Bill No. CS/HB 903, 1st Eng.

Amendment No. ___

CHAMBER ACTION

Senate	House
.	
.	
.	
.	
.	
.	

Senator Scott moved the following substitute for amendment (800576):

Senate Amendment (with title amendment)

On page 6, line 1, delete that line

and insert:

Section 2. Section 408.70, Florida Statutes, is amended to read:

408.70 Health Alliance for Small Business ~~Community health purchasing~~; legislative ~~findings and~~ intent.--It is the intent of the Legislature that a nonprofit corporation, to be known as the "Health Alliance for Small Business," be organized for the purpose of pooling by regions groups of individuals employed by small employers and the dependents of such employees into larger groups in order to facilitate the purchase of affordable group health insurance coverage.

~~(1) The Legislature finds that the current health care system in this state does not provide access to affordable health care for all persons in this state. Almost one in five persons is without health insurance. For many, entry into the~~

~~health care system is through a hospital emergency room rather than a primary care setting. The availability of preventive and primary care and managed, family-based care is limited. Health insurance underwriting practices have led to the avoidance, rather than to the sharing, of insurance risks, limiting access to coverages for small-sized employer groups and high-risk populations. Spiraling premium costs have placed health insurance policies out of the reach of many small-sized and medium-sized businesses and their employees. Lack of outcome and cost information has forced individuals and businesses to make critical health care decisions with little guidance or leverage. Health care resources have not been allocated efficiently, leading to excess and unevenly distributed capacity. These factors have contributed to the high cost of health care. Rural and other medically underserved areas have too few health care resources. Comprehensive, first-dollar coverages have allowed individuals to seek care without regard to cost. Provider competition and liability concerns have led to a medical technology arms race. Rather than competing on the basis of price and patient outcome, health care providers compete for patients on the basis of service, equipping themselves with the latest and best technologies. Managed-care and group-purchasing mechanisms are not widely available to small group purchasers. Health care regulation has placed undue burdens on health care insurers and providers, driving up costs, limiting competition, and preventing market-based solutions to cost and quality problems. Health care costs have been increasing at several times the rate of general inflation, eroding employer profits and investments, increasing government revenue requirements, reducing consumer coverages and purchasing~~

~~power, and limiting public investments in other vital governmental services.~~

~~(2) It is the intent of the Legislature that a structured health care competition model, known as "managed competition," be implemented throughout the state to improve the efficiency of the health care markets in this state. The managed competition model will promote the pooling of purchaser and consumer buying power; ensure informed cost-conscious consumer choice of managed care plans; reward providers for high-quality, economical care; increase access to care for uninsured persons; and control the rate of inflation in health care costs.~~

~~(3) The Legislature intends that state-chartered, nonprofit private purchasing organizations, to be known as "community health purchasing alliances," be established. The community health purchasing alliances shall be responsible for assisting alliance members in securing the highest quality of health care, based on current standards, at the lowest possible prices.~~

Section 3. Section 408.701, Florida Statutes, 1998 Supplement, is amended to read:

408.701 Health Alliance for Small Business ~~Community health purchasing~~; definitions.--As used in ss. 408.70-408.7045 ~~ss. 408.70-408.706~~, the term:

~~(1) "Accountable health partnership" means an organization that integrates health care providers and facilities and assumes risk, in order to provide health care services, as certified by the agency under s. 408.704.~~

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

(2)~~(3)~~ "Alliance" means the Health Alliance for Small

Business ~~a community health purchasing alliance~~.

(3)~~(4)~~ "Alliance member" means~~:~~

~~(a)~~ a small employer as defined in s. 627.6699 who~~, or~~

~~(b) The state, for the purpose of providing health benefits to state employees and their dependents through the state group insurance program and to Medicaid recipients, participants in the MedAccess program, and participants in the Medicaid buy-in program,~~

~~if such entities~~ voluntarily elects ~~choose~~ to join an alliance.

