By Senator Saunders

37-771-04

1 A bill to be entitled
2 An act relating to health maintenance
3 organizations; amending s. 408.7056, F.S.;
4 changing the name of the Statewide Provider and
5 Subscriber Assistance Program to the Subscriber
6 Assistance Program; revising a definition;
7 requiring certain records and reports to be
8 provided to the Subscriber Assistance Panel;
9 providing for penalties; amending s. 641.3154,
10 F.S.; conforming provisions to changes made by
11 the act; amending s. 641.511, F.S.; conforming
12 provisions; adopting the federal claims
13 procedures for certain commercial health
14 maintenance organizations; specifying a
15 coverage date; amending s. 641.58, F.S.;
16 conforming provisions; providing an effective
17 date.
18
19 Be It Enacted by the Legislature of the State of Florida:
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21 Section 1. Section 408.7056, Florida Statutes, is
22 amended to read:
23 408.7056 ~~Statewide Provider and~~ Subscriber Assistance
24 Program.--
25 (1) As used in this section, the term:
26 (a) "Agency" means the Agency for Health Care
27 Administration.
28 (b) "Department" means the Department of Financial
29 Services.
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1 (c) "Grievance procedure" means an established set of
2 rules that specify a process for appeal of an organizational
3 decision.
4 (d) "Health care provider" or "provider" means a
5 state-licensed or state-authorized facility, a facility
6 principally supported by a local government or by funds from a
7 charitable organization that holds a current exemption from
8 federal income tax under s. 501(c)(3) of the Internal Revenue
9 Code, a licensed practitioner, a county health department
10 established under part I of chapter 154, a prescribed
11 pediatric extended care center defined in s. 400.902, a
12 federally supported primary care program such as a migrant
13 health center or a community health center authorized under s.
14 329 or s. 330 of the United States Public Health Services Act
15 that delivers health care services to individuals, or a
16 community facility that receives funds from the state under
17 the Community Alcohol, Drug Abuse, and Mental Health Services
18 Act and provides mental health services to individuals.
19 (e) "Managed care entity" means a health maintenance
20 organization or a prepaid health clinic certified under
21 chapter 641, a prepaid health plan authorized under s.
22 409.912, or an exclusive provider organization certified under
23 s. 627.6472.
24 (f) "Office" means the Office of Insurance Regulation
25 of the Financial Services Commission.
26 (g) "Panel" means a ~~statewide provider and~~ subscriber
27 assistance panel selected as provided in subsection (11).
28 (2) The agency shall adopt and implement a program to
29 provide assistance to subscribers and providers, including
30 those whose grievances are not resolved by the managed care
31 entity to the satisfaction of the subscriber or provider. The

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1 program shall consist of one or more panels that meet as often
2 as necessary to timely review, consider, and hear grievances
3 and recommend to the agency or the office any actions that
4 should be taken concerning individual cases heard by the
5 panel. The panel shall hear every grievance filed by
6 subscribers and providers on behalf of subscribers, unless the
7 grievance:
8 (a) Relates to a managed care entity's refusal to
9 accept a provider into its network of providers;
10 (b) Is part of an internal grievance in a Medicare
11 managed care entity or a reconsideration appeal through the
12 Medicare appeals process which does not involve a quality of
13 care issue;
14 (c) Is related to a health plan not regulated by the
15 state such as an administrative services organization,
16 third-party administrator, or federal employee health benefit
17 program;
18 (d) Is related to appeals by in-plan suppliers and
19 providers, unless related to quality of care provided by the
20 plan;
21 (e) Is part of a Medicaid fair hearing pursued under
22 42 C.F.R. ss. 431.220 et seq.;
23 (f) Is the basis for an action pending in state or
24 federal court;
25 (g) Is related to an appeal by nonparticipating
26 providers, unless related to the quality of care provided to a
27 subscriber by the managed care entity and the provider is
28 involved in the care provided to the subscriber;
29 (h) Was filed before the subscriber or provider
30 completed the entire internal grievance procedure of the
31 managed care entity, the managed care entity has complied with

