By Representative Saunders

A bill to be entitled

An act relating to provider sponsored organizations; creating pt. IV of ch. 641, F.S.; providing for establishment and licensure of provider sponsored organizations; providing a short title; providing legislative intent, findings, and purposes; providing definitions; providing applicability of other laws; requiring incorporation; providing construction; providing for application for certificates of authority; providing conditions precedent to issuance or maintenance of certificates of authority; providing for effect of bankruptcy proceedings; providing for issuance of certificates of authority; providing for continuing eligibility for certificates of authority; providing surplus requirements; specifying deposit into and disposition of certain moneys in the Rehabilitation Administrative Trust Fund; providing for revocation or cancellation of certificates of authority; providing for suspending enrollment of subscribers; providing for administrative, provider, and management contracts; providing requirements for contract providers; providing for administrative penalties; providing for acquisition, merger, or consolidation; requiring an annual report; providing for examination by the Department of Insurance; providing for civil remedies; providing for injunctions; providing for

payment of judgments; providing for liquidation, rehabilitation, reorganization, and conservation; providing for application fees and filing fees; providing construction; prohibiting unfair practices relating to human immunodeficiency virus infections for contract purposes; specifying language used in contracts and advertisements; providing for standards for marketing to certain persons; providing for provider sponsored contracts; requiring disclosure of certain plan terms and conditions; requiring coverage for mammograms; providing requirements relating to breast cancer and followup care; providing for provider contracts; prohibiting certain words in organization names; providing requirements relating to certain assets, liabilities, and investments; requiring the Department of Insurance to adopt rules; providing penalties; providing for dividends; specifying prohibited activities; providing penalties; providing for orders to discontinue certain advertising; requiring licensing and appointment of agents; providing exceptions; specifying unfair methods of competition; prohibiting unfair or deceptive acts or practices; providing definitions; providing general powers and duties of the Department of Insurance; authorizing the department to take certain actions against unfair competition and unfair or deceptive acts or practices; providing for cease and desist

orders and penalty orders; providing for appeals from the department; providing a penalty for violating cease and desist orders; providing for civil liability; exempting provider service organizations from certain joint venture financial arrangement restrictions; amending ss. 641.316, 641.227, 641.47, 641.48, 641.49, 641.495, 641.51, 641.512, 641.513, 641.515, 641.54, 641.59, and 641.60, F.S., to conform; providing an effective date.

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

Section 1. Legislative findings and declarations.--

(1) The Legislature finds that a major restructuring of health care has taken place in the last several decades changing how health care is paid for and delivered and that, 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 finds that Congress has recently enacted legislation that allows provider sponsored organizations to provide coordinated care plans to Medicare enrollees through the Medicare+Choice program. The federal legislation requires each organization which offers Medicare+Choice plans to be organized under state law as an entity eligible to offer health benefit coverage in each state in which such organization offers a Medicare+Choice plan.

(3) The Legislature finds that such plans, when properly operated, will enhance the quality of medical decisionmaking while emphasizing effective cost and quality controls.

(4) The Legislature declares that it shall be the policy of this state to:

(a) Eliminate legal barriers to the organization, promotion, and expansion of provider sponsored organizations offering Medicare+Choice plans in order to encourage the development of valuable options for the Medicare beneficiaries of this state.

(b) Not extend insurance regulation or onerous reporting requirements to hospitals, physicians, single or multi-specialty groups, other licensed providers, or any combination of such entities when contracting with entities licensed pursuant to chapter 627, Florida Statutes, or part I of chapter 641, Florida Statutes, or with plans qualified and created under the Employee Retirement Income Security Act of 1974.

(c) Recognize that comprehensive provider sponsored organizations shall be exempt from operation of the insurance laws of this state except in the manner and to the extent set forth in this act.

