By Senator Siplin

19-463-03

A bill to be entitled

An act relating to a managed care patient's bill of rights; providing a short title; providing requirements and limitations for group health plans and health insurance issuers that provide health insurance coverage relating to utilization review, internal and external appeals, grievances, consumer choice options, choice of health care professionals, emergency care, specialty care, obstetrical and gynecological care, pediatric care, continuity of care, prescription drugs, access to information, interference with medical communications, discrimination against providers, payment of claims, and protection of patient advocacy; providing an effective date.

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

Section 1. (1) This act may be cited as the "Managed Care Patient's Bill of Rights Act."

(2) Each group health plan, and each health insurance issuer that provides health insurance coverage:

(a) Shall conduct utilization review activities in connection with the provision of benefits under such plan or coverage.

(b) Shall provide adequate notice in writing to the appropriate affected person of any denial of a claim for benefits and the reasons for such denial, written in a manner calculated to be understood by such person, and shall afford

such person the opportunity to request a full and fair review of such denial.

(c) Shall provide for an external appeals process for any denial of a claim for benefits.

(d) Shall establish and maintain a system to provide for the presentation and resolution of oral and written grievances regarding any aspect of the plan's or issuer's services.

(e) Which offers health insurance coverage for services which are only furnished through health care professionals and providers who are members of a network of health care professionals and providers who have entered into a contract with the plan or issuer to provide such services, shall also offer or arrange to be offered the option of health insurance coverage or health benefits for such services which are not furnished through health care professionals and providers who are members of such a network.

(f) That requires or provides for designation of a participating primary care provider, shall permit a covered person to designate any participating primary care provider who is available to accept such individual and shall permit a covered person to receive medically necessary or appropriate specialty care from any qualified participating health care professional who is available to accept such individual for such care.

(g) Which provides benefits with respect to services in an emergency department of a hospital, shall cover emergency services without the need for any prior authorization, whether or not the health care provider furnishing such services is a participating provider with respect to such services, and in a manner such that, if such

services are provided to a covered person by a nonparticipating health care provider with or without prior authorization or by a participating health care provider without prior authorization, the covered person is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating health care provider with prior authorization and without regard to any other term or condition of such coverage.

(h) Shall make or provide for referral to a specialist who is available and accessible to provide for the treatment of a covered person who has a condition or disease of sufficient seriousness and complexity to require treatment by a specialist and benefits for such treatment are provided under the plan or coverage.

(i) Which requires or provides for a covered person to designate a participating primary care health care professional, may not require authorization or a referral by the individual's primary care health care professional or otherwise for coverage of gynecological care, including preventive women's health examinations, and pregnancy-related services provided by a participating health care professional, including a physician, who specializes in obstetrics and gynecology to the extent such care is otherwise covered and shall treat the ordering of other obstetrical or gynecological care by such a participating professional as the authorization of the primary care health care professional with respect to such care under the plan or coverage.

(j) Which requires or provides for a covered person to designate a participating primary care provider for such person's child, shall permit the person to designate a

physician who specializes in pediatrics as the child's primary care provider.

(k) Upon termination of a contract between the group health plan, or the health insurance issuer, and a health care provider or termination of benefits or coverage provided by a health care provider because of a change in the terms of provider participation in a group health plan, and a covered person is undergoing treatment from the provider for an ongoing special condition at the time of such termination, shall notify the covered person on a timely basis of such termination and of the right to elect continuation of coverage of treatment by the provider under this section and permit the individual to elect to continue to be covered with respect to treatment by the provider of such condition during a transitional period. If a contract for the provision of health insurance coverage between a group health plan and a health insurance issuer is terminated and, as a result of such termination, coverage of services of a health care provider is terminated with respect to an individual, this paragraph shall apply under the plan in the same manner as if there had been a contract between the plan and the provider that had been terminated, but only with respect to benefits that are covered under the plan after the contract termination.

(l) Which provides coverage for benefits with respect to prescription drugs, and limits such coverage to drugs included in a formulary, shall ensure the participation of physicians and pharmacists in developing and reviewing such formulary, provide for disclosure of the formulary to providers, and in accordance with the applicable quality assurance and utilization review standards of the plan or issuer, provide for exceptions from the formulary limitation

when a non-formulary alternative is medically necessary and appropriate and, in the case of such an exception, apply the same cost-sharing requirements that would have applied in the case of a drug covered under the formulary.

(m) Shall provide to covered persons, upon initial enrollment or coverage and at least annually thereafter, prospective covered persons, and applicable authorities, in printed form, information relating to service area, benefits, access, out-of-area coverage, emergency coverage, percentage of premiums used for benefits, prior authorization rules, grievance and appeals procedures, quality assurance, issuer information, notice of requirements, and information available on request.

(n) Shall not prohibit or otherwise restrict a health care professional, under the provisions of any contract or agreement, or the operation of any contract or agreement, between a group health plan or health insurance issuer in relation to health insurance coverage, including any partnership, association, or other organization that enters into or administers such a contract or agreement, and a health care provider or group of health care providers, from advising a covered person who is a patient of the professional about the health status of such person or medical care or treatment for such person's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan or coverage, if the professional is acting within the lawful scope of practice.

(o) Shall not discriminate with respect to participation or indemnification as to any provider who is acting within the scope of the provider's license or

certification under the law of this state, solely on the basis of such license or certification.

(p) Shall provide for prompt payment of claims submitted for health care services or supplies furnished to a covered person with respect to benefits covered by the plan or issuer.

(q)1. May not retaliate against a covered person or health care provider based on the covered person's or provider's use of, or participation in, a utilization review process or a grievance process of the plan or issuer.

2. May not retaliate or discriminate against a protected health care professional because the professional in good faith discloses information relating to the care, services, or conditions affecting one or more covered persons of the plan or issuer to an appropriate public regulatory agency, an appropriate private accreditation body, or appropriate management personnel of the plan or issuer or initiates, cooperates, or otherwise participates in an investigation or proceeding by such an agency with respect to such care, services, or conditions.

Section 2. This act shall take effect July 1, 2003.

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SENATE SUMMARY

Creates the "Managed Care Patient's Bill of Rights Act" to provide requirements and limitations for group health plans and health insurance issuers that provide health insurance coverage relating to utilization review, internal and external appeals, grievances, consumer choice options, choice of health care professionals, emergency care, specialty care, obstetrical and gynecological care, pediatric care, continuity of care, prescription drugs, access to information, interference with medical communications, discrimination against providers, payment of claims, and protection of patient advocacy.