~~(5) "Antitrust laws" means federal and state laws intended to protect commerce from unlawful restraints, monopolies, and unfair business practices.~~

~~(6) "Associate alliance member" means any purchaser who joins an alliance for the purposes of participating on the alliance board and receiving data from the alliance at no charge as a benefit of membership.~~

~~(7) "Benefit standard" means a specified set of health services that are the minimum that must be covered under a basic health benefit plan, as defined in s. 627.6699.~~

~~(8) "Business health coalition" means a group of employers organized to share information about health services and insurance coverage, to enable the employers to obtain more cost-effective care for their employees.~~

~~(9) "Community health purchasing alliance" means a state-chartered, nonprofit organization that provides member-purchasing services and detailed information to its members on comparative prices, usage, outcomes, quality, and enrollee satisfaction with accountable health partnerships.~~

~~(10) "Consumer" means an individual user of health~~

~~care services.~~

~~(11) "Department" means the Department of Insurance.~~

~~(12) "Grievance procedure" means an established set of rules that specify a process for appeal of an organizational decision.~~

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

(5)~~(14)~~ "Health insurer" or "insurer" means a health insurer or health maintenance organization that is issued a certificate of authority ~~an organization licensed~~ by the Department of Insurance under part III of chapter 624 or part I of chapter 641.

(6)~~(15)~~ "Health plan" or "health insurance"means any health insurance policy or health maintenance organization contract issued by a health insurer ~~hospital or medical policy or contract or certificate, hospital or medical service plan contract, or health maintenance organization contract as defined in the insurance code or Health Maintenance~~

~~Organization Act~~. The term does not include accident-only, specific disease, individual hospital indemnity, credit, ~~dental-only, vision-only,~~Medicare supplement, long-term care, or disability income insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical-payment insurance.

(7) "Regional board" means the board of directors of each region of the alliance, as established under s. 408.702(1).

(8) "State board" or "board" means the board of directors of the alliance, as established under s. 408.702(2).

~~(16) "Health status" means an assessment of an individual's mental and physical condition.~~

~~(17) "Managed care" means systems or techniques generally used by third-party payors or their agents to affect access to and control payment for health care services. Managed-care techniques most often include one or more of the following: prior, concurrent, and retrospective review of the medical necessity and appropriateness of services or site of services; contracts with selected health care providers; financial incentives or disincentives related to the use of specific providers, services, or service sites; controlled access to and coordination of services by a case manager; and payor efforts to identify treatment alternatives and modify benefit restrictions for high-cost patient care.~~

~~(18) "Managed competition" means a process by which purchasers form alliances to obtain information on, and purchase from, competing accountable health partnerships.~~

~~(19) "Medical outcome" means a change in an individual's health status after the provision of health services.~~

~~(20) "Provider network" means an affiliated group of varied health care providers that is established to provide a continuum of health care services to individuals.~~

~~(21) "Purchaser" means an individual, an organization, or the state that makes health-benefit purchasing decisions on behalf of a group of individuals.~~

~~(22) "Self-funded plan" means a group health insurance plan in which the sponsoring organization assumes the financial risk of paying for all covered services provided to its enrollees.~~

~~(23) "Utilization management" means programs designed to control the overutilization of health services by reviewing their appropriateness relative to established standards or norms.~~

~~(24) "24-hour coverage" means the consolidation of such time-limited health care coverage as personal injury protection under automobile insurance into a general health insurance plan.~~

~~(25) "Agent" means a person who is licensed to sell insurance in this state pursuant to chapter 626.~~

~~(26) "Primary care physician" means a physician licensed under chapter 458 or chapter 459 who practices family medicine, general internal medicine, general pediatrics, or general obstetrics/ gynecology.~~

Section 4. Section 408.702, Florida Statutes, is amended to read:

408.702 Health Alliance for Small Business ~~Community health purchasing alliance~~; establishment; state and regional boards.--

(1) There is created the Health Alliance for Small Business, which shall operate as a nonprofit corporation

organized under chapter 617. The alliance is not a state agency. The alliance shall operate subject to the supervision and approval of a board of directors composed of the chairman of each of the regional boards of the alliance or, in lieu of the chairman, a member of a regional board designated by the chairman of that board.

(2)(a) The board of directors of each community health purchasing alliance is redesignated as a regional board of the Health Alliance for Small Business. Each regional board shall operate as a nonprofit corporation organized under chapter 617. A regional board is not a state agency.

