House _____ **Amendment NO.**____

Offered By

_____ _____

AMEND Senate Substitute No. 3 for Senate Committee Substitute for Senate Bill No. 29, Page 3, Section 338.550, Line 17, by inserting after all of said section and line the following:

"374.500. As used in sections 374.500 to 374.515, the following terms mean:

(1) "Certificate", a certificate of registration granted by the department of insurance, financial institutions and professional registration to a utilization review agent;

(2) "Director", the director of the department of insurance, financial institutions and professional registration;

(3) "Enrollee", an individual who has contracted for or who participates in coverage under a health insurance policy, an employee welfare benefit plan, a health services corporation plan or any other benefit program providing payment, reimbursement or indemnification for health care costs for himself or eligible dependents or both himself and eligible dependents. The term "enrollee" shall not include an individual who has health care coverage pursuant to a liability insurance policy, workers' compensation insurance policy, or medical payments insurance issued as a supplement to a liability policy;

(4) "Provider of record", the physician or other licensed practitioner identified to the utilization review agent as having primary responsibility for the care, treatment and services rendered to an enrollee;

(5) "Utilization review", a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, **[**~~prospective~~**]** prior authorization review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review. Utilization review shall not include elective requests for clarification of coverage;

(6) "Utilization review agent", any person or entity performing utilization review, except:

(a) An agency of the federal government;

(b) An agent acting on behalf of the federal government, but only to the extent that the agent is providing services to the federal government; or

(c) Any individual person employed or used by a utilization review agent for the purpose of performing utilization review services, including, but not limited to, individual nurses and physicians, unless such individuals are providing utilization review services to the applicable benefit plan, pursuant to a direct contractual relationship with the benefit plan;

(d) An employee health benefit plan that is self-insured and qualified pursuant to the federal Employee Retirement Income Security Act of 1974, as amended;

(e) A property-casualty insurer or an employee or agent working on behalf of a property-casualty insurer;

(f) A health carrier, as defined in section 376.1350, that is performing a review of its own health plan;

(7) "Utilization review plan", a summary of the utilization review procedures of a utilization review agent.

376.690. 1. As used in this section, the following terms shall mean:

(1) "Emergency medical condition", the same meaning given to such term in section 376.1350;

(2) "Facility", the same meaning given to such term in section 376.1350;

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(3) "Health care professional", the same meaning given to such term in section 376.1350;

(4) "Health carrier", the same meaning given to such term in section 376.1350;

(5) "Unanticipated out-of-network care", health care services received by a patient in an in-network facility from an out-of-network health care professional from the time the patient presents with an emergency medical condition until the time the patient is discharged.

2. (1) Health care professionals **[**~~may~~**]** shall send any claim for charges incurred for unanticipated out-of-network care to the patient's health carrier within one hundred eighty days of the delivery of the unanticipated out-of-network care on a U.S. Centers of Medicare and Medicaid Services Form 1500, or its successor form, or electronically using the 837 HIPAA format, or its successor.

(2) Within forty-five processing days, as defined in section 376.383, of receiving the health care professional's claim, the health carrier shall offer to pay the health care professional a reasonable reimbursement for unanticipated out-of-network care based on the health care professional's services. If the health care professional participates in one or more of the carrier's commercial networks, the offer of reimbursement for unanticipated out-of-network care shall be the amount from the network which has the highest reimbursement.

(3) If the health care professional declines the health carrier's initial offer of reimbursement, the health carrier and health care professional shall have sixty days from the date of the initial offer of reimbursement to negotiate in good faith to attempt to determine the reimbursement for the unanticipated out-of-network care.

(4) If the health carrier and health care professional do not agree to a reimbursement amount by the end of the sixty-day negotiation period, the dispute shall be resolved through an arbitration process as specified in subsection 4 of this section.

(5) To initiate arbitration proceedings, either the health carrier or health care professional must provide written notification to the director and the other party within one hundred twenty days of the end of the negotiation period, indicating their intent to arbitrate the matter and notifying the director of the billed amount and the date and amount of the final offer by each party. A claim for unanticipated out-of-network care may be resolved between the parties at any point prior to the commencement of the arbitration proceedings. Claims may be combined for purposes of arbitration, but only to the extent the claims represent similar circumstances and services provided by the same health care professional, and the parties attempted to resolve the dispute in accordance with subdivisions (3) to (5) of this subsection.

(6) No health care professional who sends a claim to a health carrier under subsection 2 of this section shall send a bill to the patient for any difference between the reimbursement rate as determined under this subsection and the health care professional's billed charge.

