By Representative Negron

A bill to be entitled

An act relating to health maintenance organizations; creating the "Managed Care Organization's Patient's Bill of Rights"; providing legislative findings and intent; specifying that the purpose of the act is to ensure that quality health care and health benefits are provided to the people of this state; providing that managed care organizations owe a fiduciary duty to provide such care; creating s. 641.275, F.S.; providing legislative intent that the rights and responsibilities of subscribers who are covered under health maintenance organization contracts be recognized and summarized; requiring health maintenance organizations to operate in conformity with such rights; requiring organizations to provide subscribers with a copy of their rights and responsibilities; listing specified requirements for organizations that are currently required by other statutes; authorizing civil remedies to enforce the rights specified in s. 641.275, F.S.; providing for actual and punitive damages and attorney's fees and costs; providing for administrative fines; providing that there is not any liability on the part of certain employers or employee organizations; requiring a plaintiff to submit a written grievance as a condition precedent to bringing an action for damages; requiring that a managed care

organization dispose of a grievance within a specified period; requiring notice of an action to enforce the rights provided under the act; authorizing the court to abate an action and require completion of an internal grievance procedure; providing certain exceptions; providing for the statute of limitations to be tolled under specified circumstances; authorizing an action for nonmonetary relief without complying with conditions precedent for the purpose of preventing potential death or serious bodily harm; providing for severability; providing an effective date.

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

Section 1. Managed Care Organization's Patient's Bill of Rights.--This act may be cited as the "Managed Care Organization's Patient's Bill of Rights."

Section 2. Legislative findings and intent.--

(1) The Legislature finds that:

(a) The health, safety, and welfare of the people of this state are fundamental state interests that the Legislature is responsible for protecting through the laws of this state.

(b) The manner in which health care is provided to the people of this state has a direct impact upon the health, safety, and welfare of state residents.

(2) The Legislature intends that this act apply to all managed care organizations and that the term "managed care organization" include health insurance carriers; health

maintenance organizations; health service plans; other managed care entities that provide health care or health benefits; and entities regulated under chapters 624 through 631, Florida Statutes, and chapter 641, Florida Statutes, which provide health care benefits. Managed care organizations are engaged in the business of insurance in this state as that term is defined under the McCarran-Ferguson Act, 15 U.S.C. ss. 1011 et seq.

(3) The purpose of this act is to regulate the business of insurance and to ensure that appropriate quality health care and health benefits are provided through managed health care to the people of this state.

(4) Managed care organizations owe a fiduciary duty to the people of this state to ensure appropriate quality health care and health benefits to maintain and maximize the health, safety, and welfare of the people of this state.

(5) To ensure that adequate remedies exist to protect the health, safety, and welfare of the people of this state, this act creates substantive rights for quality health care and health benefits and provides remedies under state law for persons who are harmed by the failure of a managed care organization to meet appropriate standards for quality health care and health benefits guaranteed under this act.

(6) It is the intent of the Legislature that all managed care organizations be given notice of a violation of a patient's rights and be provided with an opportunity to comply with the law without the necessity of filing a civil action. The Legislature recognizes, however, that the rights and remedies identified in this act are necessary to properly regulate the business of insurance in this state and to

protect the health, safety, and welfare of the people of this state.

Section 3. Section 641.275, Florida Statutes, is created to read:

641.275 Subscriber's rights and responsibilities under health maintenance contracts; required notice.--

(1) It is the intent of the Legislature that the rights and responsibilities of subscribers who are covered under health maintenance organization contracts be recognized and summarized in a statement of subscriber rights and responsibilities. An organization may not require a subscriber to waive his or her rights as a condition of coverage or treatment and must operate in conformity with such rights.

(2) Each organization must provide subscribers with a copy of their rights and responsibilities as set forth in this section, in such form as approved by the department.

(3) An organization shall:

(a) Ensure that health care services provided to subscribers are rendered under reasonable standards of quality of care consistent with the prevailing standards of medical practice in the community, as required by s. 641.51.

(b) Have a quality assurance program for health care services, as required by s. 641.51.

(c) Not modify the professional judgment of a physician unless the course of treatment is inconsistent with the prevailing standards of medical practice in the community, as required by s. 641.51.

(d) Not restrict a provider's ability to communicate information to the subscriber or patient regarding medical care options that are in the best interest of the subscriber or patient, as required by s. 641.315(5).

(e) Provide for standing referrals to specialists for subscribers with chronic and disabling conditions, as required by s. 641.51.

