By Senator Brown-Waite

10-890A-98

A bill to be entitled

An act relating to the delivery of health care services; redesignating part III of ch. 641, F.S., as part IV, and creating a new part III of ch. 641, F.S., the "Provider-Sponsored Organization Act"; providing legislative findings and purposes with respect to certain federal requirements for authorizing provider-sponsored organizations in this state to provide health care coverage to Medicare beneficiaries under the Medicare Choice plan; providing definitions; exempting provider-sponsored organizations from certain provisions of the Florida Insurance Code; requiring the incorporation of any provider-sponsored organization doing business in this state; prohibiting a provider-sponsored organization from transacting insurance business other than the offering of Medicare Choice plans; providing for determining the types of activities that require licensure by the Department of Insurance; requiring that a provider-sponsored organization obtain a certificate of authority from the department; specifying conditions precedent to issuance or maintenance of a certificate of authority; providing surplus requirements for a provider-sponsored organization that offers the Medicare Choice plan; requiring that a provider-sponsored organization deposit a specified amount into the Rehabilitation

Administrative Expense Fund of the Department of Insurance; requiring that a provider-sponsored organization maintain a valid health care provider certificate; specifying circumstances under which the department may suspend a provider-sponsored organization's authority to enroll new subscribers; providing contract requirements; authorizing the department to impose administrative penalties in lieu of suspension or revocation of a certificate; providing requirements for any acquisition, merger, or consolidation of a provider-sponsored organization; requiring that a provider-sponsored organization file an annual report; providing penalties; requiring examinations by the department; providing for civil remedies and injunctive relief; providing for the payment of a judgment by a provider-sponsored organization; specifying the delinquency proceedings that are the sole means of liquidating, reorganizing, rehabilitating, or conserving a provider-sponsored organization; providing filing fees; providing for the application of other laws; authorizing the Division of Insurance Fraud of the department to investigate violations of part III of ch. 641, F.S.; prohibiting certain unfair practices in a provider-sponsored contract with respect to exposure to the human immunodeficiency virus infection and related

matters; providing requirements for contracts and advertisements used by a provider-sponsored organization; providing marketing standards and requirements; providing requirements for provider-sponsored contracts, certificates, and member handbooks; requiring a provider-sponsored organization to make certain disclosures to prospective enrollees; requiring coverage for mammograms; providing requirements with respect to the treatment of breast cancer and followup care; providing requirements for contracts between a provider-sponsored organization and a provider of health care services; prohibiting a provider-sponsored organization from using certain words descriptive of the insurance business; providing requirements for assets, liabilities, and investments of a provider-sponsored organization; requiring the Department of Insurance to adopt rules; providing certain limitations on the payment of dividends by a provider-sponsored organization; specifying prohibited activities; providing penalties; requiring that an agent who solicits contracts and performs other activities be licensed and appointed as a health insurance agent; prohibiting certain unfair methods of competition and unfair or deceptive acts or practices; authorizing the department to conduct examinations and investigations; providing for administrative hearings;

authorizing the department to issue cease and desist orders and impose penalties; providing for appeals of a department order; providing penalties for violating a cease and desist order; providing that an action by the department does not abrogate the right to other relief; amending s. 641.227, F.S.; providing for deposits into the Rehabilitation Administrative Expense Fund by a provider-sponsored organization; providing for reimbursements; amending s. 641.316, F.S., relating to fiscal intermediary services; providing for application to provider-sponsored organizations; amending ss. 641.47, 641.48, 641.49, 641.495, F.S., relating to definitions, purpose and application, and certification requirements; providing for certain provisions regulating health care services to apply to provider-sponsored organizations; amending s. 641.51, F.S.; providing requirements for provider-sponsored organizations in requiring second medical opinions; amending s. 641.512, F.S.; requiring that a provider-sponsored organization obtain accreditation; amending s. 641.513, F.S.; providing requirements for provider-sponsored organizations in providing emergency services and care; amending s. 641.515, F.S.; authorizing the Agency for Health Care Administration to adopt rules with respect to services performed for a provider-sponsored organization; amending s.

641.54, F.S.; providing requirements for a provider-sponsored organization in making referrals; amending s. 641.59, F.S.; providing requirements for psychotherapeutic services; amending s. 641.60, F.S.; providing for a managed care program to include a provider-sponsored organization for purposes of the Statewide Managed Care Ombudsman Committee; providing an effective date.

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

Section 1. The Division of Statutory Revision is requested to redesignate part III of chapter 641, Florida Statutes, as part IV of that chapter, and a new part III of chapter 641, Florida Statutes, consisting of sections 641.4601, 641.4602, 641.4603, 641.4604, 641.4605, 641.4606, 641.4607, 641.4608, 641.4609, 641.4610, 641.4611, 641.4612, 641.4613, 641.4614, 641.4615, 641.4616, 641.4617, 641.4618, 641.4619, 641.4620, 641.4621, 641.4622, 641.4623, 641.4624, 641.4625, 641.4626, 641.4627, 641.4628, 641.4629, 641.4630, 641.4631, 641.4632, 641.4633, 641.4634, 641.4635, 641.4636, 641.4637, 641.4638, 641.4639, 641.4640, 641.4641, 641.4642, 641.4643, 641.4644, 641.4645, 641.4646, 641.4647, and 641.4648, Florida Statutes, is created to read:

Section 641.4601 Short title.--This part may be cited as the "Provider-Sponsored Organization Act."

Section 641.4602 Declaration of legislative findings and purposes.--

(1) The Legislature finds that a major restructuring of health care has taken place which has changed the way in

which health care services are paid for and delivered. Today, the emphasis is on providing cost-conscious health care services through managed care. The Legislature recognizes that alternative methods for the delivery of health care are needed to promote competition and increase patients' choices.

(2) The Legislature recognizes that the United States Congress has enacted legislation that allows provider-sponsored organizations to provide coordinated-care plans to Medicare enrollees through the Medicare Choice program. The federal legislation requires any organization that offers a Medicare Choice plan to be organized under state law as an entity eligible to offer health-benefit coverage in the state in which it offers a Medicare Choice plan.

(3) The Legislature finds that these plans, when properly operated, will enhance the quality of controls, ensuring that the provider has control over medical decisionmaking while emphasizing effective cost and quality control.

(4) Therefore, it is the policy of this state:

(a) To eliminate legal barriers to the organization, promotion, and expansion of provider-sponsored organizations that offer Medicare Choice plans in order to encourage the development of valuable options for the Medicare beneficiaries of this state.

(b) Not to extend insurance regulation or onerous reporting requirements to hospitals, physicians, single or multiple-specialty groups, other licensed providers, or any combination of such entities when contracting with entities licensed under chapter 627 or part I or when contracting with plans qualified and created under the Employee Retirement Income Security Act of 1974.

(c) To recognize that comprehensive provider-sponsored organizations are exempt from the insurance laws of this state except in the manner and to the extent set forth in this part.

641.4603 Definitions.--As used in this part, the term:

(1) "Affiliation" means a relationship between providers in which, through contract, ownership, or otherwise:

(a) One provider, directly or indirectly, controls, is controlled by, or is under common control with the other;

(b) Both providers are part of a controlled group of corporations under s. 1563 of the Internal Revenue Code of 1986;

(c) Each provider is a participant in a lawful combination under which each provider shares substantial financial risk in connection with the organization's operations; or

(d) Both providers are part of an affiliated service group under s. 414 of the Internal Revenue Code of 1986.

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

(3) "Comprehensive health care services" means services, medical equipment, and supplies required under the Medicare Choice program.

(4) "Copayment" means a specific dollar amount that the subscriber must pay upon receipt of covered health care services as required or authorized under the Medicare Choice program.

(5) "Department" means the Department of Insurance.

(6) "Emergency medical condition" means:

(a) A medical condition that manifests itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate

medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to the health of a patient, including a pregnant woman or a fetus.

2. Serious impairment of bodily functions.

3. Serious dysfunction of any bodily organ or part.

(b) With respect to a pregnant woman:

1. That there is inadequate time to effect safe transfer to another hospital prior to delivery;

2. That a transfer may pose a threat to the health and safety of the patient or fetus; or

3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

(7) "Emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital.

(8) "Entity" means any legal entity with continuing existence, including, but not limited to, a corporation, association, trust, or partnership.

(9) "Geographic area" means the county or counties, or any portion of a county or counties, within which the organization provides or arranges for comprehensive health care services to be available to its subscribers.

(10) "Provider-sponsored contract" means any contract entered into by a provider-sponsored organization that serves Medicare Choice beneficiaries.

(11) "Provider-sponsored organization" means any organization authorized under this part which:

(a) Is established, organized, and operated by a health care provider or group of affiliated health care providers;

(b) Provides a substantial proportion of the health care items and services specified in the Medicare Choice contract, as defined by the Secretary of the United States Department of Health and Human Services, directly through the provider or affiliated group of providers; and

(c) Shares, with respect to its affiliated providers, directly or indirectly, substantial financial risk in the provision of such items and services and has at least a majority financial interest in the entity.

The term "substantial proportion" shall be defined by the Secretary of the United States Department of Health and Human Services after having taken into account the need for such an organization to assume responsibility for providing significantly more than the majority of the items and services under the Medicare Choice contract through its own affiliated providers and the remainder of the items and services under such contract through providers with which the organization has an agreement to provide such items and services. Consideration will also be given to the need for the organization to provide a limited proportion of the items and services under the contract through entities that are neither affiliated with nor have an agreement with the organization.

Additionally, some variation in the definition of substantial proportion may be allowed based upon relevant differences among the organizations, such as their location in an urban or rural area.

(12) "Insolvent" or "insolvency" means that all the statutory assets of the provider-sponsored organization, if made immediately available, would not be sufficient to discharge all of its liabilities or that the provider-sponsored organization is unable to pay its debts as they become due in the usual course of business.

(13) "Provider" means any physician, hospital, or other institution, organization, or person that furnishes health care services and is licensed or otherwise authorized to practice in the state.

(14) "Reporting period" means the annual accounting period or any part thereof or the fiscal year of the provider-sponsored organization.

(15) "Statutory accounting principles" means generally accepted accounting principles, except as modified by this part.

(16) "Subscriber" means a Medicare Choice enrollee who is eligible for coverage as a Medicare beneficiary.

(17) "Surplus" means total assets in excess of total liabilities as determined by the federal rules on solvency standards established by the Secretary of the United States Department of Health and Human Services pursuant to s. 1856(a) of the Balanced Budget of 1997, for provider-sponsored organizations that offer the Medicare Choice plan.

641.4604 Applicability of other laws.--Except as provided in this part, provider-sponsored organizations shall

be governed by this part and part IV and are exempt from all other provisions of the Florida Insurance Code.

641.4605 Incorporation required.--On or after October 1, 1998, any entity that has not yet obtained a certificate of authority to operate a provider-sponsored organization in this state shall be incorporated or shall be a division of a corporation formed under chapter 607 or chapter 617 or shall be a public entity that is organized as a political subdivision. In the case of a division of a corporation, the financial requirements of this part apply to the entire corporation.

641.4606 Insurance business not authorized.--The Florida Insurance Code or this part do not authorize any provider-sponsored organization to transact any insurance business other than to offer Medicare Choice plans pursuant to s. 1855 of the Balanced Budget Act of 1997. In determining the type of activities by a provider-sponsored organization which require licensure by the department, the following shall apply:

(1) A provider-sponsored organization as defined in this part, a hospital, a physician licensed under chapter 458 or chapter 459, a single specialty group of physicians, a multispecialty group of physicians, other licensed providers, or any combination of the foregoing, when contracting with a self-insured employer to provide health care benefits to its employees, when contracting with a health maintenance organization licensed under part I or a provider-sponsored organization licensed under this part, or when contracting with an insurer, are exempt from the requirements of this chapter and chapter 627.

(2) In all of the arrangements enumerated in subsection (1), the provider group is not subject to regulation by the department because there is no contractual obligation to the employees covered under the self-insured agreement or under the agreement with the health maintenance organization, the provider-sponsored organization, or the insurer. The contractual relationship exists only between the provider group and the self-insured employer, the licensed health maintenance organization, the provider-sponsored organization, or the insurer, which entity continues to bear full and direct responsibility to the individual with no transfer of risk. If the provider group fails to perform, the employer, health maintenance organization, provider-sponsored organization, or insurer still retains the risk to either provide or pay for health care services.