1 its timeframes for completing the internal grievance
2 procedure, and the circumstances described in subsection (6)
3 do not apply;
4 (i) Has been resolved to the satisfaction of the
5 subscriber or provider who filed the grievance, unless the
6 managed care entity's initial action is egregious or may be
7 indicative of a pattern of inappropriate behavior;
8 (j) Is limited to seeking damages for pain and
9 suffering, lost wages, or other incidental expenses, including
10 accrued interest on unpaid balances, court costs, and
11 transportation costs associated with a grievance procedure;
12 (k) Is limited to issues involving conduct of a health
13 care provider or facility, staff member, or employee of a
14 managed care entity which constitute grounds for disciplinary
15 action by the appropriate professional licensing board and is
16 not indicative of a pattern of inappropriate behavior, and the
17 agency, office, or department has reported these grievances to
18 the appropriate professional licensing board or to the health
19 facility regulation section of the agency for possible
20 investigation; or
21 (l) Is withdrawn by the subscriber or provider.
22 Failure of the subscriber or the provider to attend the
23 hearing shall be considered a withdrawal of the grievance.
24 (3) The agency shall review all grievances within 60
25 days after receipt and make a determination whether the
26 grievance shall be heard. Once the agency notifies the panel,
27 the subscriber or provider, and the managed care entity that a
28 grievance will be heard by the panel, the panel shall hear the
29 grievance either in the network area or by teleconference no
30 later than 120 days after the date the grievance was filed.
31 The agency shall notify the parties, in writing, by facsimile

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1 transmission, or by phone, of the time and place of the
2 hearing. The panel may take testimony under oath, request
3 certified copies of documents, and take similar actions to
4 collect information and documentation that will assist the
5 panel in making findings of fact and a recommendation. The
6 panel shall issue a written recommendation, supported by
7 findings of fact, to the provider or subscriber, to the
8 managed care entity, and to the agency or the office no later
9 than 15 working days after hearing the grievance. If at the
10 hearing the panel requests additional documentation or
11 additional records, the time for issuing a recommendation is
12 tolled until the information or documentation requested has
13 been provided to the panel. The proceedings of the panel are
14 not subject to chapter 120.
15 (4) If, upon receiving a proper patient authorization
16 along with a properly filed grievance, the agency requests
17 medical records from a health care provider or managed care
18 entity, the health care provider or managed care entity that
19 has custody of the records has 10 days to provide the records
20 to the agency. Records include medical records, communication
21 logs associated with the grievance both to and from the
22 subscriber, contracts, and any other contents of the internal
23 grievance file associated with the complaint filed with the
24 Subscriber Assistance Program.Failure to provide requested
25 ~~medical~~ records may result in the imposition of a fine of up
26 to $500. Each day that records are not produced is considered
27 a separate violation.
28 (5) Grievances that the agency determines pose an
29 immediate and serious threat to a subscriber's health must be
30 given priority over other grievances. The panel may meet at
31 the call of the chair to hear the grievances as quickly as

1 possible but no later than 45 days after the date the
2 grievance is filed, unless the panel receives a waiver of the
3 time requirement from the subscriber. The panel shall issue a
4 written recommendation, supported by findings of fact, to the
5 office or the agency within 10 days after hearing the
6 expedited grievance.
7 (6) When the agency determines that the life of a
8 subscriber is in imminent and emergent jeopardy, the chair of
9 the panel may convene an emergency hearing, within 24 hours
10 after notification to the managed care entity and to the
11 subscriber, to hear the grievance. The grievance must be
12 heard notwithstanding that the subscriber has not completed
13 the internal grievance procedure of the managed care entity.
14 The panel shall, upon hearing the grievance, issue a written
15 emergency recommendation, supported by findings of fact, to
16 the managed care entity, to the subscriber, and to the agency
17 or the office for the purpose of deferring the imminent and
18 emergent jeopardy to the subscriber's life. Within 24 hours
19 after receipt of the panel's emergency recommendation, the
20 agency or office may issue an emergency order to the managed
21 care entity. An emergency order remains in force until:
22 (a) The grievance has been resolved by the managed
23 care entity;
24 (b) Medical intervention is no longer necessary; or
25 (c) The panel has conducted a full hearing under
26 subsection (3) and issued a recommendation to the agency or
27 the office, and the agency or office has issued a final order.
28 (7) After hearing a grievance, the panel shall make a
29 recommendation to the agency or the office which may include
30 specific actions the managed care entity must take to comply
31 with state laws or rules regulating managed care entities.

