By the Committees on Banking and Insurance; Health, Aging, and Long-Term Care; and Senator Saunders

311-1317-04

A bill to be entitled

An act relating to health maintenance organizations; amending s. 408.7056, F.S.; changing the name of the Statewide Provider and Subscriber Assistance Program to the Subscriber Assistance Program; revising a definition; requiring certain records and reports to be provided to the Subscriber Assistance Panel; providing for penalties; requiring that a quorum be present before a grievance can be heard or voted upon; establishing a maximum number of panel members; amending s. 641.3154, F.S.; conforming provisions to changes made by the act; amending s. 641.511, F.S.; conforming provisions; adopting the federal claims procedures for certain commercial health maintenance organizations; amending s. 641.58, F.S.; conforming provisions; providing an effective date.

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

Section 1. Section 408.7056, Florida Statutes, is amended to read:

408.7056 ~~Statewide Provider and~~ Subscriber Assistance Program.--

(1) As used in this section, the term:

(a) "Agency" means the Agency for Health Care Administration.

(b) "Department" means the Department of Financial Services.

(c) "Grievance procedure" means an established set of rules that specify a process for appeal of an organizational decision.

(d) "Health care provider" or "provider" means a state-licensed or state-authorized facility, a facility principally supported by a local government or by funds from a charitable organization that holds a current exemption from federal income tax under s. 501(c)(3) of the Internal Revenue Code, a licensed practitioner, a county health department established under part I of chapter 154, a prescribed pediatric extended care center defined in s. 400.902, a federally supported primary care program such as a migrant health center or a community health center authorized under s. 329 or s. 330 of the United States Public Health Services Act that delivers health care services to individuals, or a community facility that receives funds from the state under the Community Alcohol, Drug Abuse, and Mental Health Services Act and provides mental health services to individuals.

(e) "Managed care entity" means a health maintenance organization or a prepaid health clinic certified under chapter 641, a prepaid health plan authorized under s. 409.912, or an exclusive provider organization certified under s. 627.6472.

(f) "Office" means the Office of Insurance Regulation of the Financial Services Commission.

(g) "Panel" means a ~~statewide provider and~~ subscriber assistance panel selected as provided in subsection (11).

(2) The agency shall adopt and implement a program to provide assistance to subscribers and providers, including those whose grievances are not resolved by the managed care entity to the satisfaction of the subscriber or provider. The

program shall consist of one or more panels that meet as often as necessary to timely review, consider, and hear grievances and recommend to the agency or the office any actions that should be taken concerning individual cases heard by the panel. The panel shall hear every grievance filed by subscribers and providers on behalf of subscribers, unless the grievance:

(a) Relates to a managed care entity's refusal to accept a provider into its network of providers;

(b) Is part of an internal grievance in a Medicare managed care entity or a reconsideration appeal through the Medicare appeals process which does not involve a quality of care issue;

(c) Is related to a health plan not regulated by the state such as an administrative services organization, third-party administrator, or federal employee health benefit program;

(d) Is related to appeals by in-plan suppliers and providers, unless related to quality of care provided by the plan;

(e) Is part of a Medicaid fair hearing pursued under 42 C.F.R. ss. 431.220 et seq.;

(f) Is the basis for an action pending in state or federal court;

(g) Is related to an appeal by nonparticipating providers, unless related to the quality of care provided to a subscriber by the managed care entity and the provider is involved in the care provided to the subscriber;

(h) Was filed before the subscriber or provider completed the entire internal grievance procedure of the managed care entity, the managed care entity has complied with

its timeframes for completing the internal grievance procedure, and the circumstances described in subsection (6) do not apply;

(i) Has been resolved to the satisfaction of the subscriber or provider who filed the grievance, unless the managed care entity's initial action is egregious or may be indicative of a pattern of inappropriate behavior;

(j) Is limited to seeking damages for pain and suffering, lost wages, or other incidental expenses, including accrued interest on unpaid balances, court costs, and transportation costs associated with a grievance procedure;

(k) Is limited to issues involving conduct of a health care provider or facility, staff member, or employee of a managed care entity which constitute grounds for disciplinary action by the appropriate professional licensing board and is not indicative of a pattern of inappropriate behavior, and the agency, office, or department has reported these grievances to the appropriate professional licensing board or to the health facility regulation section of the agency for possible investigation; or

(l) Is withdrawn by the subscriber or provider. Failure of the subscriber or the provider to attend the hearing shall be considered a withdrawal of the grievance.

