By Representative Weissman

1 A bill to be entitled
2 An act relating to health care; requiring
3 health maintenance organizations to provide for
4 the resolution of grievances brought by
5 subscribers; specifying the services to be
6 included in a grievance system; requiring
7 health maintenance organizations to establish
8 an informal appeal process; providing for a
9 formal internal appeal process; providing for
10 an external appeal when a subscriber is
11 dissatisfied with the results of a formal
12 appeal; providing for the grievance to be
13 reviewed by an independent utilization review
14 organization; providing for a party to appeal a
15 decision by the utilization review organization
16 to the Agency for Health Care Administration;
17 requiring that the Agency for Health Care
18 Administration enter into contracts with
19 utilization review organizations for the
20 purpose of reviewing appeals; authorizing the
21 agency to adopt rules; providing for the right
22 of a subscriber to maintain an action against a
23 health maintenance organization; providing
24 definitions; providing that a health
25 maintenance organization has the duty to
26 exercise ordinary care when making treatment
27 decisions; providing that a health maintenance
28 organization is liable for damages for harm
29 caused by failure to exercise ordinary care;
30 providing certain limitations on actions;
31 providing for a claim of liability to be

1 reviewed by an independent review organization;
2 providing for the statute of limitations to be
3 tolled under certain circumstances; requiring a
4 health maintenance organization to disclose
5 certain information to subscribers and
6 prospective subscribers; specifying additional
7 information that must be provided upon the
8 request of a subscriber or prospective
9 subscriber; requiring that a health maintenance
10 organization provide notice if a provider is
11 unavailable to render services; providing
12 requirements for the notice; requiring health
13 maintenance organizations to make certain
14 allowances in developing provider profiles and
15 measuring the performance of health care
16 providers; providing for such information to be
17 made available to the Department of Insurance,
18 the Agency for Health Care Administration, and
19 subscribers; prohibiting a health maintenance
20 organization from taking retaliatory action
21 against an employee for certain actions or
22 disclosures concerning improper patient care;
23 requiring that a health maintenance
24 organization refer a subscriber to an outside
25 provider in cases in which there is not a
26 provider within the organization's network to
27 provide a covered benefit; requiring that a
28 health maintenance organization provide a
29 procedure to allow a subscriber to obtain drugs
30 that are not included in the organization's
31 drug formulary; prohibiting a health

1 maintenance organization from arbitrarily
2 interfering with certain decisions of a health
3 care provider; prohibiting a health maintenance
4 organization from discriminating against a
5 subscriber based on race, national origin, and
6 other factors; requiring health maintenance
7 organizations to establish a policy governing
8 the termination of health care providers;
9 providing requirements for the policy;
10 authorizing the Insurance Commissioner to
11 suspend or revoke a certificate of authority
12 upon finding certain violations by a health
13 maintenance organization; providing for civil
14 penalties; repealing s. 641.513, F.S., relating
15 to requirements for providing emergency
16 services and care; amending s. 627.419, F.S.;
17 providing free choice to subscribers to certain
18 health care plans, and to persons covered under
19 certain health insurance policies or contracts,
20 in the selection of specified health care
21 providers; prohibiting coercion of provider
22 selection; specifying conditions under which
23 any health care provider must be permitted to
24 provide services under a health care plan or
25 health insurance policy or contract; providing
26 limitations; providing for civil penalties;
27 providing application; amending s. 641.28,
28 F.S.; limiting the parties that may recover
29 attorney's fees and court costs in an action to
30 enforce the terms of a health maintenance
31 contract; providing an effective date.

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1 Be It Enacted by the Legislature of the State of Florida:
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3 Section 1. Managed care bill of rights.--
4 (1) GENERAL PROVISIONS.--
5 (a) Each health maintenance organization shall
6 establish a system to provide for the presentation and
7 resolution of grievances brought by a subscriber or brought by
8 a representative or provider acting on behalf of a subscriber
9 and with the subscriber's consent. Such grievance may include,
10 but need not be limited to, complaints regarding referral to a
11 specialist, quality of care, choice and accessibility of
12 providers, network adequacy, termination of coverage, denial
13 of approval for coverage, or other limitations in the receipt
14 of health care services. Each system for resolving grievances
15 must be in writing, given to each subscriber and each
16 provider, and incorporated into the health maintenance
17 contract. Each grievance system must include:
18 1. The provision of the telephone numbers and business
19 addresses of each employee of the health maintenance
20 organization who is responsible for grievance resolution.
21 2. A system to record and document the status of all
22 grievances, which must be maintained for at least 3 years.
23 3. The services of a representative to assist
24 subscribers with grievance procedures upon request.
25 4. Establishment of a specified response time for the
26 resolution of grievances, which may not exceed the time limits
27 set forth in subsection (2) or subsection (3).
28 5. A detailed description of how grievances are
29 processed and resolved.
30 6. A requirement that the determination must set forth
31 the basis for any denial and include specific information