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1 (8) A managed care entity, subscriber, or provider
2 that is affected by a panel recommendation may within 10 days
3 after receipt of the panel's recommendation, or 72 hours after
4 receipt of a recommendation in an expedited grievance, furnish
5 to the agency or office written evidence in opposition to the
6 recommendation or findings of fact of the panel.
7 (9) No later than 30 days after the issuance of the
8 panel's recommendation and, for an expedited grievance, no
9 later than 10 days after the issuance of the panel's
10 recommendation, the agency or the office may adopt the panel's
11 recommendation or findings of fact in a proposed order or an
12 emergency order, as provided in chapter 120, which it shall
13 issue to the managed care entity. The agency or office may
14 issue a proposed order or an emergency order, as provided in
15 chapter 120, imposing fines or sanctions, including those
16 contained in ss. 641.25 and 641.52. The agency or the office
17 may reject all or part of the panel's recommendation. All
18 fines collected under this subsection must be deposited into
19 the Health Care Trust Fund.
20 (10) In determining any fine or sanction to be
21 imposed, the agency and the office may consider the following
22 factors:
23 (a) The severity of the noncompliance, including the
24 probability that death or serious harm to the health or safety
25 of the subscriber will result or has resulted, the severity of
26 the actual or potential harm, and the extent to which
27 provisions of chapter 641 were violated.
28 (b) Actions taken by the managed care entity to
29 resolve or remedy any quality-of-care grievance.
30 (c) Any previous incidents of noncompliance by the
31 managed care entity.

1 (d) Any other relevant factors the agency or office
2 considers appropriate in a particular grievance.
3 (11) The panel shall consist of the Insurance Consumer
4 Advocate, or designee thereof, established by s. 627.0613; two
5 members employed by the agency and two members employed by the
6 department, chosen by their respective agencies; a consumer
7 appointed by the Governor; a physician appointed by the
8 Governor, as a standing member; and physicians who have
9 expertise relevant to the case to be heard, on a rotating
10 basis. The agency may contract with a medical director and a
11 primary care physician who shall provide additional technical
12 expertise to the panel. The medical director shall be
13 selected from a health maintenance organization with a current
14 certificate of authority to operate in Florida.
15 (12) Every managed care entity shall submit a
16 quarterly report to the agency, the office, and the department
17 listing the number and the nature of all subscribers' and
18 providers' grievances which have not been resolved to the
19 satisfaction of the subscriber or provider after the
20 subscriber or provider follows the entire internal grievance
21 procedure of the managed care entity. The agency shall notify
22 all subscribers and providers included in the quarterly
23 reports of their right to file an unresolved grievance with
24 the panel.
25 (13) A proposed order issued by the agency or office
26 which only requires the managed care entity to take a specific
27 action under subsection (7) is subject to a summary hearing in
28 accordance with s. 120.574, unless all of the parties agree
29 otherwise. If the managed care entity does not prevail at the
30 hearing, the managed care entity must pay reasonable costs and
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1 attorney's fees of the agency or the office incurred in that
2 proceeding.
3 (14)(a) Any information that identifies a subscriber
4 which is held by the panel, agency, or department pursuant to
5 this section is confidential and exempt from the provisions of
6 s. 119.07(1) and s. 24(a), Art. I of the State Constitution.
7 However, at the request of a subscriber or managed care entity
8 involved in a grievance procedure, the panel, agency, or
9 department shall release information identifying the
10 subscriber involved in the grievance procedure to the
11 requesting subscriber or managed care entity.
12 (b) Meetings of the panel shall be open to the public
13 unless the provider or subscriber whose grievance will be
14 heard requests a closed meeting or the agency or the
15 department determines that information which discloses the
16 subscriber's medical treatment or history or information
17 relating to internal risk management programs as defined in s.
18 641.55(5)(c), (6), and (8) may be revealed at the panel
19 meeting, in which case that portion of the meeting during
20 which a subscriber's medical treatment or history or internal
21 risk management program information is discussed shall be
22 exempt from the provisions of s. 286.011 and s. 24(b), Art. I
23 of the State Constitution. All closed meetings shall be
24 recorded by a certified court reporter.
25 Section 2. Subsection (4) of section 641.3154, Florida
26 Statutes, is amended to read:
27 641.3154 Organization liability; provider billing
28 prohibited.--
29 (4) A provider or any representative of a provider,
30 regardless of whether the provider is under contract with the
31 health maintenance organization, may not collect or attempt to

