By the Committee on Health Care Standards & Regulatory Reform and Representatives Logan, Maygarden and Saunders

1 A bill to be entitled
2 An act relating to health maintenance
3 organizations; amending s. 641.315, F.S.;
4 prohibiting provider contracts from restricting
5 a provider's ability to communicate certain
6 information to subscribers; creating s.
7 641.316, F.S.; providing for regulation of
8 fiscal intermediary services organizations;
9 providing requirements and restrictions;
10 requiring a bond; requiring registration with
11 the Department of Insurance; providing for
12 rules; creating the Commission on Health Care
13 Intermediaries; providing membership and
14 duties; requiring recommendations to the
15 Legislature; providing for future repeal;
16 amending s. 641.47, F.S.; providing
17 definitions; amending s. 641.495, F.S.;
18 requiring designation of a licensed physician
19 as medical director; amending s. 641.51, F.S.;
20 requiring development of policies relating to
21 out-of-network referrals; requiring written
22 procedures for standing referrals for
23 individuals who require ongoing specialty care
24 for chronic and disabling conditions; requiring
25 certain continued access to terminated treating
26 providers for subscribers with a
27 life-threatening or a disabling and
28 degenerative condition, and for certain
29 pregnant subscribers; providing limitations;
30 requiring report to the Agency for Health Care
31 Administration of access, quality of care, and

1 customer satisfaction data; requiring
2 publication of data; requiring adoption of
3 certain recommendations and goals for
4 preventive pediatric health care; amending s.
5 641.511, F.S.; specifying procedures,
6 requirements, and timeframes for addressing
7 subscriber grievances; requiring certain notice
8 to subscribers; providing for review of adverse
9 determinations; providing for certain referral
10 to the Statewide Provider and Subscriber
11 Assistance Program; providing for expedited
12 review of urgent grievances; authorizing
13 administrative sanctions for noncompliance with
14 grievance procedure requirements; amending s.
15 641.54, F.S.; requiring disclosure to
16 subscribers, upon request, of certain policies,
17 procedures, and processes relating to
18 authorization and referral for services,
19 determination of medical necessity, quality of
20 care, prescription drug benefits,
21 confidentiality of medical records, approval or
22 denial of experimental or investigational
23 treatments, addressing the needs of
24 non-English-speaking subscribers, and examining
25 qualifications of and the credentialing of
26 providers; requiring report to the agency of
27 changes in authorization and referral criteria
28 or the process used to determine medical
29 necessity; providing an effective date.
30
31 Be It Enacted by the Legislature of the State of Florida:

1 Section 1. Subsection (8) is added to section 641.315,
2 Florida Statutes, 1996 Supplement, to read:
3 641.315 Provider contracts.--
4 (8) A contract between a health maintenance
5 organization and a provider of health care services shall not
6 contain any provision restricting the provider's ability to
7 communicate information to the provider's patient regarding
8 medical care or treatment options for the patient when the
9 provider deems knowledge of such information by the patient to
10 be in the best interest of the health of the patient.
11 Section 2. Section 641.316, Florida Statutes, is
12 created to read:
13 641.316 Fiscal intermediary services.--
14 (1) It is the intent of the Legislature, through the
15 adoption of this section, to ensure the financial soundness of
16 organizations established to develop, manage, and administer
17 the business affairs of health care professional providers
18 such as medical doctors, doctors of osteopathy, doctors of
19 chiropractic, doctors of podiatric medicine, doctors of
20 dentistry, or other health professionals regulated by the
21 Department of Health.
22 (2)(a) The term "fiduciary" or "fiscal intermediary
23 services" means reimbursements received or collected on behalf
24 of health care professionals for services rendered, patient
25 and provider accounting, financial reporting and auditing,
26 receipts and collections management, compensation and
27 reimbursement disbursement services, or other related
28 fiduciary services pursuant to health care professional
29 contracts with health maintenance organizations.
30 (b) The term "fiscal intermediary services
31 organization" means a person or entity which performs

