By Senator Sebesta

20-1461-00

1 A bill to be entitled
2 An act relating to health care; amending s.
3 216.136, F.S.; creating the Mandated Health
4 Insurance Benefits and Providers Estimating
5 Conference; providing for membership and duties
6 of the conference; providing duties of
7 legislative committees that have jurisdiction
8 over health insurance matters; amending s.
9 395.1055, 400.474, 455.624, F.S.; prohibiting
10 billing an HMO subscriber for services covered
11 by the HMO; providing responsibility for
12 enforcing that prohibition against physicians
13 and against hospitals and nursing homes;
14 amending s. 408.7056, F.S.; amending the
15 membership of the statewide provider and
16 subscriber assistance panel; providing that
17 certain decisions are subject to a review
18 hearing under s. 120.574, F.S.; requiring
19 physicians and hospitals to post a sign and
20 provide a statement informing patients about
21 the toll-free health care hotline; amending s.
22 624.215, F.S.; providing that certain
23 legislative proposals must be submitted to and
24 assessed by the Mandated Health Insurance
25 Benefits and Providers Estimating Conference,
26 rather than the Agency for Health Care
27 Administration; amending guidelines for
28 assessing the impact of a proposal to
29 legislatively mandate certain health coverage;
30 providing prerequisites to legislative
31 consideration of such proposals; amending s.

1 641.50, F.S.; providing a health maintenance
2 organization subscriber's bill of benefits;
3 consolidating principles of protection found
4 in the law, including those relating to quality
5 of care and access to care; amending s. 641.51,
6 F.S.; requiring that only licensed medical
7 doctors can deny coverage on behalf of an HMO;
8 providing the basis for such a denial;
9 requiring the HMO to include with the
10 notification of an adverse determination
11 information concerning the appeal process;
12 amending s. 641.511, F.S.; providing for review
13 by an independent external review entity of an
14 HMO's decision to deny coverage; providing
15 qualifications of such entities; providing
16 rulemaking authority; allowing small-employer
17 carriers to exclude certain mandated health
18 benefits from a health insurance policy,
19 certificate, or contract; requiring reduced
20 rates on policies, certificates, or contracts
21 that bear such exclusions; requiring a notice
22 to holders of such policies, certificates, or
23 contracts; providing an effective date.
24
25 Be It Enacted by the Legislature of the State of Florida:
26
27 Section 1. Subsection (12) is added to section
28 216.136, Florida Statutes, to read:
29 216.136 Consensus estimating conferences; duties and
30 principals.--
31

1 (12) MANDATED HEALTH INSURANCE BENEFITS AND PROVIDERS
2 ESTIMATING CONFERENCE.--
3 (a) Duties.--The Mandated Health Insurance Benefits
4 and Providers Estimating Conference shall:
5 1. Develop and maintain, with the Agency for Health
6 Care Administration, a system and program of data collection
7 to assess the impact of mandated benefits and providers,
8 including costs to employers and insurers, impact of
9 treatment, cost savings in the health care system, number of
10 providers, and other appropriate data.
11 2. Prescribe the format, content, and timing of
12 information that is to be submitted to the conference and used
13 by the conference in its assessment of proposed and existing
14 mandated benefits and providers. Such format, content, and
15 timing requirements are binding upon all parties submitting
16 information to the conference for use in its assessment of
17 proposed and existing mandated benefits and providers.
18 3. Provide assessments of proposed and existing
19 mandated benefits and providers and other studies of mandated
20 benefits and provider issues as requested by the Legislature
21 or the Governor. When a legislative measure containing a
22 mandated health insurance benefit or provider is proposed, the
23 standing committee of the Legislature which has jurisdiction
24 over the proposal shall request that the conference prepare
25 and forward to the Governor and the Legislature a study that
26 provides, for each measure, a cost-benefit analysis that
27 assesses the social and financial impact and the medical
28 efficacy according to prevailing medical standards of the
29 proposed mandate. The conference has 12 months after the
30 committee makes its request in which to complete and submit
31 the conference's report. The standing committee may not