3. (1) When unanticipated out-of-network care is provided, the health care professional who sends a claim to a health carrier under subsection 2 of this section may bill a patient for no more than the cost-sharing requirements described under this section.

(2) Cost-sharing requirements shall be based on the reimbursement amount as determined under subsection 2 of this section.

(3) The patient's health carrier shall inform the health care professional of its enrollee's cost-sharing requirements within forty-five processing days of receiving a claim from the health care professional for services provided.

(4) The in-network deductible and out-of-pocket maximum cost-sharing requirements shall apply to the claim for the unanticipated out-of-network care.

4. The director shall ensure access to an external arbitration process when a health care professional and health carrier cannot agree to a reimbursement under subdivision (3) of subsection 2 of this section. In order to ensure access, when notified of a parties' intent to arbitrate, the director shall randomly select an arbitrator for each case from the department's approved list of arbitrators or entities that provide binding arbitration. The director shall specify the criteria for an approved arbitrator or entity by rule. The costs of arbitration shall be shared equally between and will be directly billed to the health care professional and health carrier. These costs will include, but are not limited to, reasonable time necessary for the arbitrator to review materials in preparation for the arbitration, travel expenses and reasonable time following the arbitration for drafting of the final decision.

5. At the conclusion of such arbitration process, the arbitrator shall issue a final decision, which shall

be binding on all parties. The arbitrator shall provide a copy of the final decision to the director. The initial request for arbitration, all correspondence and documents received by the department and the final arbitration decision shall be considered a closed record under section 374.071. However, the director may release aggregated summary data regarding the arbitration process. The decision of the arbitrator shall not be considered an agency decision nor shall it be considered a contested case within the meaning of section 536.010.

6. The arbitrator shall determine a dollar amount due under subsection 2 of this section between one hundred twenty percent of the Medicare-allowed amount and the seventieth percentile of the usual and customary rate for the unanticipated out-of-network care, as determined by benchmarks from independent nonprofit organizations that are not affiliated with insurance carriers or provider organizations.

7. When determining a reasonable reimbursement rate, the arbitrator shall consider the following factors if the health care professional believes the payment offered for the unanticipated out-of-network care does not properly recognize:

(1) The health care professional's training, education, or experience;

(2) The nature of the service provided;

(3) The health care professional's usual charge for comparable services provided;

(4) The circumstances and complexity of the particular case, including the time and place the services were provided; and

(5) The average contracted rate for comparable services provided in the same geographic area.

8. The enrollee shall not be required to participate in the arbitration process. The health care professional and health carrier shall execute a nondisclosure agreement prior to engaging in an arbitration under this section.

9. **[**~~This section shall take effect on January 1, 2019.~~

~~10.~~**]** The department of insurance, financial institutions and professional registration may promulgate rules and fees as necessary to implement the provisions of this section, including but not limited to procedural requirements for arbitration. Any rule or portion of a rule, as that term is defined in section 536.010, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536 and, if applicable, section 536.028. This section and chapter 536 are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536 to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2018, shall be invalid and void

376.1040. 1. No multiple employer self-insured health plan shall be offered or advertised to the public [~~generally~~]. No plan shall be sold, solicited, or marketed by persons or entities defined in section 375.012 or sections 376.1075 to 376.1095. Multiple employer self-insured health plans with a certificate of authority approved by the director under section 376.1002 shall be exempt from the restrictions set forth in this section.

2. A health carrier acting as an administrator for a multiple employer self insured health plan shall permit any willing licensed broker to quote, sell, solicit, or market such plan to the extent permitted by this section; provided that such broker is appointed and in good standing with the health carrier and completes all required training.

376.1042. The sale, solicitation or marketing of any plan in violation of section 376.1040 by an agent, agency or broker shall constitute a violation of section 375.141.

376.1345. 1. As used in this section, unless the context clearly indicates otherwise, terms shall have the same meaning as ascribed to them in section 376.1350.

2. No health carrier, nor any entity acting on behalf of a health carrier, shall restrict methods of reimbursement to health care providers for health care services to a reimbursement method requiring the provider to pay a fee, discount the amount of their claim for reimbursement, or remit any other form of remuneration in order to redeem the amount of their claim for reimbursement.