1 fiduciary or fiscal intermediary services to health care
2 professionals who contract with health maintenance
3 organizations.
4 (3) A fiscal intermediary services organization which
5 is operated for the purpose of acquiring and administering
6 provider contracts with managed care plans for professional
7 health care services, including, but not limited to, medical,
8 surgical, chiropractic, dental, and podiatric care, and which
9 performs fiduciary or fiscal intermediary services shall be
10 required to secure and maintain a fidelity bond in the minimum
11 amount of $10 million. This requirement shall apply to all
12 persons or entities engaged in the business of providing
13 fiduciary or fiscal intermediary services to any contracted
14 provider or provider panel. The fidelity bond shall provide
15 coverage against misappropriation of funds by the fiscal
16 intermediary or its officers, agents, or employees; must be
17 posted with the department for the benefit of managed care
18 plans, subscribers, and providers; and must be on a form
19 approved by the department. The fidelity bond must be
20 maintained and remain unimpaired as long as the fiscal
21 intermediary services organization continues in business in
22 this state and until the termination of its registration.
23 (4) All professional provider networks, regardless of
24 ownership status shall maintain operating records and
25 documentation in accordance with industry standards and
26 generally accepted accounting principles and shall have an
27 annual compliance review by a qualified certified public
28 accountant. A letter stating the network's compliance with
29 this provision shall be available for inspection by any panel
30 member or managed care plan.
31

CODING:Words ~~stricken~~ are deletions; words underlined are additions.

1 (5) A fiscal intermediary services organization may
2 not collect from the subscriber any payment other than the
3 copayment or deductible specified in the subscriber agreement.
4 (6) Any fiscal intermediary services organization must
5 register with the department and meet the requirements of this
6 section. In order to register as a fiscal intermediary
7 services organization, the organization must comply with ss.
8 641.21(1)(c) and (d) and 641.22(6). Should the department
9 determine that the fiscal intermediary services organization
10 does not meet the requirements of this section, the
11 registration shall be denied. In the event that the registrant
12 fails to maintain compliance with the provisions of this
13 section, the department may revoke or suspend the
14 registration. In lieu of revocation or suspension of the
15 registration, the department may levy an administrative
16 penalty in accordance with s. 641.25.
17 (7) The department shall promulgate rules necessary to
18 implement the provisions of this section.
19 Section 3. (1) There is hereby created the Florida
20 Commission on Health Care Intermediaries, hereinafter referred
21 to as the "commission," consisting of nine members composed of
22 a representative of hospitals selected by the Florida Hospital
23 Association; a representative of physicians selected by the
24 Florida Medical Association; a representative of health
25 insurers selected by the Health Insurance Association of
26 America; a representative of health maintenance organizations
27 selected by the Florida Association of Health Maintenance
28 Organizations; a representative of employers selected by the
29 President of the Senate; a representative of the public
30 selected by the Speaker of the House of Representatives; a
31 representative of the Association of Managed Care; the

1 Insurance Commissioner or a designee; and the head of the
2 Agency for Health Care Administration or a designee.
3 (2) The commission shall conduct an analysis of the
4 various nontraditional mechanisms whereby entities are
5 currently contracting with insurers, health maintenance
6 organizations, and other regulated entities and, through
7 capitation and other methods, assuming varying levels of risk
8 in conjunction with the provision of medical, surgical,
9 hospital, or other health care services to residents of this
10 state. The commission shall recommend to the President of the
11 Senate and the Speaker of the House of Representatives, prior
12 to January 1, 1998, any legislation needed to regulate the
13 activities of these entities.
14 (3) The commission shall develop and submit draft
15 legislation to the Speaker of the House of Representatives and
16 the President of the Senate by January 1, 1998, which would
17 permit and regulate the provision of services directly to
18 residents of this state by groups of physicians and hospitals
19 which would otherwise be prohibited as the transaction of
20 insurance. The recommended legislation shall establish
21 requirements for qualification for and retention of licensure,
22 including compliance with quality of care standards similar to
23 those established by part III of chapter 641.
24 (4) The Department of Insurance shall provide any
25 necessary staff support for the commission. Private-sector
26 members of the commission are not eligible for per diem or
27 travel expenses.
28 (5) This section is repealed on the last day of the
29 1998 Regular Session of the Legislature.
30 Section 4. Section 641.47, Florida Statutes, 1996
31 Supplement, is amended to read:

641.47 Definitions.--As used in this part, the term:

(1) "Adverse determination" means a coverage determination by an organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the organization's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and coverage for the requested service is therefore denied, reduced, or terminated.

(2)~~(1)~~ "Agency" means the Agency for Health Care Administration.

(3) "Clinical peer" means a health care professional who has demonstrable expertise to review a case, whether or not the reviewing professional is in the same or similar specialty as the health care professional who made the initial decision.

(4) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by the organization to determine, for coverage purposes, the necessity and appropriateness of health care services.