1 concerning appeal rights, procedures for an independent
2 external appeal, to whom and where to address any appeal, and
3 the applicable deadlines for appeal.
4 (b) If a health maintenance organization fails to
5 comply with any of the deadlines at any stage of the
6 organization's internal review process, or waives the
7 completion of the process, the subscriber, or the subscriber's
8 representative or provider, is relieved of the obligation to
9 complete the process and may proceed directly to the external
10 appeals process set forth in subsection (4).
11 (c) All time limits set forth in subsections (2), (3),
12 and (4) must include an additional 3 days for mailing
13 following the date of the postmark. A decision with respect to
14 urgent or emergency care must also be communicated by
15 telephone.
16 (2) INFORMAL APPEAL PROCESS.--
17 (a) Each health maintenance organization must
18 establish and maintain an informal internal appeal process
19 whereby any subscriber, or representative or provider acting
20 on behalf of a subscriber and with the subscriber's consent,
21 who has a grievance concerning any of the actions by the
22 health maintenance organization as described in paragraph
23 (1)(a) or related thereto, shall be given the opportunity to
24 discuss and appeal that determination to the medical director
25 or the physician designee who rendered the determination.
26 (b) An informal appeal under this subsection must be
27 concluded as soon as possible in accordance with the medical
28 exigencies of the case. If the appeal is from a determination
29 regarding urgent or emergency care, the appeal must be
30 resolved within 72 hours after the initial contact by the
31 subscriber or the subscriber's representative or provider. In

1 the case of all other appeals, the appeal must be resolved
2 within 5 business days after the initial contact by the
3 subscriber or the subscriber's representative or provider. If
4 an appeal under this subsection is not resolved to the
5 satisfaction of the subscriber, the health maintenance
6 organization shall provide to the subscriber, the subscriber's
7 provider, and the subscriber's representative, if applicable,
8 a written explanation of the basis for the decision on the
9 grievance and notification of the right to proceed to a formal
10 appeals process under subsection (3). The notice must be
11 postmarked within the applicable time limits prescribed in
12 this paragraph.
13 (3) FORMAL INTERNAL APPEAL PROCESS.--
14 (a) Each health maintenance organization shall
15 establish and maintain a formal internal appeal process
16 whereby any subscriber, or representative or provider acting
17 on behalf of a subscriber and with the subscriber's consent,
18 who is dissatisfied with the results of the informal appeal
19 under subsection (2) may pursue the subscriber's appeal before
20 a panel of physicians selected by the health maintenance
21 organization who have not been involved in the determination
22 being appealed.
23 (b) The members of the formal appeal panel must
24 include consultant practitioners who are trained in or who
25 practice in the same specialty that would typically manage the
26 case being appealed or must include other licensed health care
27 professionals who are mutually agreed upon by the parties. The
28 consulting practitioners or professionals may not have been
29 involved in the determination being appealed. The consulting
30 practitioners or professionals must participate in the panel's
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1 review of the case at the request of the subscriber or the
2 subscriber's representative or provider.
3 (c) Within 10 business days after an appeal is filed
4 under this subsection, the health maintenance organization
5 must acknowledge in writing to the subscriber, or the
6 subscriber's representative or provider, receipt of the
7 appeal.
8 (d) A formal appeal under this subsection must be
9 concluded as soon as possible. If the appeal is from a
10 determination regarding urgent or emergency care, the appeal
11 must be resolved within 72 hours after the filing of the
12 formal appeal. In the case of all other appeals, the appeal
13 must be resolved within 5 business days after the filing of
14 the formal appeal.
15 (e) The health maintenance organization may extend the
16 review for up to an additional 20 days if it can demonstrate
17 reasonable cause for the delay which is beyond its control and
18 if the health maintenance organization provides a written
19 progress report and explanation for the delay to the Agency
20 for Health Care Administration. The health maintenance
21 organization must notify the subscriber, and where applicable
22 the subscriber's representative or provider, of the delay
23 prior to the end of the time limitation in paragraph (d).
24 (f) If a formal appeal under this subsection is
25 denied, the health maintenance organization must notify the
26 subscriber, and where applicable the subscriber's avocate or
27 provider, of the denial. The notice must be in writing, set
28 forth the basis for the denial, and include notice of the
29 subscriber's right to proceed to an independent external
30 appeal under subsection (4). The notice must include specific
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1 instruction on how and where the subscriber may file for an
2 external appeal of the denial.
3 (4) EXTERNAL APPEAL PROCESS.--
4 (a) If a subscriber, or a subscriber's representative
5 or provider acting on behalf of a subscriber and with the
6 subscriber's consent, is dissatisfied with the results of a
7 formal internal appeal under subsection (3), the subscriber,
8 or the subscriber's representative or provider, may pursue an
9 appeal to the Agency for Health Care Administration for
10 referral to an independent utilization review organization.
11 (b) To initiate an external appeal, the subscriber, or
12 the subscriber's representative or provider, must file a
13 written request with the Agency for Health Care
14 Administration. The appeal must be filed within 30 business
15 days after receipt of the written decision of the formal
16 internal appeal under subsection (3). The agency may extend
17 for an additional 30 days the time for filing the appeal upon
18 a showing of good cause. A delay under this paragraph does not
19 affect a subscriber's right to proceed under any other
20 applicable state or federal law.
21 (c) Within 5 days after receiving a request for an
22 external appeal, the Agency for Health Care Administration
23 shall determine whether the procedural requirements described
24 in this section have been satisfied. If those requirements
25 have been satisfied, the agency shall assign the appeal to an
26 independent utilization review organization for review.
27 (d) The independent utilization review organization
28 shall assign the case for a full review within 5 days after
29 receiving an appeal under paragraph (c) and shall determine
30 whether, as a result of the health maintenance organization's
31 determination, the subscriber was deprived of any of the