3. If a health carrier initiates or changes the method used to reimburse a health care provider to a method of reimbursement that will require the health care provider to pay a fee, discount the amount of its claim for reimbursement, or remit any other form of remuneration to the health carrier or any entity acting on behalf of the health carrier in order to redeem the amount of its claim for reimbursement, the health carrier or

an entity acting on its behalf shall:

(1) Notify such health care provider of the fee, discount, or other remuneration required to receive reimbursement through the new or different reimbursement method; and

(2) In such notice, provide clear instructions to the health care provider as to how to select an alternative payment method, and upon request such alternative payment method shall be used to reimburse the provider until the provider requests otherwise.

4. A health carrier shall allow the provider to select to be reimbursed by an electronic funds transfer through the Automated Clearing House Network as required pursuant to 45 C.F.R. Sections 162.925, 162.1601, and 162.1602, and if the provider makes such selection, the health carrier shall use such reimbursement method to reimburse the provider until the provider requests otherwise.

5. Violation of this section shall be deemed an unfair trade practice under sections 375.930 to 375.948.

376.1350. For purposes of sections 376.1350 to 376.1390, the following terms mean:

(1) "Adverse determination", a determination by a health carrier or **[**~~its designee~~**]** a utilization review **[**~~organization~~**]** entity that an admission, availability of care, continued stay or other health care service furnished or proposed to be furnished to an enrollee has been reviewed and, based upon the information provided, does not meet the utilization review entity or health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or are experimental or investigational, and the payment for the requested service is therefore denied, reduced or terminated;

(2) "Ambulatory review", utilization review of health care services performed or provided in an outpatient setting;

(3) "Case management", a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions;

(4) "Certification", a determination by a health carrier or **[**~~its designee~~**]** a utilization review **[**~~organization~~**]** entity that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness, and that payment will be made for that health care service provided the patient is an enrollee of the health benefit plan at the time the service is provided;

(5) "Clinical peer", a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review;

(6) "Clinical review criteria", the written policies, written screening procedures, drug formularies or lists of covered drugs, determination rules, decision abstracts, clinical protocols **[**~~and~~**]**, medical protocols, practice guidelines, and any other criteria or rationale used by the health carrier or utilization review entity to determine the necessity and appropriateness of health care services;

(7) "Concurrent review", utilization review conducted during a patient's hospital stay or course of treatment;

(8) "Covered benefit" or "benefit", a health care service that an enrollee is entitled under the terms of a health benefit plan;

(9) "Director", the director of the department of insurance, financial institutions and professional registration;

(10) "Discharge planning", the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility;

(11) "Drug", any substance prescribed by a licensed health care provider acting within the scope of the provider's license and that is intended for use in the diagnosis, mitigation, treatment or prevention of disease. The term includes only those substances that are approved by the FDA for at least one indication;

(12) "Emergency medical condition", the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity, regardless of the final diagnosis that is given, that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:

(a) Placing the person's health in significant jeopardy;

(b) Serious impairment to a bodily function;

(c) Serious dysfunction of any bodily organ or part;

(d) Inadequately controlled pain; or

(e) With respect to a pregnant woman who is having contractions:

a. That there is inadequate time to effect a safe transfer to another hospital before delivery; or

b. That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child;

(13) "Emergency service", a health care item or service furnished or required to evaluate and treat an emergency medical condition, which may include, but shall not be limited to, health care services that are provided in a licensed hospital's emergency facility by an appropriate provider;

(14) "Enrollee", a policyholder, subscriber, covered person or other individual participating in a health benefit plan;

(15) "FDA", the federal Food and Drug Administration;

(16) "Facility", an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings;

(17) "Grievance", a written complaint submitted by or on behalf of an enrollee regarding the:

(a) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) Claims payment, handling or reimbursement for health care services; or

(c) Matters pertaining to the contractual relationship between an enrollee and a health carrier;

(18) "Health benefit plan", a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services; except that, health benefit plan shall not include any coverage pursuant to liability insurance policy, workers' compensation insurance policy, or medical payments insurance issued as a supplement to a liability policy;

(19) "Health care professional", a physician or other health care practitioner licensed, accredited or certified by the state of Missouri to perform specified health services consistent with state law;

(20) "Health care provider" or "provider", a health care professional or a facility;

(21) "Health care service", a service for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease, including but not limited to the provision of drugs or durable medical equipment;

(22) "Health carrier", an entity subject to the insurance laws and regulations of this state that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services; except that such plan shall not include any coverage pursuant to a liability insurance policy, workers' compensation insurance policy, or medical payments insurance issued as a supplement to a liability policy;

(23) "Health indemnity plan", a health benefit plan that is not a managed care plan;