(3) The agency shall review all grievances within 60 days after receipt and make a determination whether the grievance shall be heard. Once the agency notifies the panel, the subscriber or provider, and the managed care entity that a grievance will be heard by the panel, the panel shall hear the grievance either in the network area or by teleconference no later than 120 days after the date the grievance was filed. The agency shall notify the parties, in writing, by facsimile

transmission, or by phone, of the time and place of the hearing. 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 findings of fact and a recommendation. The panel shall issue a written recommendation, supported by findings of fact, to the provider or subscriber, to the managed care entity, and to the agency or the office 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 requested has been provided to the panel. The proceedings of the panel are not subject to chapter 120.

(4) If, upon receiving a proper patient authorization along with a properly filed grievance, the agency requests ~~medical~~ records from a health care provider or managed care entity, the health care provider or managed care entity that has custody of the records has 10 days to provide the records to the agency. Records include medical records, communication logs associated with the grievance both to and from the subscriber, contracts, and any other contents of the internal grievance file associated with the complaint filed with the Subscriber Assistance Program.Failure to provide requested ~~medical~~ records may result in the imposition of a fine of up to $500. Each day that records are not produced is considered a separate violation.

(5) Grievances that the agency determines pose an immediate and serious threat to a subscriber's health must be given priority over other grievances. The panel may meet at the call of the chair to hear the grievances as quickly as

possible but no later than 45 days after the date the grievance is filed, unless the panel receives a waiver of the time requirement from the subscriber. The panel shall issue a written recommendation, supported by findings of fact, to the office or the agency within 10 days after hearing the expedited grievance.

(6) 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. The panel shall, upon hearing the grievance, issue a written emergency recommendation, supported by findings of fact, to the managed care entity, to the subscriber, and to the agency or the office for the purpose of deferring the imminent and emergent jeopardy to the subscriber's life. Within 24 hours after receipt of the panel's emergency recommendation, the agency or office may issue an emergency order to the managed care entity. An emergency order remains in force until:

(a) The grievance has been resolved by the managed care entity;

(b) Medical intervention is no longer necessary; or

(c) The panel has conducted a full hearing under subsection (3) and issued a recommendation to the agency or the office, and the agency or office has issued a final order.

(7) After hearing a grievance, the panel shall make a recommendation to the agency or the office which may include specific actions the managed care entity must take to comply with state laws or rules regulating managed care entities.

(8) A managed care entity, subscriber, or provider that is affected by a panel recommendation may within 10 days after receipt of the panel's recommendation, or 72 hours after receipt of a recommendation in an expedited grievance, furnish to the agency or office written evidence in opposition to the recommendation or findings of fact of the panel.

(9) No later than 30 days after the issuance of the panel's recommendation and, for an expedited grievance, no later than 10 days after the issuance of the panel's recommendation, the agency or the office may adopt the panel's recommendation or findings of fact in a proposed order or an emergency order, as provided in chapter 120, which it shall issue to the managed care entity. The agency or office may issue a proposed order or an emergency order, as provided in chapter 120, imposing fines or sanctions, including those contained in ss. 641.25 and 641.52. The agency or the office may reject all or part of the panel's recommendation. All fines collected under this subsection must be deposited into the Health Care Trust Fund.

(10) In determining any fine or sanction to be imposed, the agency and the office may consider the following factors:

(a) The severity of the noncompliance, including the probability that death or serious harm to the health or safety of the subscriber will result or has resulted, the severity of the actual or potential harm, and the extent to which provisions of chapter 641 were violated.

(b) Actions taken by the managed care entity to resolve or remedy any quality-of-care grievance.

(c) Any previous incidents of noncompliance by the managed care entity.