1 consider such a proposed legislative measure until 12 months
2 after it has requested the report and has received the
3 conference's report on the measure.
4 4. The standing committees of the Legislature which
5 have jurisdiction over health insurance matters shall request
6 that the conference assess the social and financial impact and
7 the medical efficacy of existing mandated benefits and
8 providers. The committees shall submit to the conference by
9 January 1, 2001, a schedule of evaluations that sets forth the
10 respective dates by which the conference must have completed
11 its evaluations of particular existing mandates.
12 (b) Principals.--The Executive Office of the Governor,
13 the Insurance Commissioner, the Agency for Health Care
14 Administration, the Director of the Division of Economic and
15 Demographic Research of the Joint Legislative Management
16 Committee, and professional staff of the Senate and the House
17 of Representatives who have health insurance expertise, or
18 their designees, are the principals of the Mandated Health
19 Insurance Benefits and Providers Estimating Conference. The
20 responsibility of presiding over sessions of the conference
21 shall be rotated among the principals.
22 Section 2. Paragraph (j) is added to subsection (1) of
23 section 395.1055, Florida Statutes, to read:
24 395.1055 Rules and enforcement.--
25 (1) The agency shall adopt rules pursuant to ss.
26 120.536(1) and 120.54 to implement the provisions of this
27 part, which shall include reasonable and fair minimum
28 standards for ensuring that:
29 (j) A facility does not collect or attempt to collect
30 from a health maintenance organization subscriber any money
31

1 for services covered by the subscriber's contract with the
2 health maintenance organization.
3 Section 3. Paragraph (d) is added to subsection (2) of
4 section 400.474, Florida Statutes, to read:
5 400.474 Denial, suspension, revocation of license;
6 injunction; grounds; penalties.--
7 (2) Any of the following actions by a home health
8 agency or its employee is grounds for disciplinary action by
9 the agency:
10 (d) Violation of s. 641.351(3) prohibiting balance
11 billing of subscribers of health maintenance organizations.
12 Section 4. Subsections (2) and (11) of section
13 408.7056, Florida Statutes, are amended, present subsection
14 (15) of that section is redesignated as subsection (16), and a
15 new subsection (15) is added to that section, to read:
16 408.7056 Statewide Provider and Subscriber Assistance
17 Program.--
18 (2) The agency shall adopt and implement a program to
19 provide assistance to subscribers and providers, including
20 those whose grievances are not resolved by the managed care
21 entity to the satisfaction of the subscriber or provider. The
22 program shall consist of one or more panels that meet as often
23 as necessary to timely review, consider, and hear grievances
24 and recommend to the agency or the department any actions that
25 should be taken concerning individual cases heard by the
26 panel. The panel shall hear every grievance filed by
27 subscribers and providers on behalf of subscribers, unless the
28 grievance:
29 (a) Relates to a managed care entity's refusal to
30 accept a provider into its network of providers;
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1 (b) Is part of an internal grievance in a Medicare
2 managed care entity or a reconsideration appeal through the
3 Medicare appeals process which does not involve a quality of
4 care issue;
5 (c) Is related to a health plan not regulated by the
6 state such as an administrative services organization,
7 third-party administrator, or federal employee health benefit
8 program;
9 (d) Is related to appeals by in-plan suppliers and
10 providers, unless related to quality of care provided by the
11 plan;
12 (e) Is part of a Medicaid fair hearing pursued under
13 42 C.F.R. ss. 431.220 et seq.;
14 (f) Is the basis for an action pending in state or
15 federal court;
16 (g) Is related to an appeal by nonparticipating
17 providers, unless related to the quality of care provided to a
18 subscriber by the managed care entity and the provider is
19 involved in the care provided to the subscriber;
20 (h) Was filed before the subscriber or provider
21 completed the entire internal grievance procedure of the
22 managed care entity, the managed care entity has complied with
23 its timeframes for completing the internal grievance
24 procedure, and the circumstances described in subsection (6)
25 do not apply;
26 (i) Has been resolved to the satisfaction of the
27 subscriber or provider who filed the grievance, unless the
28 managed care entity's initial action is egregious or may be
29 indicative of a pattern of inappropriate behavior;
30 (j) Is limited to seeking damages for pain and
31 suffering, lost wages, or other incidental expenses, including

