STORAGE NAME: h0317.hp.doc
DATE: March 13, 2001

HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH PROMOTION
ANALYSIS

BILL #: HB 317

RELATING TO: Health Maintenance Organizations

SPONSOR(S): Representative(s) Negron

TIED BILL(S):

ORIGINATING COMMITTEE(S)/COUNCIL(S)/COMMITTEE(S) OF REFERENCE:

(1) HEALTH PROMOTION
(2) INSURANCE
(3) JUDICIAL OVERSIGHT
(4) COUNCIL FOR HEALTHY COMMUNITIES
(5)

I. SUMMARY:

HB 317 creates the "Managed Care Organization's Patient's Bill of Rights." The bill provides legislative findings and intent that the rights and responsibilities of subscribers who are covered under health maintenance contracts must be recognized and summarized. The bill requires health maintenance organizations to operate in conformity with such rights and to provide subscribers with a copy of their rights and responsibilities. The bill lists specified patient's rights that are currently required by other statutes. The bill also provides a list of specified responsibilities of subscribers and providers.

The bill creates a civil cause of action against a managed care organization or provider for violation of these newly created rights. The bill designates who has standing to bring a cause of action. The bill authorizes actions to enforce rights and to recover actual and punitive damages for any violation of such rights. The bill prohibits damages from being limited by any other state law. The bill authorizes prevailing plaintiffs to recover reasonable attorney's fees pursuant to s. 57.105, F.S., costs, and damages, subject to specified limitations. Damages are remedial and are in addition to and cumulative with all other legal, equitable, administrative, contractual, or informal remedies available. Defendants are liable for actual and punitive damages or $500 per violation, whichever is greater, together with court costs and reasonable plaintiff's attorney's fees. The bill does not create any liability on the part of an employer or employee organization, subject to specified limitations.

The bill requires that, prior to bringing an action, a patient must submit a written grievance to the managed care organization and receive a final disposition of the grievance. The bill provides a 30-day time limit for the managed care organization to render a final decision, subject to certain exceptions. The bill limits courts' abilities to dismiss actions for a patient's failure to comply with notice requirements. Notice requirements do not apply if harm to the patient has already occurred or is imminent. The bill provides for tolling of the statute of limitations during pendency of grievance procedures or notice.

The bill provides for severability.

The bill takes effect July 1, 2001.

The fiscal impact of this bill is indeterminable.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes []	No []	N/A [x]
2.	Lower Taxes	Yes []	No []	N/A [x]
3.	Individual Freedom	Yes [x]	No []	N/A []
4.	Personal Responsibility	Yes [x]	No []	N/A []
5.	Family Empowerment	Yes [x]	No []	N/A []

For any principle that received a "no" above, please explain:

B. PRESENT SITUATION:

Civil Liability - General Background

As of 1999, there were 89 million people in preferred provider organizations and 81.3 million in health maintenance organizations (HMOs) in the U.S.. [St. Petersburg Times, ONLINE, World and Nation, September 7, 2000, "Employers turn away from HMOs" by the New York Times.] As the number of people enrolled in managed care plans has increased, so have the number of complaints regarding the quality of care provided. Critics charge that HMOs limit physician and patient options and may compromise quality of care in efforts to control costs. These critics argue that managed care plans may have a potential to deny services to subscribers over the recommendation of the treating physician. On the other hand, managed care groups argue that their ability to decide what services are provided allows them to control over-utilization and unnecessary treatments while traditional fee-for-service and indemnity plans cannot.

As a result of these criticisms, the right to sue HMOs has been part of state legislative agendas in the past several years. To date, twenty-seven states have introduced legislation that would hold health plans accountable in civil actions. According to most of these measures, health plans or health carriers would be liable for damages caused by the plan=s failure to exercise ordinary care when making health care decisions. To date, only Texas, Georgia and Missouri have passed legislation that allow managed care organizations to be sued. In California, lawsuits will be permitted only after all internal and external grievance processes have been exhausted. Legislation passed in September 1999 established an external, dispute-resolution system that guarantees patients an independent review of treatment denied by an HMO. [Insurance Information Institute, June 2000, http://www.iii.org/inside.pl5?media=issues=/media/issues/liability.html] Of the three states which have passed HMO liability legislation, the Texas law is most similar to HB 317.

The Texas Health Care Liability Act

The Texas law codifies two causes of action against health insurers, HMOs and managed care entities. Preliminarily, it should be noted that managed care entities subject to the law are broadly defined to include,

> "any entity which delivers, administers or assumes risk for health care services with systems or techniques to control or influence the quality, accessibility, utilization or

costs and prices of such services to a defined enrollee population" [Note: Entities do not include employers or pharmacies.]

