By Representatives Sobel, Crow, Villalobos, Greenstein, Gottlieb, Levine and Barreiro

A bill to be entitled

An act relating to health care; requiring health maintenance organizations to provide for the resolution of grievances brought by subscribers; specifying the services to be included in a grievance system; requiring health maintenance organizations to establish an informal appeal process; providing for a formal internal appeal process; providing for an external appeal when a subscriber is dissatisfied with the results of a formal appeal; providing for the grievance to be reviewed by an independent utilization review organization; providing for a party to appeal a decision by the utilization review organization to the Agency for Health Care Administration; requiring that the Agency for Health Care Administration enter into contracts with utilization review organizations for the purpose of reviewing appeals; authorizing the agency to adopt rules; providing for the right of a subscriber to maintain an action against a health maintenance organization; providing definitions; providing that a health maintenance organization has the duty to exercise ordinary care when making treatment decisions; providing that a health maintenance organization is liable for damages for harm caused by failure to exercise ordinary care; providing certain limitations on actions; providing for a claim of liability to be

reviewed by an independent review organization; providing for the statute of limitations to be tolled under certain circumstances; requiring a health maintenance organization to disclose certain information to subscribers and prospective subscribers; specifying additional information that must be provided upon the request of a subscriber or prospective subscriber; requiring that a health maintenance organization provide notice if a provider is unavailable to render services; providing requirements for the notice; requiring health maintenance organizations to make certain allowances in developing provider profiles and measuring the performance of health care providers; providing for such information to be made available to the Department of Insurance, the Agency for Health Care Administration, and subscribers; prohibiting a health maintenance organization from taking retaliatory action against an employee for certain actions or disclosures concerning improper patient care; requiring 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; specifying circumstances under which a health maintenance organization must refer a subscriber to a specialist; limiting the cost of services provided by a nonparticipating provider;

providing for a standing referral to a specialist under certain circumstances; requiring that a health maintenance organization provide a procedure to allow a subscriber to obtain drugs that are not included in the organization's drug formulary; prohibiting a health maintenance organization from arbitrarily interfering with certain decisions of a health care provider; prohibiting a health maintenance organization from discriminating against a subscriber based on race, national origin, and other factors; requiring health maintenance organizations to establish a policy governing the termination of health care providers; providing requirements for the policy; authorizing the Insurance Commissioner to suspend or revoke a certificate of authority upon finding certain violations by a health maintenance organization; providing for civil penalties; creating the "Access to Emergency Medical Services Act"; providing findings and purpose; requiring a health plan that provides coverage for emergency services to cover emergency services furnished to a subscriber under specified circumstances; requiring the health plan to promptly pay for services; prohibiting a health plan from imposing certain types of cost-sharing; providing that a health plan may impose a reasonable copayment; providing requirements for a health plan with respect to providing

prior authorization; specifying circumstances under which a health plan is deemed to have approved a request for prior authorization for certain services; prohibiting a health plan from subsequently denying or reducing payment for items or services; requiring that a health plan include certain information in educational materials; providing civil penalties; requiring that the Director of Health Care Administration take certain factors into consideration in imposing a civil penalty; requiring the Agency for Health Care Administration to adopt rules; providing definitions; repealing s. 641.513, F.S., relating to requirements for providing emergency services and care; amending ss. 408.706, 627.419, F.S.; creating s. 641.3151, F.S.; deleting provisions governing recruitment and retention of health care providers in a community health purchasing alliance district; providing free choice to subscribers to certain health care plans, and to persons covered under certain health insurance policies or contracts, in the selection of specified health care providers; prohibiting coercion of provider selection; specifying conditions under which any health care provider must be permitted to provide services under a health care plan or health insurance policy or contract; amending s. 627.6577, F.S.; creating ss. 636.0165, 641.3157, F.S.; providing for freedom of choice for dental patients; providing limitations;

providing for civil penalties; providing application; amending s. 641.28, F.S.; limiting the parties that may recover attorney's fees and court costs in an action to enforce the terms of a health maintenance contract; providing an effective date.