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1 accrued interest on unpaid balances, court costs, and
2 transportation costs associated with a grievance procedure;
3 (k) Is limited to issues involving conduct of a health
4 care provider or facility, staff member, or employee of a
5 managed care entity which constitute grounds for disciplinary
6 action by the appropriate professional licensing board and is
7 not indicative of a pattern of inappropriate behavior, and the
8 agency or department has reported these grievances to the
9 appropriate professional licensing board or to the health
10 facility regulation section of the agency for possible
11 investigation; ~~or~~
12 (l) Is withdrawn by the subscriber or provider.
13 Failure of the subscriber or the provider to attend the
14 hearing shall be considered a withdrawal of the grievance; or~~.~~
15 (m) Is related to an adverse determination based on
16 medical necessity which is made by an approved independent
17 external review entity.
18 (11) The panel shall consist of members employed by
19 the agency and members employed by the department, chosen by
20 their respective agencies; a consumer appointed by the
21 Governor; a physician appointed by the Governor, as a standing
22 member; attorneys who have expertise relating to contract law,
23 on a rotating basis;and physicians who have expertise
24 relevant to the case to be heard, on a rotating basis. The
25 agency may contract with a medical director and a primary care
26 physician who shall provide additional technical expertise to
27 the panel. The medical director shall be selected from a
28 health maintenance organization with a current certificate of
29 authority to operate in Florida.
30 (15) A decision by the agency or department to not
31 require the managed care entity to take a specific action

1 under subsection (7) is subject to a summary hearing in
2 accordance with s. 120.574, unless all of the parties agree
3 otherwise.
4 Section 5. Paragraph (y) is added to subsection (1) of
5 section 455.624, Florida Statutes, to read:
6 455.624 Grounds for discipline; penalties;
7 enforcement.--
8 (1) The following acts shall constitute grounds for
9 which the disciplinary actions specified in subsection (2) may
10 be taken:
11 (y) Collecting or attempting to collect from a
12 subscriber of a health maintenance organization any money for
13 services covered by the subscriber's contract with a health
14 maintenance organization.
15 Section 6. A physician licensed under chapter 458 or
16 chapter 459 or a hospital licensed under chapter 395 shall
17 provide a consumer-assistance notice in the form of a sign
18 that is prominently displayed in the reception area and
19 clearly noticeable by all patients and in the form of a
20 written statement that is given to each person to whom medical
21 services are being provided. Such a sign or statement must
22 state that consumer information regarding a doctor, hospital,
23 or health plan is available through a toll-free number and
24 website maintained by the Agency for Health Care
25 Administration. In addition, the sign and statement must state
26 that any complaint regarding medical services received or the
27 patient's health plan may be submitted through the toll-free
28 number. The agency, in cooperation with other appropriate
29 agencies, shall establish the consumer-assistance program and
30 provide physicians and hospitals with information regarding
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the toll-free number and website and with signs for posting in facilities at no cost to the provider.

Section 7. Section 624.215, Florida Statutes, is amended to read:

624.215 Proposals for legislation which mandates health benefit coverage; review by Legislature.--

(1) LEGISLATIVE INTENT.--The Legislature finds that there is an increasing number of proposals which mandate that certain health benefits be provided by insurers and health maintenance organizations as components of individual and group policies. The Legislature further finds that many of these benefits provide beneficial social and health consequences which may be in the public interest. However, the Legislature also recognizes that most mandated benefits contribute to the increasing cost of health insurance premiums. Therefore, it is the intent of the Legislature to conduct a systematic review of current and proposed mandated or mandatorily offered health coverages and to establish guidelines for such a review. This review will assist the Legislature in determining whether mandating a particular coverage is in the public interest.

(2) MANDATED HEALTH COVERAGE; REPORT TO THE MANDATED HEALTH INSURANCE BENEFITS AND PROVIDERS ESTIMATING CONFERENCE ~~AGENCY FOR HEALTH CARE ADMINISTRATION AND LEGISLATIVE COMMITTEES~~; GUIDELINES FOR ASSESSING IMPACT.--Every person or organization seeking consideration of a legislative proposal which would mandate a health coverage or the offering of a health coverage by an insurance carrier, health care service contractor, or health maintenance organization as a component of individual or group policies, shall submit to the Mandated Health Insurance Benefits and Providers Estimating Conference

~~Agency for Health Care Administration and the legislative committees having jurisdiction~~ a report which assesses the social and financial impacts of the proposed coverage. Guidelines for assessing the impact of a proposed mandated or mandatorily offered health coverage must~~, to the extent that information is available, shall~~ include:

(a) To what extent is the treatment or service generally used by a significant portion of the population.