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1 rights described in paragraph (1)(a). The independent
2 utilization review organization shall consider all pertinent
3 medical records; reports submitted by the consulting physician
4 and other documents submitted by the parties; any applicable
5 and generally accepted practice guidelines developed by the
6 Federal Government, national or professional medical
7 societies, boards, or associations; and any applicable
8 clinical protocols or practice guidelines developed by the
9 health maintenance organization. The independent utilization
10 review organization shall refer all cases for review to a
11 consultant physician or other health care professional in the
12 same speciality or area of practice who manages the type of
13 treatment that is the subject of the appeal. All final
14 recommendations of the independent utilization review
15 organization are subject to approval by the medical director
16 of the independent utilization review organization or by an
17 alternate physician if the medical director has a conflict of
18 interest.
19 (e) The independent utilization review organization
20 shall issue its recommended decision to the Agency for Health
21 Care Administration and provide copies to the subscriber, the
22 subscriber's representative or provider if applicable, and the
23 health maintenance organization. The decision must be issued
24 as soon as possible in accordance with the medical exigencies
25 of the case which, except as provided in this paragraph, may
26 not exceed 30 business days after receipt of all documentation
27 necessary to complete the review. However, the independent
28 utilization review organization may extend its review for a
29 reasonable period due to circumstances beyond the control of
30 all parties to the action, and must advise the subscriber, the
31 subscriber's representative or provider if applicable, the

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1 health maintenance organization, and the Agency for Health
2 Care Administration in a formal statement explaining the
3 delay. If any party fails to provide documentation sought by
4 the independent utilization review organization which is
5 within that party's control, the party waives its position
6 with respect to the review.
7 (f) If the independent utilization review organization
8 determines that the subscriber was deprived of medically
9 necessary covered services, the independent utilization review
10 organization shall, in its recommended decision, advise all
11 parties of the appropriate covered health care services the
12 subscriber is entitled to receive. In all cases, the
13 independent utilization review organization shall advise all
14 parties of the basis of its recommended decision.
15 (g) Any party may appeal the recommended decision to
16 the Agency for Health Care Administration, with a copy of the
17 appeal to all other parties, within 20 days after the date the
18 decision is issued. If a decision is appealed, any other party
19 may file with the Agency for Health Care Administration its
20 position on the issues raised in the appeal, with copies to
21 all other parties, within 20 days after receipt of the initial
22 appeal.
23 (h) The Agency for Health Care Administration shall
24 issue its decision within 30 days after completion of the
25 record in the case. The decision must include an explanation
26 of the basis supporting the decision. The final decision of
27 the Agency for Health Care Administration is binding on the
28 health maintenance organization.
29 (i) The Agency for Health Care Administration shall
30 issue a report 30 days after the end of each calendar quarter
31 which summarizes all appeals and final decisions. The report

1 must maintain the confidentiality of patient information and
2 shall be provided to the Governor, the Insurance Commissioner,
3 and the appropriate substantive committees of the Senate and
4 the House of Representatives. The quarterly reports shall be
5 available to the public.
6 (5) INDEPENDENT UTILIZATION REVIEW ORGANIZATIONS.--
7 (a) The Agency for Health Care Administration shall
8 enter into contracts with as many independent utilization
9 review organizations throughout the state as the agency deems
10 necessary to conduct external appeals under this section. Each
11 independent utilization review organization must be
12 independent of any insurance carrier, and a physician may not
13 be assigned to hear any appeal that would constitute a
14 conflict of interest. As part of its contract, each
15 independent utilization review organization shall submit to
16 the Agency for Health Care Administration a list of the
17 organization's physician reviewers and the health maintenance
18 organizations, health insurers, health providers, and other
19 health care providers with whom the organization has a
20 contractual or other business arrangement. Each organization
21 shall update the list of its business relationships as
22 changes, additions, or deletions occur.
23 (b) Upon any request for an external appeal, the
24 Agency for Health Care Administration shall assign the appeal
25 to an approved independent utilization review organization on
26 a random basis. The agency may deny an assignment if, in its
27 determination, the assignment would result in a conflict of
28 interest or would otherwise create the appearance of
29 impropriety.
30 (c) The Agency for Health Care Administration shall
31 adopt rules to administer this section.

