15 representative of such organization for whose conduct it is
16 liable; and

17 2. The review would not be beneficial to the
18 subscriber.

19 (f) If the court, upon motion by the defendant health
20 maintenance organization, finds after hearing that such
21 pleading was not made in good faith, the court may enter an
22 order pursuant to paragraph (d).

23 (g) If the subscriber, or the subscriber's
24 representative, seeks to exhaust the appeals and review or
25 provides notice, as required by paragraph (a), before the
26 statute of limitations applicable to a claim against a health
27 maintenance organization has expired, the limitations period
28 is tolled until the later of:

29 1. The 30th day after the date the subscriber, or the
30 subscriber's representative, has exhausted the process for
31 appeals and review applicable under the appeals process; or

1 2. The 40th day after the date the subscriber, or the
2 subscriber's representative, gives notice under paragraph (b).

3 (h) This section does not prohibit a subscriber from
4 pursuing other appropriate remedies, including injunctive
5 relief, a declaratory judgment, or other relief available
6 under law, if the requirement of exhausting the process for
7 appeal and review places the subscriber's health in serious
8 jeopardy.

9 Section 3. Disclosure of information.--This section
10 applies to all health maintenance contracts entered into by a
11 health maintenance organization with a subscriber or group of
12 subscribers.

13 (1) Each health maintenance organization shall supply
14 written disclosure information to each subscriber, and upon
15 request to each prospective subscriber prior to enrollment,
16 which may be incorporated into the health maintenance
17 contract. If any inconsistency exists between a separate
18 written disclosure statement and the health maintenance
19 contract, the terms of the health maintenance contract shall
20 control. The information to be disclosed must include at least
21 the following:

22 (a) A description of coverage provisions; health care
23 benefits; benefit maximums, including benefit limitations; and
24 exclusions of coverage, including the definition of medical
25 necessity used in determining whether benefits will be
26 covered.

27 (b) A description of requirements for prior
28 authorization or other requirements for treatments and
29 services.

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1 (c) A description of the utilization review policies
2 and procedures used by the health maintenance organization,
3 including:
4 1. The circumstances under which utilization review
5 will be undertaken;
6 2. The toll-free telephone number of the utilization
7 review agent;
8 3. The timeframes under which utilization review
9 decisions must be made for prospective, retrospective, and
10 concurrent decisions;
11 4. The right to reconsideration;
12 5. The right to an appeal, including the expedited and
13 standard appeals processes and the timeframes for such
14 appeals;
15 6. The right to designate a representative;
16 7. A notice that all denials of claims will be made by
17 qualified health care providers and that all notices of
18 denials will include information about the basis of the
19 decision;
20 8. A notice of the right to an appeal, together with a
21 description of the appeal process established under section 1
22 of this act; and
23 9. Any further appeal rights, if any.
24 (d) A description prepared annually of the types of
25 methodologies the health maintenance organization uses to
26 reimburse health care providers, specifying the type of
27 methodology that is used to reimburse particular types of
28 providers or reimburse for the provision of particular types
29 of services. However, this paragraph does not require
30 disclosure of individual contracts or the specific details of
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1 any financial arrangement between a health maintenance
2 organization and a health care provider.

3 (e) An explanation of a subscriber's financial
4 responsibility for payment of premiums, coinsurance,
5 copayments, deductibles, and any other charges; annual limits
6 on a subscriber's financial responsibility; caps on payments
7 for covered services; and financial responsibility for
8 noncovered health care procedures, treatments, or services.

9 (f) An explanation, where applicable, of a
10 subscriber's financial responsibility for payment when
11 services are provided by a health care provider who is not
12 part of the health maintenance organization's network of
13 providers or by any provider without required authorization.

14 (g) A description of the grievance procedures to be
15 used to resolve disputes between the health maintenance
16 organization and a subscriber, including:

17 1. The right to file a grievance regarding any dispute
18 between the health maintenance organization and a subscriber;

19 2. The right to file a grievance orally when the
20 dispute is about referrals or covered benefits;

21 3. The toll-free telephone number that subscribers may
22 use to file an oral grievance;

23 4. The timeframes and circumstances for expedited and
24 standard grievances;

25 5. The right to appeal a grievance determination and
26 the procedures for filing such an appeal;

27 6. The timeframes and circumstances for expedited and
28 standard appeals;

29 7. The right to designate a representative; and

30 8. A notice that all disputes involving clinical
31 decisions will be made by qualified health care providers and

1 that all notices of determination will include information
2 about the basis of the decision and further appeal rights, if
3 any.

4 (h) A description of the procedure for obtaining
5 emergency services. Such description must include a definition
6 of emergency services, a notice that emergency services are
7 not subject to prior approval, and a description of the
8 subscriber's financial and other responsibilities regarding
9 obtaining such services, including the subscriber's financial
10 responsibilities, if any, when such services are received
11 outside the service area of the health maintenance
12 organization.

13 (i) Where applicable, a description of procedures for
14 subscribers to select and access the health maintenance
15 organization's primary and specialty care providers, including
16 notice of how to determine whether a participating provider is
17 accepting new patients.

18 (j) Where applicable, a description of the procedures
19 for changing primary and specialty care providers within the
20 health maintenance organization's network of providers.