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

Section 1. Managed care bill of rights.--

(1) GENERAL PROVISIONS.--

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

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

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

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

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

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

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

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

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

(2) INFORMAL APPEAL PROCESS.--

(a) Each health maintenance organization must establish and maintain an informal internal appeal process whereby any subscriber, or representative or provider acting on behalf of a subscriber and with the subscriber's consent, who has a grievance concerning any of the actions by the health maintenance organization as described in paragraph (1)(a) or related thereto, shall be given the opportunity to

discuss and appeal that determination to the medical director or the physician designee who rendered the determination.

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

(3) FORMAL INTERNAL APPEAL PROCESS.--

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

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

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

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

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

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

(4) EXTERNAL APPEAL PROCESS.--

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

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

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

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

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

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

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

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

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

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

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

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

(5) INDEPENDENT UTILIZATION REVIEW ORGANIZATIONS.--

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

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

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

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

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

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

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

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

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

(2) APPLICATION.--

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

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

1. Employees;

2. Agents; or

3. Representatives,

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

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

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

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

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

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

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

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

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

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

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

(3) LIMITATIONS ON ACTIONS.--

(a) A person may not maintain an action under this section against a health maintenance organization that is required to comply with the appeal process provided under section 1 of this act unless the subscriber, or the subscriber's representative:

1. Has exhausted the appeals and review applicable under the appeal process; or

2. Before instituting the action:

a. Gives written notice of the claim as provided by paragraph (b); and

b. Agrees to submit the claim to a review by an independent review organization as required by paragraph (c).

(b) Notice of intent to maintain an action must be delivered or mailed to the health maintenance organization against whom the action is made not later than the 30th day before the date the claim is filed.

(c) The subscriber, or the subscriber's representative, must submit the claim to a review by an independent review organization if the health maintenance organization against whom the claim is made requests the review not later than the 14th day after the date notice under paragraph (b) is received by the health maintenance organization. If the health maintenance organization does not request the review within the period specified by this paragraph, the subscriber, or the subscriber's representative, is not required to submit the claim to independent review before maintaining the action.

(d) Subject to paragraph (e), if the subscriber has not complied with paragraph (a), an action under this section may not be dismissed by the court, but the court may, in its

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) A description of the utilization review policies and procedures used by the health maintenance organization, including:

1. The circumstances under which utilization review will be undertaken;

2. The toll-free telephone number of the utilization review agent;

3. The timeframes under which utilization review decisions must be made for prospective, retrospective, and concurrent decisions;

4. The right to reconsideration;

5. The right to an appeal, including the expedited and standard appeals processes and the timeframes for such appeals;

6. The right to designate a representative;

7. A notice that all denials of claims will be made by qualified health care providers and that all notices of denials will include information about the basis of the decision;

8. A notice of the right to an appeal, together with a description of the appeal process established under section 1 of this act; and

9. Any further appeal rights, if any.

(d) A description prepared annually of the types of methodologies the health maintenance organization uses to reimburse health care providers, specifying the type of methodology that is used to reimburse particular types of providers or reimburse for the provision of particular types of services. However, this paragraph does not require disclosure of individual contracts or the specific details of

any financial arrangement between a health maintenance organization and a health care provider.

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

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

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

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

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

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

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

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

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

7. The right to designate a representative; and

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

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

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

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

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

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

(l) Where applicable, notice that a subscriber with a condition that requires ongoing care from a specialist may request a standing referral to such a specialist and the

procedure for requesting and obtaining such a standing referral.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Is fraudulent or criminal; or

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

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

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

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

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

(b) If the health maintenance organization, or the primary care provider in consultation with the health maintenance organization and the specialist, determines that the subscriber's care would most appropriately be coordinated by such a specialist, the health maintenance organization shall refer the subscriber to such specialist. A health maintenance organization is not required to permit a subscriber to elect to have a nonparticipating specialist, except pursuant to this section. Such referral shall be pursuant to a treatment plan approved by the health maintenance organization, in consultation with the primary care provider, if appropriate, the specialist, and the subscriber or the subscriber's representative. Such specialist shall be permitted to treat the subscriber without a referral from the subscriber's primary care provider and may authorize the referrals, procedures, tests, and other medical services that the subscriber's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan.