Section 2. Part IV of chapter 641, Florida Statutes, consisting of sections 641.801, 641.803, 641.805, 641.807, 641.809, 641.811, 641.813, 641.815, 641.817, 641.819, 641.821, 641.823, 641.825, 641.827, 641.829, 641.831, 641.833, 641.835, 641.837, 641.839, 641.841, 641.843, 641.845, 641.847, 641.849, 641.851, 641.853, 641.855, 641.857, 641.859, 641.861, 641.863, 641.865, 641.867, 641.869, 641.871, 641.873, 641.875, 641.877,

641.879, 641.881, 641.883, 641.885, 641.887, 641.889, 641.891, 641.893, and 641.895, Florida Statutes, is created to read:

641.801 Short title.--This part shall be known and may be cited as the "Provider Sponsored Organization Act."

641.803 Declaration of legislative intent, findings, and purposes.--

(1) Faced with the continuation of mounting costs of health care, coupled with the state's interest in high-quality care, the Legislature has determined that there is a need to explore alternative methods for the delivery of health care services, with a view toward achieving greater efficiency and economy in providing these services and to promote competition and increase patients' choices.

(2) Health maintenance organizations, consisting of prepaid health care plans, hereinafter referred to as "plans," are developing rapidly in many communities. Through these organizations, structured in various forms, health care services are provided directly to a group of people who make regular premium payments.

(3) These plans, when properly operated, emphasize effective cost and quality controls and enhance the quality of medical decisionmaking.

(4) It shall be the policy of this state to:

(a) Eliminate legal barriers to the organization, promotion, and expansion of comprehensive prepaid health care plans.

(b) Recognize that prepaid comprehensive health care plans shall be exempt from operation of the insurance laws of this state except in the manner and to the extent set forth in this part.

(c) Ensure that comprehensive prepaid health care plans deliver high-quality health care.

(5) Although it is the intent of this act to provide an opportunity for the development of health maintenance organizations, there is no intent to impair the present system for the delivery of health services.

(6) The Legislature has determined that the operation of a health maintenance organization without a subsisting certificate of authority or the renewal, issuance, or delivery of a health maintenance contract without a subsisting certificate of authority constitutes a danger to the citizens of this state and exposes any subscriber to immediate and irreparable injury, loss, or damage.

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

(1) "Affiliation" means a provider is affiliated with another provider, if, through contract, ownership, or otherwise:

(a) A single 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, as amended;

(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, as amended.

(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 pursuant to the Medicare+Choice program.

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

(6) "Emergency medical condition" means:

(a) A medical condition manifesting 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 to 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 provider sponsored organization provides or arranges for comprehensive health care services to be available to its subscribers.

(10) "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.

(11) "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.

(12) "Provider sponsored contract" means any contract entered into by a provider sponsored organization with Medicare+Choice beneficiaries.

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

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

(b) Provides a substantial proportion of the health care items and services as specified in the Medicare+Choice contract, as defined by the Secretary, directly through the provider or affiliated group of providers.

(c) With respect to which the affiliated providers share, directly or indirectly, substantial financial risk with respect to the provision of such items and services and have at least a majority financial interest in the entity. The term "substantial proportion" shall be as defined by the Secretary 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 for providing 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 shall also be given to the need for the organization to provide a limited proportion of the items and services under the contract through providers 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.

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

(15) "Secretary" means the Secretary of the United States Department of Health and Human Services.

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

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

(18) "Surplus" means total assets in excess of total liabilities, as determined by federal rules and regulations on solvency standards established by the Secretary pursuant to s. 1856(a) of the Balanced Budget Act of 1997, for provider sponsored organizations offering the Medicare+Choice plan.

641.807 Applicability of other laws.--Except as provided in this part, provider sponsored organizations shall be governed by the provisions of this part and part III of this chapter and shall be exempt from all other provisions of the Florida Insurance Code.

641.809 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 the provisions of either 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 shall apply to the entire corporation.

641.811 Insurance business not authorized.--Nothing in the Florida Insurance Code or this part shall be deemed to 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 the determination of the type of activities by a provider

sponsored organization that would require licensure by this state, the following apply:

(1) A provider sponsored organization as defined in this part, a hospital, a physician licensed pursuant to chapter 458 or chapter 459, a single specialty group of physicians, a multi-specialty group of physicians, other licensed providers, or any combination of such physicians and providers, when contracting with a self-insured employer to provide health care benefits to its employees, when contracting with an health maintenance organization licensed pursuant to part I or a provider sponsored organization licensed pursuant to this part, or when contracting with an insurer, are exempt from the requirements of this chapter 641 and chapter 627.

