

By the Committee on Health, Aging, and Long-Term Care; and
Senator Saunders

317-1131-04

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; requiring that a
10 quorum be present before a grievance can be
11 heard or voted upon; establishing a maximum
12 number of panel members; amending s. 641.3154,
13 F.S.; conforming provisions to changes made by
14 the act; amending s. 641.511, F.S.; conforming
15 provisions; adopting the federal claims
16 procedures for certain commercial health
17 maintenance organizations; amending s. 641.58,
18 F.S.; conforming provisions; providing an
19 effective date.

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

23 Section 1. Section 408.7056, Florida Statutes, is
24 amended to read:

25 408.7056 ~~Statewide Provider~~ and Subscriber Assistance
26 Program.--

27 (1) As used in this section, the term:

28 (a) "Agency" means the Agency for Health Care
29 Administration.

30 (b) "Department" means the Department of Financial
31 Services.

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

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

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.

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; at
5 least two members employed by the agency and at least two
6 members employed by the department, chosen by their respective
7 agencies; a consumer appointed by the Governor; a physician
8 appointed by the Governor, as a standing member; and, if
9 necessary, physicians who have expertise relevant to the case
10 to be heard, on a rotating basis. The agency may contract with
11 a medical director, and a primary care physician, or both, who
12 shall provide additional technical expertise to the panel but
13 who shall not be voting members of the panel. The medical
14 director shall be selected from a health maintenance
15 organization with a current certificate of authority to
16 operate in Florida.

17 (12) A majority of those panel members required under
18 subsection (11) shall constitute a quorum for any meeting or
19 hearing of the panel. A grievance may not be heard or voted
20 upon at any panel meeting or hearing unless a quorum is
21 present, except that a minority of the panel may adjourn a
22 meeting or hearing until a quorum is present. A panel convened
23 for the purpose of hearing a subscriber's grievance in
24 accordance with subsections (2) and (3) shall not consist of
25 more than 11 members.

26 (13)~~(12)~~ Every managed care entity shall submit a
27 quarterly report to the agency, the office, and the department
28 listing the number and the nature of all subscribers' and
29 providers' grievances which have not been resolved to the
30 satisfaction of the subscriber or provider after the
31 subscriber or provider follows the entire internal grievance

1 procedure of the managed care entity. The agency shall notify
2 all subscribers and providers included in the quarterly
3 reports of their right to file an unresolved grievance with
4 the panel.

5 (14)~~(13)~~ A proposed order issued by the agency or
6 office which only requires the managed care entity to take a
7 specific action under subsection (7) is subject to a summary
8 hearing in accordance with s. 120.574, unless all of the
9 parties agree otherwise. If the managed care entity does not
10 prevail at the hearing, the managed care entity must pay
11 reasonable costs and attorney's fees of the agency or the
12 office incurred in that proceeding.

13 (15)~~(14)~~(a) Any information that identifies a
14 subscriber which is held by the panel, agency, or department
15 pursuant to this section is confidential and exempt from the
16 provisions of s. 119.07(1) and s. 24(a), Art. I of the State
17 Constitution. However, at the request of a subscriber or
18 managed care entity involved in a grievance procedure, the
19 panel, agency, or department shall release information
20 identifying the subscriber involved in the grievance procedure
21 to the requesting subscriber or managed care entity.

22 (b) Meetings of the panel shall be open to the public
23 unless the provider or subscriber whose grievance will be
24 heard requests a closed meeting or the agency or the
25 department determines that information which discloses the
26 subscriber's medical treatment or history or information
27 relating to internal risk management programs as defined in s.
28 641.55(5)(c), (6), and (8) may be revealed at the panel
29 meeting, in which case that portion of the meeting during
30 which a subscriber's medical treatment or history or internal
31 risk management program information is discussed shall be

1 exempt from the provisions of s. 286.011 and s. 24(b), Art. I
2 of the State Constitution. All closed meetings shall be
3 recorded by a certified court reporter.