(5) "Complaint" means any expression of dissatisfaction by a subscriber, including dissatisfaction with the administration, claims practices, or provision of services, which relates to the quality of care provided by a provider pursuant to the organization's contract and which is submitted to the organization or to a state agency. A complaint is part of the informal steps of a grievance procedure and is not part of the formal steps of a grievance procedure unless it is a grievance as defined in subsection (10).

(6) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

(7)~~(2)~~ "Emergency medical condition" means:

(a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to the health of a patient, including a pregnant woman or a fetus.

2. Serious impairment to bodily functions.

3. Serious dysfunction of any bodily organ or part.

(b) With respect to a pregnant woman:

1. That there is inadequate time to effect safe transfer to another hospital prior to delivery;

2. That a transfer may pose a threat to the health and safety of the patient or fetus; or

3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

(8)~~(3)~~ "Emergency services and care" means medical screening, examination, and evaluation by a physician or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists, and if it does, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition within the service capability of a hospital.

(9)~~(4)~~ "Geographic area" means the county or counties, or any portion of a county or counties, within which the health maintenance organization provides or arranges for

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

1 comprehensive health care services to be available to its
2 subscribers.
3 (10) "Grievance" means a written complaint submitted
4 by or on behalf of a subscriber to an organization or a state
5 agency regarding the:
6 (a) Availability, coverage for the delivery, or
7 quality of health care services, including a complaint
8 regarding an adverse determination made pursuant to
9 utilization review;
10 (b) Claims payment, handling, or reimbursement for
11 health care services; or
12 (c) Matters pertaining to the contractual relationship
13 between a subscriber and an organization.
14
15 A grievance does not include a written complaint submitted by
16 or on behalf of a subscriber eligible for a grievance and
17 appeals procedure provided by an organization pursuant to
18 contract with the Federal Government under Title XVIII of the
19 Social Security Act.
20 (11)~~(5)~~ "Health care services" means comprehensive
21 health care services, as defined in s. 641.19, when applicable
22 to a health maintenance organization, and means basic
23 services, as defined in s. 641.402, when applicable to a
24 prepaid health clinic.
25 (12)~~(6)~~ "Minimum services" includes any of the
26 following: emergency care, inpatient hospital services,
27 physician care, ambulatory diagnostic treatment, and
28 preventive health care services.
29 (13)~~(7)~~ "Organization" means any health maintenance
30 organization as defined in s. 641.19 and any prepaid health
31 clinic as defined in s. 641.402.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

(14)(8) "Provider" means any physician, hospital, or other institution, organization, or person that furnishes health care services and is licensed or otherwise authorized to practice in the state. To submit or pursue a grievance on behalf of a subscriber, a provider must previously have been directly involved in the treatment or diagnosis of the subscriber.

(15) "Retrospective review" means a review, for coverage purposes, of medical necessity conducted after services have been provided to a patient.

(16)(9) "Subscriber" means an individual who has contracted, or on whose behalf a contract has been entered into, with a health maintenance organization for health care services.

(17) "Urgent grievance" means an adverse determination when the standard timeframe of the grievance procedure would seriously jeopardize the life or health of a subscriber or would jeopardize the subscriber's ability to regain maximum function.

Section 5. Subsection (11) is added to section 641.495, Florida Statutes, 1996 Supplement, to read:

641.495 Requirements for issuance and maintenance of certificate.--

(11) The organization shall designate a medical director who is a physician licensed under chapter 458 or chapter 459.

Section 6. Subsections (5), (6), (7), (8), (9), and (10) are added to section 641.51, Florida Statutes, to read:

641.51 Quality assurance program; second medical opinion requirement.--

1 (5) Each organization shall develop and maintain a
2 policy to determine when exceptional referrals to
3 out-of-network specially qualified providers should be
4 provided to address the unique medical needs of a subscriber.
5 All financial arrangements for the provision of these services
6 shall be agreed to prior to the services being rendered.
7 (6) Each organization shall develop and maintain
8 written policies and procedures for the provision of standing
9 referrals to subscribers with chronic and disabling conditions
10 which require ongoing specialty care.
11 (7) Each organization shall allow subscribers to
12 continue care for 60 days with a terminated treating provider
13 when medically necessary, provided the subscriber has a
14 life-threatening condition or a disabling and degenerative
15 condition. Each organization shall allow a subscriber who is
16 in the third trimester of pregnancy to continue care with a
17 terminated treating provider until completion of postpartum
18 care. The organization and the provider shall continue to be
19 bound by the terms of the contract for such continued care.
20 This subsection shall not apply to treating providers who have
21 been terminated by the organization for cause.
22 (8) Each organization shall release to the agency data
23 which are indicators of access and quality of care. The
24 agency shall develop rules specifying data-reporting
25 requirements for these indicators. The indicators shall
26 include the following characteristics:
27 (a) They must relate to access and quality of care
28 measures.
29 (b) They must be consistent with data collected
30 pursuant to accreditation activities and standards.
31

CODING:Words ~~stricken~~ are deletions; words underlined are additions.