(24) "Managed care plan", a health benefit plan that either requires an enrollee to use, or creates incentives, including financial incentives, for an enrollee to use, health care providers managed, owned, under contract with or employed by the health carrier;

(25) "Participating provider", a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than coinsurance, co-payments or deductibles, directly or indirectly from the health carrier;

(26) "Peer-reviewed medical literature", a published scientific study in a journal or other publication in which original manuscripts have been published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts, and that has been determined by the International Committee of Medical Journal Editors to have met the uniform requirements for manuscripts submitted to biomedical journals or is published in a journal specified by the United States Department of Health and Human Services pursuant to Section 1861(t)(2)(B) of the Social Security Act (42 U.S.C. 1395x),

as amended, as acceptable peer-reviewed medical literature. Peer-reviewed medical literature shall not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier;

(27) "Person", an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing;

(28) "Prior authorization", a certification made pursuant to a prior authorization review, or notice as required by a health carrier or utilization review entity prior to the provision of health care services;

(29) "**[**~~Prospective review~~**]** Prior authorization review", utilization review conducted prior to an admission or a course of treatment, including but not limited to pre-admission review, pre-treatment review, utilization review, and case management;

[~~(29)~~**]** (30) "Retrospective review", utilization review of medical necessity that is conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment;

[~~(30)~~**]** (31) "Second opinion", an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service;

[~~(31)~~**]** (32) "Stabilize", with respect to an emergency medical condition, that no material deterioration of the condition is likely to result or occur before an individual may be transferred;

[~~(32)~~**]** (33) "Standard reference compendia":

(a) The American Hospital Formulary Service-Drug Information; or

(b) The United States Pharmacopoeia-Drug Information;

[~~(33)~~**]** (34) "Utilization review", a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, **[**~~prospective~~**]** prior authorization review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review. Utilization review shall not include elective requests for clarification of coverage;

[~~(34)~~**]** (35) "Utilization review **[**~~organization~~**]** entity", a utilization review agent as defined in section 374.500, or an individual or entity that performs prior authorization reviews for a health carrier or health care provider. A health carrier or health care provider is a utilization review entity if it performs prior authorization review.

376.1356. Whenever a health carrier contracts to have a utilization review **[**~~organization or other~~**]** entity perform the utilization review functions required by sections 376.1350 to 376.1390 or applicable rules and regulations, the health carrier shall be responsible for monitoring the activities of the utilization review **[**~~organization or~~**]** entity with which the health carrier contracts and for ensuring that the requirements of sections 376.1350 to 376.1390 and applicable rules and regulations are met.

376.1363. 1. A health carrier shall maintain written procedures for making utilization review decisions and for notifying enrollees and providers acting on behalf of enrollees of its decisions. For purposes of this section, "enrollee" includes the representative of an enrollee.

2. For **[**~~initial~~**]** determinations, a health carrier shall make the determination within thirty-six hours, which shall include one working day, of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required:

(1) In the case of a determination to certify an admission, procedure or service, the carrier shall notify the provider rendering the service by telephone or electronically within twenty-four hours of making the **[**~~initial~~**]** certification, and provide written or electronic confirmation of a telephone or electronic notification to the enrollee and the provider within two working days of making the **[**~~initial~~**]** certification;

(2) In the case of an adverse determination, the carrier shall notify the provider rendering the service by telephone or electronically within twenty-four hours of making the adverse determination; and shall provide written or electronic confirmation of a telephone or electronic notification to the enrollee and the provider within one working day of making the adverse determination.

3. For concurrent review determinations, a health carrier shall make the determination within one working day of obtaining all necessary information:

(1) In the case of a determination to certify an extended stay or additional services, the carrier shall notify by telephone or electronically the provider rendering the service within one working day of making the certification, and provide written or electronic confirmation to the enrollee and the provider within one working day after telephone or electronic notification. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services;

(2) In the case of an adverse determination, the carrier shall notify by telephone or electronically the provider rendering the service within twenty-four hours of making the adverse determination, and provide written or electronic notification to the enrollee and the provider within one working day of a telephone or electronic notification. The service shall be continued without liability to the enrollee until the enrollee has been notified of the determination.

4. For retrospective review determinations, a health carrier shall make the determination within thirty working days of receiving all necessary information. A carrier shall provide notice in writing of the carrier's determination to an enrollee within ten working days of making the determination.