1 Section 2. Right of subscribers to maintain an action
2 against a health maintenance organization.--
3 (1) DEFINITIONS.--As used in this section, the term:
4 (a) "Appropriate and medically necessary" means the
5 standard for health care services as determined by physicians
6 and health care providers in accordance with the prevailing
7 practices and standards of the medical profession and
8 community.
9 (b) "Health care treatment decision" means a
10 determination made when medical services are actually provided
11 by the health care plan and a decision that affects the
12 quality of the diagnosis, care, or treatment provided to the
13 plans subscribers.
14 (c) "Ordinary care" means, in the case of a health
15 maintenance organization, that degree of care that a health
16 maintenance organization of ordinary prudence would use under
17 the same or similar circumstances. In the case of a person who
18 is an employee, agent, or representative of a health
19 maintenance organization, the term "ordinary care" means that
20 degree of care that a person of ordinary prudence in the same
21 profession, specialty, or area of practice would use in the
22 same or similar circumstances.
23 (2) APPLICATION.--
24 (a) A health maintenance organization has the duty to
25 exercise ordinary care when making health care treatment
26 decisions and is liable for damages for harm to a subscriber
27 which is proximately caused by its failure to exercise such
28 ordinary care.
29 (b) A health maintenance organization is also liable
30 for damages for harm to a subscriber which are proximately
31 caused by the health care treatment decisions made by its:

1. Employees;
2. Agents; or
3. Representatives,

who act on behalf of the health maintenance organization and over whom it has the right to exercise influence or control, whose actions or failure to act result in the failure to exercise ordinary care.

(c) It is a defense to any action asserted against a health maintenance organization that:

1. Neither the health maintenance organization or any employee, agent, or representative for whose conduct such health maintenance organization is liable under paragraph (b) controlled, influenced, or participated in the health care treatment decision; and

2. The health maintenance organization did not deny or delay payment for any treatment prescribed or recommended by a health care provider to the subscriber.

(d) The standards in paragraphs (a) and (b) do not create an obligation on the part of the health maintenance organization to provide treatment to a subscriber which is not covered by the health care plan.

(e) This section does not create any liability on the part of an employer, an employer group-purchasing organization, or a pharmacy licensed by the Board of Pharmacy which purchases coverage or assumes risk on behalf of its employees.

(f) A health maintenance organization may not remove a physician or health care provider from its plan or refuse to renew the physician or health care provider with its plan for

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1 advocating on behalf of a subscriber for appropriate and
2 medically necessary health care for the subscriber.
3 (g) A health maintenance organization may not enter
4 into a contract with a physician, hospital, or other health
5 care provider or pharmaceutical company which includes an
6 indemnification or hold-harmless clause for the acts or
7 conduct of the health maintenance organization. Any such
8 indemnification or hold-harmless clause in an existing
9 contract is void.
10 (h) Any law of this state prohibiting a health
11 maintenance organization from practicing medicine or being
12 licensed to practice medicine may not be asserted as a defense
13 by a health maintenance organization in an action brought
14 against it pursuant to this section or any other law.
15 (i) In an action against a health maintenance
16 organization, a finding that a physician or other health care
17 provider is an employee, agent, or representative of such
18 health maintenance organization may not be based solely on
19 proof that such person's name appears in a listing of approved
20 physicians or health care providers made available to
21 subscribers under a health care plan.
22 (j) This section does not apply to workers'
23 compensation insurance coverage.
24 (3) LIMITATIONS ON ACTIONS.--
25 (a) A person may not maintain an action under this
26 section against a health maintenance organization that is
27 required to comply with the appeal process provided under
28 section 1 of this act unless the subscriber, or the
29 subscriber's representative:
30 1. Has exhausted the appeals and review applicable
31 under the appeal process; or

1 2. Before instituting the action:
2 a. Gives written notice of the claim as provided by
3 paragraph (b); and
4 b. Agrees to submit the claim to a review by an
5 independent review organization as required by paragraph (c).
6 (b) Notice of intent to maintain an action must be
7 delivered or mailed to the health maintenance organization
8 against whom the action is made not later than the 30th day
9 before the date the claim is filed.
10 (c) The subscriber, or the subscriber's
11 representative, must submit the claim to a review by an
12 independent review organization if the health maintenance
13 organization against whom the claim is made requests the
14 review not later than the 14th day after the date notice under
15 paragraph (b) is received by the health maintenance
16 organization. If the health maintenance organization does not
17 request the review within the period specified by this
18 paragraph, the subscriber, or the subscriber's representative,
19 is not required to submit the claim to independent review
20 before maintaining the action.
21 (d) Subject to paragraph (e), if the subscriber has
22 not complied with paragraph (a), an action under this section
23 may not be dismissed by the court, but the court may, in its
24 discretion, order the parties to submit to an independent
25 review or mediation or other nonbinding alternative dispute
26 resolution and may abate the action for a period not to exceed
27 30 days for such purposes. Such orders of the court are the
28 sole remedies available to a party complaining of a
29 subscriber's failure to comply with paragraph (a).
30 (e) The subscriber is not required to comply with
31 paragraph (c) and an order of abatement or other order