(b) To what extent is the insurance coverage generally available.

(c) If the insurance coverage is not generally available, to what extent does the lack of coverage result in persons avoiding necessary health care treatment.

(d) If the coverage is not generally available, to what extent does the lack of coverage result in unreasonable financial hardship.

(e) The level of public demand for the treatment or service.

(f) The level of public demand for insurance coverage of the treatment or service.

(g) The level of interest of collective bargaining agents in negotiating for the inclusion of this coverage in group contracts.

(h) A report, prepared by a certified actuary, of the extent to which ~~To what extent will~~ the coverage will increase or decrease the cost of the treatment or service.

(i) A report, prepared by a certified actuary, of the extent to which ~~To what extent will~~ the coverage will increase the appropriate uses of the treatment or service.

(j) A report, prepared by a certified actuary, of the extent to which ~~To what extent will~~ the mandated treatment or

1 service will be a substitute for a more expensive treatment or
2 service.
3 (k) A report, prepared by a certified actuary, of the
4 extent to which ~~To what extent will~~ the coverage will increase
5 or decrease the administrative expenses of insurance companies
6 and the premium and administrative expenses of policyholders.
7 (l) A report, prepared by a certified actuary, as to
8 the impact of this coverage on the total cost of health care.
9
10 The standing committee of the Legislature which has
11 jurisdiction over the legislative proposal must request and
12 receive a report from the Mandated Health Insurance Benefits
13 and Providers Estimating Conference before the committee
14 considers the proposal. The committee may not consider a
15 legislative proposal that would mandate a health coverage or
16 the offering of a health coverage by an insurance carrier,
17 health care service contractor, or health maintenance
18 organization until after the committee's request to the
19 Mandated Health Insurance Benefits and Providers Estimating
20 Conference has been answered. As used in this section, the
21 term "health coverage mandate" includes mandating the use of a
22 type of provider.
23 Section 8. Section 641.50, Florida Statutes, is
24 created to read:
25 641.50 Health maintenance organization subscriber's
26 bill of benefits.--
27 (1) With respect to the provisions of this part, the
28 principles expressed in this section are standards that the
29 Department of Insurance and the Agency for Health Care
30 Administration must follow in carrying out their powers and
31 duties, in exercising administrative discretion, in issuing

1 administrative interpretations of the law, in enforcing the
2 law, and in adopting rules:
3 (a) A HMO shall ensure that the health care services
4 provided to its subscribers are rendered in accordance with
5 reasonable standards of quality of care which are, at a
6 minimum, consistent with the prevailing standards of medical
7 practice in the community.
8 (b) A HMO subscriber should receive high-quality
9 health care from a broad panel of providers, including timely
10 referrals, preventive care, emergency screening and services,
11 and second opinions.
12 (c) A HMO subscriber should receive access to
13 high-quality specialty care, including member-initiated care
14 from dermatologists and from gynecologists and obstetricians.
15 (d) A HMO subscriber should receive the assurance that
16 the HMO has been independently accredited by a national review
17 organization and that it is financially secure as determined
18 by this state.
19 (e) A HMO subscriber should receive continuity of
20 health care, even after the provider is no longer with the
21 HMO.
22 (f) A HMO subscriber should receive timely, concise
23 information regarding the HMO's reimbursement to providers and
24 for services.
25 (g) A HMO subscriber should have the flexibility to
26 transfer to another HMO in this state, regardless of health
27 status.
28 (h) A HMO subscriber should receive timely responses
29 to grievances and appeals within the HMO and, if the subject
30 matter of the grievance or appeal is urgent, should receive an
31 immediate response.