Under the first cause of action, a managed care organization has a "duty to exercise ordinary care when making health care treatment decisions" and may be held directly liable for "harm to an insured or enrollee proximately caused by the managed care organization's failure to exercise such ordinary care." Under the second cause of action, an MCO may also be held liable for damages for harm to an insured or enrollee proximately caused by the health care treatment decisions made by its employees, agents, ostensible agents, or representatives who are acting on its behalf and over whom it has the right to exercise influence and control or has actually exercised influence or control which result in the failure to exercise ordinary care.

A "health care treatment decision" is broadly defined as any "determination made when medical services are actually provided by the health care plan and a decision which affects the quality of the diagnosis, care or treatment provided to the plan's insureds or enrollees." Through its broad definition of covered health care treatment decisions, the Texas statute requires managed care organizations to exercise ordinary care when they (or their employees, agents and representatives) actually deliver health care services or when they make any decision which directly or indirectly impacts health care, such as health care benefits, utilization reviews, and provider selection/credentialing determinations.

The Texas law does contain certain provisions designed to deter frivolous lawsuits. For example, claimants alleging medical malpractice under the Texas law must comply with the requirements of Texas statute Section 13.01, Medical Liability and Insurance Improvement Act of Texas, as it relates to cost bonds, deposits, and expert reports. In addition, claimants complaining about denials of health care benefits or other negligence in managing care must have exhausted any internal appeal or review processes available to them under the Utilization Review Requirements of the Texas Insurance Code and agree to submit their claim to an independent review process for adverse benefit determinations. The Texas law requires an insured or enrollee to submit his or her claim challenging an adverse benefit determination to a review by an independent review organization ("IRO"), if such review is requested by the MCO. The IRO must render its decision within 30 days, including a "clear and concise statement of the clinical basis for the managed care organization's adverse determination…to be made by a physician." However, under Texas law a claimant's failure to comply with the above described appeal and review requirements will not permit dismissal of the claimant's action. Rather, the law states that such failure will permit the court to abate the action for 30 days and order independent review or non-binding mediation. Claimants may skip the independent review/mediation process in circumstances where they in good faith plead that they have already been harmed by the managed care organization's conduct and "the review would not be beneficial."

The Texas law also expressly states that it "create[s] no obligation on the part of the…[managed care organization] to provide an insured or enrollee treatment which is not covered by the healthcare plan of the entity." Further, the law forbids a finding that a physician or other health care provider is an employee, agent, ostensible agent, or representative of the MCO "based solely on proof that such person's name appears in a listing of approved physicians or healthcare providers made available to insureds or enrollees under a healthcare plan."

Under the Texas law, the corporate practice of medicine doctrine is no longer a viable defense to medical malpractice actions against a Texas managed care organization. The Texas law articulates the following "defenses" to liability: that neither the managed care organization, nor any of its employees, agents, ostensible agents or representatives for whose conduct it is liable, "controlled, influenced, or participated in the healthcare treatment decision"; and the managed care

organization "did not deny or delay payment for any treatment prescribed or recommended by a provider to the insured or enrollee." These defenses were previously available to Texas managed care organizations under common law.

Additionally, the Texas law prohibits a managed care organization from obtaining indemnification from health care providers or pharmaceutical companies for liability due to the managed care organization's own acts or conduct. This provision is apparently designed to prevent a managed care organization from attempting to avoid liability under the statute by imposing upon their affiliated healthcare providers overreaching indemnification/hold harmless provisions by which the provider is required to hold the managed care organization harmless from the consequences of the managed care organization's own conduct.

Finally, the Texas law also contains a noteworthy provision prohibiting managed care organizations from removing a physician or other healthcare provider from their networks "for advocating on behalf of an enrollee for appropriate and medically necessary care for the enrollee." Again, this provision appears to merely codify existing common law. Nevertheless, the recognition of a statutory cause of action may encourage more provider lawsuits containing such allegations.