21 (k) Where applicable, notice that a subscriber may
22 obtain a referral to a health care provider outside of the
23 organization's network when the health maintenance
24 organization does not have a health care provider in the
25 network with appropriate training and experience to meet the
26 particular health care needs of the subscriber, and the
27 procedure by which the subscriber may obtain such referral.

28 (l) Where applicable, notice that a subscriber with a
29 condition that requires ongoing care from a specialist may
30 request a standing referral to such a specialist and the
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1 procedure for requesting and obtaining such a standing
2 referral.

3 (m) Where applicable, notice that a subscriber with a
4 life-threatening condition or disease, or a degenerative and
5 disabling condition or disease, either of which requires
6 specialized medical care over a prolonged period, may request
7 a specialist responsible for providing or coordinating the
8 subscriber's medical care, and the procedure for requesting
9 and obtaining such a specialist.

10 (n) Where applicable, notice that a subscriber with a
11 life-threatening condition or disease, or a degenerative and
12 disabling condition or disease, either of which requires
13 specialized medical care over a prolonged period, may request
14 access to a specialty care center, and the procedure by which
15 such access may be obtained.

16 (o) A description of how the health maintenance
17 organization addresses the needs of non-English-speaking
18 subscribers.

19 (p) Notice of all appropriate mailing addresses and
20 telephone numbers to be used by subscribers seeking
21 information or authorization.

22 (q) Where applicable, a listing by specialty, which
23 may be in a separate document that is updated annually, of the
24 name, address, and telephone number of all participating
25 health care providers, including facilities, and the board
26 certification number of physicians.

27 (r) A description of the mechanisms by which
28 subscribers may participate in developing policies of the
29 health maintenance organization.

30 (2) Each health maintenance organization, upon the
31 request of a subscriber or prospective subscriber shall:

1 (a) Provide a list of the names, business addresses,
2 and official positions of the board of directors, officers,
3 and members of the health maintenance organization.

4 (b) Provide a copy of the most recent annual certified
5 financial statement of the health maintenance organization,
6 including its balance sheet and summary of receipts and
7 disbursements prepared by a certified public accountant.

8 (c) Provide a copy of the most recent health
9 maintenance contracts.

10 (d) Provide information relating to consumer
11 complaints compiled under section 408.10, Florida Statutes.

12 (e) Provide the procedures for protecting the
13 confidentiality of medical records and other subscriber
14 information.

15 (f) Where applicable, allow subscribers and
16 prospective subscribers to inspect drug formularies used by
17 the health maintenance organization and disclose whether
18 individual drugs are included or excluded from coverage.

19 (g) Provide a written description of the
20 organizational arrangements and ongoing procedures of the
21 health maintenance organization's quality assurance program,
22 if any.

23 (h) Provide a description of the procedures followed
24 by the health maintenance organization in making decisions
25 about the experimental or investigational nature of individual
26 drugs, medical devices, or treatments in clinical trials.

27 (i) Provide individual health care provider's
28 affiliations with participating hospitals, if any.

29 (j) Upon written request, provide specific written
30 clinical review criteria relating to a particular condition or
31 disease and, where appropriate, other clinical information

1 that the health maintenance organization considers in its
2 utilization review and a description of how it is used in the
3 utilization review process. However, to the extent such
4 information is proprietary to the health maintenance
5 organization, the information may only be used for the
6 purposes of assisting the subscriber or prospective subscriber
7 in evaluating the covered services provided by the
8 organization.

9 (k) Where applicable, provide the written application
10 procedures and minimum qualification requirements for a health
11 care provider to be considered by the health maintenance
12 organization for participation in the organization's network
13 of providers.

14 (l) Disclose any other information required by rule of
15 the Department of Insurance or the Agency for Health Care
16 Administration.

17 (3) This section does not prevent a health maintenance
18 organization from changing or updating the materials that are
19 made available to subscribers.

20 (4) As to any program where the subscriber must select
21 a primary care provider, if a participating primary care
22 provider becomes unavailable to provide services to a
23 subscriber, the health maintenance organization shall provide
24 written notice within 15 days after the date the organization
25 becomes aware of such unavailability to each subscriber who
26 has chosen the provider as his or her primary care provider.
27 If a subscriber is enrolled in a managed care plan and is
28 undergoing an ongoing course of treatment with any other
29 participating provider who becomes unavailable to continue to
30 provide services to such subscriber, and the health
31 maintenance organization is aware of such ongoing course of

1 treatment, the organization shall provide written notice
2 within 15 days after the date the organization becomes aware
3 of such unavailability to such subscriber. Each notice must
4 also describe the procedures for continuing care and for
5 choosing an alternative provider.

6 Section 4. Provider profiles.--Each health maintenance
7 organization, in developing provider profiles or otherwise
8 measuring the performance of health care providers, shall:

9 (1) Make allowances for the severity of illness or
10 condition of the patient mix;

11 (2) Make allowances for patients with multiple
12 illnesses or conditions;

13 (3) Make available to the Department of Insurance and
14 the Agency for Health Care Administration documentation of how
15 the health maintenance organization makes such allowances; and

16 (4) Inform subscribers and participating providers,
17 upon request, how the health maintenance organization
18 considers patient mix when profiling or evaluating providers.