4 Section 2. Subsection (4) of section 641.3154, Florida
5 Statutes, is amended to read:

6 641.3154 Organization liability; provider billing
7 prohibited.--

8 (4) A provider or any representative of a provider,
9 regardless of whether the provider is under contract with the
10 health maintenance organization, may not collect or attempt to
11 collect money from, maintain any action at law against, or
12 report to a credit agency a subscriber of an organization for
13 payment of services for which the organization is liable, if
14 the provider in good faith knows or should know that the
15 organization is liable. This prohibition applies during the
16 pendency of any claim for payment made by the provider to the
17 organization for payment of the services and any legal
18 proceedings or dispute resolution process to determine whether
19 the organization is liable for the services if the provider is
20 informed that the ~~such~~ proceedings are taking place. It is
21 presumed that a provider does not know and should not know
22 that an organization is liable unless:

23 (a) The provider is informed by the organization that
24 it accepts liability;

25 (b) A court of competent jurisdiction determines that
26 the organization is liable;

27 (c) The office or agency makes a final determination
28 that the organization is required to pay for the ~~such~~ services
29 subsequent to a recommendation made by the ~~Statewide Provider~~
30 ~~and~~ Subscriber Assistance Panel pursuant to s. 408.7056; or
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1 (d) The agency issues a final order that the
2 organization is required to pay for such services subsequent
3 to a recommendation made by a resolution organization pursuant
4 to s. 408.7057.

5 Section 3. Section 641.511, Florida Statutes, is
6 amended to read:

7 641.511 Subscriber grievance reporting and resolution
8 requirements.--

9 (1) Every organization must have a grievance procedure
10 available to its subscribers for the purpose of addressing
11 complaints and grievances. Every organization must notify its
12 subscribers that a subscriber must submit a grievance within 1
13 year after the date of occurrence of the action that initiated
14 the grievance, and may submit the grievance for review to the
15 ~~Statewide Provider and~~ Subscriber Assistance Program panel as
16 provided in s. 408.7056 after receiving a final disposition of
17 the grievance through the organization's grievance process.
18 An organization shall maintain records of all grievances and
19 shall report annually to the agency the total number of
20 grievances handled, a categorization of the cases underlying
21 the grievances, and the final disposition of the grievances.

22 (2) When an organization receives an initial complaint
23 from a subscriber, the organization must respond to the
24 complaint within a reasonable time after its submission. At
25 the time of receipt of the initial complaint, the organization
26 shall inform the subscriber that the subscriber has a right to
27 file a written grievance at any time and that assistance in
28 preparing the written grievance shall be provided by the
29 organization.

30 (3) Each organization's grievance procedure, as
31 required under subsection (1), must include, at a minimum:

1 (a) An explanation of how to pursue redress of a
2 grievance.

3 (b) The names of the appropriate employees or a list
4 of grievance departments that are responsible for implementing
5 the organization's grievance procedure. The list must include
6 the address and the toll-free telephone number of each
7 grievance department, the address of the agency and its
8 toll-free telephone hotline number, and the address of the
9 ~~Statewide Provider~~ and Subscriber Assistance Program and its
10 toll-free telephone number.

11 (c) The description of the process through which a
12 subscriber may, at any time, contact the toll-free telephone
13 hotline of the agency to inform it of the unresolved
14 grievance.

15 (d) A procedure for establishing methods for
16 classifying grievances as urgent and for establishing time
17 limits for an expedited review within which such grievances
18 must be resolved.

19 (e) A notice that a subscriber may voluntarily pursue
20 binding arbitration in accordance with the terms of the
21 contract if offered by the organization, after completing the
22 organization's grievance procedure and as an alternative to
23 the ~~Statewide Provider~~ and Subscriber Assistance Program. Such
24 notice shall include an explanation that the subscriber may
25 incur some costs if the subscriber pursues binding
26 arbitration, depending upon the terms of the subscriber's
27 contract.

28 (f) A process whereby the grievance manager
29 acknowledges the grievance and investigates the grievance in
30 order to notify the subscriber of a final decision in writing.

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1 (g) A procedure for providing individuals who are
2 unable to submit a written grievance with access to the
3 grievance process, which shall include assistance by the
4 organization in preparing the grievance and communicating back
5 to the subscriber.