In 1998 Aetna U.S. Healthcare, one of Texas's largest managed care entities, challenged the Texas act in federal court. The parties ultimately chose to settle the case. Through the settlement, Texas and Aetna developed a plan which, while not comprehensive, broadly addressed some of the perceived worst abuses of modern managed care. The settlement, termed an "Assurance of Voluntary Compliance," does so in a way that may avoid ERISA preemption that has hindered other states' efforts at reform. It does so by taking advantage of the fact that courts have interpreted ERISA's preemption provision as a waivable choice of law. Thus, Aetna agreed in the settlement not to assert ERISA preemption in future actions brought against it. This waiver permits the substantive provisions of the settlement governing core issues such as precertification, compensation of physicians, and continuity of care, to function without the typical federal court interference. However, Aetna did not completely waive ERISA protection. The waiver does not apply to actions brought by individuals against Aetna for violation of terms of the settlement. [Health Law Perspectives, Health Law and Policy Institute, http://www.law.uh.edu/healthlawperspectives/managed/000503texasaetna.html]

Federal Background

The impact of state managed care civil liability legislation is often limited because of preemptions of the Employee Retirement Income Security Act of 1974 (ERISA). In general, state laws may affect non-self-insured employer-sponsored plans through regulation of the insurers. However, because of ERISA, non-risk-bearing networks contracting only with self-insured plans and the self-insured plans themselves are exempt from complying with state managed care laws. Therefore, both non-self-insured and self-insured plans can be shielded by ERISA from state attempts to expand insurer liability. Plaintiffs are permitted to sue only for the value of the benefit denied, not for other damages. Because of this limitation, the effects of state-level managed care reforms are limited since many employer-sponsored plans will not be affected by such reforms. [Margaret G. Farrell, "ERISA Preemption and Regulation of Managed Health Care: The Case for Managed Federalism" American Journal of Law & Medicine, 23, nos. 2&3 (1997): 251-89.]

Multiple previous attempts to adopt an HMO Patient's Bill of Rights at the federal level have proven unsuccessful due to the debate of whether or not consumers should have the right to sue their health plans. A number of "Patient's Bill of Rights" bills have been introduced to Congress this session. The most significant difference among the various bills relate to whether or not there will be limits to damage recoveries, and if so, how much.

Recent Federal Case

In the unanimous U.S. Supreme Court decision on *Pegram v. Herdrich*, No. 98-1949 (U.S. June 12, 2000), the Court decided that an HMO physcian made a “mixed eligibility decision” and that such decisions are not fiduciary decisions under ERISA . The Court's decision was founded on its distinction between "pure eligibility decisions," which involve an HMO plan's coverage of a condition or treatment, and "treatment decisions," which involve determining how to diagnose and treat a patient and assessing the appropriate medical response. The plaintiff in this case was a member of an HMO and alleged that the provision of medical services under terms rewarding physician owners for limiting medical care created an inherent or anticipatory breach of an ERISA fiduciary duty, because the terms created an incentive to make decisions in the physicians' self-interest, rather than the plan participants' exclusive interests. The Court found that the physician’s decisions were "mixed eligibility decisions," in which her medical decisions were inextricable from the HMO's administration of plan benefits

Cynthia Herdich claimed that Dr. Lori Pegram accurately determined that she needed diagnostic tests to measure her need for an appendectomy, however, Pegram’s financial relationship with the HMO wrongly induced Pegram to delay the testing for 8 days until the HMO’s preferred hospital could perform the tests. During the delay, Herdrich’s appendix ruptured. Under Illonis law, Herdrich recovered $35,000 in damages and obtained a transfer to federal court.

The federal district court granted defendant HMO's motion to dismiss on the ground that it was not acting as an Employee Retirement Income Security Act ("ERISA") fiduciary. The Seventh Circuit reversed the dismissal. The U.S. Supreme Court reversed the Seventh Circuit's decision. The Court held that plaintiff had failed to state a claim under ERISA, based on its conclusion that "mixed eligibility decisions by HMO physicians are not fiduciary decisions under ERISA." The plaintiff had argued that the HMO, acting through its physician owners, had breached its fiduciary duty to act solely in the interest of plan beneficiaries by making decisions that affected medical treatment while influenced by the terms of the HMO's profit scheme, which ultimately rewarded the physicians for their own choices to minimize medical services. The Court's decision was founded on its distinction between "pure eligibility decisions," which involve an HMO plan's coverage of a condition or treatment, and "treatment decisions," which involve determining how to diagnose and treat a patient and assessing the appropriate medical response.