(2) In any arrangement enumerated in subsection (1), the provider group is not subject to regulation by the department due to the absence of any contractual obligation to the employees covered under the self-insured agreement, the agreement with the health maintenance organization, the provider sponsored organization, or the insurer. A contractual relationship exists only between the provider group and the self-insured employer, the licensed health maintenance organization, provider sponsored organization, or insurer, which entity shall bear the 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 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 such situations, the provider group must be appropriately licensed as a health maintenance organization, provider sponsored organization, or insurance company.

641.813 Application for certificate.--Before any entity may operate a provider sponsored organization, it shall obtain a certificate of authority from the department. The department shall accept and shall 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 III of this chapter. However, the department shall not issue a certificate of authority to any applicant which does not possess a valid health care provider certificate issued by the agency. Each application for a certificate shall be on such form as the department shall prescribe, shall be verified by the oath of two officers of the corporation and properly notarized, and shall be accompanied by the following:

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

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

(3) A list of the names, addresses, and official capacities with the organization of the persons who are to be responsible for the conduct of 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. Such persons shall fully disclose to the department and the directors of the provider sponsored

organization the extent and nature of any contracts or arrangements between them and the provider sponsored organization, including any possible conflicts 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 all of the individuals referred to 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 acceptable to the department and meeting the requirements of this act shall be included in the calculation of surplus; and

(8) Such additional reasonable data, financial statements, and other pertinent information as the department may require with respect to the determination that 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 study shall be for the greater of 3 years or until the provider sponsored organization has been projected to be profitable for 12 consecutive months.

641.815 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 insurer 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 a period of 60 days following the date of commencement of the proceeding.

641.817 Issuance of certificate of authority.--The department shall issue a certificate of authority to any entity filing a completed application in conformity with s. 641.21, within 90 days after receiving such application, 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 Department of Health pursuant to part III of this chapter.

(2) The provider sponsored organization is actuarially sound.

(3) The entity has met the applicable requirements specified in s. 641.821.

(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. However, this section does not prohibit reasonable underwriting classifications for the purposes of establishing contract rates, nor does it prohibit experience rating.

(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 that would make the proposed provider sponsored organization operation beneficial to the subscribers. The department shall not grant nor 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:

(a) The ownership, control, or management of the organization includes any person:

1. Who is incompetent or untrustworthy;

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

3. Who is so lacking in provider sponsored organization experience, ability, and standing 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 to the detriment of the public, stockholders, investors, or creditors; or

5. Whose business operations are or have been marked by business practices or conduct that is to the detriment of 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, 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 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; or

(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 was in the past 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, either when applicable to such person 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, that 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 provisions of 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 shall not be 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.

641.819 Continued eligibility for certificate of authority.--In order to maintain its eligibility for a certificate of authority, a provider sponsored organization shall continue to meet all conditions required to be met under this part and the rules promulgated thereunder for the initial application for and issuance of its certificate of authority under s. 641.817.

641.821 Surplus requirements.--Surplus requirements for provider sponsored organizations offering the

Medicare+Choice plan shall be consistent with federal rules and regulations on solvency standards established by the Secretary pursuant to s. 1856(a) of the Balanced Budget Act of 1997.

641.823 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 III of this chapter 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 of Insurance, 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 Department of Health notifies the Department of Insurance, 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 and regulations governing provider sponsored

organizations established by the Secretary 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 services or capacity for service or has engaged in deceptive, misleading, or unfair practices with respect to advertising or merchandising; or

(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 is not inconsistent with the standards established by the Secretary 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 of the department's order or submits a plan which 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 shall not be made unless requested by the provider sponsored organization; however, the department shall 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 shall include an explanation of what the medical loss ratio means and shall disclose that the medical loss ratio is not a direct reflection of quality, but must be looked at along with patient satisfaction and other standards that define quality.