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1 pursuant to paragraph (d) for failure to comply may not be
2 imposed if the subscriber has filed a pleading alleging in
3 substance that:
4 1. Harm to the subscriber has already occurred because
5 of the conduct of the health maintenance organization or
6 because of an act or omission of an employee, agent, or
7 representative of such organization for whose conduct it is
8 liable; and
9 2. The review would not be beneficial to the
10 subscriber.
11 (f) If the court, upon motion by the defendant health
12 maintenance organization, finds after hearing that such
13 pleading was not made in good faith, the court may enter an
14 order pursuant to paragraph (d).
15 (g) If the subscriber, or the subscriber's
16 representative, seeks to exhaust the appeals and review or
17 provides notice, as required by paragraph (a), before the
18 statute of limitations applicable to a claim against a health
19 maintenance organization has expired, the limitations period
20 is tolled until the later of:
21 1. The 30th day after the date the subscriber, or the
22 subscriber's representative, has exhausted the process for
23 appeals and review applicable under the appeals process; or
24 2. The 40th day after the date the subscriber, or the
25 subscriber's representative, gives notice under paragraph (b).
26 (h) This section does not prohibit a subscriber from
27 pursuing other appropriate remedies, including injunctive
28 relief, a declaratory judgment, or other relief available
29 under law, if the requirement of exhausting the process for
30 appeal and review places the subscriber's health in serious
31 jeopardy.

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1 Section 3. Disclosure of information.--This section
2 applies to all health maintenance contracts entered into by a
3 health maintenance organization with a subscriber or group of
4 subscribers.
5 (1) Each health maintenance organization shall supply
6 written disclosure information to each subscriber, and upon
7 request to each prospective subscriber prior to enrollment,
8 which may be incorporated into the health maintenance
9 contract. If any inconsistency exists between a separate
10 written disclosure statement and the health maintenance
11 contract, the terms of the health maintenance contract shall
12 control. The information to be disclosed must include at least
13 the following:
14 (a) A description of coverage provisions; health care
15 benefits; benefit maximums, including benefit limitations; and
16 exclusions of coverage, including the definition of medical
17 necessity used in determining whether benefits will be
18 covered.
19 (b) A description of requirements for prior
20 authorization or other requirements for treatments and
21 services.
22 (c) A description of the utilization review policies
23 and procedures used by the health maintenance organization,
24 including:
25 1. The circumstances under which utilization review
26 will be undertaken.
27 2. The toll-free telephone number of the utilization
28 review agent.
29 3. The timeframes under which utilization review
30 decisions must be made for prospective, retrospective, and
31 concurrent decisions.

1 4. The right to reconsideration.
2 5. The right to an appeal, including the expedited and
3 standard appeals processes and the timeframes for such
4 appeals.
5 6. The right to designate a representative.
6 7. A notice that all denials of claims will be made by
7 qualified health care providers and that all notices of
8 denials will include information about the basis of the
9 decision.
10 8. A notice of the right to an appeal, together with a
11 description of the appeal process established under section 1
12 of this act.
13 9. Any further appeal rights, if any.
14 (d) A description prepared annually of the types of
15 methodologies the health maintenance organization uses to
16 reimburse health care providers, specifying the type of
17 methodology that is used to reimburse particular types of
18 providers or reimburse for the provision of particular types
19 of services. However, this paragraph does not require
20 disclosure of individual contracts or the specific details of
21 any financial arrangement between a health maintenance
22 organization and a health care provider.
23 (e) An explanation of a subscriber's financial
24 responsibility for payment of premiums, coinsurance,
25 copayments, deductibles, and any other charges; annual limits
26 on a subscriber's financial responsibility; caps on payments
27 for covered services; and financial responsibility for
28 noncovered health care procedures, treatments, or services.
29 (f) An explanation, where applicable, of a
30 subscriber's financial responsibility for payment when
31 services are provided by a health care provider who is not

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1 part of the health maintenance organization's network of
2 providers or by any provider without required authorization.
3 (g) A description of the grievance procedures to be
4 used to resolve disputes between the health maintenance
5 organization and a subscriber, including:
6 1. The right to file a grievance regarding any dispute
7 between the health maintenance organization and a subscriber.
8 2. The right to file a grievance orally when the
9 dispute is about referrals or covered benefits.
10 3. The toll-free telephone number that subscribers may
11 use to file an oral grievance.
12 4. The timeframes and circumstances for expedited and
13 standard grievances.
14 5. The right to appeal a grievance determination and
15 the procedures for filing such an appeal.
16 6. The timeframes and circumstances for expedited and
17 standard appeals.
18 7. The right to designate a representative.
19 8. A notice that all disputes involving clinical
20 decisions will be made by qualified health care providers and
21 that all notices of determination will include information
22 about the basis of the decision and further appeal rights, if
23 any.
24 (h) A description of the procedure for obtaining
25 emergency services. Such description must include a definition
26 of emergency services, a notice that emergency services are
27 not subject to prior approval, and a description of the
28 subscriber's financial and other responsibilities regarding
29 obtaining such services, including the subscriber's financial
30 responsibilities, if any, when such services are received
31