19 Section 5. Retaliatory action prohibited.--A health
20 maintenance organization may not take any retaliatory action
21 against an employee because the employee does any the
22 following:

23 (1) Discloses, or threatens to disclose, to a
24 supervisor or any agency an activity, policy, or practice of
25 the health maintenance organization or another employer with
26 whom there is a business relationship which the employee
27 reasonably believes violates a law or rule, or, in the case of
28 an employee who is a licensed or certified health care
29 provider, reasonably believes constitutes improper quality of
30 patient care.

31

1 (2) Provides information to, or testifies before, any
2 agency conducting an investigation, hearing, or inquiry into
3 any violation of law or rule by a health maintenance
4 organization or another employer with whom there is a business
5 relationship, or, in the case of an employee who is a licensed
6 or certified health care provider, provides information to, or
7 testifies before, any agency conducting an investigation,
8 hearing, or inquiry into the quality of patient care.

9 (3) Objects to, or refuses to participate in any
10 activity, policy, or practice that the employee reasonably
11 believes:

12 (a) Violates a law or rule, or, if the employee is a
13 licensed or certified health care provider, constitutes
14 improper quality of patient care;

15 (b) Is fraudulent or criminal; or

16 (c) Is incompatible with a clear mandate of public
17 policy concerning the public health, safety, or welfare or
18 protection of the environment.

19 Section 6. Referrals to another provider.--In any case
20 in which there is not a health care provider within the health
21 maintenance organization's provider network to provide a
22 covered benefit, the health maintenance organization shall
23 arrange for a referral to a provider with the necessary
24 expertise and ensure that the subscriber obtains the covered
25 benefit at a cost that does not exceed the subscriber's cost
26 if the benefit were obtained from a participating provider.

27 Section 7. Treatment by a specialist without a
28 referral.--

29 (1)(a) A health maintenance organization shall provide
30 a procedure by which a new subscriber upon enrollment in a
31 managed care plan, or a subscriber in a managed care plan upon

1 diagnosis, who has a life-threatening condition or disease, or
2 a degenerative and disabling condition or disease, either of
3 which requires specialized medical care over a prolonged
4 period, may receive a referral to a specialist with expertise
5 in treating the life-threatening or degenerative and disabling
6 disease or condition who shall be responsible for and capable
7 of providing and coordinating the subscriber's primary and
8 specialty care.

9 (b) If the health maintenance organization, or the
10 primary care provider in consultation with the health
11 maintenance organization and the specialist, determines that
12 the subscriber's care would most appropriately be coordinated
13 by such a specialist, the health maintenance organization
14 shall refer the subscriber to such specialist. A health
15 maintenance organization is not required to permit a
16 subscriber to elect to have a nonparticipating specialist,
17 except pursuant to this section. Such referral shall be
18 pursuant to a treatment plan approved by the health
19 maintenance organization, in consultation with the primary
20 care provider, if appropriate, the specialist, and the
21 subscriber or the subscriber's representative. Such specialist
22 shall be permitted to treat the subscriber without a referral
23 from the subscriber's primary care provider and may authorize
24 the referrals, procedures, tests, and other medical services
25 that the subscriber's primary care provider would otherwise be
26 permitted to provide or authorize, subject to the terms of the
27 treatment plan.

28 (c) If a health maintenance organization refers a
29 subscriber to a nonparticipating provider, services provided
30 under the approved treatment plan shall be provided at no
31 additional cost to the subscriber beyond that which the

1 subscriber would otherwise pay for services received within
2 the network.

3 (2) In addition to the procedures provided under
4 subsection (1), a health maintenance organization that does
5 not allow direct access to all specialists shall establish and
6 implement a procedure by which a subscriber may receive a
7 standing referral to a specialist. The procedure shall provide
8 for a standing referral to a specialist if a primary care
9 provider determines, in consultation with a specialist, that a
10 subscriber needs continuing care from a specialist. The
11 referral shall be made pursuant to a treatment plan approved
12 by the health maintenance organization, in consultation with
13 the primary care provider, the specialist, and the subscriber.
14 The treatment plan may limit the number of visits to the
15 specialist, limit the period that the visits are authorized,
16 or require that the specialist provide the primary care
17 provider with regular reports on the health care provided to
18 the subscriber.

19 Section 8. Prescription drug formulary.--If a health
20 maintenance organization uses a formulary for prescription
21 drugs, the health maintenance organization must include a
22 written procedure whereby a subscriber may obtain, without
23 penalty and in a timely fashion, specific drugs and
24 medications that are not included in the formulary when:

25 (1) The formulary's equivalent has been ineffective in
26 the treatment of the subscriber's disease or condition; or

27 (2) The formulary's drug causes, or is reasonably
28 expected to cause, adverse or harmful reactions in the
29 subscriber.

30 Section 9. Arbitrary limitations or conditions for the
31 provision of services prohibited.--

1 (1) A health maintenance organization may not
2 arbitrarily interfere with or alter the decision of the health
3 care provider regarding the manner or setting in which
4 particular services are delivered if the services are
5 medically necessary or appropriate for treatment or diagnosis
6 to the extent that such treatment or diagnosis is otherwise a
7 covered benefit.

8 (2) Subsection (1) does not prohibit a health
9 maintenance organization from limiting the delivery of
10 services to one or more health care providers within a network
11 of such providers.

12 (3) As used in subsection (1), the term "medically
13 necessary or appropriate" means a service or benefit that is
14 consistent with generally accepted principles of professional
15 medical practice.