641.825 Administrative, provider, and management contracts.--

(1) The department may require a provider sponsored organization to submit any contract for administrative services, contract with a provider other than an individual physician, contract for management services, and contract with an affiliated entity to the department.

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

641.827 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 provision shall not apply to any individual physician.

641.829 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 must 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 must adopt by rule by January 1, 1999, penalty categories that specify varying ranges of monetary fines for willful violations and for nonwillful violations.

641.831 Acquisition, merger, or consolidation.--Every acquisition of a provider sponsored organization shall be subject to the provisions of s. 628.4615. However, in the case of a provider sponsored organization organized as a for-profit corporation, the provisions of s. 628.451 govern with respect to any merger or consolidation; and, in the case of a provider sponsored organization organized as a not-for-profit corporation, the provisions of s. 628.471 govern with respect to any merger or consolidation.

641.833 Annual report.--

(1) Every provider sponsored organization shall, annually within 3 months after the end of its fiscal year, or within an extension of time therefor as the department, for good cause, may grant, 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. Such report shall 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 rates, benefits, and expenses of, and any other funds available for the payment of obligations of, the organization; and

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

(g) Such other information relating to the performance of provider sponsored organizations as is required by the department.

(2) Every 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 which 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; and, upon notice by the department to that effect, 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 shall 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 "CPA," who agrees by written contract with the provider sponsored organization to comply with the provisions of this part. The contract shall state:

(a) The CPA shall provide to the HMO 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 and regulations adopted by the Secretary 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 relating 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 as mutually agreed between the department and the provider sponsored organization. The CPA must retain for review the work papers and written communications for a period of not less than 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.

641.835 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 expedient for the protection of the people 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. 445.667, medical records of individuals and records of physicians providing service under contract to the provider sponsored organization shall not be 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 shall be subject to the same terms and conditions as apply to insurers under chapter 624. In no event shall expenses of all examinations 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 power with respect thereto granted to it 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 shall be subject to the review of, and approval, disapproval, or modification by, the department.

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

641.839 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 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 pursuant thereto.

(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 pursuant to s. 1855(a)(2) of the Balanced Budget Act of 1997.

The department's authority to seek injunctive relief shall not be conditioned on having conducted any proceeding pursuant to chapter 120.

641.841 Payment of judgment by provider sponsored organization.--Except as otherwise ordered by the court or mutually agreed upon by the parties, every 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 from and after the entry thereof or, in the case of an appeal from such judgment or decree, within 60 days from and after the affirmance of the same by the appellate court.

641.843 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 constitutes the sole and exclusive means of liquidating, reorganizing, rehabilitating, or conserving a provider sponsored organization.

641.845 Fees.--Every 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.

641.847 Construction and relationship to other laws.--

(1) Every 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 of this chapter. Any person,

entity, or provider sponsored organization operating without a subsisting certificate of authority in violation of this part or rules promulgated thereunder or renewing, issuing, or delivering provider sponsored contracts without a subsisting certificate of authority in violation of this part or rules promulgated thereunder, 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 pursuant to s. 1855(a)(2) of the Balanced Budget Act of 1997.

(3) The solicitation of subscribers by a provider sponsored organization or its representatives shall not be construed to be violative of 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 pursuant to 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 the investigation of any violation of this part.

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

641.849 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 organization contract with respect to exposure to the human immunodeficiency virus infection and related matters, and thereby 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 which are issued in this state or which are issued outside this state but cover residents of this state to the extent the provisions of this section are not inconsistent with rules and regulations established by the Secretary for the Medicare+Choice program. This section shall 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:

(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) UTILIZATION OF MEDICAL TESTS.--

(a) With respect to the issuance of or the underwriting of a provider sponsored organization contract regarding exposure to the HIV infection and sickness or medical conditions derived from such infection, a provider sponsored organization shall only utilize medical tests which are reliable predictors of risk. A test which 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 which is rejected or not recommended by the Centers for Disease Control or the federal Food and Drug Administration is a test which is deemed to be not reliable for the purposes of this section. If a specific Centers for Disease Control or federal Food and Drug Administration recommended test indicates the existence or

potential existence of exposure by 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 Centers for Disease Control or federal Food and Drug Administration recommended test protocol and shall utilize any applicable Centers for Disease Control or federal Food and Drug Administration recommended followup tests or series of tests 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 shall include 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 shall raise 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 which 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; and