(f) Allow a female subscriber to select an obstetrician/gynecologist as her primary care physician, as required by s. 641.19(13)(e).

(g) Provide direct access, without prior authorization, for a female subscriber to visit a obstetrician/gynecologist, as required by s. 641.51(11).

(h) Provide direct access, without prior authorization, to a dermatologist, as required by s. 641.31(33).

(i) Not limit coverage for the length of stay in a hospital for a mastectomy for any time period that is less than that determined to be medically necessary by the treating physician, as required by s. 641.31(31).

(j) Not limit coverage for the length of a maternity or newborn stay in a hospital or for followup care outside the hospital to any time period less than that determined to be medically necessary by the treating provider, as required by s. 641.31(18).

(k) Not exclude coverage for bone marrow transplant procedures determined by the Agency for Health Care Administration to not be experimental, as required by s. 627.4236.

(l) Not exclude coverage for drugs on the ground that the drug is not approved by the United States Food and Drug Administration, as required by s. 627.4239.

(m) Give the subscriber the right to a second medical opinion as required by s. 641.51(5).

(n) Allow subscribers to continue treatment from a provider after the provider's contract with the organization has been terminated, as required by s. 641.51(8).

(o) Establish a procedure for resolving subscriber grievances, including review of adverse determinations by the organization and expedited review of urgent subscriber grievances, as required by s. 641.511.

(p) Notify subscribers of the right to an independent external review of grievances not resolved by the organization, as required by s. 408.7056.

(q) Provide, without prior authorization, coverage for emergency services and care, as required by s. 641.513.

(r) Not require or solicit genetic information or use genetic test results for any insurance purposes, as required by s. 627.4301.

(s) Promptly pay or deny claims as required by s. 641.3155.

(t) Provide information to subscribers regarding benefits, limitations, resolving grievances, emergency services and care, treatment by noncontract providers, list of contract providers, authorization and referral process, the process used to determine whether services are medically necessary, quality assurance program, prescription drug benefits and use of a drug formulary, confidentiality and disclosure of medical records, process of determining experimental or investigational medical treatments, and process used to examine qualifications of contract providers, as required by ss. 641.31, 641.495, and 641.54.

(4) The statement of rights in subsection (3) is a summary of selected requirements for organizations contained

in other sections of the Florida Statutes. This section does not alter the requirements of such other sections.

(5)(a) Patients and providers are responsible for providing, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters that relate to the patient's health.

(b) A patient is responsible for reporting unexpected changes in his or her condition.

(c) A patient is responsible for reporting to the recommending physician whether he or she understands a contemplated medical course of action and what is expected of him or her.

(d) A patient is responsible for following the treatment plan recommended.

(e) A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

(f) A patient is responsible for following the procedures of the managed care organization for selecting a primary care physician and obtaining referrals.

(g) A patient is responsible for reading and ensuring the accuracy and completeness of information on an application to the best of his or her ability, and for not signing any blank, incomplete, or inaccurate form.

(h) A patient is responsible for reading and understanding the contract of his or her managed care organization.

(i) A patient is responsible for paying the monthly premium, even if the patient is involved in a financial dispute with the managed care organization.

(j) A patient is responsible for paying his or her coinsurance, deductibles, or copayments.

(k) A patient is responsible for arranging for prior approval before accepting care from a noncontracted provider, except in an emergency, as defined in s. 641.19, and for understanding the financial consequences of failing to obtain prior approval.

Section 4. Civil remedy to enforce rights.--

(1) Any person whose rights, as specified in s. 641.275, Florida Statutes, are violated has a cause of action against the managed care organization or provider. The action may be brought by the person, by the person's guardian, by an individual or organization acting on behalf of the person with the consent of the person or his or her guardian, or by the personal representative of the estate of a deceased person. The action may be brought in any court of competent jurisdiction to enforce such rights and recover actual and punitive damages for any violation of the rights of the person. The damages recoverable include all reasonably foreseeable harm caused by the violation of the rights specified in s. 641.275, Florida Statutes. The damages are not limited by any other state law. Punitive damages may be awarded for conduct that is willful, wanton, gross, flagrant, reckless, or consciously indifferent to the rights of an individual protected by this act. Any plaintiff who prevails in such an action may recover reasonable attorney's fees, costs of the action, and damages, unless the court finds that the plaintiff has acted in bad faith or with malicious purpose or that there was a complete absence of a justiciable issue of law or fact. A prevailing defendant may claim reasonable attorney's fees under s. 57.105, Florida Statutes. The

remedies provided in this section are remedial and are in addition to and cumulative with all other legal, equitable, administrative, contractual, or informal remedies available to the people of this state or to state agencies.