16 Section 10. Discrimination prohibited.--

17 (1) Subject to subsection (2), a health maintenance
18 organization, with respect to health insurance coverage, may
19 not discriminate against a subscriber in the delivery of
20 health care services consistent with the benefits covered
21 under the health maintenance contract, or coverage required by
22 law, based on race, color, ethnicity, national origin,
23 religion, sex, age, mental or physical disability, sexual
24 orientation, genetic information, or source of payment.

25 (2) Subsection (1) does not apply to eligibility for
26 coverage; the offering or guaranteeing of an offer of
27 coverage; the application of an exclusion for a preexisting
28 condition, consistent with applicable law; or premiums charged
29 for coverage under the health maintenance contract.

30 Section 11. Termination of a provider.--Each health
31 maintenance organization shall establish a policy governing

1 the termination of providers. The policy must assure the
2 continued coverage of services at the contract price by a
3 terminated provider for up to 120 calendar days in cases where
4 it is medically necessary for the subscriber to continue
5 treatment with the terminated provider. The case of the
6 pregnancy of a subscriber constitutes medical necessity and
7 coverage of services by the terminated provider shall continue
8 to the postpartum evaluation of the subscriber, up to 6 weeks
9 after delivery. The policy must clearly state that the
10 determination as to the medical necessity of a subscriber's
11 continued treatment with a terminated provider is subject to
12 the appeal procedures set forth in section 1 of this act.

13 Section 12. (1) The Insurance Commissioner may
14 suspend or revoke a certificate of authority issued under part
15 I of chapter 641, Florida Statutes, or deny an application for
16 a certificate of authority, if the commissioner finds that:

17 (a) The health maintenance organization is operating
18 significantly in contravention of its basic organizational
19 document, unless amendments to the basic organizational
20 document or other submissions that are consistent with the
21 operations of the organization have been filed with and
22 approved by the commissioner.

23 (b) The health maintenance organization does not
24 provide or arrange for basic health care services.

25 (c) The health maintenance organization is unable to
26 fulfill its obligations to furnish health care coverage.

27 (d) The health maintenance organization is no longer
28 financially responsible and may reasonably be expected to be
29 unable to meet its obligations to subscribers or prospective
30 subscribers.

31

1 (e) The health maintenance organization has failed to
2 correct, within the time prescribed, any deficiency occurring
3 due to the impairment of the prescribed minimum net worth of
4 the health maintenance organization.

5 (f) The health maintenance organization has failed to
6 implement the grievance procedures and appeal process required
7 by section 1 of this act in a reasonable manner to resolve
8 valid complaints.

9 (g) The health maintenance organization, or a person
10 acting on behalf of the organization, has intentionally
11 advertised or merchandised the services of the organization in
12 an untrue, a misrepresentative, a misleading, a deceptive, or
13 an unfair manner.

14 (h) The continued operation of the health maintenance
15 organization would be hazardous to the subscribers of the
16 organization.

17 (i) The health maintenance organization has otherwise
18 failed to substantially comply with part I of chapter 641,
19 Florida Statutes.

20 (2) The Insurance Commissioner may impose a civil
21 penalty of not more than \$25,000 against a health maintenance
22 organization for each cause listed in subsection (1). The
23 civil penalties may not exceed \$100,000 against any one health
24 maintenance organization in 1 calendar year. The penalty may
25 be imposed in addition to or instead of a suspension or
26 revocation of the organization's certificate of authority.

27 Section 13. (1) SHORT TITLE.--This section may be
28 cited as the "Access to Emergency Medical Services Act."

29 (2) FINDINGS; PURPOSE.--

30 (a)1. State law requires emergency physicians and
31 other providers to evaluate, treat, and stabilize any

1 individual who seeks treatment in a hospital emergency
2 department.

3 2. An emergency physician is specifically prohibited
4 from delaying any treatment needed to evaluate or stabilize an
5 individual in order to determine the status of the
6 individual's health insurance.

7 3. Many health plans routinely deny payment for
8 required emergency services furnished to their enrollees,
9 basing such denials on:

10 a. Failure to obtain prior approval for such services
11 from the plan; or

12 b. An after-the-fact determination that the medical
13 condition identified through the required evaluation was not
14 an emergency medical condition.

15 4. Such denials by health plans impose significant
16 financial burdens on:

17 a. Enrollees who, based on symptoms that reasonably
18 suggest a medical emergency, prudently seek care in a hospital
19 emergency department; and

20 b. Emergency physicians, the hospital emergency
21 departments, and others who furnish emergency services to
22 enrollees.

23 5. These burdens discourage enrollees from seeking
24 emergency care in cases where it is appropriate and,
25 ultimately, threaten the financial livelihood of hospital
26 emergency departments that provide emergency services to the
27 entire population, including beneficiaries of the Medicare and
28 Medicaid programs and of other health care programs.

29 6. Health plans have engaged in practices that
30 discourage the appropriate use of the 911 emergency telephone
31 number and that adversely impact the health of enrollees.