(b) The regional board replacing such community health purchasing alliance shall assume the rights and obligations of each former community health purchasing alliance as necessary to fulfill the former alliance's contractual obligations existing on the effective date of this act. Nothing in this section shall impair or otherwise affect any such contract.

(3)~~(1) There is created a community health purchasing alliance in each of the 11 health service planning districts established under s. 408.032. Each alliance must be operated as a state-chartered, nonprofit private organization organized pursuant to chapter 617.~~There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member of the board of directors of the ~~a community health purchasing~~ alliance or of any regional board, or their ~~its~~ employees or agents, for any action taken by a ~~the~~ board in the performance of its powers and duties under ss. 408.70-408.7045 ~~ss. 408.70-408.706~~.

(4)~~(2)~~ The number and geographical boundaries of alliance districts may be revised by the state board ~~Three or fewer alliances located in contiguous districts that are not~~

~~primarily urban may merge into a single alliance~~ upon approval of the agency based on ~~upon~~ a showing by the ~~alliance~~ board ~~members~~ that the members of the ~~each~~ alliance would be better served ~~under a combined alliance~~. If the number or boundaries of regional alliances are revised, the members of the new regional boards for the affected regions must be representative of the members of the former regional boards of the affected regions in a method established by the state board which reasonably provides for proportionate representation of former board members.~~Board members of each alliance shall serve as the board of the combined alliance.~~

(5)~~(3)~~ The ~~An~~ alliance ~~is the only entity that is allowed to operate as an alliance in a particular district and~~ must operate for the benefit of its members who are~~:~~small employers, as defined in s. 627.6699~~; the state on behalf of its employees and the dependents of such employees; Medicaid recipients; and associate alliance members~~. The ~~An~~ alliance is the exclusive entity for the oversight and coordination of alliance member purchases. Any health plan offered through the ~~an~~ alliance must be offered by a health insurer ~~an accountable health partnership~~ and the ~~an~~ alliance may not directly provide insurance; directly contract, for purposes of providing insurance, with a health care provider or provider network; or bear any risk, or form self-insurance plans among its members. ~~An alliance may form a network with other alliances in order to improve services provided to alliance members.~~Nothing in ss. 408.70-408.7045 ~~ss. 408.70-408.706~~ limits or authorizes the formation of business health coalitions; however, a person or entity that pools together or assists in purchasing health coverage for small employers, as defined in s. 627.6699, ~~state employees and their dependents,~~

~~and Medicaid, Medicaid buy-in, and MedAccess recipients~~ may not discriminate in its activities based on the health status or historical or projected claims experience of such employers or recipients.

~~(4) Each alliance shall capitalize on the expertise of existing business health coalitions.~~

(6)~~(5)~~ Membership ~~or associate membership~~ in the ~~an~~ alliance and participation by health insurers are ~~is~~ voluntary.

(7) The state board of the alliance may:

(a) Establish minimum requirements of alliance membership, consistent with the definition of the term "small employer" in s. 627.6699, including any documentation that an applicant must submit to establish eligibility for membership.

(b) Establish administrative and accounting procedures for its operation and for the operation of the regional boards, and require regional boards to submit program reports to the state board or the agency.

(c) Receive and accept grants, loans, advances, or funds from any public or private agency, and receive and accept, from any source, contributions of money, property, labor, or any other thing of value.

(d) Hire employees or contract with qualified, independent third parties for any service necessary to carry out the regional board's powers and duties, as authorized under ss. 408.70-408.7045. However, the board may not hire an insurance agent who engages in activities on behalf of the alliance for which an insurance agent's license is required by chapter 626.

(8) Each regional board of the alliance may:

(a) Negotiate with health insurers to offer health

plans to alliance members under terms and conditions as agreed to between the regional board, as group policyholder, and the health insurer. The regional board and the insurer may negotiate and agree to health plan selection, benefit design, premium rates, and other terms of coverage, subject to the requirements of the Florida Insurance Code.

(b) Establish conditions of alliance membership consistent with the minimum requirements established by the state board.