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. Sexual orientation shall not be used in the underwriting process or in the determination of which subscribers or applicants for enrollment shall be tested for exposure to the HIV infection. Neither the marital status, the living arrangements, the occupation, the gender, the beneficiary designation, nor the zip code or other territorial classification of an applicant shall be used to establish the applicant's sexual orientation.

(e) A provider sponsored organization may inquire whether a person has been tested positive for exposure to the HIV infection or been 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 shall 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 regarding medical test results with respect to the HIV infection or a specific sickness or medical condition derived from such infection. Information regarding specific test results shall 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 shall not be furnished to an insurance industry or provider sponsored organization data bank if a review of the information would identify the individual and the specific test results.

(g) No laboratory may be used by an insurer or insurance support organization for the processing of HIV-related tests unless it 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 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 organization contract shall not exclude coverage of a member of a subscriber group 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, provided that this prohibition shall not apply to persons applying for enrollment where individual underwriting is otherwise allowed by law.

(b) No provider sponsored organization contract shall 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.

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

(1)(a) All provider sponsored contracts or forms shall 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 shall be affixed to and shall become a part of the contract or form. Any such translation shall be furnished to the department as part of the filing of the provider sponsored contract form. No translation of a provider sponsored contract form shall be approved by the department unless the translation accurately reflects the substance of the provider sponsored contract form in translation.

(2) The text of all advertisements by a provider sponsored organization, if printed or broadcast in a language other than English, also shall 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 disclosing or disseminating 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.

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

(1) Every provider sponsored organization marketing 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 offering 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. 641.881:

(a) No provider sponsored organization or person representing such provider sponsored organization shall employ any method of marketing having the effect of or tending 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 organization contract.

(b) No participating provider, employee, or agent of such participating provider shall be an agent for or conduct any sales activities for a provider sponsored organization with whom they have a provider contract.

641.855 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 shall contain all of the provisions and disclosures required by this section.

(2) Every provider sponsored contract, certificate, or member handbook shall 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 or by any insurer or entity which is underwriting any of the services offered by the provider sponsored organization. The contract, certificate, or member handbook shall also state where and in what manner the comprehensive health care services may be obtained.

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

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

(5) A provider sponsored organization providing 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) No alteration of any written application for any provider sponsored contract shall be made by any person other

than the applicant without his or her 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) No contract shall 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 shall state that emergency services and care shall be provided to subscribers in emergency situations not permitting treatment through the provider sponsored organization's providers, without prior notification to and approval of the organization. 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 rules and regulations established by the Secretary governing Medicare+Choice benefits. The Medicare+Choice contract, certificate, or member handbook shall contain the definition of "emergency services and care" as specified in s. 641.805(7), shall describe procedures for determination by the provider sponsored organization of whether the services qualify for reimbursement as emergency services and care, and shall contain specific examples of what does constitute 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 and regulations established by the Secretary 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 ("Medicare"), parts A and/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 United States Department of Health and Human Services, 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 United States Department of Health and Human Services, Health Care Financing Administration, in a timely manner so as to effectuate the next available disenrollment date, as prescribed by such 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 of the United States Department of Health and Human Services 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 a provider sponsored organization 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 as specified herein. 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 or any other person receiving 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 providing 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 provider sponsored organization services in the same service area of the provider sponsored organization.

(11) To the extent this subsection is not inconsistent, under s. 1856(b)(3) of the Balanced Budget Act of 1997, with rules and regulations established by the Secretary for the Medicare+Choice program:

(a) Provider sponsored contracts that provide 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 outpatient care as required by this subsection in a manner that is less than favorable than the benefits provided for any preceding portion of such stay.