1 outside the service area of the health maintenance
2 organization.
3 (i) Where applicable, a description of procedures for
4 subscribers to select and access the health maintenance
5 organization's primary and specialty care providers, including
6 notice of how to determine whether a participating provider is
7 accepting new patients.
8 (j) Where applicable, a description of the procedures
9 for changing primary and specialty care providers within the
10 health maintenance organization's network of providers.
11 (k) Where applicable, notice that a subscriber may
12 obtain a referral to a health care provider outside of the
13 organization's network when the health maintenance
14 organization does not have a health care provider in the
15 network with appropriate training and experience to meet the
16 particular health care needs of the subscriber, and the
17 procedure by which the subscriber may obtain such referral.
18 (l) Where applicable, notice that a subscriber with a
19 condition that requires ongoing care from a specialist may
20 request a standing referral to such a specialist and the
21 procedure for requesting and obtaining such a standing
22 referral.
23 (m) Where applicable, notice that a subscriber with a
24 life-threatening condition or disease, or a degenerative and
25 disabling condition or disease, either of which requires
26 specialized medical care over a prolonged period, may request
27 a specialist responsible for providing or coordinating the
28 subscriber's medical care, and the procedure for requesting
29 and obtaining such a specialist.
30 (n) Where applicable, notice that a subscriber with a
31 life-threatening condition or disease, or a degenerative and

1 disabling condition or disease, either of which requires
2 specialized medical care over a prolonged period, may request
3 access to a specialty care center, and the procedure by which
4 such access may be obtained.
5 (o) A description of how the health maintenance
6 organization addresses the needs of non-English-speaking
7 subscribers.
8 (p) Notice of all appropriate mailing addresses and
9 telephone numbers to be used by subscribers seeking
10 information or authorization.
11 (q) Where applicable, a listing by specialty, which
12 may be in a separate document that is updated annually, of the
13 name, address, and telephone number of all participating
14 health care providers, including facilities, and the board
15 certification number of physicians.
16 (r) A description of the mechanisms by which
17 subscribers may participate in developing policies of the
18 health maintenance organization.
19 (2) Each health maintenance organization, upon the
20 request of a subscriber or prospective subscriber shall:
21 (a) Provide a list of the names, business addresses,
22 and official positions of the board of directors, officers,
23 and members of the health maintenance organization.
24 (b) Provide a copy of the most recent annual certified
25 financial statement of the health maintenance organization,
26 including its balance sheet and summary of receipts and
27 disbursements prepared by a certified public accountant.
28 (c) Provide a copy of the most recent health
29 maintenance contracts.
30 (d) Provide information relating to consumer
31 complaints compiled under s. 408.10, Florida Statutes.

1 (e) Provide the procedures for protecting the
2 confidentiality of medical records and other subscriber
3 information.
4 (f) Where applicable, allow subscribers and
5 prospective subscribers to inspect drug formularies used by
6 the health maintenance organization and disclose whether
7 individual drugs are included or excluded from coverage.
8 (g) Provide a written description of the
9 organizational arrangements and ongoing procedures of the
10 health maintenance organization's quality assurance program,
11 if any.
12 (h) Provide a description of the procedures followed
13 by the health maintenance organization in making decisions
14 about the experimental or investigational nature of individual
15 drugs, medical devices, or treatments in clinical trials.
16 (i) Provide individual health care provider's
17 affiliations with participating hospitals, if any.
18 (j) Upon written request, provide specific written
19 clinical review criteria relating to a particular condition or
20 disease and, where appropriate, other clinical information
21 that the health maintenance organization considers in its
22 utilization review and a description of how it is used in the
23 utilization review process. However, to the extent such
24 information is proprietary to the health maintenance
25 organization, the information may only be used for the
26 purposes of assisting the subscriber or prospective subscriber
27 in evaluating the covered services provided by the
28 organization.
29 (k) Where applicable, provide the written application
30 procedures and minimum qualification requirements for a health
31 care provider to be considered by the health maintenance

1 organization for participation in the organization's network
2 of providers.
3 (l) Disclose any other information required by rule of
4 the Department of Insurance or the Agency for Health Care
5 Administration.
6 (3) This section does not prevent a health maintenance
7 organization from changing or updating the materials that are
8 made available to subscribers.
9 (4) As to any program where the subscriber must select
10 a primary care provider, if a participating primary care
11 provider becomes unavailable to provide services to a
12 subscriber, the health maintenance organization shall provide
13 written notice within 15 days after the date the organization
14 becomes aware of such unavailability to each subscriber who
15 has chosen the provider as his or her primary care provider.
16 If a subscriber is enrolled in a managed care plan and is
17 undergoing an ongoing course of treatment with any other
18 participating provider who becomes unavailable to continue to
19 provide services to such subscriber, and the health
20 maintenance organization is aware of such ongoing course of
21 treatment, the organization shall provide written notice
22 within 15 days after the date the organization becomes aware
23 of such unavailability to such subscriber. Each notice must
24 also describe the procedures for continuing care and for
25 choosing an alternative provider.
26 Section 4. Provider profiles.--Each health maintenance
27 organization, in developing provider profiles or otherwise
28 measuring the performance of health care providers, shall:
29 (1) Make allowances for the severity of illness or
30 condition of the patient mix.
31