The Court found that plaintiff had based her claims on "mixed eligibility decisions," in which the physician's medical decisions were inextricable from the HMO's administration of plan benefits. The Court determined that Congress had not intended to treat HMOs as fiduciaries under ERISA to the extent that HMOs make mixed eligibility decisions through their employee physicians. The Court found support for this assessment in the consequences that would result if plaintiff's argument were accepted. For example, the Court found that, "for all practical purposes, every claim of fiduciary breach by an HMO physician making a mixed decision would boil down to a malpractice claim, and the fiduciary standard would be nothing but the malpractice standard traditionally applied in actions against physicians." Explaining that "Congress had no such haphazard boons in prospect when it defined the ERISA fiduciary duty, nor such a risk to the efficiency of federal courts as a new fiduciary-malpractice jurisdiction would pose in welcoming such unheard-of fiduciary litigation," the Court ruled that mixed eligibility decisions are not ERISA fiduciary decisions, and thus reversed the Seventh Circuit's decision. [American Medical Association, Department of News and Information, http://www.ama-assn.org/]

Federal McCarran-Ferguson Act

The McCarran-Ferguson Act provides a limited exemption to the insurance industry from the federal antitrust laws. The act provides that the Sherman Anti-Trust Act, the Clayton Act, and the Federal Trade Commission Act apply to the business of insurance "to the extent that such business is not regulated by state law." That limited exemption from federal antitrust law does not extend to "any agreement to boycott, coerce or intimidate, or act of boycott, coercion, or intimidation." The act also declares that the business of insurance shall be subject to regulation and taxation by the states. After passage of the act in 1945, all states enacted some form of rate regulation to qualify for the exemption. The practical import of the antitrust exemption has been eroded in recent years as courts have narrowed the definition of the business of insurance and broadened the definition of boycott, and as an increasing number of states have subjected the industry to state antitrust law. [National Association of Insurance Commissioners, http://www.naic.org/products/libr/sub46.htm]

Florida Background

Florida was the first state to require HMOs to be nationally accredited. By law, HMOs must ensure access to primary and special care, give members the right to a second medical opinion, and establish procedures for resolving member grievances. Florida law also provides HMO subscribers with additional protections through requirements set out in s. 641.511, F.S., relating to subscriber grievance reporting and resolution requirements. Florida also created the first state external review process in 1985, the Statewide Provider and Subscriber Assistance Panel.

Section 641.511, F.S., Subscriber Grievance Reporting and Resolution Requirements

This section requires that every HMO must have a grievance procedure available to its subscribers for the purpose of addressing complaints and grievances, and provides certain requirements that an HMO must meet when carrying out its grievance procedures. Under this section, every organization must have a grievance procedure available to its subscribers. Every organization must notify its subscribers of the program. Subscribers must submit grievances within 1 year after the date of occurrence. After receiving a final disposition of the grievance from the organization, subscribers may submit the grievance for review to the Statewide Provider and Subscriber Assistance Panel. Except for expedited reviews of urgent grievances, an organization must resolve a grievance within 60 days after the receipt of the grievance or within 90 days if the grievance involves the collection of information outside the service area. These times may be tolled under specified limited circumstances.

Each organization's grievance procedure must include, at a minimum:

- An explanation of how to pursue redress of a grievance;
- The names of the appropriate employees or departments that are responsible for implementing the grievance procedure (including address and toll-free telephone hotline number of the Agency for Health Care Administration to inform it of unresolved grievances);
- A procedure for establishing methods for classifying grievances as urgent and for establishing an expedited review within which such grievances must be resolved; and
- A notice that a subscriber may voluntarily purse binding arbitration in accordance with the terms of the contract if offered by the organization, after completing the organization's grievance procedure and as an alternative to the Statewide Provider and Subscriber Assistance Program, including an explanation of potential costs;
- A process whereby the grievance manager acknowledges the grievance and investigates the grievance in order to notify the subscriber of the final decision in writing; and

- A procedure for providing individuals who are unable to submit a written grievance with access to the grievance process.

The agency may impose administrative sanctions against an organization for noncompliance with this section.

Section 408.7056, F.S., Florida Statewide Provider and Subscriber Assistance Program

The Statewide Provider and Subscriber Assistance Program is authorized by s. 408.7056, F.S., and is administered by the Agency for Health Care Administration. The program is designed to assist subscribers and policyholders of managed care entities and providers whose grievances are not resolved by the managed care entity to the satisfaction of the subscriber or provider. The agency refers grievances to the panel that hold hearings on the grievance and issue recommendations to the agency or to the Department of Insurance for a final order.

The agency is required to review all grievances within 60 days after receipt and make a determination whether the grievance must be heard. Once the agency notifies the panel, the subscriber or provider, and the managed care entity that a grievance will be heard, the panel hears the grievance no later than 120 days after the date the grievance was filed. The panel may take testimony under oath, request certified copies of documents, and take similar actions to collect information and documentation that will assist the panel in making finding of fact and a recommendation. The panel must issue a written recommendation, supported by findings of fact no later than 15 working days after hearing the grievance. If, at the hearing, the panel requests additional documentation or additional records, the time for issuing a recommendation is tolled until the information or documentation has been provided to the panel.

