By Senators Silver, Kurth, Mitchell, Campbell, Dawson and Klein

38-305-00

1 A bill to be entitled
2 An act relating to health care; providing for
3 liability of managed care entities to
4 subscribers in a health care plan for damages
5 for harm proximately caused by a failure to
6 exercise ordinary care; providing defenses;
7 providing conditions; providing definitions;
8 prohibiting certain activities; providing
9 nonapplicability to workers' compensation
10 insurance coverage; providing a limitation on
11 cause of action; providing for appeal of a
12 subscriber's claim to an independent review
13 organization; providing for tolling of statute
14 of limitations; providing for immediate appeals
15 under certain conditions; requiring the Agency
16 for Health Care Administration to establish and
17 certify independent review organizations;
18 providing for notice to subscribers of their
19 right to appeal an adverse determination to an
20 independent review organization; providing
21 responsibilities of the agency to provide
22 certain information to independent review
23 organizations; authorizing the agency to adopt
24 rules; prescribing information to be included
25 in an application for certification as an
26 independent review organization; prohibiting an
27 independent review organization from being a
28 subsidiary of a managed care entity or a trade
29 or professional association of managed care
30 entities; providing for immunity from liability
31 for damages for review organizations; repealing

1 s. 408.7056, F.S., relating to the Statewide
2 Provider and Subscriber Assistance Program;
3 providing an effective date.
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5 Be It Enacted by the Legislature of the State of Florida:
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7 Section 1. Definitions.--As used in this act:
8 (1) "Adverse determination" means determination by a
9 managed care entity that the health care services furnished or
10 proposed to be furnished to a subscriber are not medically
11 necessary.
12 (2) "Appropriate and medically necessary treatment"
13 means treatment that meets the standard for health care
14 services as determined by providers in accordance with the
15 prevailing practices and standards of the medical profession
16 and community.
17 (3) "Health care plan" means any plan whereby a person
18 undertakes to provide, arrange for, pay for, or reimburse any
19 part of the cost of any health care services.
20 (4) "Health care provider" means a provider as defined
21 in chapter 636 or chapter 641, Florida Statutes.
22 (5) "Health care treatment decision" means a
23 determination made when medical services are actually provided
24 by the health care plan which affects the quality of the
25 diagnosis, care, or treatment provided to the plan's
26 enrollees.
27 (6) "Health maintenance organization" means an
28 organization as defined in section 641.19, Florida Statutes.
29 (7) "Independent review organization" means an
30 organization certified by the Agency for Health Care
31 Administration.