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

subscriber would otherwise pay for services received within the network.

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

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

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

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

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

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

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

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

Section 10. Discrimination prohibited.--

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) FINDINGS; PURPOSE.--

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

individual who seeks treatment in a hospital emergency department.

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

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

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

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

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

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

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

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

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

(b) The purpose of this section is to:

1. Require health plans to cover and pay for their fair share for emergency services that hospital emergency departments are required to provide.

2. Protect health plan enrollees by establishing a uniform definition of the term "emergency medical condition," which is based on the average knowledge of a prudent layperson.

3. Prohibit health plans from requiring prior approval for required emergency services.

4. Assure that health plans promote the appropriate use of the 911 emergency telephone number.

(3) EQUITABLE HEALTH PLAN COVERAGE WITH RESPECT TO EMERGENCY SERVICES.--

(a) A health plan that provides any coverage with respect to emergency services must cover emergency services furnished to an enrollee of the plan without regard to:

1. Whether or not the provider that furnishes the emergency services has a contractual or other arrangement with the plan for the provision of such services to the enrollee; and

2. Prior authorization.

(b)1. A health plan that provides any coverage with respect to emergency services:

a. Shall determine and make prompt payment in a reasonable and appropriate amount for such services.

b. Except as provided in subparagraph 2., may not impose cost-sharing for services furnished in a hospital emergency department which is calculated in a manner that imposes a greater percentage of cost-sharing with respect to

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

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

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

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

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

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

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

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

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

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

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

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

(d) A health plan:

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

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

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

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

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

(4) ENFORCEMENT.--

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

1. Ten thousand dollars for each such violation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Serious impairment to bodily functions.

3. Serious dysfunction of any bodily organ or part.

(d) "Emergency services" means:

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

2. Ancillary services routinely available to such department,

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

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

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

1. Coverage only for accidental death or dismemberment.

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

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

4. Coverage issued as a supplement to liability insurance.

5. Workers' compensation or similar insurance.

6. Automobile medical-payment insurance.

7. Coverage for a specified disease or illness.

8. A long-term care policy.

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

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

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

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

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

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

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

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

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

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

organization, prepaid health plan, or accountable health partnership is entitled at all times to free, full, and absolute choice in the selection of a provider or facility licensed or permitted under chapter 458, chapter 459, chapter 460, chapter 461, chapter 463, chapter 465, or chapter 466. It is expressly forbidden for any health plan to contain any provision that would require or coerce a subscriber to the plan to use any provider other than the provider selected by the subscriber. Health maintenance organizations, managed care provider organizations, prepaid health plans, and accountable health partnerships must allow any health care provider to participate as a service provider under a health plan offered by the health maintenance organization, managed care organization, prepaid health plan, or accountable health partnership, if the health care provider agrees to:

1. Accept the reimbursement rates negotiated by the health maintenance organization, managed care provider organization, prepaid health plan, or accountable health partnership with other health care providers that provide the same service under the health plan; and

2. Comply with all guidelines relating to quality of care and utilization criteria which must be met by other employee or nonemployee providers.

(b) A health maintenance organization, managed care provider organization, prepaid health plan, or accountable health partnership that violates paragraph (a) is subject to a civil fine in the amount of:

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

2. If the Director of Health Care Administration determines that the entity has engaged in a pattern of violations of paragraph (a), up to $100,000 for each

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

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

627.419 Construction of policies.--

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

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

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

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

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

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

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

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

641.3151 Subscriber freedom of choice.--

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

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

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

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

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

627.6577 Freedom of choice for dental patients.--

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

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

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

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

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

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

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

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

636.0165 Freedom of choice for dental patients.--

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

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

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

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

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

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

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

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

641.3157 Freedom of choice for dental patients.--

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

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

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

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

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

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

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

Section 23. This act shall take effect October 1, 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.)