1 (c) They must be consistent with frequency
2 requirements under the accreditation process.
3 The agency shall develop by rule a uniform format for
4 publication of the data for the public which shall contain
5 explanations of the data collected and the relevance of such
6 data. The agency shall publish such data no less frequently
7 than every 2 years.
8 (9) Each organization shall conduct a standardized
9 customer satisfaction survey, as developed by the agency by
10 rule, of its membership at intervals specified by the agency.
11 The survey shall be consistent with surveys required by
12 accrediting organizations and may contain up to 10 additional
13 questions based on concerns specific to Florida. Survey data
14 shall be submitted to the agency, which shall make comparative
15 findings available to the public.
16 (10) Each organization shall adopt recommendations for
17 preventive pediatric health care consistent with early
18 periodic screening, diagnosis, and treatment requirements
19 developed for the Medicaid program. Each organization shall
20 establish goals to achieve 80-percent compliance by July 1,
21 1998, and 90-percent compliance by July 1, 1999, for their
22 enrolled pediatric population.
23 Section 7. Section 641.511, Florida Statutes, is
24 amended to read:
25 641.511 Subscriber grievance reporting and resolution
26 requirements.--
27 (1) Every organization must have a grievance procedure
28 available to its subscribers for the purpose of addressing
29 complaints and grievances. Every organization must notify its
30 subscribers that a subscriber must submit a grievance within 1
31 year after the date of occurrence of the action that initiated

1 the grievance, and may submit the grievance for review to the
2 Statewide Provider and Subscriber Assistance Program panel as
3 provided in s. 408.7056 after receiving a final disposition of
4 the grievance through the organization's grievance process.
5 An ~~The health maintenance~~ organization shall maintain records
6 of all grievances and shall report annually to the agency
7 ~~department a description of~~ the total number of grievances
8 handled, a categorization of the cases underlying the
9 grievances, and the final disposition ~~resolution~~ of the
10 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.
31

CODING:Words ~~stricken~~ are deletions; words underlined are additions.

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.
14 Such notice shall include an explanation that the subscriber
15 may 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; such review must be requested within 30 days after the
30 organization's transmittal of the final determination notice
31 of an adverse determination. A majority of the panel shall be

1 persons who previously were not involved in the initial
2 adverse determination. A person who previously was involved
3 in the adverse determination may appear before the panel to
4 present information or answer questions. The panel shall have
5 the authority to bind the organization to the panel's
6 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) 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 such time limitations are tolled until such
3 information is provided. After the organization receives the
4 requested information, the time allowed for completion of the
5 grievance process resumes.
6 (6)(a) An organization shall establish written
7 procedures for the expedited review of an urgent grievance. A
8 request for an expedited review may be submitted orally or in
9 writing and shall be subject to the review procedures of this
10 section, if it meets the criteria of this section. Unless it
11 is submitted in writing, for purposes of the grievance
12 reporting requirements in subsection (1), the request shall be
13 considered an appeal of a utilization review decision and not
14 a grievance. Expedited review procedures shall be available to
15 a subscriber and to the provider acting on behalf of a
16 subscriber. For purposes of this subsection, "subscriber"
17 includes the legal representative of a subscriber.
18 (b) Expedited reviews shall be evaluated by an
19 appropriate clinical peer or peers. The clinical peer or peers
20 shall not have been involved in the initial adverse
21 determination.
22 (c) In an expedited review, all necessary information,
23 including the organization's decision, shall be transmitted
24 between the organization and the subscriber, or the provider
25 acting on behalf of the subscriber, by telephone, facsimile,
26 or the most expeditious method available.
27 (d) In an expedited review, an organization shall make
28 a decision and notify the subscriber, or the provider acting
29 on behalf of the subscriber, as expeditiously as the
30 subscriber's medical condition requires, but in no event more
31 than 72 hours after receipt of the request for review. If the