1 collect money from, maintain any action at law against, or
2 report to a credit agency a subscriber of an organization for
3 payment of services for which the organization is liable, if
4 the provider in good faith knows or should know that the
5 organization is liable. This prohibition applies during the
6 pendency of any claim for payment made by the provider to the
7 organization for payment of the services and any legal
8 proceedings or dispute resolution process to determine whether
9 the organization is liable for the services if the provider is
10 informed that the ~~such~~ proceedings are taking place. It is
11 presumed that a provider does not know and should not know
12 that an organization is liable unless:
13 (a) The provider is informed by the organization that
14 it accepts liability;
15 (b) A court of competent jurisdiction determines that
16 the organization is liable;
17 (c) The office or agency makes a final determination
18 that the organization is required to pay for the ~~such~~ services
19 subsequent to a recommendation made by the ~~Statewide Provider~~
20 ~~and~~ Subscriber Assistance Panel pursuant to s. 408.7056; or
21 (d) The agency issues a final order that the
22 organization is required to pay for such services subsequent
23 to a recommendation made by a resolution organization pursuant
24 to s. 408.7057.
25 Section 3. Section 641.511, Florida Statutes, is
26 amended to read:
27 641.511 Subscriber grievance reporting and resolution
28 requirements.--
29 (1) Every organization must have a grievance procedure
30 available to its subscribers for the purpose of addressing
31 complaints and grievances. Every organization must notify its

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1 subscribers that a subscriber must submit a grievance within 1
2 year after the date of occurrence of the action that initiated
3 the grievance, and may submit the grievance for review to the
4 ~~Statewide Provider and~~ Subscriber Assistance Program panel as
5 provided in s. 408.7056 after receiving a final disposition of
6 the grievance through the organization's grievance process.
7 An organization shall maintain records of all grievances and
8 shall report annually to the agency the total number of
9 grievances handled, a categorization of the cases underlying
10 the grievances, and the final disposition of the grievances.
11 (2) When an organization receives an initial complaint
12 from a subscriber, the organization must respond to the
13 complaint within a reasonable time after its submission. At
14 the time of receipt of the initial complaint, the organization
15 shall inform the subscriber that the subscriber has a right to
16 file a written grievance at any time and that assistance in
17 preparing the written grievance shall be provided by the
18 organization.
19 (3) Each organization's grievance procedure, as
20 required under subsection (1), must include, at a minimum:
21 (a) An explanation of how to pursue redress of a
22 grievance.
23 (b) The names of the appropriate employees or a list
24 of grievance departments that are responsible for implementing
25 the organization's grievance procedure. The list must include
26 the address and the toll-free telephone number of each
27 grievance department, the address of the agency and its
28 toll-free telephone hotline number, and the address of the
29 ~~Statewide Provider and~~ Subscriber Assistance Program and its
30 toll-free telephone number.
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1 (c) The description of the process through which a
2 subscriber may, at any time, contact the toll-free telephone
3 hotline of the agency to inform it of the unresolved
4 grievance.
5 (d) A procedure for establishing methods for
6 classifying grievances as urgent and for establishing time
7 limits for an expedited review within which such grievances
8 must be resolved.
9 (e) A notice that a subscriber may voluntarily pursue
10 binding arbitration in accordance with the terms of the
11 contract if offered by the organization, after completing the
12 organization's grievance procedure and as an alternative to
13 the ~~Statewide Provider and~~ Subscriber Assistance Program. Such
14 notice shall include an explanation that the subscriber may
15 incur some costs if the subscriber pursues binding
16 arbitration, depending upon the terms of the subscriber's
17 contract.
18 (f) A process whereby the grievance manager
19 acknowledges the grievance and investigates the grievance in
20 order to notify the subscriber of a final decision in writing.
21 (g) A procedure for providing individuals who are
22 unable to submit a written grievance with access to the
23 grievance process, which shall include assistance by the
24 organization in preparing the grievance and communicating back
25 to the subscriber.
26 (4)(a) With respect to a grievance concerning an
27 adverse determination, an organization shall make available to
28 the subscriber a review of the grievance by an internal review
29 panel; <u>the</u> ~~such~~ review must be requested within 30 days after
30 the organization's transmittal of the final determination
31 notice of an adverse determination. A majority of the panel