Grievances that the agency determines pose an immediate and serious threat to a subscriber's health must be given priority over other grievances. When the agency determines that the life of a subscriber is in imminent and emergent jeopardy, the chair of the panel may convene an emergency hearing, within 24 hours after notification to the managed care entity and to the subscriber, to hear the grievance. The grievance must be heard notwithstanding that the subscriber has not completed the internal grievance procedure of the managed care entity. Within 24 hours after receipt of the panel's emergency recommendation, the agency or the department may issue an emergency order to the managed care entity. The agency or department may issue a proposed order or an emergency order, imposing fines or sanctions. All fines collected under this subsection must be deposited into the Health Care Trust Fund.

The program does not provide assistance for grievances related to providers unless it is related to the quality of care provided to a subscriber. The program does not provide assistance for a grievance for "unpaid balances." The program does not typically provide assistance for grievances related to provider disputes for late payments or underpayments.

According to statistics from the Agency for Health Care Administration, the administering agency for the state's external review process, 65 percent of all cases heard by the panel are decided in favor of the consumer.

The Patient Protection Act of 2000

Chapter 2000-256, Laws of Florida, "The Patient Protection Act of 2000" (Act), among its other provisions, created s. 641.185, F.S. This section restated into one section existing HMO patient protections available under other statutes as a means of increasing public awareness of the protections available in other sections of the law. The new section directed the Department of

Insurance and the Agency for Health Care Administration to follow a series of principles in exercising their powers and duties with respect to HMOs:

- Reasonable standards of quality of care consistent with the prevailing standards of medical practice in the community, pursuant to ss. 641495(1) and 641.51, F.S.;
- Receipt of quality health care from broad panel of providers, including referrals and preventive care pursuant to s. 641401(1), F.S., and emergency screening and services, pursuant to ss. 641.31(12) and 641.513, F.S.;
- Independent accreditation of an HMO by a national review organization, pursuant to s. 641.512, F.S., and HMO financial security as determined by the state, pursuant to ss. 641.221, 641.255, and 641.228, F.S.;
- Continuity of health care, even after the provider is no longer with the HMO, pursuant to s. 641.51(7), F.S.;
- Timely, concise information regarding the HMO's reimbursement to providers and services pursuant, to ss. 641.31 and 641.31015, F.S.;
- Subscriber flexibility to transfer to another Florida HMO, regardless of health status, pursuant to ss. 641.228, 641.3104, 641.3111, 641.3921, and 641.3922, F.S.;
- Eligibility for coverage without discrimination against individual participants and beneficiaries of group plans based on health status, pursuant to s. 641.31073, F.S.;
- Provision of the following as part of a group health contract:
    - coverage for preexisting conditions pursuant to s. 641.31071, F.S.;
    - guaranteed renewability of coverage pursuant to s. 641.31074, F.S.;
    - notice of cancellation, pursuant to s. 641.3108, F.S.;
    - extension of benefits, pursuant to s. 641.3111, F.S.;
    - conversion on termination of eligibility, pursuant to s. 641.3921, F.S.; and
    - provide for conversion contracts and conditions, pursuant to s. 641.3922, F.S..
- Timely and, if necessary, urgent grievances and appeals within the HMO, pursuant to ss. 41.228, 641.31(5), 641.47, and 641.511, F.S.;
- Timely and, if necessary, urgent review by an independent state external review organization for unresolved grievances and appeals, pursuant to s. 408.7056;
- Written notice to subscribers at least 30 days in advance of a rate change pursuant to s. 641.31(3)(b), F.S. In the case of a group member, there may be a contractual agreement with the HMO to have the employer provide the required notice to the individual members of the group, pursuant to s. 641.31(3)(b), F.S.;
- Subscriber receipt of the applicable HMO contract, certificate, or member handbook specifying:
    - all the provisions, disclosure, and limitations required, pursuant to s. 641.31(1), F.S.;
    - the covered services, including those services, medical conditions, and provider types specified in ss. 641.31, 641.31094, 641.31095, 641.31096, 641.51(10), and 641.513, F.S.; and
    - where and in what manner services may be obtained, pursuant to s. 641.31(4), F.S.

The Act also states that "[t]his section shall not be construed as creating a civil cause of action by any subscriber or provider against any health maintenance organization."

In addition, among a variety of other actions, the Act:

- Prevented HMO contracts from prohibiting physicians from providing inpatient services to their patients in a contracted hospital;
- Required adverse determinations to be made by an allopathic or osteopathic physician;
- Required notice to the patient and the provider of reason for denial of care;

- Required providers, under contract with HMOs, to post and prominently display notice of addresses and toll-free telephone numbers of the Agency for Health Care Administration, the Department of Insurance; and the Statewide Provider and Subscriber Assistance Program; and
- Required providers to provide the address and telephone number of the organization's grievance department upon request.