(c) Provide to alliance members standardized information for comparing health plans offered through the alliance.

(d) Offer health plans to alliance members, subject to the terms and conditions agreed to by the state board and participating health insurers.

(e) Market and publicize the coverage and services offered by the alliance.

(f) Collect premiums from alliance members on behalf of participating health insurers.

(g) Assist members in resolving disputes between health insurers and alliance members, consistent with grievance procedures required by law.

(h) Set reasonable fees for alliance membership, services offered by the alliance, and late payment of premiums by alliance members for which the alliance is responsible.

(i) Receive and accept grants, loans, advances, or funds from any public or private agency, and receive and accept, from any source, contributions of money, property, labor, or any other thing of value.

(j) Hire employees or contract with qualified, independent third parties for any service necessary to carry

out the regional board's powers and duties as authorized under ss. 408.70-408.7045. However, a regional board may not hire an insurance agent who engages in activities on behalf of the alliance for which an insurance agent's license is required by chapter 626.

(9) No state agency may expend or provide funds to the Alliance that would subsidize the pricing of health insurance policies for its members or the cost of the alliance's activities, unless the Legislature specifically authorizes such expenditure.

~~(6) Each community health purchasing alliance has the following powers, duties, and responsibilities:~~

~~(a) Establishing the conditions of alliance membership in accordance with ss. 408.70-408.706.~~

~~(b) Providing to alliance members clear, standardized information on each accountable health partnership and each health plan offered by each accountable health partnership, including information on price, enrollee costs, quality, patient satisfaction, enrollment, and enrollee responsibilities and obligations; and providing accountable health partnership comparison sheets in accordance with agency rule to be used in providing members and their employees with information regarding standard, basic, and specialized coverage that may be obtained through the accountable health partnerships.~~

~~(c) Annually offering to all alliance members all accountable health partnerships and health plans offered by the accountable health partnerships which meet the requirements of ss. 408.70-408.706, and which submit a responsive proposal as to information necessary for accountable health partnership comparison sheets, and~~

~~providing assistance to alliance members in selecting and obtaining coverage through accountable health partnerships that meet those requirements.~~

~~(d) Requesting proposals for the standard and basic health plans, as defined in s. 627.6699, from all accountable health partnerships in the district; providing, in the format required by the alliance in the request for proposals, the necessary information for accountable health partnership comparison sheets; and offering to its members health plans of accountable health partnerships which meet those requirements.~~

~~(e) Requesting proposals from all accountable health partnerships in the district for specialized benefits approved by the alliance board based on input from alliance members, determining if the proposals submitted by the accountable health partnerships meet the requirements of the request for proposals, and offering them as options through riders to standard plans and basic plans. This paragraph does not limit an accountable health partnership's ability to offer other specialized benefits to alliance members.~~

~~(f) Distributing to health care purchasers, placing special emphasis on the elderly, retail price data on prescription drugs and their generic equivalents, durable medical equipment, and disposable medical supplies which is provided by the agency pursuant to s. 408.063(3) and (4).~~

~~(g) Establishing administrative and accounting procedures for the operation of the alliance and members' services, preparing an annual alliance budget, and preparing annual program and fiscal reports on alliance operations as required by the agency.~~

~~(h) Developing and implementing a marketing plan to publicize the alliance to potential members and associate~~

~~members and developing and implementing methods for informing the public about the alliance and its services.~~

~~(i) Developing grievance procedures to be used in resolving disputes between members and the alliance and disputes between the accountable health partnerships and the alliance. Any member of, or accountable health partnership that serves, an alliance may appeal to the agency any grievance that is not resolved by the alliance.~~

~~(j) Ensuring that accountable health partnerships have grievance procedures to be used in resolving disputes between members and an accountable health partnership. A member may appeal to the alliance any grievance that is not resolved by the accountable health partnership. An accountable health partnership that is a health maintenance organization must follow the grievance procedures established in ss. 408.7056 and 641.31(5).~~

~~(k) Maintaining all records, reports, and other information required by the agency, ss. 408.70-408.706, or other state and local laws.~~