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1 shall be persons who previously were not involved in the
2 initial adverse determination. A person who previously was
3 involved in the adverse determination may appear before the
4 panel to present information or answer questions. The panel
5 shall have the authority to bind the organization to the
6 panel's decision.
7 (b) An organization shall ensure that a majority of
8 the persons reviewing a grievance involving an adverse
9 determination are providers who have appropriate expertise.
10 An organization shall issue a copy of the written decision of
11 the review panel to the subscriber and to the provider, if
12 any, who submits a grievance on behalf of a subscriber. In
13 cases where there has been a denial of coverage of service,
14 the reviewing provider shall not be a provider previously
15 involved with the adverse determination.
16 (c) An organization shall establish written procedures
17 for a review of an adverse determination. Review procedures
18 shall be available to the subscriber and to a provider acting
19 on behalf of a subscriber.
20 (d) In any case when the review process does not
21 resolve a difference of opinion between the organization and
22 the subscriber or the provider acting on behalf of the
23 subscriber, the subscriber or the provider acting on behalf of
24 the subscriber may submit a written grievance to the ~~Statewide~~
25 ~~Provider and~~ Subscriber Assistance Program.
26 (5)<u>(a)</u> Except as provided in subsection (6), the
27 organization shall resolve a grievance within 60 days after
28 receipt of the grievance, or within a maximum of 90 days if
29 the grievance involves the collection of information outside
30 the service area. These time limitations are tolled if the
31 organization has notified the subscriber, in writing, that

1 additional information is required for proper review of the
2 grievance and that the ~~such~~ time limitations are tolled until
3 such information is provided. After the organization receives
4 the requested information, the time allowed for completion of
5 the grievance process resumes. Subject to the exceptions in
6 subsection (6), the Employee Retirement Income Security Act of
7 1974 (ERISA), as implemented by 29 C.F.R. 2560.503-1 is
8 adopted and incorporated by reference as applicable to all
9 commercial organizations that administer small and large group
10 health plans and are subject to this section. The claims
11 procedures of the regulations establish the minimum standards
12 for grievance processes for small and large group health plans
13 in this state.
14 (b) Commercial organizations subject to this
15 subsection shall comply with 29 C.F.R. 2560.503-1 for all new
16 or amended small or large group health plans that become
17 effective on or after January 1, 2005.
18 (6)(a) An organization shall establish written
19 procedures for the expedited review of an urgent grievance. A
20 request for an expedited review may be submitted orally or in
21 writing and shall be subject to the review procedures of this
22 section, if it meets the criteria of this section. Unless it
23 is submitted in writing, for purposes of the grievance
24 reporting requirements in subsection (1), the request shall be
25 considered an appeal of a utilization review decision and not
26 a grievance. Expedited review procedures shall be available to
27 a subscriber and to the provider acting on behalf of a
28 subscriber. For purposes of this subsection, "subscriber"
29 includes the legal representative of a subscriber.
30 (b) Expedited reviews shall be evaluated by an
31 appropriate clinical peer or peers. The clinical peer or peers

1 shall not have been involved in the initial adverse
2 determination.
3 (c) In an expedited review, all necessary information,
4 including the organization's decision, shall be transmitted
5 between the organization and the subscriber, or the provider
6 acting on behalf of the subscriber, by telephone, facsimile,
7 or the most expeditious method available.
8 (d) In an expedited review, an organization shall make
9 a decision and notify the subscriber, or the provider acting
10 on behalf of the subscriber, as expeditiously as the
11 subscriber's medical condition requires, but in no event more
12 than 72 hours after receipt of the request for review. If the
13 expedited review is a concurrent review determination, the
14 service shall be continued without liability to the subscriber
15 until the subscriber has been notified of the determination.
16 (e) An organization shall provide written confirmation
17 of its decision concerning an expedited review within 2
18 working days after providing notification of that decision, if
19 the initial notification was not in writing.
20 (f) An organization shall provide reasonable access,
21 not to exceed 24 hours after receiving a request for an
22 expedited review, to a clinical peer who can perform the
23 expedited review.
24 (g) In any case when the expedited review process does
25 not resolve a difference of opinion between the organization
26 and the subscriber or the provider acting on behalf of the
27 subscriber, the subscriber or the provider acting on behalf of
28 the subscriber may submit a written grievance to the ~~Statewide~~
29 ~~Provider and~~ Subscriber Assistance Program.
30 (h) An organization shall not provide an expedited
31 retrospective review of an adverse determination.