C. EFFECT OF PROPOSED CHANGES:

HB 317 creates the "Managed Care Organization's Patient's Bill of Rights." The bill provides legislative findings and intent. The bill specifies that the purpose of the act is to ensure that quality health care and health benefits are provided to the people of this state. The bill provides that managed care organizations owe a fiduciary duty to provide such care to their subscribers.

The bill provides legislative intent that the rights and responsibilities of subscribers who are covered under health maintenance organization contracts must be recognized and summarized. The bill requires health maintenance organizations to operate in conformity with such rights and requires the organizations to provide subscribers with a copy of their rights and responsibilities. The bill lists specified requirements for managed care organizations that are currently required by other statutes.

The bill authorizes civil remedies to enforce the rights as specified and provides actual and punitive damages, attorney's fees and costs, and authorizes administrative fines. The bill provides that there is no liability on the part of certain employers or employee organizations.

The bill requires a plaintiff to submit a written grievance to the managed care organization prior to bringing an action for damages. Managed care organizations are required to dispose of a grievance within a 30-day period, subject to specified exceptions, or the grievance is deemed to be adverse to the managed care organization. The bill authorizes an action for nonmonetary relief without complying with notice provisions if the harm to the patient has already occurred or is imminent.

The bill provides for severability and an effective date.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Provides the short title, the "Managed Care Organization's Patient's Bill of Rights."

Section 2. Creates "Legislative Findings and Intent" as follows:

Subsection (1) provides Legislative findings and intent, addressing the health, safety, and welfare of the people of this state as a fundament state interest. and the legislative responsibility for protecting this interest through the laws of this state; and that the manner in which health care is provided has a direct impact upon the health, safety, and welfare of the state residents.

Subsection (2) provides for the application of the act as follows:

- The intent of this act is to apply to all managed care organizations;
- The term "managed care organization" includes: health insurance carriers; health maintenance organizations; health service plans; other managed care entities that provide health care or health benefits; and entities regulated under chapters 624 through 631, F.S. and chapter 641, F.S., which provide health care benefits;
- Provides that managed care organizations are engaged in the business of insurance in this state as the term is defined under the McCarran-Ferguson Act, 15 U.S.C. ss.1011 et.

Seq. [NOTE: The McCarran-Ferguson Act is a federal act that placed the primary responsibility for regulating health insurance companies and HMOs that service private sector (commercial) plan members at the state level.]

Subsection (3) provides the purpose of the act, to regulate the business of insurance and to ensure that appropriate quality health care benefits are provided through managed health care.

Subsection (4) provides that managed care organizations owe a fiduciary duty to the people of this state to ensure appropriate quality health care and health benefits.

Subsection (5) provides for the creation of substantive rights for quality health care and health benefits and provides remedies under state law for persons who are harmed by the failure of a managed care organization to meet appropriate standards for quality health care and health benefits guaranteed under this act.

Subsection (6) provides Legislative intent that all managed care organizations be given notice of a violation of a patient's rights and be provided with an opportunity to comply with the law without the necessity of filing a civil action. Also recognizes that the rights and remedies identified in the act are necessary to properly regulate the business of insurance and to protect the public.

Section 3. Creates s. 641.275, F.S., relating to subscriber's rights and responsibilities under health maintenance contracts and required notice, as follows:

Subsection (1) provides Legislative intent relating to the recognition and summary of the rights and responsibilities of subscribers who are covered under health maintenance organization contracts. Provides that an organization must not require a subscriber to waive his or her rights as a condition of coverage or treatment and requires the organization to operate in conformity with such rights.

Subsection (2) provides that each organization must provide subscribers with a copy of their rights and responsibilities as listed in this section, in a form that is approved by the Department of Insurance.