- 1 (b) The purpose of this section is to:
- 2 1. Require health plans to cover and pay for their
- 3 fair share for emergency services that hospital emergency
- 4 departments are required to provide.
- 5 2. Protect health plan enrollees by establishing a
- 6 uniform definition of the term "emergency medical condition,"
- 7 which is based on the average knowledge of a prudent
- 8 layperson.
- 9 3. Prohibit health plans from requiring prior approval
- 10 for required emergency services.
- 11 4. Assure that health plans promote the appropriate
- 12 use of the 911 emergency telephone number.
- 13 (3) EQUITABLE HEALTH PLAN COVERAGE WITH RESPECT TO
- 14 EMERGENCY SERVICES.--
- 15 (a) A health plan that provides any coverage with
- 16 respect to emergency services must cover emergency services
- 17 furnished to an enrollee of the plan without regard to:
- 18 1. Whether or not the provider that furnishes the
- 19 emergency services has a contractual or other arrangement with
- 20 the plan for the provision of such services to the enrollee;
- 21 and
- 22 2. Prior authorization.
- 23 (b)1. A health plan that provides any coverage with
- 24 respect to emergency services:
- 25 a. Shall determine and make prompt payment in a
- 26 reasonable and appropriate amount for such services.
- 27 b. Except as provided in subparagraph 2., may not
- 28 impose cost-sharing for services furnished in a hospital
- 29 emergency department which is calculated in a manner that
- 30 imposes a greater percentage of cost-sharing with respect to
- 31

1 such services when compared to comparable services furnished
2 in other settings.

3 2. A health plan may impose a reasonable copayment in
4 lieu of coinsurance to deter inappropriate use of services of
5 a hospital emergency department.

6 (c)1. If an enrollee of a health plan receives
7 emergency services from an emergency department pursuant to a
8 screening evaluation conducted by a treating physician or
9 other emergency department personnel and, pursuant to the
10 evaluation by such physician or personnel, identifies items
11 and services, other than emergency services, promptly needed
12 by the enrollee, the health plan shall provide access 24 hours
13 a day, 7 days a week, to such persons as are authorized to
14 make any prior authorization determinations with respect to
15 coverage of such promptly needed items and services.

16 2. A health plan is deemed to have approved a request
17 for a prior authorization for such promptly needed items and
18 services if the physician or other personnel:

19 a. Has attempted to contact such a person for
20 authorization to provide:

21 (I) An appropriate referral for the items and
22 services; or

23 (II) The items and services or access to the person
24 has not been provided, as required under subparagraph 1.; or

25 b. Has requested such authorization and the
26 authorization is not denied within 30 minutes after the time
27 the request was made.

28 3. If a physician or, in the case of a managed care
29 plan, a participating physician or other person authorized to
30 make prior authorization determinations for the plan, refers
31 an enrollee to a hospital emergency department for evaluation

1 or treatment, a request for prior authorization of the items
2 and services reasonably furnished the enrollee pursuant to
3 such referral shall be deemed to have been made and approved.

4 4.a. Approval of a request for a prior authorization
5 determination, including a deemed approval under subparagraph
6 2. or subparagraph 3., shall be treated as approval of any
7 health care items and services required to treat the medical
8 condition identified pursuant to a screening evaluation under
9 subparagraph 1.

10 b. A health plan may not subsequently deny or reduce
11 payment for an item or service furnished pursuant to such an
12 approval unless the approval was based on fraudulent
13 information about the medical condition of an enrollee.

14 (d) A health plan:

15 1. Must include, in any educational materials the plan
16 makes available to its enrollees on the procedures for
17 obtaining emergency services:

18 a. A statement that it is appropriate for an enrollee
19 to use the 911 emergency telephone number for an emergency
20 medical condition; and

21 b. An explanation of what constitutes an emergency
22 medical condition.

23 2. May not discourage appropriate use of the 911
24 emergency telephone number by an enrollee with an emergency
25 medical condition.

26 3. May not deny coverage or payment for an item or
27 service solely on the basis that an enrollee used the 911
28 emergency telephone number to summon treatment for an
29 emergency medical condition.

30 (4) ENFORCEMENT.--
31

1 (a) A health plan that violates a requirement of
2 subsection (3) is subject to a civil penalty of not more than
3 the greater of:

4 1. Ten thousand dollars for each such violation.

5 2. Three times the amount that the health plan would
6 have paid for items and services if the plan had not violated
7 subsection (3).

8 3. In the case of a pattern of repeated and
9 substantial violations, \$1 million.

10 (b) In determining the amount of any civil penalty
11 under this section, the Director of Health Care Administration
12 shall take into account whether a health plan has taken
13 corrective action, such as:

14 1. Paying for items and services for which coverage or
15 payment has been denied in violation of subsection (3); or

16 2. Establishing policies and procedures to prevent the
17 same type of violation from occurring in the future.

18 (c) The Director of Health Care Administration may,
19 out of any civil penalty collected under this section, pay an
20 enrollee or provider, as appropriate, an amount equal to the
21 amount the health plan would have paid for an item or service,
22 if any, if the plan had not denied coverage or payment for
23 such item or service in violation of subsection (3).

24 (d) For purposes of paragraph (a), the Director of
25 Health Care Administration shall consider at least the
26 following acts or omissions as violations of subsection (3).

27 1. Failing to cover emergency services in violation of
28 paragraph (3)(a).

29 2. Failing to provide for payment for emergency
30 services in violation of sub-subparagraph (3)(b)1.a.

31

1 3. Imposing cost-sharing in violation of
2 sub-subparagraph (3)(b)1.b.

3 4. Failing to provide access to prior authorization
4 determinations in violation of subparagraph (3)(c)1.

5 5. Failing to pay for services that are deemed to be
6 approved under subparagraph (3)(c)2.