(3) The department has regulatory jurisdiction when any health care provider group becomes the ultimate risk-bearer and is directly obligated to individuals to provide, arrange, or pay for health care services. In these situations, the provider group must be appropriately licensed as a health maintenance organization, a provider-sponsored organization, or an insurance company.

641.4607 Application for certificate.--Before any entity may operate a provider-sponsored organization, it must obtain a certificate of authority from the department. The department shall accept and shall immediately begin its review of an application for a certificate of authority anytime after an organization has filed an application for a health care provider certificate pursuant to part IV. However, the department may not issue a certificate of authority to any applicant that does not possess a valid health care provider

certificate issued by the agency. Each application for a certificate must be on a form prescribed by the department, must be verified by the oath of two officers of the corporation and properly notarized, and must be accompanied by:

(1) A copy of the articles of incorporation and all amendments thereto;

(2) A copy of the bylaws, rules, and regulations, or similar document, if any, regulating the conduct of the affairs of the applicant;

(3) A list of the names, addresses, and official capacities of the persons who are to be responsible for conducting the affairs of the provider-sponsored organization, including all officers, directors, and owners of in excess of 5 percent of the common stock of the corporation. Each such person must fully disclose to the department and to the directors of the provider-sponsored organization the extent and nature of any contract or arrangement between him or her and the provider-sponsored organization, including any possible conflict of interest;

(4) A complete biographical statement on forms prescribed by the department, and an independent investigation report and fingerprints obtained pursuant to chapter 624, of each individual listed in subsection (3);

(5) A statement generally describing the provider-sponsored organization, its operations, and its grievance procedures;

(6) A statement describing with reasonable certainty the geographic area or areas to be served by the provider-sponsored organization;

(7) An audited financial statement prepared on the basis of statutory accounting principles and certified by an independent certified public accountant, except that surplus notes that are acceptable to the department and meet the requirements of this part shall be included in the calculation of surplus; and

(8) Any additional data, financial statements, or other pertinent information required by the department with respect to determining whether the applicant can provide the services to be offered, including a comprehensive feasibility study, performed by a certified actuary in conjunction with a certified public accountant. The feasibility study must cover a period of 3 years or the period ending on the date that the provider-sponsored organization projects that it will have been profitable for 12 consecutive months, whichever period is longer.

641.4608 Conditions precedent to issuance or maintenance of certificate of authority; effect of bankruptcy proceedings.--

(1) As a condition precedent to the issuance or maintenance of a certificate of authority, a provider-sponsored organization must file or have on file with the department:

(a) An acknowledgment that a delinquency proceeding pursuant to part I of chapter 631 or supervision by the department pursuant to ss. 624.80-624.87 constitutes the sole and exclusive method for the liquidation, rehabilitation, reorganization, or conservation of a provider-sponsored organization.

(b) A waiver of any right to file or be subject to a bankruptcy proceeding.

(2) The commencement of a bankruptcy proceeding either by or against a provider-sponsored organization shall, by operation of law:

(a) Terminate the provider-sponsored organization's certificate of authority.

(b) Vest in the department for the use and benefit of the subscribers of the provider-sponsored organization the title to any deposits of the insurer held by the department.

If the proceeding is initiated by a party other than the provider-sponsored organization, the operation of subsection (2) shall be stayed for 60 days following the date of commencement of the proceeding.

641.4609 Issuance of certificate of authority.--The department shall, within 90 days after receipt, issue a certificate of authority to any entity filing a completed application in conformity with s. 641.4607, upon payment of the prescribed fees and upon the department's being satisfied that:

(1) As a condition precedent to the issuance of any certificate, the entity has obtained a health care provider certificate from the agency pursuant to part IV.

(2) The provider-sponsored organization is actuarially sound.

(3) The entity has met the applicable requirements specified in s. 641.4611.

(4) The procedures for offering comprehensive health care services and offering and terminating contracts to subscribers will not unfairly discriminate on the basis of age, sex, race, health, or economic status.

(5) The entity furnishes evidence of adequate insurance coverage or an adequate plan for self-insurance to respond to claims for injuries arising out of the furnishing of comprehensive health care.

(6) The ownership, control, and management of the entity is competent and trustworthy and possesses managerial experience sufficient to make the proposed operation of the provider-sponsored organization beneficial to the subscribers. The department may not grant or continue authority to transact the business of a provider-sponsored organization in this state at any time during which the department has good reason to believe that the ownership, control, or management of the organization includes:

(a) Any person:

1. Who is incompetent or untrustworthy;

2. Who is so lacking in expertise as to make the operation of the provider-sponsored organization hazardous to potential and existing subscribers;

3. Who is so lacking in experience, ability, and standing with respect to a provider-sponsored organization as to jeopardize the reasonable promise of successful operation;

4. Who is affiliated, directly or indirectly, through ownership, control, reinsurance transactions, or other business relations, with any person whose business operations are or have been marked by business practices or conduct that is detrimental to the public, stockholders, investors, or creditors; or

5. Whose business operations are or have been marked by business practices or conduct that is detrimental to the public, stockholders, investors, or creditors.

(b) Any person, including any stock subscriber, stockholder, or incorporator, who exercises or has the ability to exercise effective control of the organization, or who influences or has the ability to influence the transaction of the business of the provider-sponsored organization, who does not possess the financial standing and business experience for the successful operation of the provider-sponsored organization.

(c) Any person, including any stock subscriber, stockholder, or incorporator, who exercises or has the ability to exercise effective control of the organization, or who influences or has the ability to influence the transaction of the business of the provider-sponsored organization, who has been found guilty of, or has pled guilty or no contest to, any felony or crime punishable by imprisonment of 1 year or more under the laws of the United States or any state thereof or under the laws of any other country, which felony or crime involves moral turpitude, without regard to whether a judgment or conviction has been entered by the court having jurisdiction in such case. However, in the case of a provider-sponsored organization operating under a subsisting certificate of authority, the provider-sponsored organization shall remove any such person immediately upon discovery of the conditions set forth in this paragraph when applicable to such person or under the order of the department, and the failure to so act by the organization is grounds for revocation or suspension of the provider-sponsored organization's certificate of authority.

(d) Any person, including any stock subscriber, stockholder, or incorporator, who exercises or has the ability to exercise effective control of the organization, or who

influences or has the ability to influence the transaction of the business of the provider-sponsored organization, who is now or has in the past been affiliated, directly or indirectly, through ownership interest of 10 percent or more, control, or reinsurance transactions, with any business, corporation, or other entity that has been found guilty of or has pleaded guilty or nolo contendere to any felony or crime punishable by imprisonment for 1 year or more under the laws of the United States, any state, or any other country, regardless of adjudication. In the case of a provider-sponsored organization operating under a subsisting certificate of authority, the provider-sponsored organization shall immediately remove such person or immediately notify the department of such person upon discovery of the conditions set forth in this paragraph or upon order of the department. The failure to remove such person, provide such notice, or comply with such order constitutes grounds for suspension or revocation of the provider-sponsored organization's certificate of authority.

(7) The entity has a blanket fidelity bond in the amount of $100,000, issued by a licensed insurance carrier in this state, which will reimburse the entity in the event that anyone handling the funds of the entity either misappropriates or absconds with the funds. All employees handling the funds shall be covered by the blanket fidelity bond. An agent licensed under the Florida Insurance Code may either directly or indirectly represent the provider-sponsored organization in the solicitation, negotiation, effectuation, procurement, receipt, delivery, or forwarding of any provider-sponsored organization subscriber's contract or collect or forward any consideration paid by the subscriber to the provider-sponsored

organization, and the licensed agent is not required to post the bond required by this subsection.

(8) The provider-sponsored organization has a grievance procedure that will facilitate the resolution of subscriber grievances and that includes both formal and informal steps available within the organization.

641.4610 Continued eligibility for certificate of authority.--In order to maintain its eligibility for a certificate of authority, a provider-sponsored organization must continue to meet all conditions required to be met under this part and the rules adopted under this part for the initial application for and issuance of its certificate of authority under s. 641.4609.

641.4611 Surplus requirements.--Surplus requirements for provider-sponsored organizations offering the Medicare Choice plan must be consistent with the federal rules on solvency standards established by the Secretary of the United States Department of Health and Human Services pursuant to s. 1856(a) of the Balanced Budget Act of 1997.

641.4612 Rehabilitation Administrative Expense Fund.--

(1) The department may not issue or permit to exist a certificate of authority to operate a provider-sponsored organization in this state unless the organization has deposited with the department $10,000 in cash for use in the Rehabilitation Administrative Expense Fund as established in s. 641.227.

(2) Upon successful rehabilitation of a provider-sponsored organization, the organization shall reimburse the fund for the amount of expenses incurred by the department during the court-ordered rehabilitation period.

(3) If a court of competent jurisdiction orders liquidation of a provider-sponsored organization, the fund shall be reimbursed for expenses incurred by the department as provided for in chapter 631.

(4) Each deposit made under this section shall be allowed as an asset for purposes of determining the financial condition of the provider-sponsored organization. The deposit shall be refunded to the organization only when the organization both ceases operation as a provider-sponsored organization and no longer holds a subsisting certificate of authority.

641.4613 Revocation or cancellation of certificate of authority; suspension of enrollment of new subscribers; terms of suspension.--

(1) The maintenance of a valid and current health care provider certificate issued pursuant to part IV is a condition of the maintenance of a valid and current certificate of authority issued by the department to operate a provider-sponsored organization. Denial or revocation of a health care provider certificate shall be deemed to be an automatic and immediate cancellation of a provider-sponsored organization's certificate of authority. At the discretion of the department, nonrenewal of a health care provider certificate may be deemed to be an automatic and immediate cancellation of a provider-sponsored organization's certificate of authority if the agency notifies the department, in writing, that the health care provider certificate will not be renewed.

(2) The department may suspend the authority of a provider-sponsored organization to enroll new subscribers or revoke any certificate issued to a provider-sponsored

organization, or order compliance within 30 days, if it finds that any of the following conditions exists:

(a) The organization is not operating in compliance with this part.

(b) The plan is no longer actuarially sound or the organization does not have the minimum surplus as required by rules governing provider-sponsored organizations established by the Secretary of United States Department of Health and Human Services pursuant to s. 1856(a) of the Balanced Budget Act of 1997.

(c) The organization has advertised, merchandised, or attempted to merchandise its services in such a manner as to misrepresent its service or capacity for service or has engaged in deceptive, misleading, or unfair practices with respect to advertising or merchandising.

(d) The organization is insolvent.

(3) Whenever the financial condition of the provider-sponsored organization is such that, if not modified or corrected, its continued operation would result in impairment or insolvency, the department may order the provider-sponsored organization to file with the department and implement a corrective-action plan designed to do one or more of the following:

(a) Reduce the total amount of present potential liability for benefits by reinsurance or other means.

(b) Reduce the volume of new business being accepted.

(c) Reduce the expenses of the provider-sponsored organization by specified methods.

(d) Suspend or limit the writing of new business for a period of time.

(e) Require an increase in the provider-sponsored organization's net worth which increase is not inconsistent with the standards established by the Secretary of the United States Department of Health and Human Services pursuant to s. 1856(a) of the Balanced Budget Act of 1997.

If the provider-sponsored organization fails to submit a plan within 30 days after the department's order or submits a plan that is insufficient to correct the provider-sponsored organization's financial condition, the department may order the provider-sponsored organization to implement one or more of the corrective actions listed in this subsection.

(4) The department shall, in its order suspending the authority of a provider-sponsored organization to enroll new subscribers, specify the period during which the suspension is to be in effect and the conditions, if any, which must be met by the provider-sponsored organization prior to reinstatement of its authority to enroll new subscribers. The order of suspension is subject to rescission or modification by further order of the department prior to the expiration of the suspension period. Reinstatement may not be made unless requested by the provider-sponsored organization. However, the department may not grant reinstatement if it finds that the circumstances for which the suspension occurred still exist or are likely to recur.