6 (4)(a) With respect to a grievance concerning an
7 adverse determination, an organization shall make available to
8 the subscriber a review of the grievance by an internal review
9 panel; the ~~such~~ review must be requested within 30 days after
10 the organization's transmittal of the final determination
11 notice of an adverse determination. A majority of the panel
12 shall be persons who previously were not involved in the
13 initial adverse determination. A person who previously was
14 involved in the adverse determination may appear before the
15 panel to present information or answer questions. The panel
16 shall have the authority to bind the organization to the
17 panel's decision.

18 (b) An organization shall ensure that a majority of
19 the persons reviewing a grievance involving an adverse
20 determination are providers who have appropriate expertise.
21 An organization shall issue a copy of the written decision of
22 the review panel to the subscriber and to the provider, if
23 any, who submits a grievance on behalf of a subscriber. In
24 cases where there has been a denial of coverage of service,
25 the reviewing provider shall not be a provider previously
26 involved with the adverse determination.

27 (c) An organization shall establish written procedures
28 for a review of an adverse determination. Review procedures
29 shall be available to the subscriber and to a provider acting
30 on behalf of a subscriber.

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1 (d) In any case when the review process does not
2 resolve a difference of opinion between the organization and
3 the subscriber or the provider acting on behalf of the
4 subscriber, the subscriber or the provider acting on behalf of
5 the subscriber may submit a written grievance to the ~~Statewide~~
6 ~~Provider and~~ Subscriber Assistance Program.

7 (5) Except as provided in subsection (6), the
8 organization shall resolve a grievance within 60 days after
9 receipt of the grievance, or within a maximum of 90 days if
10 the grievance involves the collection of information outside
11 the service area. These time limitations are tolled if the
12 organization has notified the subscriber, in writing, that
13 additional information is required for proper review of the
14 grievance and that the ~~such~~ time limitations are tolled until
15 such information is provided. After the organization receives
16 the requested information, the time allowed for completion of
17 the grievance process resumes. The Employee Retirement Income
18 Security Act of 1974 (ERISA) as implemented by 29 C.F.R.
19 2560.503-1 is adopted and incorporated by reference as
20 applicable to all organizations that administer small and
21 large group health plans that are subject to 29 C.F.R.
22 2560.503-1. The claims procedures of the regulations of the
23 Employee Retirement Income Security Act of 1974 (ERISA) as
24 implemented by 29 C.F.R. 2560.503-1 shall be the minimum
25 standards for grievance processes for small and large group
26 health plans that are subject to 29 C.F.R. 2560.503-1.

27 (6)(a) An organization shall establish written
28 procedures for the expedited review of an urgent grievance. A
29 request for an expedited review may be submitted orally or in
30 writing and shall be subject to the review procedures of this
31 section, if it meets the criteria of this section. Unless it

1 is submitted in writing, for purposes of the grievance
2 reporting requirements in subsection (1), the request shall be
3 considered an appeal of a utilization review decision and not
4 a grievance. Expedited review procedures shall be available to
5 a subscriber and to the provider acting on behalf of a
6 subscriber. For purposes of this subsection, "subscriber"
7 includes the legal representative of a subscriber.

8 (b) Expedited reviews shall be evaluated by an
9 appropriate clinical peer or peers. The clinical peer or peers
10 shall not have been involved in the initial adverse
11 determination.

12 (c) In an expedited review, all necessary information,
13 including the organization's decision, shall be transmitted
14 between the organization and the subscriber, or the provider
15 acting on behalf of the subscriber, by telephone, facsimile,
16 or the most expeditious method available.

17 (d) In an expedited review, an organization shall make
18 a decision and notify the subscriber, or the provider acting
19 on behalf of the subscriber, as expeditiously as the
20 subscriber's medical condition requires, but in no event more
21 than 72 hours after receipt of the request for review. If the
22 expedited review is a concurrent review determination, the
23 service shall be continued without liability to the subscriber
24 until the subscriber has been notified of the determination.

25 (e) An organization shall provide written confirmation
26 of its decision concerning an expedited review within 2
27 working days after providing notification of that decision, if
28 the initial notification was not in writing.

29 (f) An organization shall provide reasonable access,
30 not to exceed 24 hours after receiving a request for an
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1 expedited review, to a clinical peer who can perform the
2 expedited review.