7 6. Failing to include educational materials as
8 required by subparagraph (3)(d)1.

9 7. Discouraging the appropriate use of the 911
10 emergency telephone number, or denying payment if the enrollee
11 uses the 911 emergency telephone number, in violation of
12 subparagraph (3)(d)2., or subparagraph (3)(d)3.

13 (5) RULES.--The Agency for Health Care Administration
14 shall adopt rules to administer this section.

15 (6) DEFINITIONS.--As used in this section, the term:

16 (a) "Cost-sharing" means any deductible, coinsurance
17 amount, copayment, or other out-of-pocket payment that an
18 enrollee is responsible for paying with respect to a health
19 care item or service covered under a health plan.

20 (b) "Emergency department" includes a trauma center.

21 (c) "Emergency medical condition" means a medical
22 condition, the onset of which is sudden, which manifests
23 itself by symptoms of sufficient severity, including severe
24 pain, which a prudent layperson, who possesses an average
25 knowledge of health and medicine, could reasonably expect that
26 the absence of immediate medical attention would result in:

27 1. Placing the person's health in serious jeopardy.

28 2. Serious impairment to bodily functions.

29 3. Serious dysfunction of any bodily organ or part.

30 (d) "Emergency services" means:

31

1 1. Health care items and services furnished in the
2 emergency department of a hospital; and

3 2. Ancillary services routinely available to such
4 department,

5
6 to the extent that the items and services are required to
7 evaluate and treat an emergency medical condition until the
8 condition is stabilized.

9 (e) "Enrollee" means an individual enrolled with a
10 health plan.

11 (f) "Health plan" means any plan or arrangement that
12 provides, or pays the cost of, health benefits, whether
13 through insurance, reimbursement, or otherwise. The term does
14 not include:

15 1. Coverage only for accidental death or
16 dismemberment.

17 2. Coverage that provides wages or payments in lieu of
18 wages for any period during which the employee is absent from
19 work due to sickness or injury.

20 3. A Medicare supplemental policy, as defined in
21 section 1882(g)(1) of the Social Security Act.

22 4. Coverage issued as a supplement to liability
23 insurance.

24 5. Workers' compensation or similar insurance.

25 6. Automobile medical-payment insurance.

26 7. Coverage for a specified disease or illness.

27 8. A long-term care policy.

28 9. A federally funded health care program, unless such
29 a program contracts with a health plan to provide items and
30 services to individuals eligible for benefits under the
31 program.

1 (g) "Managed care plan" means a health plan that
2 provides or arranges for the provision of health care items
3 and services to enrollees primarily through participating
4 physicians and providers.

5 (h) "Participating" means, with respect to a physician
6 or provider, a physician or provider that furnishes health
7 care items and services to enrollees of a managed care plan
8 under an agreement with the plan.

9 (i) "Prior authorization determination" means a
10 determination, before the provision of the items and services
11 and as a condition of coverage of the items and services under
12 the plan, that coverage will be provided for the items and
13 services under the plan.

14 (j) "Stabilized" means that no material deterioration
15 of an emergency medical condition is likely, within reasonable
16 medical probability, to result or occur before an individual
17 can be transferred in compliance with the requirements of
18 section 1867 of the Social Security Act.

19 (k) "911 emergency telephone number" includes, in the
20 case of a geographic area where 911 is not in use for
21 emergencies, any other telephone number that is in use for
22 emergencies.

23 Section 14. Section 641.513, Florida Statutes, is
24 repealed.

25 Section 15. Subsection (11) of section 408.706,
26 Florida Statutes, is amended to read:

27 408.706 Community health purchasing alliances;
28 accountable health partnerships.--

29 (11)(a) Notwithstanding any other provision of law to
30 the contrary, any subscriber to a health plan offered by or
31 through a health maintenance organization, managed care

1 organization, prepaid health plan, or accountable health
2 partnership is entitled at all times to free, full, and
3 absolute choice in the selection of a provider or facility
4 licensed or permitted under chapter 458, chapter 459, chapter
5 460, chapter 461, chapter 463, chapter 465, or chapter 466.
6 It is expressly forbidden for any health plan to contain any
7 provision that would require or coerce a subscriber to the
8 plan to use any provider other than the provider selected by
9 the subscriber. Health maintenance organizations, managed
10 care provider organizations, prepaid health plans, and
11 accountable health partnerships must allow any health care
12 provider to participate as a service provider under a health
13 plan offered by the health maintenance organization, managed
14 care organization, prepaid health plan, or accountable health
15 partnership, if the health care provider agrees to:
16 1. Accept the reimbursement rates negotiated by the
17 health maintenance organization, managed care provider
18 organization, prepaid health plan, or accountable health
19 partnership with other health care providers that provide the
20 same service under the health plan; and
21 2. Comply with all guidelines relating to quality of
22 care and utilization criteria which must be met by other
23 employee or nonemployee providers.
24 (b) A health maintenance organization, managed care
25 provider organization, prepaid health plan, or accountable
26 health partnership that violates paragraph (a) is subject to a
27 civil fine in the amount of:
28 1. Up to \$25,000 for each violation; or
29 2. If the Director of Health Care Administration
30 determines that the entity has engaged in a pattern of
31 violations of paragraph (a), up to \$100,000 for each