Subsection (3) requires managed care organizations to meet the following requirements:

- Standards of medical practice in the community, as required by s. 641.51, F.S.;
- Quality assurance program, as required by s. 641.51, F.S.;
- The professional judgment of a physician, except as is consistent with s. 641.51, F.S.;
- A provider's ability to communicate information to the subscriber or patient regarding medical care options, as required by s. 641.315(5), F.S.;
- Standing referrals to specialists, as required by s. 641.51, F.S.;
- Selection of an obstetrician/gynecologist by a female subscriber, as required by s. 641.51(11), F.S.;
- Dermatologist direct access, as required by s. 641.31(33); F.S.;
- The length of stay in a hospital for a mastectomy, consistent with s. 641.31(3), F.S.;
- Coverage for the length of a maternity or newborn stay in a hospital or for follow-up care outside the hospital, as required by s. 641.31(18), F.S.;
- Coverage for bone marrow transplant procedures, as required by s. 627.4236, F.S.;
- Coverage for drugs, as required by s. 627.4239, F.S.;
- A second medical opinion, as required by s. 641.51(5), F.S.;

- Continuing treatment from a provider after the provider's contract with the organization has been terminated, as required by s. 641.51(8), F.S.;
- Resolving subscriber grievances, including review of adverse determinations and expedited review of urgent subscriber grievances, as required by s. 641.511, F.S.;
- The right to an independent external review of grievances not resolved by the organization, as required by s. 408.7056, F.S.;
- Coverage for emergency services and care, as required by s. 641.513, F.S.;
- Genetic information or use of genetic test results, as required by s. 627.4301, F.S.;
- Promptly pay or deny claims, as required by s. 641.3155, F.S.; and
- Provision of information to subscribers regarding a variety of coverage and process issues, as required by ss. 641.259, 641.495, and 541.54, F.S.

Subsection (4) indicates that the statement of rights contained in newly created subsection (3) is a summary of selected requirements for organizations contained in other sections of Florida Statutes, and that this section does not alter the requirements of such other sections.

Subsection (5) provides requirements relating to patient's and provider's responsibilities, as follows:

- For patients and providers, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters that relate to the patient's health.
- For a patient: reporting unexpected changes in his or her condition; reporting to the recommending physician whether he or she understands a contemplated medical course of action and what is expected of him or her; following the treatment plan recommended; keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility; following the procedures of the managed care organization for selecting a primary care physician and obtaining referrals; reading and ensuring the accuracy and completeness of information on an application to the best of his or her ability, and for not signing any blank, incomplete, or inaccurate form; reading and understanding the contract of his or her managed care organization; paying the monthly premium, even if the patient is involved in a financial dispute with the managed care organization; paying his or her coinsurance, deductibles, or copayments; and arranging for prior approval before accepting care from a noncontracted provider, except in an emergency, as defined in s. 641.19, F.S., and for understanding the financial consequences of failing to obtain prior approval.

Section 4. Provides for civil remedy to enforce rights, as follows:

Subsection (1) authorizes the following:

- Any person whose rights, as specified in s. 641.275, F.S., are violated has a cause of action against the managed care organization or provider;
- The action may be brought by the person, by the person's guardian, by an individual or organization acting on behalf of the person with the consent of the person or his or her guardian, or by the personal representative of the estate of a deceased person;
- The action may be brought in any court of competent jurisdiction to enforce such rights and recover actual and punitive damages for any violation of the rights of the person;
- The damages recoverable include all reasonably foreseeable harm caused by the violation of the rights specified in s. 641.275, F.S.;
- The damages are not limited by any other state law;
- Punitive damages may be awarded for conduct that is willful, wanton, gross, flagrant, reckless, or consciously indifferent to the rights of an individual protected by this act;

- Any plaintiff who prevails in such an action may recover reasonable attorney's fees, costs of the action, and damages, unless the court finds that the plaintiff has acted in bad faith or with malicious purpose or that there was a complete absence of a justiciable issue of law or fact;
- A prevailing defendant may claim reasonable attorney's fees under s. 57.105, F.S.; and
- The remedies provided in this section are remedial and in addition to and cumulative with all other legal, equitable, administrative, contractual, or informal remedies available to the people of this state or to state agencies.

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

Subsection (3) states that:

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

Subsection (4) provides the following:

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

Paragraph (b) provides that, if the patient does not submit a grievance to the managed care organization within 1 year after the action giving rise to the grievance, as required by s. 641.511(1), F.S., the patient is not required to submit a grievance prior to initiating and maintaining a cause of action to enforce his or her rights. Under such circumstances, the patient must provide a written notice of intent to pursue a civil action for a violation of the managed care organization's patient's bill of rights 30 days prior to initiating such an action. The notice must include the following:

- The alleged violation of the patient's rights;
- The facts and circumstances giving rise to the violation;
- The name of any individual involved in the violation; and
- A statement that the notice is given in order to give the managed care organization the opportunity to comply with the law.

Subsection (5) provides that if the patient does not comply with subsection (4), the court may not dismiss the action. However, the court may order that the patient complete the internal grievance procedure of the managed care organization, as provided for in paragraph (4)(a), or give the 30 days' notice, as provided in paragraph (4)(b). Authorizes the court to abate an action for such

purposes for not more than 60 days. Provides that such orders of the court are the only remedies available to a party that complains of a patient's failure to comply with subsection (4).