~~(l) Receiving and accepting grants, loans, advances, or funds from any public or private agency; and receiving and accepting contributions, from any source, of money, property, labor, or any other thing of value.~~

~~(m) Contracting, as authorized by alliance members, with a qualified, independent third party for any service necessary to carry out the powers and duties required by ss. 408.70-408.706.~~

~~(n) Developing a plan to facilitate participation of providers in the district in an accountable health partnership, placing special emphasis on ensuring participation by minority physicians in accountable health~~

~~partnerships if such physicians are available. The use of the term "minority" in ss. 408.70-408.706 is consistent with the definition of "minority person" provided in s. 288.703(3).~~

~~(o) Ensuring that any health plan reasonably available within the jurisdiction of an alliance, through a preferred provider network, a point of service product, an exclusive provider organization, a health maintenance organization, or a pure indemnity product, is offered to members of the alliance. For the purposes of this paragraph, "pure indemnity product" means a health insurance policy or contract that does not provide different rates of reimbursement for a specified list of physicians and a "point of service product" means a preferred provider network or a health maintenance organization which allows members to select at a higher cost a provider outside of the network or the health maintenance organization.~~

~~(p) Petitioning the agency for a determination as to the cost-effectiveness of collecting premiums on behalf of participating accountable health partnerships. If determined by the agency to be cost-effective, the alliance may establish procedures for collecting premiums from members and distribute them to the participating accountable health partnerships. This may include the remittance of the share of the group premium paid by both an employer and an enrollee. If an alliance assumes premium collection responsibility, it shall also assume liability for uncollected premium. This liability may be collected through a bad debt surcharge on alliance members to finance the cost of uncollected premiums. The alliance shall pay participating accountable health partnerships their contracting premium amounts on a prepaid monthly basis, or as otherwise mutually agreed upon.~~

~~(7) Each alliance shall set reasonable fees for membership in the alliance which will finance all reasonable and necessary costs incurred in administering the alliance.~~

(9)~~(8)~~ Each regional board ~~alliance~~ shall annually report to the state board on the operations of the alliance in that region, including program and financial operations, and shall provide for annual internal and independent audits.

(10)~~(9)~~ The alliance, the state board, and regional boards ~~A community health purchasing alliance~~ may not engage in any activities for which an insurance agent's license is required by chapter 626. Any licensed health agent in good standing with the Department of Insurance, who is otherwise appointed to sell health insurance in this state, may place alliance members coverage with an insurer selected to provide such coverage by a regional board without being required to secure an appointment with such insurer. An insurer shall not be liable for the acts of an agent not appointed by it in producing alliance business. This subsection does not prohibit the alliance from requiring minimal training or education related to activities of the alliance.

(11)~~(10)~~ The powers and responsibilities of the ~~a community health purchasing~~ alliance with respect to purchasing health plans ~~services~~ from health insurers ~~accountable health partnerships~~ do not extend beyond those enumerated in ss. 408.70-408.7045 ~~ss. 408.70-408.706~~.

(12) The Office of the Auditor General may audit and inspect the operations and records of the alliance.

Section 5. Section 408.703, Florida Statutes, is amended to read:

408.703 Small employer members of the alliance ~~community health purchasing alliances~~; eligibility

requirements.--

(1) The board ~~agency~~ shall establish conditions of participation in the alliance for small employers, as defined in s. 627.6699, which must include, but need not be limited to:

(a) Assurance that the group is a valid small employer and is not formed for the purpose of securing health benefit coverage. This assurance must include requirements for sole proprietors and self-employed individuals which must be based on a specified requirement for the time that the sole proprietor or self-employed individual has been in business, required filings to verify employment status, and other requirements to ensure that the individual is working.

(b) Assurance that the individuals in the small employer group are employees and have not been added for the purpose of securing health benefit coverage.

~~(2) The agency may not require a small employer to pay any portion of premiums as a condition of participation in an alliance.~~

(2)~~(3)~~ The board ~~agency~~ may require a small employer seeking membership to agree to participate in the alliance for a specified minimum period of time, not to exceed 1 year.