(5) The department shall calculate and publish at least annually the medical loss ratios of all licensed provider-sponsored organizations. The publication must include an explanation of what the medical loss ratio means and shall disclose that the medical loss ratio is not a direct measure

of quality but must be looked at along with patient satisfaction and other standards that define quality.

641.4614 Administrative, provider, and management contracts.--

(1) The department may require a provider-sponsored organization to submit to the department any contract for administrative services or contract-management services or any contract with an affiliated entity.

(2) After review of a contract, the department may order the provider-sponsored organization to cancel the contract in accordance with the terms of the contract and applicable law if it determines that the fees to be paid by the provider-sponsored organization under the contract are so unreasonably high as compared with similar contracts entered into by the provider-sponsored organization, or as compared with similar contracts entered into by other provider-sponsored organizations in similar circumstances, that the contract is detrimental to the subscribers, stockholders, investors, or creditors of the provider-sponsored organization.

(3) All contracts for administrative services, management services, and provider services, other than individual physician contracts and contracts with affiliated entities entered into or renewed by a provider-sponsored organization on or after October 1, 1998, must contain a provision that the contract shall be canceled upon issuance of an order by the department pursuant to this section.

641.4615 Contract providers.--Each provider-sponsored organization shall file, upon the request of the department, financial statements for all contract providers of comprehensive health care services who have assumed, through

capitation or other means, more than 10 percent of the health care risks of the provider-sponsored organization. However, this section does not apply to any individual physician.

641.4616 Administrative penalty in lieu of suspension or revocation.--If the department finds that one or more grounds exist for the revocation or suspension of a certificate issued under this part, the department may, in lieu of revocation or suspension, impose a fine upon the provider-sponsored organization. With respect to any nonwillful violation, the fine may not exceed $2,500 per violation. Such fines may not exceed an aggregate amount of $25,000 for all nonwillful violations arising out of the same action. With respect to any knowing and willful violation of a lawful order or rule of the department or a provision of this part, the department may impose upon the organization a fine in an amount not to exceed $20,000 for each such violation. Such fines may not exceed an aggregate amount of $250,000 for all knowing and willful violations arising out of the same action. The department shall adopt by rule by January 1, 1999, penalty categories that specify varying ranges of monetary fines for willful violations and for nonwillful violations.

641.4617 Acquisition, merger, or consolidation.--Each acquisition of a provider-sponsored organization is subject to s. 628.4615. However, in the case of a provider-sponsored organization organized as a for-profit corporation, s. 628.451 governs with respect to any merger or consolidation, and, in the case of a provider-sponsored organization organized as a not-for-profit corporation, s. 628.471 governs with respect to any merger or consolidation.

641.4618 Annual report.--

(1) Each provider-sponsored organization shall, annually within 3 months after the end of its fiscal year, or within an extension of time granted by the department for good cause, in a form prescribed by the department, file a report with the department, verified by the oath of two officers of the organization or, if not a corporation, of two persons who are principal managing directors of the affairs of the organization, properly notarized, showing its condition on the last day of the immediately preceding reporting period. The report must include:

(a) A financial statement of the organization filed on a computer diskette using a format acceptable to the department;

(b) A financial statement of the organization filed on forms acceptable to the department;

(c) An audited financial statement of the organization, including its balance sheet and a statement of operations for the preceding year certified by an independent certified public accountant, prepared in accordance with statutory accounting principles;

(d) The number of provider-sponsored contracts issued and outstanding and the number of provider-sponsored contracts terminated;

(e) The number and amount of damage claims for medical injury initiated against the provider-sponsored organization and any of the providers engaged by it during the reporting year, broken down into claims with and without formal legal process, and the disposition, if any, of each such claim;

(f) An actuarial certification that:

1. The provider-sponsored organization is actuarially sound, which certification shall consider the premiums,

benefits, and expenses of, and any other funds available for the payment of obligations of, the organization; and

2. Claims incurred but not reported and claims reported but not fully paid have been adequately provided for; and

(g) Any other information relating to the performance of provider-sponsored organizations which is required by the department.

(2) Each provider-sponsored organization shall file quarterly, within 45 days after each of its quarterly reporting periods, an unaudited financial statement of the organization as described in paragraphs (1)(a) and (b). The quarterly report shall be verified by the oath of two officers of the organization, properly notarized.

(3) Any provider-sponsored organization that neglects to file an annual report or quarterly report in the form and within the time required by this section shall forfeit up to $1,000 for each day for the first 10 days during which the neglect continues and shall forfeit up to $2,000 for each day after the first 10 days during which the neglect continues. Upon notice by the department, the organization's authority to enroll new subscribers or to do business in this state shall cease while such default continues. The department shall deposit all sums collected by it under this section to the credit of the Insurance Commissioner's Regulatory Trust Fund. The department may not collect more than $100,000 for each report.

(4) Each authorized provider-sponsored organization shall retain an independent certified public accountant, hereinafter referred to as a "CPA," who agrees by written

contract with the provider-sponsored organization to comply with this part. The contract must state:

(a) The CPA shall provide to the provider-sponsored organization audited financial statements consistent with this part.

(b) Any determination by the CPA that the provider-sponsored organization does not meet minimum surplus requirements as set forth in rules governing provider-sponsored organizations adopted by the United States Department of Health and Human Services pursuant to s. 1856(a) of the Balanced Budget Act of 1997 shall be stated by the CPA, in writing, in the audited financial statement.

(c) The completed work papers and any written communications between the CPA firm and the provider-sponsored organization which relate to the audit of the provider-sponsored organization shall be made available for review on a visual-inspection-only basis by the department at the offices of the provider-sponsored organization, at the department, or at any other reasonable place mutually agreed to between the department and the provider-sponsored organization. The CPA must retain the work papers and written communications for review for at least 6 years.

(5) To facilitate uniformity in financial statements and to facilitate department analysis, the department may by rule adopt the form for financial statements of a provider-sponsored organization, including supplements, as approved by the National Association of Insurance Commissioners in 1995, and may adopt subsequent amendments thereto if the methodology remains substantially consistent, and may by rule require each provider-sponsored organization to submit to the department all or part of the information

contained in the annual statement in a computer-readable form compatible with the electronic data processing system specified by the department.

641.4619 Examination by the department.--

(1) The department shall examine the affairs, transactions, accounts, business records, and assets of any provider-sponsored organization as often as it deems necessary for the protection of the Medicare beneficiaries of this state, but not less frequently than once every 3 years. In lieu of making its own financial examination, the department may accept an independent certified public accountant's audit report prepared on a statutory accounting basis consistent with this part. However, except when the medical records are requested and copies furnished pursuant to s. 455.667, medical records of individuals and records of physicians providing services under contract to the provider-sponsored organization are not subject to audit, although they may be subject to subpoena by court order upon a showing of good cause. For the purpose of examinations, the department may administer oaths to and examine the officers and agents of a provider-sponsored organization concerning its business and affairs. The examination of each provider-sponsored organization by the department is subject to the same terms and conditions that apply to insurers under chapter 624. Expenses of all examinations may not exceed a maximum of $20,000 for any 1-year period. Any rehabilitation, liquidation, conservation, or dissolution of a provider-sponsored organization shall be conducted under the supervision of the department, which shall have all powers with respect to the provider-sponsored organization granted to the department under the laws

governing the rehabilitation, liquidation, reorganization, conservation, or dissolution of life insurance companies.

(2) The department may contract, at reasonable fees for work performed, with qualified, impartial outside sources to perform audits or examinations or portions thereof pertaining to the qualification of an entity for issuance of a certificate of authority or to determine continued compliance with the requirements of this part. Any contracted assistance shall be under the direct supervision of the department. The results of any contracted assistance are subject to the review of, and approval, disapproval, or modification by, the department.

641.4620 Civil remedy.--In any civil action brought to enforce the terms and conditions of a provider-sponsored contract, the prevailing party may recover reasonable attorney's fees and court costs. This section does not authorize a civil action against the department, its employees, or the director of the agency.

641.4621 Injunction.--In addition to the penalties and other enforcement provisions of this part, the department is vested with the power to seek both temporary and permanent injunctive relief when:

(1) A provider-sponsored organization is being operated by any person or entity without a subsisting certificate of authority, unless a waiver has been granted by the Secretary of the United States Department of Health and Human Services pursuant to s. 1855(a)(2) of the Balanced Budget Act of 1997.

(2) Any person, entity, or provider-sponsored organization has engaged in any activity prohibited by this part or any rule adopted under this part.

(3) Any provider-sponsored organization, person, or entity is renewing, issuing, or delivering a provider-sponsored contract or contracts without a subsisting certificate of authority, unless a waiver has been granted by the Secretary of the United States Department of Health and Human Services under s. 1855(a)(2) of the Balanced Budget Act of 1997.

The department's authority to seek injunctive relief is not conditioned on the department conducting any proceeding pursuant to chapter 120.

641.4622 Payment of judgment by provider-sponsored organization.--Except as otherwise ordered by the court or mutually agreed-upon by the parties, each judgment or decree entered in any of the courts of this state against any provider-sponsored organization for the recovery of money shall be fully satisfied within 60 days after the entry thereof or, in the case of an appeal from such judgment or decree, within 60 days after the affirmance of the judgment or decree by the appellate court.

641.4623 Liquidation, rehabilitation, reorganization, and conservation; exclusive methods of remedy.--A delinquency proceeding under part I of chapter 631 or supervision by the department under ss. 624.80-624.87 constitute the sole and exclusive means of liquidating, reorganizing, rehabilitating, or conserving a provider-sponsored organization.

641.4624 Fees.--Each provider-sponsored organization shall pay to the department the following fees:

(1) For filing a copy of its application for a certificate of authority or amendment thereto, a nonrefundable fee in the amount of $1,000.

(2) For filing each annual report, which must be filed on computer diskettes, $150.

641.4625 Construction and relationship to other laws.--

(1) Each provider-sponsored organization shall accept the standard health claim form prescribed pursuant to s. 627.647.

(2) Except as provided in this part, the Florida Insurance Code does not apply to provider-sponsored organizations certificated under this part, and provider-sponsored organizations certificated under this part are not subject to part I or part II. Any person, entity, or provider-sponsored organization operating without a subsisting certificate of authority in violation of this part or rules adopted under this part, or renewing, issuing, or delivering provider-sponsored contracts without a subsisting certificate of authority in violation of this part or rules adopted under this part, in addition to being subject to the provisions of this part is subject to the provisions of the Florida Insurance Code as defined in s. 624.01, unless a waiver has been granted by the Secretary of the United States Department of Health and Human Services under s. 1855(a)(2) of the Balanced Budget Act of 1997.

(3) The solicitation of subscribers by a provider-sponsored organization or its representatives does not violate any provisions of law relating to solicitation or advertising by health professionals if the provider-sponsored organization is operating pursuant to a subsisting certificate of authority or operating pursuant to a waiver granted by the Secretary of the United States Department of Health and Human

Services under s. 1855(a)(2) of the Balanced Budget Act of 1997.

(4) The Division of Insurance Fraud of the department is vested with all powers granted to it under the Florida Insurance Code with respect to investigating any violation of this part.

(5) Each provider-sponsored organization must comply with s. 627.4301.

641.4626 Human immunodeficiency virus infection and acquired immune deficiency syndrome for contract purposes.--

(1) PURPOSE.--The purpose of this section is to prohibit unfair practices in a provider-sponsored contract with respect to exposure to the human immunodeficiency virus infection and related matters, and thereby to reduce the possibility that a provider-sponsored organization subscriber or applicant may suffer unfair discrimination when subscribing to or applying for the contractual services of a provider-sponsored organization.

(2) SCOPE.--This section applies to all provider-sponsored contracts that are issued in this state or that are issued outside this state but cover residents of this state to the extent that the provisions of this section are not inconsistent with the rules established by the Secretary of the United States Department of Health and Human Services for the Medicare Choice program. This section does not prohibit a provider-sponsored organization from contesting a contract or claim to the extent allowed by law.

(3) DEFINITIONS.--As used in this section, the term:

(a) "AIDS" means acquired immune deficiency syndrome.

(b) "ARC" means AIDS-related complex.