1 (2) Make allowances for patients with multiple
2 illnesses or conditions.
3 (3) Make available to the Department of Insurance and
4 the Agency for Health Care Administration documentation of how
5 the health maintenance organization makes such allowances.
6 (4) Inform subscribers and participating providers,
7 upon request, how the health maintenance organization
8 considers patient mix when profiling or evaluating providers.
9 Section 5. Retaliatory action prohibited.--A health
10 maintenance organization may not take any retaliatory action
11 against an employee because the employee does any of the
12 following:
13 (1) Discloses, or threatens to disclose, to a
14 supervisor or any agency an activity, policy, or practice of
15 the health maintenance organization or another employer with
16 whom there is a business relationship which the employee
17 reasonably believes violates a law or rule, or, in the case of
18 an employee who is a licensed or certified health care
19 provider, reasonably believes constitutes improper quality of
20 patient care.
21 (2) Provides information to, or testifies before, any
22 agency conducting an investigation, hearing, or inquiry into
23 any violation of law or rule by a health maintenance
24 organization or another employer with whom there is a business
25 relationship, or, in the case of an employee who is a licensed
26 or certified health care provider, provides information to, or
27 testifies before, any agency conducting an investigation,
28 hearing, or inquiry into the quality of patient care.
29 (3) Objects to, or refuses to participate in, any
30 activity, policy, or practice that the employee reasonably
31 believes:

1 (a) Violates a law or rule, or, if the employee is a
2 licensed or certified health care provider, constitutes
3 improper quality of patient care;
4 (b) Is fraudulent or criminal; or
5 (c) Is incompatible with a clear mandate of public
6 policy concerning the public health, safety, or welfare or
7 protection of the environment.
8 Section 6. Referrals to another provider.--In any case
9 in which there is not a health care provider within the health
10 maintenance organization's provider network to provide a
11 covered benefit, the health maintenance organization shall
12 arrange for a referral to a provider with the necessary
13 expertise and ensure that the subscriber obtains the covered
14 benefit at a cost that does not exceed the subscriber's cost
15 if the benefit were obtained from a participating provider.
16 Section 7. Prescription drug formulary.--If a health
17 maintenance organization uses a formulary for prescription
18 drugs, the health maintenance organization must include a
19 written procedure whereby a subscriber may obtain, without
20 penalty and in a timely fashion, specific drugs and
21 medications that are not included in the formulary when:
22 (1) The formulary's equivalent has been ineffective in
23 the treatment of the subscriber's disease or condition; or
24 (2) The formulary's drug causes, or is reasonably
25 expected to cause, adverse or harmful reactions in the
26 subscriber.
27 Section 8. Arbitrary limitations or conditions for the
28 provision of services prohibited.--
29 (1) A health maintenance organization may not
30 arbitrarily interfere with or alter the decision of the health
31 care provider regarding the manner or setting in which

1 particular services are delivered if the services are
2 medically necessary or appropriate for treatment or diagnosis
3 to the extent that such treatment or diagnosis is otherwise a
4 covered benefit.
5 (2) Subsection (1) does not prohibit a health
6 maintenance organization from limiting the delivery of
7 services to one or more health care providers within a network
8 of such providers.
9 (3) As used in subsection (1), the term "medically
10 necessary or appropriate" means a service or benefit that is
11 consistent with generally accepted principles of professional
12 medical practice.
13 Section 9. Discrimination prohibited.--
14 (1) Subject to subsection (2), a health maintenance
15 organization, with respect to health insurance coverage, may
16 not discriminate against a subscriber in the delivery of
17 health care services consistent with the benefits covered
18 under the health maintenance contract, or coverage required by
19 law, based on race, color, ethnicity, national origin,
20 religion, sex, age, mental or physical disability, sexual
21 orientation, genetic information, or source of payment.
22 (2) Subsection (1) does not apply to eligibility for
23 coverage; the offering or guaranteeing of an offer of
24 coverage; the application of an exclusion for a preexisting
25 condition, consistent with applicable law; or premiums charged
26 for coverage under the health maintenance contract.
27 Section 10. Termination of a provider.--Each health
28 maintenance organization shall establish a policy governing
29 the termination of providers. The policy must assure the
30 continued coverage of services at the contract price by a
31 terminated provider for up to 120 calendar days in cases where

1 it is medically necessary for the subscriber to continue
2 treatment with the terminated provider. The case of the
3 pregnancy of a subscriber constitutes medical necessity and
4 coverage of services by the terminated provider shall continue
5 to the postpartum evaluation of the subscriber, up to 6 weeks
6 after delivery. The policy must clearly state that the
7 determination as to the medical necessity of a subscriber's
8 continued treatment with a terminated provider is subject to
9 the appeal procedures set forth in section 1 of this act.
10 Section 11. (1) The Insurance Commissioner may
11 suspend or revoke a certificate of authority issued under part
12 I of chapter 641, Florida Statutes, or deny an application for
13 a certificate of authority, if the commissioner finds that:
14 (a) The health maintenance organization is operating
15 significantly in contravention of its basic organizational
16 document, unless amendments to the basic organizational
17 document or other submissions that are consistent with the
18 operations of the organization have been filed with and
19 approved by the commissioner.
20 (b) The health maintenance organization does not
21 provide or arrange for basic health care services.
22 (c) The health maintenance organization is unable to
23 fulfill its obligations to furnish health care coverage.
24 (d) The health maintenance organization is no longer
25 financially responsible and may reasonably be expected to be
26 unable to meet its obligations to subscribers or prospective
27 subscribers.
28 (e) The health maintenance organization has failed to
29 correct, within the time prescribed, any deficiency occurring
30 due to the impairment of the prescribed minimum net worth of
31 the health maintenance organization.