~~(4) If a member small employer offers more than one accountable health partnership or health plan and the employer contributes to coverage of employees or dependents of the employee, the alliance shall require that the employer contribute the same dollar amount for each employee, regardless of the accountable health partnership or benefit plan chosen by the employee.~~

~~(5) An employer that employs 30 or fewer employees must offer at least 2 accountable health partnerships or~~

~~health plans to its employees, and an employer that employs 31 or more employees must offer 3 or more accountable health partnerships or health plans to its employees.~~

(3)~~(6)~~ Notwithstanding any other law, if a small employer member loses eligibility to purchase health care through the ~~a community health purchasing~~ alliance solely because the business of the small employer member expands to more than 50 and less than 75 eligible employees, the small employer member may, at its next renewal date, purchase coverage through the alliance for not more than 1 additional year.

Section 6. Section 408.704, Florida Statutes, 1998 Supplement, is amended to read:

408.704 Agency duties and responsibilities related to the alliance ~~community health purchasing alliances~~.--

(1) The agency shall supervise the operation of the alliance.~~assist in developing a statewide system of community health purchasing alliances. To this end, the agency is responsible for:~~

~~(1) Initially and thereafter annually certifying that each community health purchasing alliance complies with ss. 408.70-408.706 and rules adopted pursuant to ss. 408.70-408.706. The agency may decertify any community health purchasing alliance if the alliance fails to comply with ss. 408.70-408.706 and rules adopted by the agency.~~

(2) The agency shall conduct ~~Providing administrative startup funds. Each contract for startup funds is limited to $275,000.~~

~~(3) Conducting~~ an annual review of the performance of the ~~each~~ alliance to ensure that the alliance is in compliance with ss. 408.70-408.7045 ~~ss. 408.70-408.706~~. To assist the

agency in its review, the ~~each~~ alliance shall submit, quarterly, data to the agency, including, but not limited to, employer enrollment by employer size, ~~industry sector,~~ previous insurance status, and count; number of total eligible employers in the alliance district participating in the alliance; number of insured lives by county and insured category, including employees, dependents, and other insured categories, represented by alliance members; profiles of potential employer membership by county; premium ranges for each health insurer ~~accountable health partnership~~ for alliance member categories; type and resolution of member grievances; membership fees; and alliance financial statements. A summary of this annual review shall be provided to the Legislature and to each alliance.

~~(4) Developing accountable health partnership comparison sheets to be used in providing members and their employees with information regarding the accountable health partnership.~~

~~(5) Establishing a data system for accountable health partnerships.~~

~~(a) The agency shall establish an advisory data committee comprised of the following representatives of employers, medical providers, hospitals, health maintenance organizations, and insurers:~~

~~1. Two representatives appointed by each of the following organizations: Associated Industries of Florida, the Florida Chamber of Commerce, the National Federation of Independent Businesses, and the Florida Retail Federation;~~

~~2. One representative of each of the following organizations: the Florida League of Hospitals, the Association of Voluntary Hospitals of Florida, the Florida~~

~~Hospital Association, the Florida Medical Association, the Florida Osteopathic Medical Association, the Florida Chiropractic Association, the Florida Chapter of the National Medical Association, the Association of Managed Care Physicians, the Florida Insurance Council, the Florida Association of Domestic Insurers, the Florida Association of Health Maintenance Organizations; and~~

~~3. One representative of governmental health care purchasers and three consumer representatives, to be appointed by the agency.~~

~~(b) The advisory data committee shall issue a report and recommendations on each of the following subjects as each is completed. A final report covering all subjects must be included in the final Florida Health Plan to be submitted to the Legislature on December 31, 1993. The report shall include recommendations regarding:~~

~~1. Types of data to be collected. Careful consideration shall be given to other data collection projects and standards for electronic data interchanges already in process in this state and nationally, to evaluating and recommending the feasibility and cost-effectiveness of various data collection activities, and to ensuring that data reporting is necessary to support the evaluation of providers with respect to cost containment, access, quality, control of expensive technologies, and customer satisfaction analysis. Data elements to be collected from providers include prices, utilization, patient outcomes, quality, and patient satisfaction. The completion of this task is the first priority of the advisory data committee. The agency shall begin implementing these data collection activities immediately upon receipt of the recommendations, but no later~~