(c) "HIV" means human immunodeficiency virus identified as the causative agent of AIDS.

(4) USE OF MEDICAL TESTS.--

(a) With respect to the issuance of or the underwriting of a provider-sponsored contract regarding exposure to the HIV infection and sickness or medical conditions derived from such infection, a provider-sponsored organization may use only medical tests that are reliable predictors of risk. A test that is recommended by the Centers for Disease Control or by the federal Food and Drug Administration is deemed to be reliable for the purposes of this section. A test that is rejected or not recommended by the Centers for Disease Control or the federal Food and Drug Administration is not a reliable test for the purposes of this section. If a specific test recommended by the Centers for Disease Control or by the federal Food and Drug Administration indicates the existence or potential existence of exposure to the HIV infection or a sickness or medical condition related to the HIV infection, before relying on a single test result to deny or limit coverage or to rate the coverage the provider-sponsored organization shall follow the applicable test protocol recommended by the Centers for Disease Control or by the federal Food and Drug Administration and shall use any applicable followup tests or series of tests that are recommended by the Centers for Disease Control or by the federal Food and Drug Administration to confirm the indication.

(b) Prior to testing, the provider-sponsored organization must disclose its intent to test the person for the HIV infection or for a specific sickness or medical condition derived therefrom and must obtain the person's

written informed consent to administer the test. Written informed consent includes a fair explanation of the test, including its purpose, potential uses, and limitations, and the meaning of its results and the right to confidential treatment of information. Use of a form approved by the department raises a conclusive presumption of informed consent.

(c) An applicant shall be notified of a positive test result by a physician designated by the applicant or, in the absence of such designation, by the Department of Health. Such notification must include:

1. Face-to-face posttest counseling on the meaning of the test results, the possible need for additional testing, and the need to eliminate behavior that might spread the disease to others.

2. The availability in the geographic area of any appropriate health care services, including mental health care, and appropriate social and support services.

3. The benefits of locating and counseling any individual by whom the infected individual may have been exposed to human immunodeficiency virus and any individual whom the infected individual may have exposed to the virus.

4. The availability, if any, of the services of public health authorities with respect to locating and counseling any individual described in subparagraph 3.

(d) A medical test for exposure to the HIV infection or for a sickness or medical condition derived from such infection shall only be required of or given to a person if the test is required or given to all subscribers or applicants or if the decision to require the test is based on the person's medical history.

(e) A provider-sponsored organization may inquire whether a person has been tested positive for exposure to the HIV infection or diagnosed as having AIDS or ARC caused by the HIV infection or other sickness or medical condition derived from such infection. A provider-sponsored organization may not inquire whether a person has been tested for or has received a negative result from a specific test for exposure to the HIV infection or for a sickness or medical condition derived from such infection.

(f) A provider-sponsored organization shall maintain strict confidentiality concerning any medical test results with respect to an HIV infection or a specific sickness or medical condition derived from such infection. Information regarding specific test results may not be disclosed outside the provider-sponsored organization, its employees, its marketing representatives, or its insurance affiliates, except to the person tested and to persons designated in writing by the person tested. Specific test results may not be furnished to any data bank of the insurance industry or provider-sponsored organization if a review of the information would identify the individual tested or the specific test results.

(g) An insurer or insurance support organization may not use a laboratory for processing HIV-related tests unless the laboratory is certified by the United States Department of Health and Human Services under the Clinical Laboratories Improvement Act of 1967, permitting testing of specimens obtained in interstate commerce, and unless the laboratory subjects itself to ongoing proficiency testing by the College of American Pathologists, the American Association of Bio Analysts, or an equivalent program approved by the Centers for

Disease Control of the United States Department of Health and Human Services.

(5) RESTRICTIONS ON CONTRACT EXCLUSIONS AND LIMITATIONS.--

(a) A provider-sponsored contract may not exclude coverage of an individual because of a positive test result for exposure to the HIV infection or a specific sickness or medical condition derived from such infection, either as a condition for or subsequent to the issuance of the contract. However, this paragraph does not apply to a person who applies for enrollment if individual underwriting is otherwise allowed by law.

(b) A provider-sponsored contract may not exclude or limit coverage for exposure to the HIV infection or a specific sickness or medical condition derived from such infection, except as provided in a preexisting condition clause.

641.4627 Language used in contracts and advertisements; translations.--

(1)(a) Each contract or form used by a provider-sponsored organization must be printed in English.

(b) If the negotiations by a provider-sponsored organization with a member leading up to the effectuation of a provider-sponsored contract are conducted in a language other than English, the provider-sponsored organization shall supply to the member a written translation of the contract, which translation accurately reflects the substance of the contract and is in the language used to negotiate the contract. The written translation must be affixed to and shall become a part of the contract or form.

(2) The text of each advertisement by a provider-sponsored organization, if printed or broadcast in a

language other than English, shall also be available in English and shall be furnished to the department upon request. As used in this subsection, the term "advertisement" means any advertisement, circular, pamphlet, brochure, or other printed material that discloses or disseminates advertising material or information by a provider-sponsored organization to prospective or existing subscribers and includes any radio or television transmittal of an advertisement or information.

641.4628 Standards for marketing to persons eligible for Medicare.--

(1) Each provider-sponsored organization that markets its coverage to Medicare participants or persons eligible for Medicare in this state, directly or through its agents, shall:

(a) Establish marketing procedures to assure that any comparison of benefits between Medicare or any other provider-sponsored organization that offers such coverage by its agents will be fair and accurate.

(b) Establish marketing procedures to assure proper notification to the Medicare participant of enrollment or disenrollment from the provider-sponsored organization. Such notification shall be made in a timely manner.

(c) Display prominently by type, stamp, or other appropriate means, on the first page of the application and contract, the following:

"Notice to buyer: When you enroll in this provider-sponsored organization, you will be disenrolled from Medicare. The buyer should be aware that in order to receive payment or coverage for services, such services must be rendered by physicians, hospitals, and other health care providers designated by the

provider-sponsored organization. If the services are rendered by a nonparticipating physician, hospital, or other health care provider, the purchaser may be liable for payment for such services except in very limited circumstances."

(d) Inquire and otherwise make every reasonable effort to identify whether a prospective Medicare participant has previously been enrolled in either the same provider-sponsored organization as a Medicare participant or in another provider-sponsored organization as a Medicare participant.

(2) In addition to the practices prohibited in s. 641.4642:

(a) A provider-sponsored organization or a person who represents such provider-sponsored organization may not employ any method of marketing which has the effect of or tends to induce the purchase of health care plans through fraud, deceit, force, fright, threat whether explicit or implied, intimidation, harassment, or undue pressure to purchase or recommend the purchase of a provider-sponsored contract.

(b) A participating provider, employee, or agent of such participating provider may not be an agent for or conduct any sales activities for a provider-sponsored organization with whom the provider, employee, or agent has a provider contract.

641.4629 Provider-sponsored contracts.--

(1) Any entity issued a certificate and otherwise in compliance with this part may enter into contracts in this state to provide Medicare Choice benefits to subscribers in exchange for a premium payment. Each subscriber shall be given a copy of the applicable provider-sponsored contract,

certificate, or member handbook. Whichever document is provided to a subscriber must contain all of the provisions and disclosures required by this section.

(2) Each provider-sponsored contract, certificate, or member handbook must clearly state all of the services to which a subscriber is entitled under the Medicare Choice contract and must include a clear and understandable statement of any limitations on the services or kinds of services to be provided, including any copayment feature or schedule of benefits required by the contract. The contract, certificate, or member handbook must also state where and in what manner the comprehensive health care services may be obtained.

(3) Each subscriber shall receive a clear and understandable description of the method of the provider-sponsored organization for resolving subscriber grievances, and the method must be set forth in the contract, certificate, or member handbook. The organization shall also furnish, at the time of initial enrollment and when necessary due to substantial changes in the grievance process, a separate and additional communication notifying each Medicare Choice subscriber of his or her rights and responsibilities under the grievance process.

(4) A provider-sponsored organization may coordinate benefits on the same basis as an insurer under s. 627.4235.

(5) A provider-sponsored organization that provides medical benefits or payments to a subscriber who suffers injury, disease, or illness by virtue of the negligent act or omission of a third party is entitled to reimbursement from the subscriber in accordance with s. 768.76(4).

(6) A person other than the applicant may not alter any written application for any provider-sponsored contract

without the applicant's written consent, except that insertions may be made by the provider-sponsored organization, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

(7) A contract may not contain any waiver of rights or benefits provided to or available to subscribers under the provisions of any law or rule applicable to provider-sponsored organizations.

(8) Each Medicare Choice contract, certificate, or member handbook must state that emergency services and care shall be provided without prior notification to and approval of the organization to subscribers in emergency situations that do not permit treatment through the provider-sponsored organization's providers. Not less than 75 percent of the reasonable charges for covered services and supplies shall be paid by the organization, up to the subscriber contract benefit limits. Payment also may be subject to additional applicable copayment provisions, not to exceed $100 per claim, if not inconsistent with federal rules established by the Secretary of the United States Department of Health and Human Services governing Medicare Choice benefits. The Medicare Choice contract, certificate, or member handbook must define the terms "emergency services and care" and "emergency medical condition" as specified in s. 641.4603(6) and (7), must describe the procedures by which the provider-sponsored organization determines whether the services qualify for reimbursement as emergency services and care, and must contain specific examples of what constitutes an emergency. In providing for emergency services and care as a covered

service, a provider-sponsored organization shall be governed by s. 641.513.

(9) In addition to the requirements of this section, and if not inconsistent with the rules established by the Secretary of the United States Department of Health and Human Services for the Medicare Choice program, with respect to a person who is entitled to have payments for health care costs made under Medicare, Title XVIII of the Social Security Act, parts A or B:

(a) The provider-sponsored organization shall mail or deliver notification to the Medicare beneficiary of the date of enrollment in the provider-sponsored organization within 10 days after receiving notification of enrollment approval from the Health Care Financing Administration. When a Medicare beneficiary who is a subscriber of the provider-sponsored organization requests disenrollment from the organization, the organization shall mail or deliver to the beneficiary notice of the effective date of the disenrollment within 10 days after receipt of the written disenrollment request. The provider-sponsored organization shall forward the disenrollment request to the Health Care Financing Administration in a timely manner so as to effectuate the next available disenrollment date, as prescribed by the federal agency.

(b) The provider-sponsored contract, certificate, or member handbook shall be delivered to the subscriber no later than the earlier of 10 working days after the provider-sponsored organization and the Health Care Financing Administration approve the subscriber's enrollment application or the effective date of coverage of the subscriber under the provider-sponsored contract. However, if notice from the

Health Care Financing Administration of its approval of the subscriber's enrollment application is received by the provider-sponsored organization after the effective coverage date prescribed by the Health Care Financing Administration, the provider-sponsored organization shall deliver the contract, certificate, or member handbook to the subscriber within 10 days after receiving such notice. When a Medicare recipient is enrolled in a provider-sponsored organization program, the contract, certificate, or member handbook shall be accompanied by an identification sticker with instruction to the Medicare beneficiary to place the sticker on the Medicare identification card.

(10) Each provider-sponsored organization that provides for inpatient and outpatient services by allopathic hospitals shall provide, as an option of the subscriber, similar inpatient and outpatient services by hospitals accredited by the American Osteopathic Association when such services are available in the same service area of the provider-sponsored organization and the osteopathic hospital agrees to provide the services specified in this part. As a condition precedent to providing osteopathic inpatient and outpatient services through an osteopathic hospital that has not entered into a written contract with the provider-sponsored organization, the provider-sponsored organization may require the subscriber who receives osteopathic services to release the provider-sponsored organization from any liability arising from any act of omission or commission constituting malpractice in the delivery of osteopathic care from that hospital. The osteopathic hospital that provides the inpatient and outpatient services for the provider-sponsored organization

shall charge rates that do not exceed the osteopathic hospital's usual and customary rates, less the average discount provided by allopathic hospitals providing the services in the same service area of the provider-sponsored organization.