5. A written notification of an adverse determination shall include the principal reason or reasons for the determination, including the clinical rationale, and the instructions for initiating an appeal or reconsideration of the determination**[**~~, and the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination~~**]**. A health carrier shall provide the clinical rationale in writing for an adverse determination, including the clinical review criteria used to make that determination, to the health care provider and to any party who received notice of the adverse determination **[**~~and who requests such information~~**]**.

6. A health carrier shall have written procedures to address the failure or inability of a provider or an enrollee to provide all necessary information for review. These procedures shall be made available to health care providers on the health carrier's website or provider portal. In cases where the provider or an enrollee will not release necessary information, the health carrier may deny certification of an admission, procedure or service.

7. Provided the patient is an enrollee of the health benefit plan, no utilization review entity shall revoke, limit, condition, or otherwise restrict a prior authorization within forty-five working days of the date the health care provider receives the prior authorization.

8. Provided the patient is an enrollee of the health benefit plan at the time the service is provided, no health carrier, utilization review entity, or health care provider shall bill an enrollee for any health care service for which a prior authorization was in effect at the time the health care service was provided, except as consistent with cost-sharing requirements applicable to a covered benefit under the enrollee's health benefit plan. Such cost-sharing shall be subject to and applied toward any in-network deductible or out-of-pocket maximum applicable to the enrollee's health benefit plan.

376.1364. 1. Any utilization review entity performing prior authorization review shall provide a unique confirmation number to a provider upon receipt from that provider of a request for prior authorization. Except as otherwise requested by the provider in writing, unique confirmation numbers shall be transmitted or otherwise communicated through the same medium through which the requests for prior authorization were made.

2. No later than January 1, 2021, utilization review entities shall accept and respond to requests for prior authorization of drug benefits through a secure electronic transmission using the National Council for Prescription Drugs SCRIPT Standard Version 2017071 or a backwards-compatible successor adopted by the United States Department of Health and Human Services. For purposes of this subsection, facsimile, proprietary payer portals, and electronic forms shall not be considered electronic transmission.

3. No later than January 1, 2021, utilization review entities shall accept and respond to requests for prior authorization of health care services and mental health services electronically. For purposes of this subsection, facsimile, proprietary payer portals, and electronic forms shall not be considered electronic transmission.

4. No later than January 1, 2021, each health carrier utilizing prior authorization review shall develop a single secure electronic prior authorization cover page for all of its health benefit plans utilizing prior authorization review, which the carrier or its utilization review entity shall use to accept and respond to, and which providers shall use to submit, requests for prior authorization. Such cover page shall include, but

not be limited to, fields for patient or enrollee information, referring or requesting provider information, rendering or attending provider information, and required clinical information, and shall be supplemented by additional clinical information as required by the health carrier or utilization review entity.

376.1372. 1. In the certificate of coverage and the member handbook provided to enrollees, a health carrier shall include a clear and comprehensive description of its utilization review procedures, including the procedures for obtaining review of adverse determinations, and a statement of rights and responsibilities of enrollees with respect to those procedures.

2. A health carrier shall include a summary of its utilization review procedures in material intended for prospective enrollees.

3. A health carrier shall print on its membership cards a toll-free telephone number to call for utilization review decisions.

4. (1) A health carrier or utilization review entity shall make any current prior authorization requirements or restrictions, including written clinical review criteria, readily accessible on its website or provider portal. Requirements and restrictions, including step therapy protocols as such term is defined in section 376.2030, shall be described in detail.

(2) No health carrier or utilization review entity shall amend or implement a new prior authorization requirement or restriction prior to the change being reflected on the carrier or utilization review entity's website or provider portal as specified in subdivision (1) of this subsection.

(3) Health carriers and utilization review entities shall provide participating providers with written or electronic notice of the new or amended requirement not less than sixty days prior to implementing the requirement or restriction.

376.1385. 1. Upon receipt of a request for second-level review, a health carrier shall submit the grievance to a grievance advisory panel consisting of:

(1) Other enrollees;

(2) Representatives of the health carrier that were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance; and

(3) Where the grievance involves an adverse determination, a majority of persons that are **[**~~appropriate~~**]** clinical peers licensed to practice in the same or similar specialty as would typically manage the case being reviewed that were not involved in the circumstances giving rise to the grievance or in any subsequent investigation or determination of the grievance.

2. Review by the grievance advisory panel shall follow the same time frames as a first level review, except as provided for in section 376.1389 if applicable. Any decision of the grievance advisory panel shall include notice of the enrollee's or the health carrier's or plan sponsor's rights to file an appeal with the director's office of the grievance advisory panel's decision. The notice shall contain the toll-free telephone number and address of the director's office."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.