(d) Any other relevant factors the agency or office considers appropriate in a particular grievance.

(11) The panel shall consist of the Insurance Consumer Advocate, or designee thereof, established by s. 627.0613; at least two members employed by the agency and at least two members employed by the department, chosen by their respective agencies; a consumer appointed by the Governor; a physician appointed by the Governor, as a standing member; and, if necessary, physicians who have expertise relevant to the case to be heard, on a rotating basis. The agency may contract with a medical director, ~~and~~ a primary care physician, or both, who shall provide additional technical expertise to the panel but who shall not be voting members of the panel. The medical director shall be selected from a health maintenance organization with a current certificate of authority to operate in Florida.

(12) A majority of those panel members required under subsection (11) shall constitute a quorum for any meeting or hearing of the panel. A grievance may not be heard or voted upon at any panel meeting or hearing unless a quorum is present, except that a minority of the panel may adjourn a meeting or hearing until a quorum is present. A panel convened for the purpose of hearing a subscriber's grievance in accordance with subsections (2) and (3) shall not consist of more than 11 members.

(13)~~(12)~~ Every managed care entity shall submit a quarterly report to the agency, the office, and the department listing the number and the nature of all subscribers' and providers' grievances which have not been resolved to the satisfaction of the subscriber or provider after the subscriber or provider follows the entire internal grievance

procedure of the managed care entity. The agency shall notify all subscribers and providers included in the quarterly reports of their right to file an unresolved grievance with the panel.

(14)~~(13)~~ A proposed order issued by the agency or office which only requires the managed care entity to take a specific action under subsection (7) is subject to a summary hearing in accordance with s. 120.574, unless all of the parties agree otherwise. If the managed care entity does not prevail at the hearing, the managed care entity must pay reasonable costs and attorney's fees of the agency or the office incurred in that proceeding.

(15)~~(14)~~(a) Any information that identifies a subscriber which is held by the panel, agency, or department pursuant to this section is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution. However, at the request of a subscriber or managed care entity involved in a grievance procedure, the panel, agency, or department shall release information identifying the subscriber involved in the grievance procedure to the requesting subscriber or managed care entity.

(b) Meetings of the panel shall be open to the public unless the provider or subscriber whose grievance will be heard requests a closed meeting or the agency or the department determines that information which discloses the subscriber's medical treatment or history or information relating to internal risk management programs as defined in s. 641.55(5)(c), (6), and (8) may be revealed at the panel meeting, in which case that portion of the meeting during which a subscriber's medical treatment or history or internal risk management program information is discussed shall be

exempt from the provisions of s. 286.011 and s. 24(b), Art. I of the State Constitution. All closed meetings shall be recorded by a certified court reporter.

Section 2. Subsection (4) of section 641.3154, Florida Statutes, is amended to read:

641.3154 Organization liability; provider billing prohibited.--

(4) A provider or any representative of a provider, regardless of whether the provider is under contract with the health maintenance organization, may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency a subscriber of an organization for payment of services for which the organization is liable, if the provider in good faith knows or should know that the organization is liable. This prohibition applies during the pendency of any claim for payment made by the provider to the organization for payment of the services and any legal proceedings or dispute resolution process to determine whether the organization is liable for the services if the provider is informed that the ~~such~~ proceedings are taking place. It is presumed that a provider does not know and should not know that an organization is liable unless:

(a) The provider is informed by the organization that it accepts liability;

(b) A court of competent jurisdiction determines that the organization is liable;

(c) The office or agency makes a final determination that the organization is required to pay for the ~~such~~ services subsequent to a recommendation made by the ~~Statewide Provider and~~ Subscriber Assistance Panel pursuant to s. 408.7056; or

(d) The agency issues a final order that the organization is required to pay for such services subsequent to a recommendation made by a resolution organization pursuant to s. 408.7057.