(11) To the extent that this section is not inconsistent, pursuant to s. 1856(b)(3) of the Balanced Budget Act of 1997, with the rules established by the Secretary of the United States Department of Health and Human Services for the Medicare Choice program:

(a) A provider-sponsored contract that provides coverage, benefits, or services for breast cancer treatment may not limit inpatient hospital coverage for mastectomies to any period that is less than that determined by the treating physician under contract with the provider-sponsored organization to be medically necessary in accordance with prevailing medical standards and after consultation with the covered patient. Such contract must also provide coverage for outpatient postsurgical followup care in keeping with prevailing medical standards by a licensed health care professional under contract with the provider-sponsored organization qualified to provide postsurgical mastectomy care. The treating physician under contract with the provider-sponsored organization, after consultation with the covered patient, may choose that the outpatient care be provided at the most medically appropriate setting, which may include the hospital, treating physician's office, outpatient center, or home of the covered patient.

(b) A provider-sponsored organization subject to this subsection may not:

1. Deny to a covered person eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the contract for the purpose of avoiding the requirements of this subsection;

2. Provide monetary payments or rebates to a covered patient to accept less than the minimum protections available under this subsection;

3. Penalize or otherwise reduce or limit the reimbursement of an attending provider solely because the attending provider provided care to a covered patient under this subsection;

4. Provide incentives, monetary or otherwise, to an attending provider solely to induce the provider to provide care to a covered patient in a manner inconsistent with this subsection; or

5. Subject to the other provisions of this subsection, restrict benefits for any portion of a period within a hospital length of stay or for outpatient care as required by this subsection in a manner that is less favorable than the benefits provided for any preceding portion of such stay or for preceding outpatient care.

(c)1. This subsection does not require a covered patient to have the mastectomy in the hospital or stay in the hospital for a fixed period of time following the mastectomy.

2. This subsection does not prevent a contract from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits pursuant to this subsection, except that such cost-sharing may not exceed cost-sharing with other benefits.

(d) Except as provided in paragraph (b), this subsection does not affect any agreement between a

provider-sponsored organization and a hospital or other health care provider with respect to reimbursement for health care services provided, rate negotiations with providers, or capitation of providers, and does not prohibit appropriate utilization review or case management by the provider-sponsored organization.

(e) As used in this subsection, the term "mastectomy" means the removal of all or part of the breast for medically necessary reasons as determined by a licensed physician.

(12) To the extent that this section is not inconsistent, pursuant to s. 1856(b)(3) of the Balanced Budget Act of 1997, with the rules established by the Secretary of the United States Department of Health and Human Services for the Medicare Choice program, a provider-sponsored contract that provides coverage for mastectomies must also provide coverage for prosthetic devices and breast reconstructive surgery incident to the mastectomy. As used in this subsection, the term "breast reconstructive surgery" means surgery to reestablish symmetry between the two breasts. Such surgery must be in a manner chosen by the treating physician under contract with the provider-sponsored organization, consistent with prevailing medical standards, and in consultation with the patient. The provider-sponsored organization may charge an appropriate additional premium for the coverage required by this subsection. The coverage for prosthetic devices and breast reconstructive surgery is subject to any deductible and coinsurance conditions.

641.4630 Provider-sponsored organization; disclosure of terms and conditions of plan.--Each provider-sponsored organization shall provide prospective enrollees with written information about the terms and conditions of the plan so that

the prospective enrollees can make informed decisions about accepting a managed-care system of health care delivery. However, information about where, in what manner, and from whom the comprehensive health care services or specific health care services can be obtained need be disclosed only upon request by the prospective enrollee. All marketing materials distributed by the provider-sponsored organization must contain a notice in boldfaced type which states that the information required under this section is available to the prospective enrollee upon request.

641.4631 Coverage for mammograms.--

(1) To the extent that this section is not inconsistent, pursuant to s.1856(b)(3) of the Balanced Budget Act of 1997, with the rules established by the Secretary of the United States Department of Health and Human Services for the Medicare Choice program, each provider-sponsored contract issued or renewed on or after October 1, 1998, must provide coverage for at least the following:

(a) A baseline mammogram for any woman who is 35 years of age or older, but younger than 40 years of age.

(b) A mammogram every 2 years for any woman who is 40 years of age or older, but younger than 50 years of age, or more frequently based on the patient's physician's recommendations.

(c) A mammogram every year for any woman who is 50 years of age or older.

(d) One or more mammograms a year, based upon a physician's recommendation for any woman who is at risk for breast cancer because of a personal or family history of breast cancer; because of having a history of biopsy-proven benign breast disease; because of having a mother, sister, or

daughter who has had breast cancer; or because a woman has not given birth before the age of 30.

(2) The coverage required by this section is subject to the deductible and copayment provisions applicable to outpatient visits, and is also subject to all other terms and conditions applicable to other benefits. A provider-sponsored organization shall make available to the subscriber as part of the application, for an appropriate additional premium, the coverage required in this section without such coverage being subject to any deductible or copayment provisions in the contract.

641.4632 Requirements with respect to breast cancer and routine followup care.--To the extent that this section is not inconsistent, pursuant to s. 1856(b)(3) of the Balanced Budget Act of 1997, with the rules established by the Secretary of the United States Department of Health and Human Services for the Medicare Choice program, routine followup care to determine whether a breast cancer has recurred in a person who has been previously determined to be free of breast cancer does not constitute medical advice, diagnosis, care, or treatment for purposes of determining preexisting conditions unless evidence of breast cancer is found during or as a result of the followup care.

641.4633 Provider contracts.--

(1) Whenever a contract exists between a provider-sponsored organization and a provider, and the organization fails to meet its obligations to pay fees for services already rendered to a subscriber, the provider-sponsored organization is liable for such fee or fees rather than the subscriber, and the contract must so state.

(2) A subscriber of a provider-sponsored organization is not liable to any provider of health care services for any services covered by the provider-sponsored organization.

(3) A provider of services or any representative of such provider may not collect or attempt to collect from a subscriber any money for services covered by the provider-sponsored organization and a provider or representative of such provider may not maintain any action at law against a subscriber to collect money owed to such provider by the provider-sponsored organization.

(4) Each contract between a provider-sponsored organization and a provider of health care services must be in writing and contain a provision that the subscriber is not liable to the provider for any services covered by the subscriber's contract with the provider-sponsored organization.

(5) This section does not apply to the amount of any deductible or copayment which is not covered by the contract of the provider-sponsored organization.

(6)(a) Each provider contract must specify that:

1. The provider shall provide 60 days' advance written notice to the provider-sponsored organization and the department before canceling the contract with the provider-sponsored organization for any reason; and

2. Nonpayment for goods or services rendered by the provider to the provider-sponsored organization is not a valid reason for avoiding the 60-day advance notice of cancellation.

(b) Each contract must specify that the provider-sponsored organization will provide 60 days' advance written notice to the provider and the department before canceling, without cause, the contract with the provider,

except in a case in which a patient's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action by the Board of Medicine or other governmental agency.

(7) Upon receipt by the provider-sponsored organization of a 60-day cancellation notice, the provider-sponsored organization may, if requested by the provider, terminate the contract in less than 60 days if the provider-sponsored organization is not financially impaired or insolvent.

(8) A contract between a provider-sponsored organization and a provider of health care services may not contain any provision that restricts the provider's ability to communicate information to the provider's patient regarding medical care or treatment options for the patient when the provider deems knowledge of such information by the patient to be in the best interest of the health of the patient.

641.4634 Certain words prohibited in name of organization.--

(1) An entity certificated as a provider-sponsored organization, other than a licensed insurer insofar as its name is concerned, may not use in its name, contracts, or literature any of the words "insurance," "casualty," "surety," or "mutual," or any other words descriptive of the insurance, casualty, or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in the state.

(2) A person, entity, or health care plan that is not certificated under this part may not use in its name, logo, contracts, or literature the phrase "provider-sponsored organization" or the initials "PSO"; imply, directly or

indirectly, that it is a provider-sponsored organization; or hold itself out to be a provider-sponsored organization.

641.4635 Assets, liabilities, and investments.--Assets, liabilities, and investments for provider-sponsored organizations that offer the Medicare Choice plan must be consistent with the federal rules on solvency standards established by the Secretary of the United States Department of Health and Human Services pursuant to s. 1856(a) of the Balanced Budget Act of 1997.

641.4636 Adoption of rules; penalty for violation.--The department shall adopt rules necessary to carry out the provisions of this part which must be consistent with the federal rules for the Medicare Choice plan established by the Secretary of the United States Department of Health and Human Services pursuant to the Balanced Budget Act of 1997. An entity that violates a rule adopted under this section is subject to s. 641.4613.

641.4637 Dividends.--

(1) A provider-sponsored organization may not pay any dividend or distribute cash or other property to stockholders except out of that part of its available and accumulated surplus funds which is derived from realized net operating profits on its business and net realized capital gains. Dividend payments or distributions to stockholders may not exceed 10 percent of such surplus in any one year unless otherwise approved by the department. In addition to such limited payments, a provider-sponsored organization may make dividend payments or distributions out of the organization's entire net operating profits and realized net capital gains derived during the immediately preceding calendar or fiscal year, as applicable.

(2) The department may not approve a dividend or distribution in excess of the maximum amount allowed in subsection (1) unless it determines that the distribution or dividend does not jeopardize the financial condition of the provider-sponsored organization.

(3) Any director of a provider-sponsored organization who knowingly votes for or concurs in the declaration or payment of a dividend to stockholders when such declaration or payment violates this section commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083, and is jointly and severally liable, together with other such directors likewise voting for or concurring, for any loss thereby sustained by creditors of the provider-sponsored organization to the extent of such dividend.

(4) Any stockholder who receives such an illegal dividend is liable in the amount thereof to the provider-sponsored organization.

(5) The department may revoke or suspend the certificate of authority of a provider-sponsored organization that has declared or paid an illegal dividend.

641.4638 Prohibited activities; penalties.--

(1) Any person or entity that knowingly renews, issues, or delivers any provider-sponsored contract without first obtaining and thereafter maintaining a certificate of authority, unless a waiver has been granted by the Secretary of the United States Department of Health and Human Services pursuant to s. 1855(a)(2) of the Balanced Budget Act of 1997, commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(2) Except as provided in subsection (1), any person, entity, or provider-sponsored organization that knowingly violates this part commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(3) Any agent or representative, solicitor, examining physician, applicant, or other person who knowingly makes any false and fraudulent statement or representation in, or with reference to, any application or negotiation for coverage by a provider-sponsored organization, in addition to any other penalty provided by law, commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(4) Any agent, representative, solicitor, collector, or other person who, while acting on behalf of a provider-sponsored organization, receives or collects its funds or premium payments and fails to satisfactorily account for or turn over, when required, all such funds or payments, in addition to the other penalties provided for by law, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(5) Any person who, without authority granted by a provider-sponsored organization, collects or secures cash advances, premium payments, or other funds owing to the provider-sponsored organization or otherwise conducts the business of a provider-sponsored organization without its authority, in addition to the other penalties provided for by law, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

641.4639 Order to discontinue certain advertising.--If, in the opinion of the department, any advertisement by a provider-sponsored organization violates this part, the department may enter an immediate order

requiring that the use of the advertisement be discontinued. If requested by the provider-sponsored organization, the department shall conduct a hearing within 10 days after the entry of such order. If, after the hearing or by agreement with the provider-sponsored organization, a final determination is made that the advertising did in fact violate this part, the department may, in lieu of revoking the certificate of authority, require the organization to publish a corrective advertisement, impose an administrative penalty of up to $10,000, and, in the case of an initial solicitation, require that the provider-sponsored organization, prior to accepting any application received in response to the advertisement, provide an acceptable clarification of the advertisement to each individual applicant.

641.4640 Agent licensing and appointment required; exceptions.--

(1) With respect to a provider-sponsored contract, a person may not, unless licensed and appointed as a health insurance agent in accordance with the applicable provisions of the Florida Insurance Code:

(a) Solicit contracts or procure applications; or

(b) Engage or hold himself or herself out as engaging in the business of analyzing or abstracting provider-sponsored contracts or of counseling, advising, or giving opinions to persons relative to such contracts other than as a consulting actuary advising a provider-sponsored organization or as a salaried and bona fide full-time employee so counseling and advising his or her employer relative to coverage for the employer and his or her employees.