(2) Upon an adverse adjudication, the defendant is liable for actual and punitive damages as provided in subsection (1) or $500 per violation of the managed care organization's patient's bill of rights, whichever is greater, together with court costs and reasonable attorney's fees incurred by the plaintiff.

(3) This section does not create any liability on the part of an employer of a patient or that employer's employees, unless the employer is the patient's managed care entity. This section does not create any liability on the part of an employee organization, a voluntary employee-beneficiary organization, or a similar organization, unless such organization is the patient's managed care entity and makes coverage determinations under a managed care plan.

(4)(a) As a condition precedent to bringing an action under this section, the patient must have submitted a written grievance to the managed care organization and received a final disposition of the grievance from the managed care organization. For purposes of this section, if a managed care organization fails to render a final disposition of the grievance within 30 days, the disposition shall be deemed to be adverse to the managed care organization. The 30-day time limit does not apply if the medical records necessary for a review of the grievance are not available or if a delay in the final disposition of the grievance is caused by the patient.

(b) If the patient does not submit a grievance to the managed care organization within 1 year after the action

giving rise to the grievance, as required by s. 641.511(1), Florida Statutes, the patient is not required to submit a grievance as a condition precedent to initiating and maintaining a cause of action to enforce his or her rights. However, the patient must provide 30 days' written notice to the managed care organization of the patient's intent to pursue a civil action for a violation of the managed care organization's patient's bill of rights. The notice must include:

1. The alleged violation of the patient's rights.

2. The facts and circumstances giving rise to the violation.

3. The name of any individual involved in the violation.

4. A statement that the notice is given in order to give the managed care organization the opportunity to comply with the law.

(5) If the patient does not comply with subsection (4), the court may not dismiss the action, but may order that the patient complete the internal grievance procedure of the managed care organization, as provided in paragraph (4)(a), or give the 30 days' notice, as provided in paragraph (4)(b). The court may abate the action for such purposes for not more than 60 days. Such orders of the court are the only remedies available to a party that complains of a patient's failure to comply with subsection (4).

(6) Subsection (4) does not apply if harm to the patient has already occurred or is imminent.

(7) The statute of limitations with respect to an action that may be brought under this section is tolled upon submission of a grievance in accordance with s. 641.511,

Florida Statutes, or submission of 30 days' notice, whichever is applicable, and the time such grievance or notice is pending is not included within the period limiting the time for bringing such action.

(8) There is no other condition precedent to bringing an action under this section.

(9)(a) It is the intent of the Legislature that this section provide to the people of this state the ability to enforce their rights through equitable, injunctive, or other relief, in addition to relief for monetary damages. A claim for nonmonetary relief may be brought in conjunction with a claim for monetary damages by complying with subsection (4).

(b) An action for nonmonetary relief may also be brought under this section without complying with the conditions precedent that are identified in subsection (4) if immediate relief is necessary to prevent potential death or serious bodily harm. The court shall provide for an expedited hearing to resolve the matter in a manner designed to avoid potential death or serious bodily harm.

Section 5. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Section 6. This act shall take effect July 1, 2001, and shall apply to contracts issued or renewed on or after that date.

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HOUSE SUMMARY

Creates the "Managed Care Organization's Patient's Bill of Rights." Provides legislative intent that the rights and responsibilities of subscribers who are covered under health maintenance organization contracts be recognized and summarized. Requires health maintenance organizations to operate in conformity with such rights and to provide subscribers with a copy of their rights and responsibilities. Lists specified requirements for organizations that are currently required by other statutes. Authorizes civil remedies to enforce the rights specified in the act. Provides for actual and punitive damages, attorney's fees and costs, and administrative fines. Provides that there is not any liability on the part of certain employers or employee organizations. Requires a plaintiff to submit a written grievance as a condition precedent to bringing an action for damages. Requires that a managed care organization dispose of a grievance within a specified period. Requires notice of an action to enforce the rights provided under the act. Authorizes the court to abate an action and require completion of an internal grievance procedure, and provides certain exceptions. Provides for the statute of limitations to be tolled under specified circumstances. Authorizes an action for nonmonetary relief without complying with conditions precedent for the purpose of preventing potential death or serious bodily harm.