1 ~~violation. The ability to recruit and retain alliance district~~
2 ~~health care providers in its provider network. For provider~~
3 ~~networks initially formed in an alliance district after July~~
4 ~~1, 1993, an accountable health partnership shall make offers~~
5 ~~as to provider participation in its provider network to~~
6 ~~relevant alliance district health care providers for at least~~
7 ~~60 percent of the available provider positions. A provider who~~
8 ~~is made an offer may participate in an accountable health~~
9 ~~partnership as long as the provider abides by the terms and~~
10 ~~conditions of the provider network contract, provides services~~
11 ~~at a rate or price equal to the rate or price negotiated by~~
12 ~~the accountable health partnership, and meets all of the~~
13 ~~accountable health partnership's qualifications for~~
14 ~~participation in its provider networks including, but not~~
15 ~~limited to, network adequacy criteria. For purposes of this~~
16 ~~subsection, "alliance district health care provider" means a~~
17 ~~health care provider who is licensed under chapter 458,~~
18 ~~chapter 459, chapter 460, chapter 461, chapter 464, or chapter~~
19 ~~465 who has practiced in Florida for more than 1 year within~~
20 ~~the alliance district served by the accountable health~~
21 ~~partnership.~~

22 Section 16. Subsection (9) is added to section
23 627.419, Florida Statutes, 1998 Supplement, to read:

24 627.419 Construction of policies.--

25 (9)(a) Notwithstanding any other provision of law to
26 the contrary, any person covered under any health insurance
27 policy, health care services plan, or other contract that
28 provides for payment for medical expense benefits or
29 procedures is entitled at all times to free, full, and
30 absolute choice in the selection of a provider or facility
31 licensed or permitted under chapter 458, chapter 459, chapter

1 460, chapter 461, chapter 463, chapter 465, or chapter 466.
2 It is expressly forbidden for any health plan to contain any
3 provision that would require or coerce a person covered by the
4 plan to use any provider other than the provider selected by
5 the subscriber. Any health insurance policy, health care
6 services plan, or other contract that provides for payment for
7 medical expense benefits or procedures must allow any health
8 care provider to participate as a service provider under a
9 health plan offered by the health insurance policy, health
10 care services plan, or other contract that provides for
11 payment for medical expense benefits or procedures, if the
12 health care provider agrees to:

13 1. Accept the reimbursement rates negotiated by the
14 health insurance policy, health care services plan, or other
15 contract that provides for payment for medical expense
16 benefits or procedures with other health care providers that
17 provide the same service under the health plan; and

18 2. Comply with all guidelines relating to quality of
19 care and utilization criteria which must be met by other
20 providers with whom the health insurance policy, health care
21 services plan, or other contract that provides for payment for
22 medical expense benefits or procedures has contractual
23 arrangements for those services.

24 (b) The provider of any health insurance policy,
25 health care services plan, or other contract that violates
26 paragraph (a) is subject to a civil fine in the amount of:

27 1. Up to \$25,000 for each violation; or

28 2. If the Insurance Commissioner determines that the
29 provider has engaged in a pattern of violations of paragraph
30 (a), up to \$100,000 for each violation.

31

1 Section 17. Section 641.3151, Florida Statutes, is
2 created to read:

3 641.3151 Subscriber freedom of choice.--

4 (1) Notwithstanding any other provision of law to the
5 contrary, any subscriber to a health plan offered by or
6 through a health maintenance organization or managed care
7 organization is entitled at all times to free, full, and
8 absolute choice in the selection of a provider or facility
9 licensed or permitted under chapter 458, chapter 459, chapter
10 460, chapter 461, chapter 463, chapter 465, or chapter 466. It
11 is expressly forbidden for any health plan to contain any
12 provision that would require or coerce a subscriber to the
13 plan to use any provider other than the provider selected by
14 the subscriber. Health maintenance organizations and managed
15 care provider organizations must allow any health care
16 provider to participate as a service provider under a health
17 plan offered by the health maintenance organization or managed
18 care organization, if the health care provider agrees to:

19 (a) Accept the reimbursement rates negotiated by the
20 health maintenance organization or managed care provider
21 organization with other health care providers that provide the
22 same service under the health plan; and

23 (b) Comply with all guidelines relating to quality of
24 care and utilization criteria which must be met by other
25 employee or nonemployee providers.

26 Section 18. Section 627.6577, Florida Statutes, is
27 amended to read:

28 (Substantial rewording of section. See
29 s. 627.6577, F.S., for present text.)

30 627.6577 Freedom of choice for dental patients.--

31

1 (1) A dental insurance policy that is delivered,
2 renewed, or issued for delivery, or otherwise contracted for
3 in this state by a health insurer or dental service plan
4 corporation may not:

5 (a) Prohibit any person who is a party to or
6 beneficiary of the policy from selecting the dentist of his or
7 her choice, nor interfere with such selection.

8 (b) Deny any dentist the right to participate as a
9 contracting provider for the policy or plan if the dentist
10 agrees to comply with the terms set forth in the insurer's
11 standard provider document and to accept the corresponding
12 reimbursement rates applicable to the provider document.

13 (2) An insurer dental service plan corporation must
14 make payment or reimbursement to a noncontracting provider
15 dentist in the same amounts and according to the same
16 procedures as the insurer makes payment or reimbursement to a
17 contracting dentist for the same services.