(2) All qualifications, disciplinary provisions, licensing and appointment procedures, fees, and related

matters contained in the Florida Insurance Code which apply to the licensing and appointment of health insurance agents by insurers apply to provider-sponsored organizations and to persons licensed or appointed by the provider-sponsored organization as its agents.

(3) An examination, license, or appointment is not required of any regular salaried officer or employee of a provider-sponsored organization who devotes substantially all of his or her services to activities other than the solicitation of provider-sponsored contracts from the public and who does not receive a commission or other compensation that is directly dependent upon the solicitation of such contracts.

(4) Each agent and provider-sponsored organization must comply with and be subject to the applicable provisions of ss. 409.912(18) and 641.4640, and each company or entity that appoints agents must comply with s. 626.451 when marketing for any provider-sponsored organization licensed under this part.

641.4641 Unfair methods of competition and unfair or deceptive acts or practices prohibited.--A person, entity, or provider-sponsored organization may not engage in this state in any trade practice that is defined in this part as, or determined pursuant to s. 641.4643 to be, an unfair method of competition or an unfair or deceptive act or practice that involves the business of a provider-sponsored organization.

641.4642 Unfair methods of competition and unfair or deceptive acts or practices defined.--The following acts are unfair methods of competition and unfair or deceptive acts or practices:

(1) MISREPRESENTATION AND FALSE ADVERTISING OF PROVIDER-SPONSORED CONTRACTS.--Knowingly making, issuing, or circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison that:

(a) Misrepresents the benefits, advantages, conditions, or terms of any provider-sponsored contract.

(b) Is misleading or is a misrepresentation as to the financial condition of any person.

(c) Uses any name or title of any contract which misrepresents the true nature of the contract.

(d) Is a misrepresentation for the purpose of inducing, or tending to induce, the lapse, forfeiture, exchange, conversion, or surrender of any provider-sponsored contract under the Medicare Choice program.

(e) Misrepresents the benefits, nature, characteristics, uses, standard, quantity, quality, cost, rate, scope, source, or geographic origin or location of any goods or services available from or provided by, directly or indirectly, any provider-sponsored organization.

(f) Misrepresents the affiliation, connection, or association of any goods, services, or business establishment.

(g) Advertises goods or services with intent not to sell them as advertised.

(h) Disparages the goods, services, or business of another person by any false or misleading representation.

(i) Misrepresents the sponsorship, endorsement, approval, or certification of goods or services.

(j) Uses an advertising format that, by virtue of the design, location, or size of printed matter, is deceptive or

misleading or that would be deceptive or misleading to any reasonable person.

(k) Offers to provide a service that the provider-sponsored organization is unable to provide.

(l) Misrepresents the availability of a service provided by the provider-sponsored organization, either directly or indirectly, including the availability of the service as to location.

(2) FALSE INFORMATION AND ADVERTISING GENERALLY.--Knowingly making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public:

(a) In a newspaper, magazine, or other publication;

(b) In the form of a notice, circular, pamphlet, letter, or poster;

(c) Over any radio or television station; or

(d) In any other way,

an advertisement, announcement, or statement that contains any assertion, representation, or statement with respect to the business of the provider-sponsored organization which is untrue, deceptive, or misleading.

(3) DEFAMATION.--Knowingly making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of, any oral or written statement, or any pamphlet, circular, article, or literature, that is false or maliciously critical of any person and that is calculated to injure such person.

(4) FALSE STATEMENTS AND ENTRIES.--

(a) Knowingly:

1. Filing with any supervisory or other public official;

2. Making, publishing, disseminating, or circulating;

3. Delivering to any person;

4. Placing before the public; or

5. Causing, directly or indirectly, to be made, published, disseminated, circulated, or delivered to any person, or place before the public,

any material false statement.

(b) Knowingly making any false entry of a material fact in any book, report, or statement of any person.

(5) UNFAIR CLAIM-SETTLEMENT PRACTICES.--

(a) Attempting to settle claims on the basis of an application or any other material document that was altered without notice to, or knowledge or consent of, the subscriber or group of subscribers to a provider-sponsored organization.

(b) Making a material misrepresentation to the subscriber for the purpose and with the intent of effecting settlement of claims, loss, or damage under a provider-sponsored contract on less favorable terms than those provided in, and contemplated by, the contract.

(c) Committing or performing with such frequency as to indicate a general business practice any of the following:

1. Failing to adopt and implement standards for the proper investigation of claims.

2. Misrepresenting pertinent facts or contract provisions relating to coverage at issue.

3. Failing to acknowledge and act promptly upon communications with respect to claims.

4. Denying of claims without conducting reasonable investigations based upon available information.

5. Failing to affirm or deny coverage of claims upon written request of the subscriber within a reasonable time, which may not exceed 30 days after a claim or proof-of-loss statements have been completed and documents pertinent to the claim have been requested in a timely manner and received by the provider-sponsored organization.

6. Failing to promptly provide a reasonable explanation in writing to the subscriber of the basis in the provider-sponsored contract which relates to the facts or applicable law for denying a claim or offering a compromise settlement.

7. Failing to provide, upon written request of a subscriber, an itemized statement verifying that services and supplies were furnished, if such statement is necessary for submitting other insurance claims covered by individual specified disease or limited benefit policies. However the organization may charge a reasonable fee to cover the cost of preparing such statement.

8. Failing to provide any subscriber with services, care, or treatment contracted-for pursuant to any provider-sponsored contract without a reasonable basis for believing that a legitimate defense exists for not providing such services, care, or treatment. To the extent that a national disaster, war, riot, civil insurrection, epidemic, or any other emergency or similar event not within the control of the provider-sponsored organization results in the inability of the facilities, personnel, or financial resources of the provider-sponsored organization to provide or arrange for provision of a health service in accordance with requirements

of this part, the provider-sponsored organization is required only to make a good-faith effort to provide or arrange for provision of the service, taking into account the impact of the event. For the purposes of this paragraph, an event is not within the control of the provider-sponsored organization if the provider-sponsored organization cannot exercise influence or dominion over its occurrence.

(6) FAILURE TO MAINTAIN COMPLAINT-HANDLING PROCEDURES.--Failure of any person to maintain a complete record of all the complaints received since the date of the most recent examination of the provider-sponsored organization by the department. For the purposes of this subsection, the term "complaint" means any written communication primarily expressing a grievance and requesting a remedy to the grievance.

(7) OPERATING WITHOUT A SUBSISTING CERTIFICATE OF AUTHORITY.--Operating a provider-sponsored organization by any person or entity without a subsisting certificate of authority or renewal, issuance, or delivery of any provider-sponsored contract by a provider-sponsored organization, person, or entity without a subsisting certificate of authority, unless a waiver has been granted by the Secretary of the United States Department of Health and Human Services under s. 1855(a)(2) of the Balanced Budget Act of 1997.

(8) MISREPRESENTATION IN PROVIDER-SPONSORED ORGANIZATION APPLICATIONS.--Knowingly making false or fraudulent statements or representations on, or relative to, an application for a provider-sponsored contract for the purpose of obtaining a fee, commission, money, or other benefits from any agent, representative, or broker of a provider-sponsored organization or any individual.

(9) TWISTING.--Knowingly making any misleading representations or incomplete or fraudulent comparisons of any provider-sponsored contracts or provider-sponsored organizations or of any insurance policies or insurers for the purpose of inducing, or intending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or provider-sponsored contract or to take out a provider-sponsored contract or policy of insurance in another provider-sponsored organization or insurer.

(10) ILLEGAL DEALINGS IN PREMIUMS; EXCESS OR REDUCED CHARGES FOR PROVIDER-SPONSORED COVERAGE.--

(a) Knowingly collecting any sum as a premium or charge for provider-sponsored coverage that is not then provided or is not in due course to be provided, subject to acceptance of the risk by the provider-sponsored organization, by a provider-sponsored contract issued by a provider-sponsored organization as permitted by this part.

(b) Knowingly collecting as a premium or charge for provider-sponsored coverage any sum in excess of or less than the premium or charge applicable to provider-sponsored coverage.

(11) FALSE CLAIMS; OBTAINING OR RETAINING MONEY DISHONESTLY.--Knowingly presenting or causing to be presented to any provider-sponsored organization, by any agent or representative, physician, claimant, or other person, a false claim for payment.

(12) PROHIBITED DISCRIMINATORY PRACTICES.--Refusing to provide services or care to a subscriber solely because medical services may be or have been sought for injuries resulting from an assault, battery, sexual assault, sexual

battery, or any other offense by a family or household member, as defined in s. 741.28(2), or by another who is or was residing in the same dwelling unit.

(13) MISREPRESENTATION IN PROVIDER-SPONSORED ORGANIZATION; AVAILABILITY OF PROVIDERS.--Knowingly misleading a potential enrollee as to the availability of providers.

641.4643 General powers and duties of the department.--In addition to the powers and duties set forth in s. 624.307, the department may examine and investigate the affairs of every person, entity, or provider-sponsored organization in order to determine whether the person, entity, or provider-sponsored organization is operating in accordance with this part or has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by s. 641.4641.

641.4644 Defined unfair practices; hearings, witnesses, appearances, production of books, and service of process.--

(1) Whenever the department has reason to believe that any person, entity, or provider-sponsored organization has engaged, or is engaging, in this state in any unfair method of competition or any unfair or deceptive act or practice as defined in s. 461.4642 or is operating a provider-sponsored organization without a certificate of authority as required by this part, unless a waiver has been granted by the Secretary of the United States Department of Health and Human Services under s. 1855(a)(2) of the Balanced Budget Act of 1997, and that a proceeding by the department with respect to any such activity would be in the interest of the public, the department shall conduct or cause to have conducted a hearing in accordance with chapter 120.

(2) The department, a duly empowered hearing officer, or an administrative law judge shall, during the conduct of such hearing, have those powers enumerated in s. 120.569. However, the penalty for failing to comply with a subpoena or with an order directing discovery is limited to a fine not to exceed $1,000 per violation.

(3) Statements of charges, notices, and orders under this part may be served by anyone duly authorized by the department, either in the manner provided by law for service of process in civil actions or by certifying and mailing a copy thereof to the person, entity, or provider-sponsored organization affected by the statement, notice, order, or other process at her or his or its residence or principal office or place of business. The verified return by the person so serving such statement, notice, order, or other process, setting forth the manner of the service, is proof of service, and the return postcard receipt for such statement, notice, order, or other process, certified and mailed as required, is proof of service.

641.4645 Cease and desist and penalty orders.--After the hearing provided in s. 641.4644, the department shall enter a final order in accordance with s. 120.569. If it is determined that the person, entity, or provider-sponsored organization charged has engaged in an unfair or deceptive act or practice or the unlawful operation of a provider-sponsored organization without a subsisting certificate of authority, the department shall also issue an order requiring the violator to cease and desist from engaging in such method of competition, act, or practice or unlawful operation of a provider-sponsored organization. Further, if the act or practice constitutes a violation of s. 641.4642 or s.

641.4644, the department may, at its discretion, order any one or more of the following:

(1) Suspension or revocation of the provider-sponsored organization's certificate of authority if it knew, or reasonably should have known, it was in violation of this part.

(2) If it is determined that the person or entity charged has engaged in the business of operating a provider-sponsored organization without a certificate of authority, unless a waiver has been granted by the Secretary of the United States Department of Health and Human Services under s. 1855(a)(2) of the Balanced Budget Act of 1997, an administrative penalty, which may not exceed $1,000 for each provider-sponsored contract offered or effectuated.

641.4646 Appeals from the department.--Any person, entity, or provider-sponsored organization that is subject to an order of the department under s. 641.4645 or s. 641.4647 may obtain a review of the order by filing an appeal therefrom in accordance with the procedures for appeal under s. 120.68.

641.4647 Penalty for violating cease and desist orders.--Any person, entity, or provider-sponsored organization that violates a cease and desist order of the department under s. 641.4645 while such order is in effect, after notice and hearing as provided in s. 641.4644, is subject, at the discretion of the department, to any one or more of the following:

(1) A monetary penalty of not more than $200,000 as to all matters determined in the hearing.