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

Subsection (7) provides that the statute of limitations, with respect to an action that may be brought under this section, is tolled upon submission of a grievance in accordance with s. 641.511, F.S., or upon submission of 30 days' notice, whichever is applicable, and the time of the grievance or notice is pending is not included within the period limiting the time for bringing such action.

Subsection (8) provides that there is no other condition precedent to bringing an action under this section.

Subsection (9) provides the following:

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

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

Section 5. Provides severability of any provision of this act or its application to any person or circumstance in the event the provision is found to be invalid.

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

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

N/A

2. Expenditures:

According to AHCA, this bill has no immediate, quantifiable fiscal impact on the agency.

According to the Department of Insurance, this bill imposes no direct fiscal impact for the regulatory divisions; however, the civil remedy provisions could have an indeterminate fiscal impact on the "legal casework."

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

N/A

2. Expenditures:

According to AHCA, the proposed bill may increase litigation and result in higher insurance costs to local governments that provide health insurance for their employees.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Private plaintiffs would have another recourse against HMOs, the financial impact of which is not known.

According to ACHA, the proposed bill exposes HMOs to liability for actual damages, punitive damages, and attorney's fees for violation of specific "rights." Permitting subscribers to sue the HMO for punitive damages for any violation of rights specified in this Act is likely to increase the costs for HMOs to operate in the State. Additionally, the "rights" specified in the bill are vague and may initially lead to a large number of lawsuits. The costs to the HMOs will likely be shifted to subscribers. In addition, all HMOs are effected equally. As the costs of lawsuits rises, some HMOs may stop providing coverage in Florida. As a result of increased premiums employers may stop providing health insurance.

D. FISCAL COMMENTS:

N/A

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds to take an action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill dos not reduce the authority that municipalities or counties have to raise revenue in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill dos not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

N/A

B. RULE-MAKING AUTHORITY:

N/A

C. OTHER COMMENTS:

Section 1. HB 317 ignores the requirements of the s. 641.185, F.S., health maintenance organization subscriber protections, as adopted in the 2000 Legislative session. The bill ignores the requirements of s. 641.511, F.S, subscriber grievance reporting and resolution requirements. The bill ignores the requirements of s. 408.7056, the Statewide Provider and Subscriber Assistance Program. As a result of ignoring these existing resolution programs there is a multiplicity of conflicting programs for resolution of patient grievances, some with financial incentives and some without such incentives.

Section 2. HB 317 places the definition of "managed care organization" within the Legislative findings and intent section. The is not the typical location for such a definition.

HB 317 timeframes for review of grievances are not consistent with current internal grievance requirements as contained in s. 641.511, F.S., relating to subscriber grievance reporting and resolution requirements. The timeframes contained in the bill are also not consistent with s. 408.7056, F.S., Florida Statewide Provider and Subscriber Assistance Panel.

Section 3. Several of the provisions contained in HB 317 are also found in several other places in statutes. Because all of the "rights" are not found in one place, the bill may add to the confusion as to which grievance process is available for resolution of a particular situation.

Section 4. Some subscriber rights contained in other sections of law are not contained in this bill. This may result in some confusion as to which "rights" are subject to actual and punitive damage awards under the provisions of this bill and which are subject to more limited remedies found elsewhere in existing statutes.

Section 6. This act takes effect on July 1, 2001, and applies to contracts issued on or renewed on or after that date. The would appear to provide insufficient time for the managed care organizations to redraft and reprint their contracts and handbooks.

Department of Insurance:

Section 2. There is a need for the statement of legislative intent to be amended to become more specific than the reference to "other managed care entities that provide health care or health care benefits."

Section. 3. The regulatory section created at s. 641.275, F.S., does not conform to the existent statement of "subscriber protections" at s. 641.185, F.S., If enacted, the new statute could pose a regulatory conflict for HMOs.

Agency for Health Care Administration: The proposed bill is likely to generate litigation from managed care subscribers who believe that their rights have been violated. The rights specified in the bill are vague and may encourage frivolous lawsuits.

General Staff Comment: As previously noted, existing s. 641.185, F.S., provides HMO "subscriber protections" and indicates that these protections do not create a civil cause of action against an HMO. This bill, in section 3, provides HMO subscribers' rights and responsibilities, and

indicates that such rights do create a cause of action against an HMO. The result will create a statutory conflict and confusion for the HMO industry and subscribers.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

N/A

VII. SIGNATURES:

COMMITTEE ON HEALTH PROMOTION:

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