1 expedited review is a concurrent review determination, the
2 service shall be continued without liability to the subscriber
3 until the subscriber has been notified of the determination.
4 (e) An organization shall provide written confirmation
5 of its decision concerning an expedited review within 2
6 working days after providing notification of that decision, if
7 the initial notification was not in writing.
8 (f) An organization shall provide reasonable access,
9 not to exceed 24 hours after receiving a request for an
10 expedited review, to a clinical peer who can perform the
11 expedited review.
12 (g) In any case when the expedited review process does
13 not resolve a difference of opinion between the organization
14 and the subscriber or the provider acting on behalf of the
15 subscriber, the subscriber or the provider acting on behalf of
16 the subscriber may submit a written grievance to the Statewide
17 Provider and Subscriber Assistance Program.
18 (h) An organization shall not provide an expedited
19 retrospective review of an adverse determination.
20 (7)~~(2)~~ Each ~~health maintenance~~ organization shall send
21 to the agency ~~department~~ a copy of its annual and quarterly
22 grievance reports submitted to the Department of Insurance
23 pursuant to s. 408.7056(2).
24 (8)~~(3)~~ The agency ~~department~~ shall investigate all
25 reports of unresolved quality of care grievances received
26 from:
27 (a) Annual and quarterly grievance reports submitted
28 by the ~~health maintenance~~ organization to the Department of
29 Insurance.
30
31

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

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

(9)(a)~~(4)~~ The agency ~~department~~ shall advise subscribers with grievances to follow their organization's ~~the health maintenance organization~~ formal grievance process for resolution prior to review by the Statewide Provider and Subscriber Assistance Program ~~department~~. The subscriber may, however, submit a copy of the grievance to the agency at any time during the process.

(b) Requiring completion of the organization's grievance process before the Statewide Provider and Subscriber Assistance Program panel's review does ~~However, this shall~~ not preclude the agency ~~department~~ from investigating any complaint or grievance before the organization makes its final determination ~~prior to completion of the health maintenance organization's formal grievance process~~.

(10)~~(5)~~ Each organization must notify the subscriber in a final decision letter that the subscriber may request review of the organization's decision concerning the grievance by the Statewide Provider and Subscriber Assistance Program, as provided in s. 408.7056, if the grievance is not resolved to the satisfaction of the subscriber. The final decision letter must inform the subscriber that the request for review must be made within 365 days after receipt of the final decision letter, must explain how to initiate such a review, and must include the addresses and toll-free telephone numbers of the agency and the Statewide Provider and Subscriber Assistance Program.~~A quality of care grievance which remains unresolved after a subscriber has followed the full grievance procedure of the organization, after review by the department,~~

CODING:Words ~~stricken~~ are deletions; words underlined are additions.

1 ~~may be presented to the Statewide Subscriber Assistance~~
2 ~~Program Panel as set forth in s. 408.7056.~~
3 (11) The agency may impose administrative sanction, in
4 accordance with s. 641.52, against an organization for
5 noncompliance with this section.
6 Section 8. Subsections (3), (4), and (5) are added to
7 section 641.54, Florida Statutes, to read:
8 641.54 ~~Hospital and physician~~ Information
9 disclosure.--
10 (3) The organization shall make available to
11 subscribers, upon request, a detailed description of the
12 authorization and referral process for health care services.
13 Any changes in the organization's authorization and referral
14 process shall be reported to the agency immediately.
15 (4) The organization shall make available to
16 subscribers, upon request, a detailed description of the
17 process used to determine whether health care services are
18 "medically necessary." Any change in the organization's
19 definition of "medically necessary" or the process used to
20 determine medical necessity shall be reported to the agency
21 immediately.
22 (5) Each organization shall provide to subscribers,
23 upon request, the following:
24 (a) A description of the organization's quality
25 assurance program.
26 (b) Policies and procedures relating to the
27 organization's prescription drug benefits, including the
28 disclosure, upon request of a subscriber or potential
29 subscriber, of whether the organization uses a formulary. A
30 subscriber or potential subscriber may also request
31

1 information as to whether a specific drug is covered by the
2 organization.
3 (c) Policies and procedures relating to the
4 confidentiality and disclosure of the subscriber's medical
5 records.
6 (d) The decisionmaking process used for approving or
7 denying experimental or investigational medical treatments.
8 (e) Policies and procedures for addressing the needs
9 of non-English-speaking subscribers.
10 (f) A detailed description of the process used to
11 examine qualifications of and the credentialing of all
12 providers under contract with or employed by the organization.
13 Section 9. This act shall take effect July 1, 1997.
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31