Section 3. Section 641.511, Florida Statutes, is amended to read:

641.511 Subscriber grievance reporting and resolution requirements.--

(1) Every organization must have a grievance procedure available to its subscribers for the purpose of addressing complaints and grievances. Every organization must notify its subscribers that a subscriber must submit a grievance within 1 year after the date of occurrence of the action that initiated the grievance, and may submit the grievance for review to the ~~Statewide Provider and~~ Subscriber Assistance Program panel as provided in s. 408.7056 after receiving a final disposition of the grievance through the organization's grievance process. An organization shall maintain records of all grievances and shall report annually to the agency the total number of grievances handled, a categorization of the cases underlying the grievances, and the final disposition of the grievances.

(2) When an organization receives an initial complaint from a subscriber, the organization must respond to the complaint within a reasonable time after its submission. At the time of receipt of the initial complaint, the organization shall inform the subscriber that the subscriber has a right to file a written grievance at any time and that assistance in preparing the written grievance shall be provided by the organization.

(3) Each organization's grievance procedure, as required under subsection (1), must include, at a minimum:

(a) An explanation of how to pursue redress of a grievance.

(b) The names of the appropriate employees or a list of grievance departments that are responsible for implementing the organization's grievance procedure. The list must include the address and the toll-free telephone number of each grievance department, the address of the agency and its toll-free telephone hotline number, and the address of the ~~Statewide Provider and~~ Subscriber Assistance Program and its toll-free telephone number.

(c) The description of the process through which a subscriber may, at any time, contact the toll-free telephone hotline of the agency to inform it of the unresolved grievance.

(d) A procedure for establishing methods for classifying grievances as urgent and for establishing time limits for an expedited review within which such grievances must be resolved.

(e) A notice that a subscriber may voluntarily pursue 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. Such notice shall include an explanation that the subscriber may incur some costs if the subscriber pursues binding arbitration, depending upon the terms of the subscriber's contract.

(f) A process whereby the grievance manager acknowledges the grievance and investigates the grievance in order to notify the subscriber of a final decision in writing.

(g) A procedure for providing individuals who are unable to submit a written grievance with access to the grievance process, which shall include assistance by the organization in preparing the grievance and communicating back to the subscriber.

(4)(a) With respect to a grievance concerning an adverse determination, an organization shall make available to the subscriber a review of the grievance by an internal review panel; the ~~such~~ review must be requested within 30 days after the organization's transmittal of the final determination notice of an adverse determination. A majority of the panel shall be persons who previously were not involved in the initial adverse determination. A person who previously was involved in the adverse determination may appear before the panel to present information or answer questions. The panel shall have the authority to bind the organization to the panel's decision.

(b) An organization shall ensure that a majority of the persons reviewing a grievance involving an adverse determination are providers who have appropriate expertise. An organization shall issue a copy of the written decision of the review panel to the subscriber and to the provider, if any, who submits a grievance on behalf of a subscriber. In cases where there has been a denial of coverage of service, the reviewing provider shall not be a provider previously involved with the adverse determination.

(c) An organization shall establish written procedures for a review of an adverse determination. Review procedures shall be available to the subscriber and to a provider acting on behalf of a subscriber.

(d) In any case when the review process does not resolve a difference of opinion between the organization and the subscriber or the provider acting on behalf of the subscriber, the subscriber or the provider acting on behalf of the subscriber may submit a written grievance to the ~~Statewide Provider and~~ Subscriber Assistance Program.

(5) Except as provided in subsection (6), the organization shall resolve a grievance within 60 days after receipt of the grievance, or within a maximum of 90 days if the grievance involves the collection of information outside the service area. These time limitations are tolled if the organization has notified the subscriber, in writing, that additional information is required for proper review of the grievance and that the ~~such~~ time limitations are tolled until such information is provided. After the organization receives the requested information, the time allowed for completion of the grievance process resumes. The Employee Retirement Income Security Act of 1974 (ERISA) as implemented by 29 C.F.R. 2560.503-1 is adopted and incorporated by reference as applicable to all organizations that administer small and large group health plans that are subject to 29 C.F.R. 2560.503-1. The claims procedures of the regulations of the Employee Retirement Income Security Act of 1974 (ERISA) as implemented by 29 C.F.R. 2560.503-1 shall be the minimum standards for grievance processes for claims for benefits for small and large group health plans that are subject to 29 C.F.R. 2560.503-1.