(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 shall 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 this subsection is not inconsistent, under s. 1856(b)(3) of the Balanced Budget Act of 1997, with rules and regulations established by the Secretary 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 shall be subject to any deductible and coinsurance conditions.

641.857 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 in accordance with s. 641.855(2) 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.

641.859 Coverage for mammograms.--

(1) To the extent this section is not inconsistent, under s. 1856(b)(3) of the Balanced Budget Act of 1997, with rules and regulations established by the Secretary for the Medicare+Choice program, every provider sponsored contract issued or renewed on or after October 1, 1998, shall 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.

641.861 Requirements with respect to breast cancer and routine followup care.--To the extent this section is not inconsistent, under s. 1856(b)(3) of the Balanced Budget Act of 1997, with rules and regulations established by the Secretary 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.

641.863 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 shall be liable for such fee or fees rather than the subscriber; and the contract shall so state.

(2) No subscriber of a provider sponsored organization shall be liable to any provider of health care services for any services covered by the provider sponsored organization.

(3) No provider of services or any representative of such provider shall collect or attempt to collect from a provider sponsored organization subscriber any money for

services covered by a provider sponsored organization and no provider or representative of such provider may maintain any action at law against a subscriber of a provider sponsored organization to collect money owed to such provider by a provider sponsored organization.

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

(5) The provisions of this section shall not be construed to apply to the amount of any deductible or copayment which is not covered by the contract of the provider sponsored organization.

(6)(a) All provider contracts shall contain the following provisions:

1. The contracts must provide that 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. The contract must also provide that nonpayment for goods or services rendered by the provider to the provider sponsored organization shall not be a valid reason for avoiding the 60-day advance notice of cancellation.

(b) The contracts must provide 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 shall not contain any provision restricting 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.

641.865 Certain words prohibited in name of organization.--

(1) No entity certificated as a provider sponsored organization, other than a licensed insurer insofar as its name is concerned, shall use in its name, contracts, or literature any of the words "insurance," "casualty," "surety," "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) No person, entity, or health care plan not certificated under the provisions of this part shall 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.

641.867 Assets, liabilities, and investments.--Assets, liabilities, and investments for provider sponsored organizations offering the Medicare+Choice plan shall be consistent with the federal rules and regulations on solvency standards established by the Secretary pursuant to s. 1856(a) of the Balanced Budget Act of 1997.

641.869 Adoption of rules; penalty for violation.--The department shall adopt rules necessary to carry out the provisions of this part which shall be consistent with rules and regulations established by the Secretary pursuant to the Balanced Budget Act of 1997 for Medicare+Choice plans. Any violation of a rule adopted under this section shall subject the violating entity to the provisions of s. 641.823.

641.871 Dividends.--

(1) A provider sponsored organization shall 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 shall 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 provider sponsored 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 shall not approve a dividend or distribution in excess of the maximum amount allowed in

subsection (1) unless it determines that the distribution or dividend would 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 declaration or payment of a dividend to stockholders when such declaration is in violation of this section is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083, and shall be 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 receiving such an illegal dividend shall be 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 which has declared or paid such an illegal dividend.

641.873 Prohibited activities; penalties.--

(1) Any person or entity which 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 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 or s. 775.083.

(2) Except as provided in subsection (1), any person, entity, or provider sponsored organization which knowingly violates the provisions of this part is guilty of 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 statements or representation in, or with reference to, any application or negotiation for provider sponsored organization coverage is, in addition to any other penalty provided by law, guilty of 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 is, in addition to the other penalties provided for by law, guilty of 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 is, in addition to the other penalties provided for by law, guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

641.875 Order to discontinue certain advertising.--If in the opinion of the department any advertisement by a provider sponsored organization violates any of the provisions of 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 of 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 was in fact violative of any provision of this part, the department may, in lieu of revocation of the certificate of authority, require the publication of 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.

641.877 Agent licensing and appointment required; exceptions.--

(1) With respect to a provider sponsored contract, no person shall, 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 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 shall apply to provider sponsored organizations and

to persons licensed or appointed by the provider sponsored organization as their 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 organization contracts from the public and who receives no commission or other compensation directly dependent upon the solicitation of such contracts. This exemption does not apply to the solicitation of Medicaid eligible subscribers.