1 (8) "Life-threatening condition" means a disease or
2 other medical condition with respect to which death is
3 probable unless the course of the disease or condition is
4 interrupted.
5 (9) "Managed care entity" means a health maintenance
6 organization or a prepaid health clinic certified under
7 chapter 641, Florida Statutes, a prepaid health plan
8 authorized under section 409.912, Florida Statutes, or an
9 exclusive provider organization certified under section
10 627.6472, Florida Statutes.
11 (10) "Ordinary care" means, in the case of a managed
12 care entity, that degree of care which a managed care entity
13 of ordinary prudence would use under the same or similar
14 circumstances. In the case of a person who is an employee,
15 agent, ostensible agent, or representative of a managed care
16 entity, "ordinary care" means that degree of care which a
17 person of ordinary prudence in the same profession, specialty,
18 or area of practice would use in the same or similar
19 circumstances.
20 (11) "Physician" means:
21 (a) An individual licensed to practice medicine in
22 this state; or
23 (b) A professional limited liability company organized
24 under the laws of this state to provide physician services.
25 (12) "Subscriber" means an individual who is enrolled
26 in a health care plan, including his or her covered
27 dependents.
28 Section 2. Application.--
29 (1) A managed care entity has the duty to exercise
30 ordinary care when making health care treatment decisions and
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1 is liable for damages for harm to a subscriber proximately
2 caused by its failure to exercise such ordinary care.
3 (2) A managed care entity plan is also liable for
4 damages for harm to a subscriber proximately caused by the
5 health care treatment decisions made by its employees, agents,
6 ostensible agents, or representatives who are acting on its
7 behalf and over whom it has the right to exercise influence or
8 control or has actually exercised influence or control which
9 decisions result in the failure to exercise ordinary care.
10 (3) It is a defense to any action asserted against a
11 managed care entity that:
12 (a) Neither the managed care entity, nor any employee,
13 agent, ostensible agent, or representative for whose conduct
14 such managed care entity is liable under subsection (2),
15 controlled, influenced, or participated in the health care
16 treatment decision; and
17 (b) The managed care entity did not deny or delay
18 payment of any treatment prescribed or recommended by a health
19 care provider to the subscriber.
20 (4) The standards in subsections (1) and (2) create no
21 obligation on the part of the managed care entity to provide
22 to a subscriber treatment that is not covered by the health
23 care plan of the entity.
24 (5) This act does not create any liability on the part
25 of an employer, an employer group purchasing organization, or
26 a licensed pharmacy that purchases coverage or assumes risk on
27 behalf of its employees.
28 (6) A managed care entity may not remove a health care
29 provider from its plan or refuse to renew the physician or
30 health care provider with its plan for advocating on behalf of
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1 a subscriber for appropriate and medically necessary health
2 care for the subscriber.
3 (7) A managed care entity may not enter into a
4 contract with another health care provider or pharmaceutical
5 company which includes an indemnification or hold-harmless
6 clause for the acts or conduct of the managed care entity. Any
7 such indemnification or hold-harmless clause in an existing
8 contract is void.
9 (8) Nothing in any law of this state prohibiting a
10 managed care entity from practicing medicine or being licensed
11 to practice medicine may be asserted as a defense by such
12 managed care entity in an action brought against it under this
13 act or any other law.
14 (9) In an action against a managed care entity, a
15 finding that a health care provider is an employee, agent,
16 ostensible agent, or representative of such managed care
17 entity may not be based solely on proof that such person's
18 name appears in a listing of approved health care providers
19 made available to a subscriber under a health care plan.
20 (10) This act does not apply to workers' compensation
21 insurance coverage.
22 (11) A subscriber who files an action under this act
23 shall comply with the requirements of cost bonds, deposits,
24 and expert reports.
25 Section 3. Limitations on causes of action.--
26 (1) A subscriber may not maintain a cause of action
27 under this act against a managed care entity that is required
28 to comply with grievance resolution procedures until the
29 subscriber has:
30 (a) Exhausted any applicable appeals and review
31 procedures; or

1 (b) Before instituting the action:
2 1. Gives written notice of the claim as provided by
3 subsection (2); and
4 2. Agrees to submit the claim to a review by an
5 independent review organization as provided in subsection (3).
6 (2) Notice must be delivered or mailed to the managed
7 care entity against whom the action is made not later than the
8 30th day before the date the claim is filed.
9 (3) The subscriber or the subscriber's representative
10 must submit the claim to a review by an independent review
11 organization if the managed care entity against whom the claim
12 is made requests the review not later than the 14th day after
13 the date notice is received by the managed care entity. If the
14 managed care entity does not request the review within the
15 specified period, the subscriber or the subscriber's
16 representative is not required to submit the claim to review
17 by an independent review organization before maintaining the
18 action.
19 (4) Subject to subsection (5), if the subscriber has
20 not complied with subsection (1), an action may not be
21 dismissed by the court, but the court may, in its discretion,
22 order the parties to submit to an independent review or
23 mediation or other nonbinding alternative dispute resolution
24 and may abate the action for such purposes for a period not to
25 exceed 30 days. Such orders of the court shall be the sole
26 remedy available to a party complaining of a subscriber's
27 failure to comply with subsection (1).
28 (5) The subscriber is not required to comply with
29 subsection (3), and no abatement or other court order pursuant
30 to subsection (4) for failure to comply may be imposed, if the
31 subscriber has filed a pleading alleging in substance that:

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1 (a) Harm to the subscriber has already occurred
2 because of the conduct of the managed care entity or because
3 of an act or omission of an employee, agent, ostensible agent,
4 or representative of such entity for whose conduct the entity
5 is liable; and
6 (b) The review would not be beneficial to the
7 subscriber, unless the court, upon motion by a defendant
8 entity, finds after hearing that such pleading was not made in
9 good faith, in which case the court may enter an order
10 pursuant to subsection (4).
11 (6) If the subscriber or the subscriber's
12 representative seeks to exhaust the appeals and review process
13 as provided under the managed care entity's grievance
14 resolution procedures or provides notice before the statute of
15 limitations applicable to a claim against a managed care
16 entity has expired, the limitations period is tolled until the
17 later of:
18 (a) The 30th day after the date the subscriber or the
19 subscriber's representative has exhausted the process for
20 appeals and review; or
21 (b) The 40th day after the date the subscriber or the
22 subscriber's representative gives notice.
23 (7) This section does not prohibit a subscriber from
24 pursuing other appropriate remedies, including injunctive
25 relief, a declaratory judgment, or relief available under law,
26 if the requirement of exhausting the process for appeal and
27 review places the subscriber's health in serious jeopardy.
28 Section 4. Immediate appeal.--Notwithstanding any
29 other law, in a circumstance involving a subscriber's
30 life-threatening condition, the subscriber is entitled to an
31 immediate appeal to an independent review organization and is

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1 not required to comply with a managed care entity's grievance
2 procedures and review process. For purposes of this section,
3 "life-threatening condition" means a disease or other medical
4 condition with respect to which death is probable unless the
5 course of the disease or condition is interrupted.
6 Section 5. Independent review of adverse
7 determinations.--
8 (1) The Agency for Health Care Administration shall,
9 by rule, provide for the establishment of independent review
10 organizations and prescribe procedures for hearing appeals
11 from a managed care entity's adverse determination of a
12 subscriber's claim.
13 (2) A managed care entity must notify any subscriber
14 who receives an adverse determination under the managed care
15 entity's grievance procedure of the subscriber's right to seek
16 review of the adverse determination by an independent review
17 organization assigned by the Agency for Health Care
18 Administration.
19 (3) A managed care entity shall, when requested,
20 provide the following information to the appropriate
21 independent review organization not later than the third
22 business day after the date of receipt of the request:
23 (a) Any medical records of the subscriber which are
24 relevant to the review;
25 (b) Any documents used in making the determination to
26 be reviewed by the organization;
27 (c) The written notification described in this act;
28 (d) Any documentation or written information submitted
29 to the agency or department in support of the appeal;
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1 (e) A list of each physician or health care provider
2 who has provided care to the subscriber and who may have
3 medical records relevant to the appeal; and
4 (f) Confidential information in its custody.
5 (4) A managed care entity must comply with the
6 independent review organization's determination with respect
7 to the medical necessity or appropriateness of health care
8 items and services for a subscriber.
9 (5) A managed care entity must pay for the independent
10 review.
11 Section 6. Notification to subscriber.--The grievance
12 and review procedures of a managed care entity must include:
13 (1) Notification by a managed care entity to the
14 subscriber of the subscriber's right to appeal an adverse
15 determination to an independent review organization;
16 (2) Notification by a managed care entity to a
17 subscriber of the procedures for appealing an adverse
18 determination to an independent review organization; and
19 (3) Notification by a managed care entity to a
20 subscriber who has a life-threatening condition of the
21 subscriber's right to immediate review by an independent
22 review organization and the procedures for obtaining that
23 review.
24 Section 7. Certification and designation of
25 independent review organizations.--
26 (1) The Agency for Health Care Administration shall:
27 (a) Adopt rules for:
28 1. The certification, selection, and operation of
29 independent review organizations; and
30 2. The suspension and revocation of the certification.
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1 (b) Designate annually each organization that meets
2 the standards required of an independent review organization.
3 (c) Charge fees to fund the operations of independent
4 review organizations.
5 (d) Provide ongoing oversight of the independent
6 review organizations to ensure continued compliance with the
7 rules adopted by the agency.
8 (2) The rules must ensure:
9 (a) The timely response of an independent review
10 organization;
11 (b) The confidentiality of medical records transmitted
12 to an independent review organization for use in independent
13 reviews;
14 (c) The qualifications and independence of each health
15 care provider or physician making review determinations for an
16 independent review organization;
17 (d) The fairness of the procedures used by an
18 independent review organization in making the determinations;
19 and
20 (e) Timely notice to subscribers of the results of the
21 independent review, including the clinical basis for the
22 determination.
23 (3) The rules adopted must include standards that
24 require each independent review organization to make its
25 determination:
26 (a) No later than the earlier of:
27 1. The 15th day after the date the independent review
28 organization receives the information necessary to make the
29 determination; or
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1 2. The 20th day after the date the independent review
2 organization receives the request that the determination be
3 made; and
4 (b) In the case of a life-threatening condition, no
5 later than the earlier of:
6 1. The 5th day after the date the independent review
7 organization receives the information necessary to make the
8 determination; or
9 2. The 8th day after the date the independent review
10 organization receives the request that the determination be
11 made.
12 Section 8. Independent review organizations.--
13 (1) To be certified as an independent review
14 organization, an organization must submit to the Agency for
15 Health Care Administration an application in the form required
16 by the agency. The application must include:
17 (a) For an applicant that is publicly held, the name
18 of each stockholder or owner of more than 5 percent of any
19 stock or options;
20 (b) The name of any holder of bonds or notes of the
21 applicant that exceed $100,000;
22 (c) The name and type of business of each corporation
23 or other organization that the applicant controls or is
24 affiliated with and the nature and extent of the affiliation
25 or control;
26 (d) The name and a biographical sketch of each
27 director, officer, and executive of the applicant and any
28 entity the applicant controls and a description of any
29 relationship the named individual has with:
30 1. A health benefit plan;
31 2. A health maintenance organization;