18 (3) A health insurer or dental service plan
19 corporation that violates subsection (1) or subsection (2) is
20 subject to a civil fine in the amount of:

21 (a) Up to \$25,000 for each violation; or

22 (b) If the Insurance Commissioner determines that the
23 provider has engaged in a pattern of violations of subsection
24 (1) or subsection (2), up to \$100,000 for each violation.

25 Section 19. Section 636.0165, Florida Statutes, is
26 created to read:

27 636.0165 Freedom of choice for dental patients.--

28 (1) A dental insurance policy that is delivered,
29 renewed, or issued for delivery, or otherwise contracted for
30 in this state by a health insurer or dental service plan
31 corporation may not:

1 (a) Prohibit any person who is a party to or
2 beneficiary of such policy from selecting the dentist of his
3 or her choice, nor interfere with such selection.

4 (b) Deny any dentist the right to participate as a
5 contracting provider for such policy or plan if the dentist
6 agrees to comply with the terms set forth in the insurer's
7 standard provider document and agrees to accept the
8 corresponding reimbursement rates applicable to the provider
9 document.

10 (2) A prepaid limited health services organization
11 must make payment or reimbursement to a noncontracting
12 provider dentist in the same amounts and according to the same
13 procedures as the insurer makes payment or reimbursement to a
14 contracting dentist for the same services.

15 (3) A health insurer or dental service plan
16 corporation that violates subsection (1) or subsection (2) is
17 subject to a civil fine in the amount of:

18 (a) Up to \$25,000 for each violation; or

19 (b) If the Insurance Commissioner determines that the
20 provider has engaged in a pattern of violations of subsection
21 (1) or subsection (2), up to \$100,000 for each violation.

22 Section 20. Section 641.3157, Florida Statutes, is
23 created to read:

24 641.3157 Freedom of choice for dental patients.--

25 (1) A dental insurance policy that is delivered,
26 renewed, or issued for delivery, or otherwise contracted for
27 in this state by a health insurer or dental service plan
28 corporation may not:

29 (a) Prohibit any person who is a party to or
30 beneficiary of such policy from selecting the dentist of his
31 or her choice, nor interfere with such selection.

1 (b) Deny any dentist the right to participate as a
2 contracting provider for the policy or plan if the dentist
3 agrees to comply with the terms set forth in the insurer's
4 standard provider document and to accept the corresponding
5 reimbursement rates applicable to the provider document.

6 (2) A health maintenance organization or managed care
7 organization must make payment or reimbursement to a
8 noncontracting provider dentist in the same amounts and
9 according to the same procedures as the insurer makes payment
10 or reimbursement to a contracting dentist for the same
11 services.

12 Section 21. The provisions of sections 15 through 20
13 of this act do not apply to any health insurance policy that
14 is in force before the effective date of this act but do apply
15 to such policies at the next renewal period immediately
16 following October 1, 1999.

17 Section 22. Section 641.28, Florida Statutes, is
18 amended to read:

19 641.28 Civil remedy.--In any civil action brought to
20 enforce the terms and conditions of a health maintenance
21 organization contract, only the prevailing subscriber, or a
22 representative or provider acting on behalf of a subscriber,
23 ~~party~~ is entitled to recover reasonable attorney's fees and
24 court costs. ~~This section shall not be construed to authorize~~
25 ~~a civil action against the department, its employees, or the~~
26 ~~Insurance Commissioner or against the Agency for Health Care~~
27 ~~Administration, its employees, or the director of the agency.~~

28 Section 23. This act shall take effect October 1,
29 1999.

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SENATE SUMMARY

Requires health maintenance organizations to provide an appeal process to resolve grievances brought by subscribers; Provides for an external appeal when a subscriber is dissatisfied with the results of a formal appeal. Provides for the Agency for Health Care Administration to adopt rules governing the appeal process. Provides that a subscriber may maintain an action against a health maintenance organization that has not exercised ordinary care in making treatment decisions. Provides for a claim of liability to be reviewed by an independent review organization. Provides requirements for profiles of health care providers and the measurement of the performance of health care providers. Prohibits a health maintenance organization from taking retaliatory action against an employee for certain actions or disclosures concerning improper patient care. Requires that a health maintenance organization refer a subscriber to an outside provider in cases in which there is not a provider within the organization's network to provide a covered benefit. Provides for a standing referral to a specialist under certain circumstances. Prohibits a health maintenance organization from arbitrarily interfering with certain decisions of a health care provider. Authorizes the Insurance Commissioner to suspend or revoke a certificate of authority upon finding certain violations by a health maintenance organization. Creates the "Access to Emergency Medical Services Act." Requires that if a health plan provides coverage for emergency services, the health plan must pay for emergency services without regard to whether the health plan has a contract with the provider that furnished the emergency services and without regard to prior authorization. Authorizes a health plan to impose a copayment for emergency services. Provides for civil penalties to be imposed for violation of the act. Requires that the Agency for Health Care Administration adopt rules. Repeals current provisions governing the recruitment and retention of health care providers in a community health purchasing alliance district. Provides that subscribers are entitled to free, full, and absolute choice of providers offering physician, chiropractic, podiatry, optometry, pharmacy, or dental services, and prohibits coercion or coercive requirements relating to subscriber selection. Prohibits dental insurance policies from restricting a subscriber's choice or refusing payment to noncontracting dental service providers who meet certain requirements. Provides for civil fines for violations. (See bill for details.)