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1 (i) A HMO subscriber should receive timely review by
2 an independent external review organization in this state of
3 unresolved grievances and appeals and, if the matter to be
4 reviewed is urgent, should immediately receive such review.
5 (2) This section does not create a civil cause of
6 action by any subscriber or provider against any health
7 maintenance organization.
8 Section 9. Present subsections (5), (6), (7), (8),
9 (9), and (10) of section 641.51, Florida Statutes, are
10 redesignated as subsections (6), (7), (8), (9), (10), and
11 (11), respectively, and a new subsection (5) is added to that
12 section, to read:
13 641.51 Quality assurance program; second medical
14 opinion requirement.--
15 (5) The organization shall ensure that only a
16 physician licensed under chapter 458 or chapter 459, or a
17 physician licensed in another state under similar licensing
18 requirements, may render an adverse determination regarding a
19 service provided by a physician licensed under chapter 458 or
20 chapter 459 and shall submit to the treating provider and the
21 subscriber written notification regarding the organization's
22 adverse determination within 2 working days after the
23 subscriber or provider is notified of the adverse
24 determination. The written notification must include the
25 utilization review criteria or benefits provisions used in
26 arriving at the adverse determination and must be signed by an
27 authorized representative of the organization. The
28 organization must include with the notification of an adverse
29 determination information concerning the process for appealing
30 adverse determinations.
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1 Section 10. Present subsections (4), (6), (7), (8),
2 (9), (10), and (11) of section 641.511, Florida Statutes, are
3 redesignated as subsections (7), (9), (10), (11), (12), (13),
4 and (14), respectively, present subsection (5) of that section
5 is redesignated as subsection (8) and amended, and new
6 subsections (4), (5), and (6) are added to that section, to
7 read:
8 641.511 Subscriber grievance reporting and resolution
9 requirements.--
10 (4)(a) With respect to a grievance concerning an
11 adverse determination based on medical necessity, an
12 organization, upon request of the affected subscriber, shall
13 make available within 30 days after the request is made a
14 review of the grievance by an approved independent external
15 review entity. A subscriber must request the review within 30
16 days after the organization's transmittal of the final
17 determination notice of an adverse determination based on
18 medical necessity. The external review entity's decision
19 resulting from such a requested review is binding on both the
20 subscriber and the organization and is not appealable to the
21 Statewide Provider and Subscriber Assistance Program.
22 (b) The agency shall establish, by rule, a system by
23 which each organization is to be assigned an independent
24 review entity for external reviews. The system established by
25 the agency must require organizations to use independent
26 review entities on a rotating basis as appropriate.
27 (c) The independent review entity shall make its
28 determination in accordance with the timeframes set forth in
29 this section. In making its decision, the independent review
30 entity that conducts the review must take into account all of
31 the following:

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1 1. Information submitted by the health plan, the
2 enrollee, and the enrollee's provider, including:
3 a. The relevant provisions in the certificate of
4 coverage or policy and how they were applied;
5 b. The enrollee's medical records; and
6 c. The standards, criteria, and clinical rationale
7 used by the health plan to make its decision.
8 2. Findings, studies, research, and other relevant
9 documents of government agencies and nationally recognized
10 organizations, including the National Institutes of Health or
11 any board recognized by the National Institutes of Health, the
12 National Cancer Institute, the National Academy of Sciences,
13 the United States Food and Drug Administration, the Health
14 Care Financing Administration of the United States Department
15 of Health and Human Services, and the Agency for Health Care
16 Research and Quality.
17 3. Peer-reviewed scientific studies, research, or
18 literature published in or accepted for publication by medical
19 journals that meet nationally recognized requirements for
20 scientific manuscripts and that submit most of their published
21 articles for review by experts who are not part of the
22 editorial staff.
23 (d) The independent review entity's decision must
24 include a description of the enrollee's condition, the
25 principal reasons for the decision, and an explanation of the
26 clinical rationale for the decision.
27 (e) The independent review entity shall base its
28 decision on the information submitted under paragraph (c);
29 however, the entity may request additional information if
30 necessary. In making its decision, the independent review
31