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1 3. An insurer;
2 4. A health care provider; or
3 5. A group representing any of the entities described
4 by subparagraphs 1. through 4.;
5 (e) A description of the areas of expertise of the
6 health care professionals making review determinations for the
7 applicant; and
8 (f) The procedures to be used by the independent
9 review organization in making review determinations.
10 (2) The independent review organization must annually
11 submit the information required by section 7. If at any time
12 there is a material change in the information included in the
13 application, the independent review organization must submit
14 updated information to the Agency for Health Care
15 Administration.
16 (3) An independent review organization may not be a
17 subsidiary of, or in any way owned or controlled by, a managed
18 care entity or a trade or professional association of managed
19 care entities.
20 (4) An independent review organization conducting a
21 review is not liable for damages arising from the
22 determination made by the organization. This subsection does
23 not apply to an act or omission of the independent review
24 organization which is made in bad faith or which involves
25 gross negligence.
26 Section 9. Section 408.7056, Florida Statutes, is
27 repealed.
28 Section 10. This act shall take effect October 1,
29 2000.
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2 SENATE SUMMARY

Provides a cause of action for damages for harm to a subscriber in a health care plan as a result of a managed care entity's failure to exercise ordinary care. Provides definitions. Provides conditions and procedures. Provides nonapplicability to specified entities. Provides a limitation on bringing a cause of action. Requires a subscriber to comply with specified grievance procedures and to agree to submit the claim to an independent review organization under certain circumstances. Requires notice to subscribers of their rights. Provides for certification, designation, and operation of independent review organizations and for suspension and revocation of certification. Authorizes the Agency for Health Care Administration to adopt rules to accomplish these purposes. Provides guidelines for rules. Provides for application procedures and forms for certification. Requires an independent review organization to provide annual updates of certain information to the agency. Provides that an independent review organization may not be a subsidiary of a managed care entity. Provides limited immunity from damages for such organizations. Repeals s. 408.7056, F.S., relating to the Statewide Provider and Subscriber Assistance Program.

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