(4) All agents and provider sponsored organizations shall comply with and be subject to the applicable provisions of this section and s. 409.912(18), and all companies and entities appointing agents shall comply with s. 626.451, when marketing for any provider sponsored organization licensed pursuant to this part, including those organizations under contract with the Agency for Health Care Administration to provide health care services to Medicaid recipients or any private entity providing health care services to Medicaid recipients pursuant to a prepaid health plan contract with the Agency for Health Care Administration.

641.879 Unfair methods of competition and unfair or deceptive acts or practices prohibited.--No person, entity, or provider sponsored organization shall engage in this state in any trade practice which is defined in this part as, or determined pursuant to s. 641.883 to be, an unfair method of competition or an unfair or deceptive act or practice involving the business of provider sponsored organizations.

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

defined as 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 which:

(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 misrepresenting the true nature thereof.

(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 which, by virtue of the design, location, or size of printed matter, is deceptive or misleading or which would be deceptive or misleading to any reasonable person.

(k) Offers to provide a service which 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 containing 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,

which is false or maliciously critical of any person and which 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 which 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; or

(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 not to 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 provide promptly a reasonable explanation in writing to the subscriber of the basis in the provider sponsored contract in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement;

7. Failing to provide, upon written request of a subscriber, itemized statements verifying that services and supplies were furnished, where such statement is necessary for the submission of other insurance claims covered by individual specified disease or limited benefit policies, provided that the organization may receive from the subscriber a reasonable administrative charge for the cost of preparing such statement; or

8. Failing to provide any subscriber with services, care, or treatment contracted for pursuant to any provider sponsored contract without a reasonable basis to believe 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) OPERATION WITHOUT A SUBSISTING CERTIFICATE OF AUTHORITY.--Operation of a provider sponsored organization by any person or entity without a subsisting certificate of authority therefor or renewal, issuance, or delivery of any provider sponsored contract by a provider sponsored organization, person, or entity without a subsisting certificate of authority.

(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 provider sponsored organization; agent; or representative, broker, or 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 which 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, in accordance with the applicable classifications and rates as filed with the department, and as specified in the provider sponsored contract.

(11) FALSE CLAIMS; OBTAINING OR RETAINING MONEY DISHONESTLY.--Any agent or representative, physician, claimant, or other person who causes to be presented to any

provider sponsored organization a false claim for payment knowing the same to be false.

(12) PROHIBITED DISCRIMINATORY PRACTICES.--A provider sponsored organization may not refuse 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 potential enrollees as to the availability of providers.

641.883 General powers and duties of the department.--In addition to the powers and duties set forth in s. 624.307, the department shall have the power to 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 the provisions of 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. 641.879.

641.885 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. 641.881 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 pursuant to s. 1856(a)(2) of the Balanced Budget Act of 1997, and that a proceeding by it in respect thereto would be to 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, during the conduct of such hearing, shall have those powers enumerated in s. 120.569; however, the penalties for failure to comply with a subpoena or with an order directing discovery shall be 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, shall be proof of the same, and the return postcard receipt for such statement, notice, order, or other process, certified and mailed as aforesaid, shall be proof of service of the same.

641.887 Cease and desist and penalty orders.--After the hearing provided in s. 641.885, 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. 641.879 or s. 641.881, 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 pursuant to s. 1856(a)(2) of the Balanced Budget Act of 1997, an administrative penalty not to exceed $1,000 for each provider sponsored contract offered or effectuated.

641.889 Appeals from the department.--Any person, entity, or provider sponsored organization subject to an order of the department under s. 641.887 or s. 641.891 may obtain a review of the order by filing an appeal therefrom in accordance with the provisions and procedures for appeal under s. 120.68.

641.891 Penalty for violation of cease and desist orders.--Any person, entity, or provider sponsored organization which violates a cease and desist order of the department under s. 641.887 while such order is in effect, after notice and hearing as provided in s. 641.885, shall be 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 such hearing.