(2) Suspension or revocation of the provider-sponsored organization's certificate of authority.

641.4648 Civil liability.--The provisions of this part are cumulative to rights under the general civil and common law, and an action by the department does not abrogate any right to damages or other relief in any court.

Section 2. Section 641.227, Florida Statutes, is amended to read:

641.227 Rehabilitation Administrative Expense Fund.--

(1) The department may ~~shall~~ not issue or permit to exist a certificate of authority to operate a health maintenance organization or provider-sponsored organization in this state unless the organization has deposited with the department $10,000 in cash for use in the Rehabilitation Administrative Expense Fund as established in subsection (2).

(2) The department shall maintain all deposits received under this section and all income from such deposits in trust in an account titled "Rehabilitation Administrative Expense Fund." The fund shall be administered by the department and shall be used for the purpose of payment of the administrative expenses of the department during any rehabilitation of a health maintenance organization or provider-sponsored organization, when rehabilitation is ordered by a court of competent jurisdiction.

(3) Upon successful rehabilitation of a health maintenance organization or provider-sponsored organization, the organization shall reimburse the fund for the amount of expenses incurred by the department during the court-ordered rehabilitation period.

(4) If a court of competent jurisdiction orders liquidation of a health maintenance organization or provider-sponsored organization, the fund shall be reimbursed

for expenses incurred by the department as provided for in chapter 631.

(5) Each deposit made under this section shall be allowed as an asset for purposes of determination of the financial condition of the health maintenance organization or provider-sponsored organization. The deposit shall be refunded to the organization only when the organization both ceases operation as a health maintenance organization or provider-sponsored organization and no longer holds a subsisting certificate of authority.

Section 3. Paragraph (b) of subsection (2) and subsection (5) of section 641.316, Florida Statutes, are amended to read:

641.316 Fiscal intermediary services.--

(2)

(b) The term "fiscal intermediary services organization" means a person or entity that ~~which~~ performs fiduciary or fiscal intermediary services to health care professionals who contract with health maintenance organizations or provider-sponsored organizations other than a fiscal intermediary services organization owned, operated, or controlled by a hospital licensed under chapter 395, an insurer licensed under chapter 624, a third-party administrator licensed under chapter 626, a prepaid limited health organization licensed under chapter 636, a health maintenance organization licensed under this chapter, or a provider-sponsored organization licensed under this chapter, or physician group practices as defined in s. 455.236(3)(f).

(5) Any fiscal intermediary services organization, other than a fiscal intermediary services organization owned, operated, or controlled by a hospital licensed under chapter

395, an insurer licensed under chapter 624, a third-party administrator licensed under chapter 626, a prepaid limited health organization licensed under chapter 636, a health maintenance organization licensed under this chapter, a provider-sponsored organization licensed under this chapter, or physician group practices as defined in s. 455.236(3)(f), must register with the department and meet the requirements of this section. In order to register as a fiscal intermediary services organization, the organization must comply with ss. 641.21(1)(c) and (d) and 641.22(6). Should the department determine that the fiscal intermediary services organization does not meet the requirements of this section, the registration shall be denied. In the event that the registrant fails to maintain compliance with the provisions of this section, the department may revoke or suspend the registration. In lieu of revocation or suspension of the registration, the department may levy an administrative penalty in accordance with s. 641.25.

Section 4. A provider-sponsored organization is exempt from section 455.654, Florida Statutes, for the provision of health care services to enrollees of a Medicare Choice plan.

Section 5. Subsections (9), (10), (11), (13), and (16) of section 641.47, Florida Statutes, are amended to read:

641.47 Definitions.--As used in this part, the term:

(9) "Geographic area" means the county or counties, or any portion of a county or counties, within which the health maintenance organization or provider-sponsored organization provides or arranges for comprehensive health care services to be available to its subscribers.

(10) "Grievance" means a written complaint submitted by or on behalf of a subscriber to an organization or a state agency regarding the:

(a) Availability, coverage for the 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 a subscriber and an organization.

A grievance does not include a written complaint submitted by or on behalf of a subscriber eligible for a grievance and appeals procedure provided by an organization pursuant to contract with the Federal Government under Title XVIII of the Social Security Act which is governed by the rules established by the Secretary of the United States Department of Health and Human Services under the Balanced Budget Act of 1997, as it applies to provider-sponsored organizations that offer Medicare Choice plans.

(11) "Health care services" means:

(a) Comprehensive health care services, as defined in s. 641.19, when applicable to a health maintenance organization.

(b) The benefit package for Medicare beneficiaries established by the Federal Government, when applicable to a provider-sponsored organization.~~, and means~~

(c) Basic services, as defined in s. 641.402, when applicable to a prepaid health clinic.

(13) "Organization" means any health maintenance organization as defined in s. 641.19, any provider-sponsored organization as defined in s. 641.4603, and any prepaid health clinic as defined in s. 641.402.

(16) "Subscriber" means an individual who has contracted, or on whose behalf a contract has been entered into, with a health maintenance organization for health care services. In the case of a provider-sponsored organization as defined in s. 641.4603, the term also means a Medicare beneficiary.

Section 6. Section 641.48, Florida Statutes, is amended to read:

641.48 Purpose and application of part.--The purpose of this part is to ensure that health maintenance organizations, provider-sponsored organizations, and prepaid health clinics deliver high-quality health care to their subscribers. To achieve this purpose, this part requires all such organizations to obtain a health care provider certificate from the agency as a condition precedent to obtaining a certificate of authority to do business in Florida from the Department of Insurance, under part I, ~~or~~ part II, or part III ~~of this chapter~~.

Section 7. Section 641.49, Florida Statutes, is amended to read:

641.49 Certification of health maintenance organization, provider-sponsored organization, and prepaid health clinic as health care providers; application procedure.--

(1) A ~~No~~ person or governmental unit may not ~~shall~~ establish, conduct, or maintain a health maintenance organization, a provider-sponsored organization, or a prepaid

health clinic in this state without first obtaining a health care provider certificate under this part.

(2) The Department of Insurance may ~~shall~~ not issue a certificate of authority under part I, ~~or~~ part II, or part III ~~of this chapter~~ to any applicant that ~~which~~ does not possess a valid health care provider certificate issued by the agency under this part.

(3) Each application for a health care provider certificate must ~~shall~~ be on a form prescribed by the agency. The following information and documents shall be submitted by an applicant and maintained, after certification under this part, by each organization and shall be available for inspection or examination by the agency at the offices of an organization at any time during regular business hours. The agency shall give reasonable notice to an organization prior to any onsite inspection or examination of its records or premises conducted under this section. The agency may require that the following information or documents be submitted with the application:

(a) A copy of the articles of incorporation and all amendments to the articles.

(b) A copy of the bylaws, rules and regulations, or similar form of document, if any, regulating the conduct of the affairs of the applicant or organization.

(c) A list of the names, addresses, and official capacities with the applicant or organization of the persons who are to be responsible for the conduct of the affairs of the applicant or organization, including all officers and directors of the corporation. Such persons shall fully disclose to the agency and the directors of the applicant or organization the extent and nature of any contracts or

arrangements between them and the applicant or organization, including any possible conflicts of interest.

(d) The name and address of the applicant and the name by which the applicant or organization is to be known.

(e) A statement generally describing the applicant or organization and its operations.

(f) A copy of the form for each group and individual contract, certificate, subscriber handbook, and any other similar documents issued to subscribers.

(g) A statement describing the manner in which health care services shall be regularly available.

(h) A statement that the applicant has an established network of health care providers which is capable of providing the health care services that are to be offered by the organization.

(i) The locations at which health care services shall be regularly available to subscribers.

(j) The type of health care personnel engaged to provide the health care services and the quantity of the personnel of each type.

(k) A statement giving the present and projected number of subscribers to be enrolled yearly for the next 3 years.

(l) A statement indicating the source of emergency services and care on a 24-hour basis.

(m) A statement that the physicians employed by the applicant have been formally organized as a medical staff and that the applicant's governing body has designated a chief of medical staff.

(n) A statement describing the manner in which the applicant or organization assures the maintenance of a medical

records system in accordance with accepted medical records' standards and practices.

(o) If general anesthesia is to be administered in a facility not licensed by the agency, a copy of architectural plans that meet the requirements for institutional occupancy (NFPA 101 Life Safety Code, current edition as adopted by the State Fire Marshal).

(p) A description of the applicant's or organization's internal quality assurance program, including committee structure, as required under s. 641.51.

(q) A description and supporting documentation concerning how the applicant or ~~health maintenance~~ organization will comply with internal risk management program requirements under s. 641.55.

(r) An explanation of how coverage for emergency services and care is to be effected outside the applicant's or ~~health maintenance~~ organization's stated geographic area.

(s) A statement and map describing with reasonable accuracy the specific geographic area to be served.

(t) A nonrefundable application fee of $1,000.

(u) Such additional information as the agency may reasonably require.

Section 8. Subsections (1) and (3) of section 641.495, Florida Statutes, are amended to read:

641.495 Requirements for issuance and maintenance of certificate.--

(1) The agency shall<u>, within 90 days after receipt,</u> issue a health care provider certificate to an applicant filing a completed application in conformity with ss. 641.48 and 641.49, upon payment of the prescribed fee, and upon the agency's being satisfied that the applicant has the ability to

provide quality of care consistent with the prevailing professional standards of care and which applicant otherwise meets the requirements of this part.

(3) The organization shall demonstrate its capability to provide health care services in the geographic area that it proposes to service. In addition, each health maintenance organization or provider-sponsored organization shall notify the agency of its intent to expand its geographic area at least 60 days prior to the date it plans to begin providing health care services in the new area. Prior to the date the health maintenance organization or provider-sponsored organization begins enrolling members in the new area, it must submit a notarized affidavit, signed by two officers of the organization who have the authority to legally bind the organization, to the agency describing and affirming its existing and projected capability to provide health care services to its projected number of subscribers in the new area. The notarized affidavit shall further assure that, 15 days prior to providing health care services in the new area, the health maintenance organization or provider-sponsored organization shall be able, through documentation or otherwise, to demonstrate that it shall be capable of providing services to its projected subscribers for at least the first 60 days of operation. If the agency determines that the organization is not capable of providing health care services to its projected number of subscribers in the new area, the agency may issue an order as required under chapter 120 prohibiting the organization from expanding into the new area. In any proceeding under chapter 120, the agency shall have the burden of establishing that the organization is not

capable of providing health care services to its projected number of subscribers in the new area.

Section 9. Paragraph (c) of subsection (4) of section 641.51, Florida Statutes, is amended to read:

641.51 Quality assurance program; second medical opinion requirement.--

(4)

(c) For second opinions provided by contract physicians the organization is prohibited from charging a fee to the subscriber in an amount in excess of the subscriber fees established by contract for referral contract physicians. The organization shall pay the amount of all charges, which are usual, reasonable, and customary in the community, for second opinion services performed by a physician not under contract with the organization, but may require the subscriber to be responsible for up to 40 percent of such amount. The organization may require that any tests deemed necessary by a noncontract physician shall be conducted by the organization. The organization may deny reimbursement rights granted under this section in the event the subscriber seeks in excess of three such referrals per year if such subsequent referral costs are deemed by the organization to be evidence that the subscriber has unreasonably overutilized the second opinion privilege. A subscriber thus denied reimbursement under this section shall have recourse to grievance procedures as specified in ss. 408.7056, 641.495, and 641.511. The organization's physician's professional judgment concerning the treatment of a subscriber derived after review of a second opinion shall be controlling as to the treatment obligations of the health maintenance organization <u>or provider-sponsored organization</u>. Treatment not authorized by the health

maintenance organization or provider-sponsored organization shall be at the subscriber's expense.

Section 10. Section 641.512, Florida Statutes, is amended to read:

641.512 Accreditation and external quality assurance assessment.--

(1)(a) To promote the quality of health care services provided by health maintenance organizations, provider-sponsored organizations, and prepaid health clinics in this state, the department shall require each health maintenance organization, provider-sponsored organizations, and prepaid health clinic to be accredited within 1 year after ~~of~~ the organization's receipt of its certificate of authority and to maintain accreditation by an accreditation organization approved by the department, as a condition of doing business in the state.