1 (7) Each organization shall send to the agency a copy
2 of its quarterly grievance reports submitted to the office
3 <u>under</u> ~~pursuant to~~ s. 408.7056(12).
4 (8) The agency shall investigate all reports of
5 unresolved quality of care grievances received from:
6 (a) Annual and quarterly grievance reports submitted
7 by the organization to the office.
8 (b) Review requests of subscribers whose grievances
9 remain unresolved after the subscriber has followed the full
10 grievance procedure of the organization.
11 (9)(a) The agency shall advise subscribers with
12 grievances to follow their organization's formal grievance
13 process for resolution prior to review by the ~~Statewide~~
14 ~~Provider and~~ Subscriber Assistance Program. The subscriber
15 may, however, submit a copy of the grievance to the agency at
16 any time during the process.
17 (b) Requiring completion of the organization's
18 grievance process before the ~~Statewide Provider and~~ Subscriber
19 Assistance Program panel's review does not preclude the agency
20 from investigating any complaint or grievance before the
21 organization makes its final determination.
22 (10) Each organization must notify the subscriber in a
23 final decision letter that the subscriber may request review
24 of the organization's decision concerning the grievance by the
25 ~~Statewide Provider and~~ Subscriber Assistance Program, as
26 provided in s. 408.7056, if the grievance is not resolved to
27 the satisfaction of the subscriber. The final decision letter
28 must inform the subscriber that the request for review must be
29 made within 365 days after receipt of the final decision
30 letter, must explain how to initiate such a review, and must
31 include the addresses and toll-free telephone numbers of the

1 agency and the ~~Statewide Provider and~~ Subscriber Assistance
2 Program.
3 (11) Each organization, as part of its contract with
4 any provider, must require the provider to post a consumer
5 assistance notice prominently displayed in the reception area
6 of the provider and clearly noticeable by all patients. The
7 consumer assistance notice must state the addresses and
8 toll-free telephone numbers of the Agency for Health Care
9 Administration, the ~~Statewide Provider and~~ Subscriber
10 Assistance Program, and the Department of Financial Services.
11 The consumer assistance notice must also clearly state that
12 the address and toll-free telephone number of the
13 organization's grievance department shall be provided upon
14 request. The agency may adopt rules to implement this section.
15 (12) The agency may impose administrative sanction, in
16 accordance with s. 641.52, against an organization for
17 noncompliance with this section.
18 Section 4. Subsection (4) of section 641.58, Florida
19 Statutes, is amended to read:
20 641.58 Regulatory assessment; levy and amount; use of
21 funds; tax returns; penalty for failure to pay.--
22 (4) The moneys received and deposited into the Health
23 Care Trust Fund shall be used to defray the expenses of the
24 agency in the discharge of its administrative and regulatory
25 powers and duties under this part, including conducting an
26 annual survey of the satisfaction of members of health
27 maintenance organizations; contracting with physician
28 consultants for the ~~Statewide Provider and~~ Subscriber
29 Assistance Panel; maintaining offices and necessary supplies,
30 essential equipment, and other materials, salaries and
31 expenses of required personnel; and discharging the

1 administrative and regulatory powers and duties imposed under
2 this part.
3 Section 5. This act shall take effect upon becoming a
4 law.
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6 ***
7 SENATE SUMMARY
8 Changes the name of the Statewide Provider and Subscriber
9 Assistance Program to the Subscriber Assistance Program.
10 Requires certain records and reports to be provided to
11 the Subscriber Assistance Panel. Provides for penalties.
Adopts the federal claims procedures for certain
specified commercial health maintenance organizations.
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