1 entity shall consider safety, efficacy, appropriateness,
2 cost-effectiveness, and the benefit plan of the organization.
3 (f) The organization shall provide any coverage that
4 the independent review entity determines to be medically
5 necessary. The independent review entity may not require
6 coverage for services that are specifically excluded by the
7 organization in its certificate of coverage. The review
8 entity's decision applies only to the individual enrollee's
9 external review.
10 (g) This section does not require an organization to
11 provide coverage for out-of-network services, procedures, or
12 tests.
13 (h) The organization is responsible for the cost of
14 the initial external review.
15 (i) The independent review entity shall provide its
16 decision to the enrollee, the treating provider, and the
17 organization, and the decision must include:
18 1. The findings for either the organization or the
19 enrollee regarding each issue under review;
20 2. The proposed service, treatment, device, or supply
21 for which the review was performed;
22 3. The relevant provisions in the certificate of
23 coverage or policy and how they were applied; and
24 4. The relevant provisions of any nationally
25 recognized and peer-reviewed medical or scientific documents
26 used in the external review.
27 (j) The decision of the independent review entity is
28 binding on the organization.
29 (k) Independent review entities and their agents may
30 not be held liable for subsequent actions of the organization.
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1 (l) All parties that participate in the independent
2 review process, including the attending health care provider,
3 the organization, and the independent review entity, are
4 immune from liability for their actions taken in accordance
5 with the findings of the independent review entity.
6 (m) The decision of the independent review entity may
7 not be made for the convenience of the patient, the
8 organization, or the physician or other health care provider.
9 (n) The patient, the organization, and the physician
10 or other health care provider involved in the external review
11 may submit written complaints to the agency regarding any
12 independent review entity's practice or practices believed to
13 be an inappropriate application of the requirements set forth
14 in this subsection. The agency shall promptly review the
15 complaint and, if it determines that the actions of the
16 independent review entity are inappropriate, shall take such
17 corrective action as it considers necessary, including, but
18 not limited to, decertification or suspension of the
19 independent review entity.
20 (5)(a) To be certified as an independent review entity
21 under this section, an entity must submit to the agency an
22 application on a form developed by the agency. The application
23 must include the following:
24 1. The name of each stockholder or owner of more than
25 5 percent of any stock or options of an applicant;
26 2. The name of any holder of bonds or notes of the
27 applicant in an amount that exceeds $100,000;
28 3. The name and type of business of each corporation
29 or other organization that the applicant controls or with
30 which it is affiliated and the nature and extent of the
31 affiliation or control;

1 4. The name and a biographical sketch of each
2 director, officer, and executive of the applicant and any
3 entity listed under subparagraphs 1.-3. and a description of
4 any relationship that the named individual has with an insurer
5 as defined in s. 624.03 or with a provider of health care
6 services;
7 5. The percentage of the applicant's revenues which is
8 anticipated to be derived from reviews conducted under this
9 section;
10 6. A description of the minimum qualifications applied
11 by the independent review entity in selecting health care
12 professionals to perform external reviews and the areas of
13 expertise and the medical credentials of the health care
14 professionals who are currently available to perform external
15 reviews; and
16 7. The procedures to be used by the independent review
17 entity in making external review determinations.
18
19 If at any time there is a material change in the information
20 included in the application, the independent review entity
21 must submit updated information to the agency.
22 (b) An independent review entity that is accredited by
23 a nationally recognized accreditation organization is in
24 compliance with the requirements of paragraph (a).
25 (c) Each independent review entity shall submit to the
26 agency annually, in a form acceptable to the agency, the
27 information required by paragraph (a).
28 (d) An independent review entity may not be a
29 subsidiary of, or in any way affiliated with or owned or
30 controlled by, an insurer or a trade or professional
31 association of payers.

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1 (e) An independent review entity may not be a
2 subsidiary of, or in any way owned or controlled by, a health
3 care provider or a professional trade association of health
4 care providers.
5 (f) A health care provider who is acting as a reviewer
6 for an independent review entity must be in good standing and
7 must hold a nonrestricted license in a state of the United
8 States.
9 (g) A health care provider who is acting as a reviewer
10 for an independent review entity must hold a current
11 certification by a recognized American medical specialty board
12 in the area appropriate to the subject of the review, must be
13 an expert in the treatment of the enrollee's medical condition
14 under review, and must have actual clinical experience
15 relating to that medical condition.
16 (h) The independent review entity shall have a
17 quality-assurance mechanism to ensure the timeliness and
18 quality of the review, the qualifications and independence of
19 the reviewer, and the confidentiality of medical records and
20 review materials.
21 (i) Neither the independent review entity nor any
22 reviewers of the entity may have any material, professional,
23 familial, or financial conflict of interest with any of the
24 following:
25 1. The patient;
26 2. The insurer or organization involved in the review;
27 3. Any officer, director, or management employee of
28 such an insurer or organization;
29 4. The health care provider proposing the service or
30 treatment or any associated independent practice association
31 (IPA);