1 (f) The health maintenance organization has failed to
2 implement the grievance procedures and appeal process required
3 by section 1 of this act in a reasonable manner to resolve
4 valid complaints.
5 (g) The health maintenance organization, or a person
6 acting on behalf of the organization, has intentionally
7 advertised or merchandised the services of the organization in
8 an untrue, a misrepresentative, a misleading, a deceptive, or
9 an unfair manner.
10 (h) The continued operation of the health maintenance
11 organization would be hazardous to the subscribers of the
12 organization.
13 (i) The health maintenance organization has otherwise
14 failed to substantially comply with part I of chapter 641,
15 Florida Statutes.
16 (2) The Insurance Commissioner may impose a civil
17 penalty of not more than $25,000 against a health maintenance
18 organization for each cause listed in subsection (1). The
19 civil penalties may not exceed $100,000 against any one health
20 maintenance organization in 1 calendar year. The penalty may
21 be imposed in addition to or instead of a suspension or
22 revocation of the organization's certificate of authority.
23 Section 12. Section 641.513, Florida Statutes, is
24 repealed.
25 Section 13. Subsection (9) is added to section
26 627.419, Florida Statutes, to read:
27 627.419 Construction of policies.--
28 (9)(a) Notwithstanding any other provision of law to
29 the contrary, any person covered under any health insurance
30 policy, health care services plan, or other contract that
31 provides for payment for medical expense benefits or

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1 procedures is entitled at all times to free, full, and
2 absolute choice in the selection of a provider or facility
3 licensed or permitted under chapter 458, chapter 459, chapter
4 460, chapter 461, chapter 463, chapter 465, or chapter 466.
5 It is expressly forbidden for any health plan to contain any
6 provision that would require or coerce a person covered by the
7 plan to use any provider other than the provider selected by
8 the subscriber. Any health insurance policy, health care
9 services plan, or other contract that provides for payment for
10 medical expense benefits or procedures must allow any health
11 care provider to participate as a service provider under a
12 health plan offered by the health insurance policy, health
13 care services plan, or other contract that provides for
14 payment for medical expense benefits or procedures, if the
15 health care provider agrees to:
16 1. Accept the reimbursement rates negotiated by the
17 health insurance policy, health care services plan, or other
18 contract that provides for payment for medical expense
19 benefits or procedures with other health care providers that
20 provide the same service under the health plan; and
21 2. Comply with all guidelines relating to quality of
22 care and utilization criteria which must be met by other
23 providers with whom the health insurance policy, health care
24 services plan, or other contract that provides for payment for
25 medical expense benefits or procedures has contractual
26 arrangements for those services.
27 (b) The provider of any health insurance policy,
28 health care services plan, or other contract that violates
29 paragraph (a) is subject to a civil fine in the amount of:
30 1. Up to $25,000 for each violation; or
31

2. If the Insurance Commissioner determines that the provider has engaged in a pattern of violations of paragraph (a), up to $100,000 for each violation.

Section 14. The provisions of section 13 of this act do not apply to any health insurance policy that is in force before the effective date of this act but do apply to such policies at the next renewal period immediately following October 1, 2001.

Section 15. Section 641.28, Florida Statutes, is amended to read:

641.28 Civil remedy.--In any civil action brought to enforce the terms and conditions of a health maintenance organization contract, only the prevailing subscriber, or a representative or provider acting on behalf of a subscriber, ~~party~~ is entitled to recover reasonable attorney's fees and court costs. ~~This section shall not be construed to authorize a civil action against the department, its employees, or the Insurance Commissioner or against the Agency for Health Care Administration, its employees, or the director of the agency.~~

Section 16. This act shall take effect October 1, 2001.

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2 HOUSE SUMMARY

3 Requires health maintenance organizations to provide an appeal process to resolve grievances brought by
4 subscribers. Provides for an external appeal when a subscriber is dissatisfied with the results of a formal
5 appeal. Directs the Agency for Health Care Administration to adopt rules governing the appeal process. Provides
6 that a subscriber may maintain an action against a health maintenance organization that has not exercised ordinary
7 care in making treatment decisions. Provides for a claim of liability to be reviewed by an independent review
8 organization. Provides requirements for profiles of health care providers and the measurement of the
9 performance of health care providers. Prohibits a health maintenance organization from taking retaliatory action
10 against an employee for certain actions or disclosures concerning improper patient care. Requires that a health
11 maintenance organization refer a subscriber to an outside provider in cases in which there is not a provider within
12 the organization's network to provide a covered benefit. Prohibits a health maintenance organization from
13 arbitrarily interfering with certain decisions of a health care provider. Authorizes the Insurance
14 Commissioner to suspend or revoke a certificate of authority upon finding certain violations by a health
15 maintenance organization. Provides that subscribers are entitled to free, full, and absolute choice of providers
16 offering physician, chiropractic, podiatry, optometry, pharmacy, or dental services, and prohibits coercion or
17 coercive requirements relating to subscriber selection. Provides for civil fines for violations. See bill for
18 details.

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