~~than January 1, 1994. The data shall be submitted by hospitals, other licensed health care facilities, pharmacists, and group practices as defined in s. 455.654(3)(f).~~

~~2. A standard data set, a standard cost-effective format for collecting the data, and a standard methodology for reporting the data to the agency, or its designee, and to the alliances. The reporting mechanisms must be designed to minimize the administrative burden and cost to health care providers and carriers. A methodology shall be developed for aggregating data in a standardized format for making comparisons between accountable health partnerships which takes advantage of national models and activities.~~

~~3. Methods by which the agency should collect, process, analyze, and distribute the data.~~

~~4. Standards for data interpretation. The advisory data committee shall actively solicit broad input from the provider community, carriers, the business community, and the general public.~~

~~5. Structuring the data collection process to:~~

~~a. Incorporate safeguards to ensure that the health care services utilization data collected is reviewed by experienced, practicing physicians licensed to practice medicine in this state;~~

~~b. Require that carrier customer satisfaction data conclusions are validated by the agency;~~

~~c. Protect the confidentiality of medical information to protect the patient's identity and to protect the privacy of individual physicians and patients. Proprietary data submitted by insurers, providers, and purchasers are confidential pursuant to s. 408.061; and~~

~~d. Afford all interested professional medical and~~

~~hospital associations and carriers a minimum of 60 days to review and comment before data is released to the public.~~

~~6. Developing a data collection implementation schedule, based on the data collection capabilities of carriers and providers.~~

~~(c) In developing data recommendations, the advisory data committee shall assess the cost-effectiveness of collecting data from individual physician providers. The initial emphasis must be placed on collecting data from those providers with whom the highest percentages of the health care dollars are spent: hospitals, large physician group practices, outpatient facilities, and pharmacies.~~

~~(d) The agency shall, to the maximum extent possible, adopt and implement the recommendations of the advisory data committee. The agency shall report all recommendations of the advisory data committee to the Legislature and submit an implementation plan.~~

~~(e) The travel expenses of the participants of the advisory data committee must be paid by the participant or by the organization that nominated the participant.~~

~~(6) Collecting, compiling, and analyzing data on accountable health partnerships and providing statistical information to alliances.~~

~~(7) Receiving appeals by members of an alliance and accountable health partnerships whose grievances were not resolved by the alliance. The agency shall review these appeals pursuant to chapter 120. Records or reports submitted as a part of a grievance proceeding conducted as provided for under this subsection are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution. Records or reports of patient care quality~~

~~assurance proceedings obtained or made by any member of a community health purchasing alliance or any member of an accountable health partnership and received by the agency as a part of a proceeding conducted pursuant to this subsection are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution. Portions of meetings held pursuant to the provisions of this subsection during which records held confidential pursuant to the provisions of this subsection are discussed are exempt from the provisions of s. 286.011 and s. 24(b), Art. I of the State Constitution. All portions of any meeting closed to the public shall be recorded by a certified court reporter. For any portion of a meeting that is closed, the reporter shall record the times of commencement and termination of the meeting, all discussion and proceedings, the names of all persons present at any time, and the names of all persons speaking. No portion of the closed meeting shall be off the record. The court reporter's notes shall be fully transcribed and given to the appropriate records custodian within a reasonable time after the meeting. A copy of the original transcript, with information otherwise confidential or exempt from public disclosure redacted, shall be made available for public inspection and copying 3 years after the date of the closed meeting.~~

Section 7. Section 408.7045, Florida Statutes, is amended to read:

408.7045 ~~Community health purchasing~~ Alliance marketing requirements.--

(1) The ~~Each~~ alliance shall use appropriate, efficient, and standardized means to notify members of the availability of sponsored health coverage from the alliance.

(2) The ~~Each~~ alliance shall make available to members

marketing materials that accurately summarize the benefit plans that are offered by its health insurer ~~accountable health partnerships~~ and the rates, costs, and accreditation information relating to those plans.