(6)(a) An organization shall establish written procedures for the expedited review of an urgent grievance. A request for an expedited review may be submitted orally or in writing and shall be subject to the review procedures of this

section, if it meets the criteria of this section. Unless it is submitted in writing, for purposes of the grievance reporting requirements in subsection (1), the request shall be considered an appeal of a utilization review decision and not a grievance. Expedited review procedures shall be available to a subscriber and to the provider acting on behalf of a subscriber. For purposes of this subsection, "subscriber" includes the legal representative of a subscriber.

(b) Expedited reviews shall be evaluated by an appropriate clinical peer or peers. The clinical peer or peers shall not have been involved in the initial adverse determination.

(c) In an expedited review, all necessary information, including the organization's decision, shall be transmitted between the organization and the subscriber, or the provider acting on behalf of the subscriber, by telephone, facsimile, or the most expeditious method available.

(d) In an expedited review, an organization shall make a decision and notify the subscriber, or the provider acting on behalf of the subscriber, as expeditiously as the subscriber's medical condition requires, but in no event more than 72 hours after receipt of the request for review. If the expedited review is a concurrent review determination, the service shall be continued without liability to the subscriber until the subscriber has been notified of the determination.

(e) An organization shall provide written confirmation of its decision concerning an expedited review within 2 working days after providing notification of that decision, if the initial notification was not in writing.

(f) An organization shall provide reasonable access, not to exceed 24 hours after receiving a request for an

expedited review, to a clinical peer who can perform the expedited review.

(g) In any case when the expedited review process does not resolve a difference of opinion between the organization and the subscriber or the provider acting on behalf of the subscriber, the subscriber or the provider acting on behalf of the subscriber may submit a written grievance to the ~~Statewide Provider and~~ Subscriber Assistance Program.

(h) An organization shall not provide an expedited retrospective review of an adverse determination.

(7) Each organization shall send to the agency a copy of its quarterly grievance reports submitted to the office under s. 408.7056(13)~~pursuant to s. 408.7056(12)~~.

(8) The agency shall investigate all reports of unresolved quality of care grievances received from:

(a) Annual and quarterly grievance reports submitted by the organization to the office.

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

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

(b) Requiring completion of the organization's grievance process before the ~~Statewide Provider and~~ Subscriber Assistance Program panel's review does not preclude the agency from investigating any complaint or grievance before the organization makes its final determination.

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

(11) Each organization, as part of its contract with any provider, must require the provider to post a consumer assistance notice prominently displayed in the reception area of the provider and clearly noticeable by all patients. The consumer assistance notice must state the addresses and toll-free telephone numbers of the Agency for Health Care Administration, the ~~Statewide Provider and~~ Subscriber Assistance Program, and the Department of Financial Services. The consumer assistance notice must also clearly state that the address and toll-free telephone number of the organization's grievance department shall be provided upon request. The agency may adopt rules to implement this section.

(12) The agency may impose administrative sanction, in accordance with s. 641.52, against an organization for noncompliance with this section.

Section 4. Subsection (4) of section 641.58, Florida Statutes, is amended to read:

641.58 Regulatory assessment; levy and amount; use of funds; tax returns; penalty for failure to pay.--

(4) The moneys received and deposited into the Health Care Trust Fund shall be used to defray the expenses of the agency in the discharge of its administrative and regulatory powers and duties under this part, including conducting an annual survey of the satisfaction of members of health maintenance organizations; contracting with physician consultants for the ~~Statewide Provider and~~ Subscriber Assistance Panel; maintaining offices and necessary supplies, essential equipment, and other materials, salaries and expenses of required personnel; and discharging the administrative and regulatory powers and duties imposed under this part.

Section 5. This act shall take effect upon becoming a law.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN COMMITTEE SUBSTITUTE FOR CS for SB 1066

Clarifies that the ERISA (Employee Retirement Income Security Act of 1974) claims procedures for grievance processes which are adopted under the bill are limited to claims for benefits for small and large group health plans.