3 (g) In any case when the expedited review process does
4 not resolve a difference of opinion between the organization
5 and the subscriber or the provider acting on behalf of the
6 subscriber, the subscriber or the provider acting on behalf of
7 the subscriber may submit a written grievance to the ~~Statewide~~
8 ~~Provider and~~ Subscriber Assistance Program.

9 (h) An organization shall not provide an expedited
10 retrospective review of an adverse determination.

11 (7) Each organization shall send to the agency a copy
12 of its quarterly grievance reports submitted to the office
13 under s. 408.7056(13)~~pursuant to s. 408.7056(12)~~.

14 (8) The agency shall investigate all reports of
15 unresolved quality of care grievances received from:

16 (a) Annual and quarterly grievance reports submitted
17 by the organization to the office.

18 (b) Review requests of subscribers whose grievances
19 remain unresolved after the subscriber has followed the full
20 grievance procedure of the organization.

21 (9)(a) The agency shall advise subscribers with
22 grievances to follow their organization's formal grievance
23 process for resolution prior to review by the ~~Statewide~~
24 ~~Provider and~~ Subscriber Assistance Program. The subscriber
25 may, however, submit a copy of the grievance to the agency at
26 any time during the process.

27 (b) Requiring completion of the organization's
28 grievance process before the ~~Statewide Provider and~~ Subscriber
29 Assistance Program panel's review does not preclude the agency
30 from investigating any complaint or grievance before the
31 organization makes its final determination.

1 (10) Each organization must notify the subscriber in a
2 final decision letter that the subscriber may request review
3 of the organization's decision concerning the grievance by the
4 ~~Statewide Provider and~~ Subscriber Assistance Program, as
5 provided in s. 408.7056, if the grievance is not resolved to
6 the satisfaction of the subscriber. The final decision letter
7 must inform the subscriber that the request for review must be
8 made within 365 days after receipt of the final decision
9 letter, must explain how to initiate such a review, and must
10 include the addresses and toll-free telephone numbers of the
11 agency and the ~~Statewide Provider and~~ Subscriber Assistance
12 Program.

13 (11) Each organization, as part of its contract with
14 any provider, must require the provider to post a consumer
15 assistance notice prominently displayed in the reception area
16 of the provider and clearly noticeable by all patients. The
17 consumer assistance notice must state the addresses and
18 toll-free telephone numbers of the Agency for Health Care
19 Administration, the ~~Statewide Provider and~~ Subscriber
20 Assistance Program, and the Department of Financial Services.
21 The consumer assistance notice must also clearly state that
22 the address and toll-free telephone number of the
23 organization's grievance department shall be provided upon
24 request. The agency may adopt rules to implement this section.

25 (12) The agency may impose administrative sanction, in
26 accordance with s. 641.52, against an organization for
27 noncompliance with this section.

28 Section 4. Subsection (4) of section 641.58, Florida
29 Statutes, is amended to read:

30 641.58 Regulatory assessment; levy and amount; use of
31 funds; tax returns; penalty for failure to pay.--

1 (4) The moneys received and deposited into the Health
2 Care Trust Fund shall be used to defray the expenses of the
3 agency in the discharge of its administrative and regulatory
4 powers and duties under this part, including conducting an
5 annual survey of the satisfaction of members of health
6 maintenance organizations; contracting with physician
7 consultants for the ~~Statewide Provider~~ and Subscriber
8 Assistance Panel; maintaining offices and necessary supplies,
9 essential equipment, and other materials, salaries and
10 expenses of required personnel; and discharging the
11 administrative and regulatory powers and duties imposed under
12 this part.

13 Section 5. This act shall take effect upon becoming a
14 law.

15
16 STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
17 COMMITTEE SUBSTITUTE FOR
18 Senate Bill 1066

19 The Committee Substitute differs from SB 1066 in the following
20 ways:

- 21 1. Membership of the Subscriber Assistance Panel is modified
to provide flexibility in the composition of the panel.
- 22 2. A maximum number of panel members is established.
- 23 3. A quorum must be present before a grievance can be heard or
24 voted upon.
- 25 4. The January 1, 2005 effective date for compliance with
federal standards is deleted.

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