(b) If an ~~In the event that no~~ accreditation organization is not ~~can be~~ approved by the department, the department shall require each health maintenance organization, provider-sponsored organization, and prepaid health clinic to have an external quality assurance assessment performed by a review organization approved by the department, as a condition of doing business in the state. The assessment shall be conducted within 1 year after ~~of~~ the organization's receipt of its certificate of authority and every 2 years thereafter, or when the department deems additional assessments necessary.

(2) The accreditation or review organization must have nationally recognized experience in the activities of a health maintenance organization or a provider-sponsored organization ~~activities~~ and in the appraisal of medical practice and quality assurance in the setting of a health maintenance

organization or a provider-sponsored organization ~~setting~~. The accreditation or review organization may ~~shall~~ not currently be involved in the operation of the health maintenance organization, provider-sponsored organization, or prepaid health clinic, or ~~nor~~ in the delivery of health care services to its subscribers. The accreditation or review organization may ~~shall~~ not have contracted or conducted consultations within the last 2 years for other than accreditation purposes of the health maintenance organization, provider-sponsored organization, or prepaid health clinic seeking accreditation or under quality assurance assessment.

(3) A representative of the department shall accompany the accreditation or review organization throughout the accreditation or assessment process, but may ~~shall~~ not participate in the final accreditation or assessment determination. The accreditation or review organization shall monitor and evaluate the quality and appropriateness of patient care, the organization's pursuance of opportunities to improve patient care and resolve identified problems, and the effectiveness of the internal quality assurance program required for the certification of a health maintenance organization, a provider-sponsored organization, or a ~~and~~ prepaid health clinic certification pursuant to s. 641.49(3)(p)~~s. 641.49(3)(o)~~.

(4) The accreditation or assessment process shall include a review of:

(a) All documentation necessary to determine the current professional credentials of employed health care providers or physicians providing service under contract to the health maintenance organization, provider-sponsored organization, or prepaid health clinic.

(b) At least a representative sample of not fewer than 50 medical records of individual subscribers. When selecting a sample, any and all medical records may be subject to review. The sample of medical records shall be representative of all subscribers' records.

(5) Every organization shall submit its books, documentations, and medical records and take appropriate action as may be necessary to facilitate the accreditation or assessment process.

(6) The accreditation or review organization shall issue a written report of its findings to the board of directors of the health maintenance organization, the provider-sponsored organization, ~~organization's~~ or the prepaid health clinic ~~clinic's board of directors~~. A copy of the report shall be submitted to the department by the organization within 30 business days after ~~of~~ its receipt by the health maintenance organization, provider-sponsored organization, or prepaid health clinic.

(7) The expenses of the accreditation or assessment process of each organization, including any expenses incurred pursuant to this section, shall be paid by the organization.

Section 11. Section 641.513, Florida Statutes, is amended to read:

641.513 Requirements for providing emergency services and care.--

(1) In providing for emergency services and care as a covered service, a health maintenance organization or a provider-sponsored organization may not:

(a) Require prior authorization for the receipt of prehospital transport or treatment or for emergency services and care.

(b) Indicate that emergencies are covered only if care is secured within a certain period of time.

(c) Use terms such as "life threatening" or "bona fide" to qualify the kind of emergency that is covered.

(d) Deny payment based on the subscriber's failure to notify the health maintenance organization or provider-sponsored organization in advance of seeking treatment or within a certain period of time after the care is given.

(2) Prehospital and hospital-based trauma services and emergency services and care must be provided to a subscriber of a health maintenance organization or provider-sponsored organization as required under ss. 395.1041, 395.4045, and 401.45.

(3)(a) When a subscriber is present at a hospital seeking emergency services and care, the determination as to whether an emergency medical condition, as defined in s. 641.47 exists shall be made, for the purposes of treatment, by a physician of the hospital or, to the extent permitted by applicable law, by other appropriate licensed professional hospital personnel under the supervision of the hospital physician. The physician or the appropriate personnel shall indicate in the patient's chart the results of the screening, examination, and evaluation. The health maintenance organization or provider-sponsored organization shall compensate the provider for the screening, evaluation, and examination that is reasonably calculated to assist the health care provider in arriving at a determination as to whether the patient's condition is an emergency medical condition. The health maintenance organization or provider-sponsored organization shall compensate the provider for emergency

services and care. If a determination is made that an emergency medical condition does not exist, payment for services rendered subsequent to that determination is governed by the contract under which the subscriber is covered.

(b) If a determination has been made that an emergency medical condition exists and the subscriber has notified the hospital, or the hospital emergency personnel otherwise have knowledge that the patient is a subscriber of the health maintenance organization or provider-sponsored organization, the hospital must make a reasonable attempt to notify the subscriber's primary care physician, if known, or the health maintenance organization or provider-sponsored organization, if the health maintenance organization or provider-sponsored organization had previously requested in writing that the notification be made directly to the health maintenance organization or provider-sponsored organization, of the existence of the emergency medical condition. If the primary care physician is not known, or has not been contacted, the hospital must:

1. Notify the health maintenance organization or provider-sponsored organization as soon as possible prior to discharge of the subscriber from the emergency care area; or

2. Notify the health maintenance organization or provider-sponsored organization within 24 hours or on the next business day after admission of the subscriber as an inpatient to the hospital.

If notification required by this paragraph is not accomplished, the hospital must document its attempts to notify the health maintenance organization or provider-sponsored organization of the circumstances that

precluded attempts to notify the health maintenance organization or provider-sponsored organization. A health maintenance organization or provider-sponsored organization may not deny payment for emergency services and care based on a hospital's failure to comply with the notification requirements of this paragraph. ~~Nothing in~~ This paragraph does not ~~shall~~ alter any contractual responsibility of a subscriber to make contact with the health maintenance organization or provider-sponsored organization subsequent to receiving treatment for the emergency medical condition.

(c) If the subscriber's primary care physician responds to the notification, the hospital physician and the primary care physician may discuss the appropriate care and treatment of the subscriber. The health maintenance organization or provider-sponsored organization may have a member of the hospital staff with whom it has a contract participate in the treatment of the subscriber within the scope of the physician's hospital staff privileges. The subscriber may be transferred, in accordance with state and federal law, to a hospital that has a contract with the health maintenance organization or provider-sponsored organization and has the service capability to treat the subscriber's emergency medical condition. Notwithstanding any other state law, a hospital may request and collect insurance or financial information from a patient in accordance with federal law, which is necessary to determine if the patient is a subscriber of a health maintenance organization or provider-sponsored organization, if emergency services and care are not delayed.

(4) A subscriber may be charged a reasonable copayment, as provided in s. 641.31(12), for the use of an emergency room.

(5) Reimbursement for services pursuant to this section by a provider who does not have a contract with the health maintenance organization or provider-sponsored organization shall be the lesser of:

(a) The provider's charges;

(b) The usual and customary provider charges for similar services in the community where the services were provided; or

(c) The charge mutually agreed to by the health maintenance organization or provider-sponsored organization and the provider within 60 days after ~~of~~ the submittal of the claim.

Such reimbursement shall be net of any applicable copayment authorized pursuant to subsection (4).

(6) Reimbursement for services under this section provided to subscribers who are Medicaid recipients by a provider for whom no contract exists between the provider and the health maintenance organization or provider-sponsored organization shall be the lesser of:

(a) The provider's charges;

(b) The usual and customary provider charges for similar services in the community where the services were provided;

(c) The charge mutually agreed to by the entity and the provider within 60 days after submittal of the claim; or

(d) The Medicaid rate.

Section 12. Subsection (4) of section 641.515, Florida Statutes, is amended to read:

641.515 Investigation by the agency.--

(4) The agency shall adopt ~~promulgate~~ rules imposing upon physicians and hospitals performing services for a health maintenance organization or provider-sponsored organization standards of care generally applicable to physicians and hospitals.

Section 13. Subsections (1) and (2) of section 641.54, Florida Statutes, are amended to read:

641.54 Information disclosure.--

(1) Every health maintenance organization or provider-sponsored organization shall maintain a current list, by geographic area, of all hospitals that ~~which~~ are routinely and regularly used by the organization, indicating to which hospitals the organization may refer particular subscribers for nonemergency services. The list shall also include all physicians under the organization's direct employ or who are under contract or other arrangement with the organization to provide health care services to subscribers. The list shall contain the following information for each physician:

(a) Name.

(b) Office location.

(c) Medical area or areas of specialty.

(d) Board certification or eligibility in any area.

(e) License number.

(2) The list shall be made available, upon request, to the department. The list shall also be made available, upon request:

(a) With respect to negotiation, application, or effectuation of a group health maintenance contract, to the employer or other person who will hold the contract on behalf of the subscriber group. The list may be restricted to

include only physicians and hospitals in the group's geographic area.

(b) With respect to an individual health maintenance contract or any contract offered to a person who is entitled to have payments for health care costs made under Medicare, to the person considering or making application to, or under contract with, the health maintenance organization or provider-sponsored organization. The list may be restricted to include only physicians and hospitals in the person's geographic area.

Section 14. Section 641.59, Florida Statutes, is amended to read:

641.59 Psychotherapeutic services; records and reports.--A health maintenance organization, provider-sponsored organization, or prepaid health clinic, as defined in this chapter, must maintain strict confidentiality against unauthorized or inadvertent disclosure of confidential information to persons inside or outside the health maintenance organization, provider-sponsored organization, or prepaid health clinic regarding psychotherapeutic services provided to subscribers by psychotherapists licensed under chapter 490 or chapter 491 and psychotherapeutic records and reports related to the services. A report, in lieu of records, may be submitted by a psychotherapist in support of the services. Such report must include clear statements summarizing the subscriber's presenting symptoms, what transpired in any provided therapy, what progress, if any, was made by the subscriber, and results obtained. However, the health maintenance organization, provider-sponsored organization, or prepaid health clinic may require the records upon which the report is based, if the report does not contain

sufficient information supporting the services. A psychotherapist submitting records in support of services may obscure portions to conceal the names, identities, or identifying information of people other than the subscriber if this information is unnecessary to utilization review, quality management, discharge planning, case management, or claims processing conducted by the health maintenance organization, provider-sponsored organization, or prepaid health clinic. A health maintenance organization, provider-sponsored organization, or prepaid health clinic may provide aggregate data that ~~which~~ does not disclose subscriber identities or identities of other persons to entities such as payors, sponsors, researchers, and accreditation bodies.

Section 15. Paragraph (f) of subsection (1) of section 641.60, Florida Statutes, is amended to read:

641.60 Statewide Managed Care Ombudsman Committee.--

(1) As used in ss. 641.60-641.75:

(f) "Managed care program" means a health care delivery system that emphasizes primary care and integrates the financing and delivery of services to enrolled individuals through arrangements with selected providers, formal quality assurance and utilization review, and financial incentives for enrollees to use the program's providers. Such a health care delivery system may include arrangements in which providers receive prepaid set payments to coordinate and deliver all inpatient and outpatient services to enrollees or arrangements in which providers receive a case management fee to coordinate services and are reimbursed on a fee-for-service basis for the services they provide. A managed care program may include a state-licensed health maintenance organization, a provider-sponsored organization, a Medicaid prepaid health

plan, a Medicaid primary care case management program, or other similar program.

Section 16. This act shall take effect October 1, 1998.

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SENATE SUMMARY

Creates the "Provider-Sponsored Organization Act" within ch. 641, F.S. Authorizes provider-sponsored organizations to do business in this state and offer health care coverage to Medicare beneficiaries under the federal Medicare Choice plan. Provides for the regulation of provider-sponsored organizations by the Department of Insurance in a manner similar to the regulation of health maintenance organizations. Requires that the department issue certificates of authority to qualified provider-sponsored organizations. Requires that a provider-sponsored organization maintain certification as a health care provider. Authorizes the department to conduct inspections, issue cease and desist orders, and impose penalties. Provides requirements for a provider-sponsored organization in marketing its services and in soliciting subscribers. Prohibits certain unfair and deceptive trade practices and acts. Provides penalties. Authorizes the department to adopt rules. (See bill for details.)