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1 5. The institution at which the service or treatment
2 has been or would be provided; or
3 6. The development or manufacture of the principal
4 drug, device, procedure, or other therapy proposed for the
5 enrollee whose treatment is under review.
6 (j) The term "conflict of interest" does not include:
7 1. A contract under which an academic medical center
8 or other similar medical center provides health care services
9 to enrollees, except for academic medical centers that would
10 provide the service under review;
11 2. Health care provider affiliations that are limited
12 to staff privileges; or
13 3. An expert reviewer's relationship with an insurer
14 as a contracting health care provider, except for a provider
15 proposed to provide the service under review.
16 (6) The agency has the authority to make rules to
17 implement this section.
18 (8)~~(5)~~ Except as provided in subsection(9)~~(6)~~, the
19 organization shall resolve a grievance within 60 days after
20 receipt of the grievance, or within a maximum of 90 days if
21 the grievance involves the collection of information outside
22 the service area. These time limitations are tolled if the
23 organization has notified the subscriber, in writing, that
24 additional information is required for proper review of the
25 grievance and that such time limitations are tolled until such
26 information is provided. After the organization receives the
27 requested information, the time allowed for completion of the
28 grievance process resumes.
29 Section 11. Small-employer carriers, allowable
30 exclusions; rates; required notice.--
31 (1) As used in this section, the term:

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1 (a) "Mandated health benefit" means any law that
2 requires a carrier to:
3 1. Provide coverage for specific medical or
4 health-related services, treatments, medications, or
5 practices.
6 2. Provide coverage for services that are specific to
7 health care practitioners.
8 3. Offer coverage for specific services, treatments,
9 medications, or practices or expand an existing coverage to
10 include specific services, treatments, medications, or
11 practices.
12 4. Provide reimbursement to a specific health care
13 practitioner.
14 (b) "Small-employer carrier" includes both insurers
15 and health maintenance organizations that offer health plans
16 to employer groups of 1-50 employees.
17 (2) Notwithstanding any other provision of law, a
18 small-employer carrier may deliver or issue for delivery a
19 health insurance policy or certificate, or a health plan
20 contract, that does not include mandated health benefits.
21 (3) Each health insurance policy or certificate or
22 health plan contract issued as authorized under subsection (2)
23 must have rates that average statewide at least 25 percent
24 less than the carrier's average statewide rates for the
25 standard health benefit plan and must clearly display the
26 following notice:
27 "THIS PLAN DOES NOT PROVIDE COVERAGE FOR VARIOUS BENEFITS
28 MANDATED BY FLORIDA LAW. READ YOUR POLICY CAREFULLY."
29 Section 12. This act shall take effect July 1, 2000.
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CODING: Words ~~stricken~~ are deletions; words underlined are additions.

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SENATE SUMMARY

Creates the Mandated Health Insurance Benefits and Providers Estimating Conference. Provides for membership and duties of the conference. Provides duties of legislative committees that have jurisdiction over health insurance matters. Prohibits billing an HMO subscriber for services covered by the HMO. Provides responsibility for enforcing that prohibition against physicians and against hospitals and nursing homes. Amends the membership of the statewide provider and subscriber assistance panel by adding an attorney. Provides that certain decisions are subject to a review hearing. Requires physicians and hospitals to provide notice informing patients about the toll-free health care hotline. Provides that certain legislative proposals must be submitted to and assessed by the Mandated Health Insurance Benefits and Providers Estimating Conference. Amends guidelines for assessing the impact of a proposal to legislatively mandate certain health coverage. Provides prerequisites to legislative consideration of such proposals. Provides an HMO subscriber's bill of benefits. Requires that only licensed medical doctors can deny coverage on behalf of an HMO. Provides the basis for such a denial. Requires the HMO to include with the notification of an adverse determination information concerning the appeal process. Providing for review by an independent external review entity of an HMO's decision to deny coverage. Provides qualifications of such entities. Provides rulemaking authority to the agency for Health Care Administration. Allows small-employer carriers to exclude certain mandated health benefits from a health insurance policy, certificate, or contract. Provides conditions for such exclusions.

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