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

641.893 Civil liability.--The provisions of this part are cumulative to rights under the general civil and common law, and no action of the department shall abrogate such rights to damage or other relief in any court.

641.895 Exemption.--Provider service organizations are exempt from s. 455.654 in providing health care services for Medicare+Choice enrollees.

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

641.316 Fiscal intermediary services.--

(2)(a) The term "fiduciary" or "fiscal intermediary services" means reimbursements received or collected on behalf of health care professionals for services rendered, patient and provider accounting, financial reporting and auditing, receipts and collections management, compensation and reimbursement disbursement services, or other related fiduciary services pursuant to health care professional contracts with health maintenance organizations or provider sponsored organizations.

(b) The term "fiscal intermediary services organization" means a person or entity 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 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 or a provider sponsored organization licensed under chapter 636, a health maintenance 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. Section 641.227, Florida Statutes, is amended to read:

641.227 Rehabilitation Administrative Expense Fund.--

(1) The department shall not issue or permit to exist a certificate of authority to operate a health maintenance organization or 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 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 a provider sponsored organization, when rehabilitation is ordered by a court of competent jurisdiction.

(3) Upon successful rehabilitation of a health maintenance organization or 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.

(4) If a court of competent jurisdiction orders liquidation of a health maintenance organization or a 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 the provider sponsored organization. The deposit shall be refunded to the organization only when the organization both ceases operation as a health maintenance organization or a provider sponsored organization and no longer holds a subsisting certificate of authority.

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 contract is governed by the rules and regulations established by the Secretary of the United States Department of Health and Human Services pursuant to the Balanced Budget Act of 1997 as it applies to provider sponsored organizations offering Medicare+Choice plans.

(11) "Health care services" means comprehensive health care services, as defined in s. 641.19, when applicable to a

health maintenance organization, the benefit package for Medicare beneficiaries established by the federal government when applicable to provider sponsored organizations, and means 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. 641.805, 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, or in the case of a provider sponsored organization, 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 IV of this chapter.

Section 7. Subsections (1) and (2) and paragraphs (q) and (r) of subsection (3) of section 641.49, Florida Statutes, are amended to read:

641.49 Certification of health maintenance organization, provider sponsored organization, and prepaid

health clinic as health care providers; application procedure.--

(1) No person or governmental unit shall establish, conduct, or maintain a health maintenance organization, 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 shall not issue a certificate of authority under part I, ~~or~~ part II, or part IV of this chapter to any applicant 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 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:

(q) A description and supporting documentation concerning how the applicant, ~~or~~ health maintenance organization, or provider sponsored 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, or provider sponsored organization's stated geographic area.

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) Within 90 days after receiving an application for a health care provider certificate, the agency shall 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 or provider sponsored organization. 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 organization, and prepaid health clinic to be accredited within 1 year 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) In the event that no accreditation organization 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 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 health maintenance organization or provider sponsored organization activities and in the appraisal of medical practice and quality assurance in a health maintenance organization setting or, in the case of provider sponsored organizations, in the appraisal of medical practice and quality assurance in the provider sponsored organization setting. The accreditation or review organization shall not currently be involved in the operation of the health maintenance organization, provider sponsored organization, or prepaid health clinic, nor in the delivery of health care services to its subscribers. The accreditation or review organization 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 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 health maintenance organization, provider sponsored organization, and prepaid health clinic certification pursuant to 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 health maintenance organization's, provider sponsored organization's, or prepaid health clinic's board of directors. A copy of the report shall be submitted to the department by the organization within 30 business days 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 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 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 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 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 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. Subsection (1) and paragraph (b) of subsection (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 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:

(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 the 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 or prepaid health clinic. A health maintenance organization, provider sponsored organization, or prepaid health clinic may provide aggregate data 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 of the year in which enacted.

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HOUSE SUMMARY

Creates pt. IV of ch. 641, F.S., to provide for establishing, licensing, regulating, administering, and enforcing compliance by provider sponsored organizations, which provide a substantial proportion of the health care items and services required in Medicare+Choice contract under the Medicare+Choice program, as an alternative to health maintenance organizations.