~~(3) Annually, the alliance shall offer each member small employer all accountable health partnerships available in the alliance and provide them with the appropriate materials relating to those plans. The member small employer may choose which health benefit plans shall be offered to eligible employees and may change the selection each year. The employee may be given options with regard to health plans and the type of managed care system under which his or her benefits will be provided.~~

~~(4) An alliance may notify the agency of any marketing practices or materials that it finds are contrary to the fair and affirmative marketing requirements of the program. Upon the request of an alliance, the agency shall request the Department of Insurance to investigate the practices and the Department of Insurance may take any action authorized for a violation of the insurance code or the Health Maintenance Organization Act.~~

Section 8. Paragraph (b) of subsection (6) of section 627.6699, Florida Statutes, 1998 Supplement, is amended to read:

627.6699 Employee Health Care Access Act.--

(6) RESTRICTIONS RELATING TO PREMIUM RATES.--

(b) For all small employer health benefit plans that are subject to this section and are issued by small employer carriers on or after January 1, 1994, premium rates for health benefit plans subject to this section are subject to the following:

1. Small employer carriers must use a modified community rating methodology in which the premium for each small employer must be determined solely on the basis of the eligible employee's and eligible dependent's gender, age, family composition, tobacco use, or geographic area as determined under paragraph (5)(j) ~~(5)(k)~~.

2. Rating factors related to age, gender, family composition, tobacco use, or geographic location may be developed by each carrier to reflect the carrier's experience. The factors used by carriers are subject to department review and approval.

3. Small employer carriers may not modify the rate for a small employer for 12 months from the initial issue date or renewal date, unless the composition of the group changes or benefits are changed. However, a small employer carrier may modify the rate one time prior to 12 months after the initial issue date for a small employer who enrolls under a previously issued group policy that has a common anniversary date for all employers covered under the policy, if the carrier discloses to the employer in a clear and conspicuous manner the date of the first renewal and the fact that the premium may increase on or after that date and if the insurer demonstrates to the department that efficiencies in administration are achieved and reflected in the rates charged to small employers covered under the policy.

4. A small employer carrier may issue a policy to a group association with rates that reflect a premium credit for expense savings attributable to administrative activities being performed by the group association, if these expense savings are specifically documented in the carrier's rate filing and are approved by the department. Any such credit may

not be based on different morbidity assumptions or on any other factor related to the health status or claims experience of the group or its members. ~~Carriers participating in the alliance program, in accordance with ss. 408.700-408.707, may apply a different community rate to business written in that program.~~

(c) For all small employer health benefit plans that are subject to this section, that are issued by small employer carriers before January 1, 1994, and that are renewed on or after January 1, 1995, renewal rates must be based on the same modified community rating standard applied to new business.

(d) Notwithstanding s. 627.401(2), this section and ss. 627.410 and 627.411 apply to any health benefit plan provided by a small employer carrier that provides coverage to one or more employees of a small employer regardless of where the policy, certificate, or contract is issued or delivered, if the health benefit plan covers employees or their covered dependents who are residents of this state.

Section 9. Sections 408.7041, 408.7042, 408.7055, and 408.706, Florida Statutes, are repealed.

Section 10. This act shall take effect July 1, 1999.

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

On page 1, lines 2-9, delete those lines

and insert:

An act relating to health insurance for small employers; amending s. 627.6699, F.S.; modifying definitions; requiring small employer

carriers to begin to offer and issue all small employer benefit plans on a specified date; deleting the requirement that basic and standard small employer health benefit plans be issued; providing additional requirements for determining premium rates for benefit plans; providing for applicability of the act to plans provided by small employer carriers that are insurers or health maintenance organizations notwithstanding the provisions of certain other specified statutes under specified conditions; amending s. 408.70, F.S.; providing legislative intent for the organization of a nonprofit corporation for providing affordable group health insurance; amending s. 408.701, F.S.; revising definitions; amending s. 408.702, F.S.; creating the Health Alliance for Small Business; deleting authorization for community health purchasing alliances; creating a board of governors for the alliance; specifying organizational requirements; specifying that the alliance is not a state agency; redesignating community health purchasing alliances as regional boards of the alliance; revising provisions related to liability of board members, number and boundary of alliance districts, eligibility for alliance membership, and powers of the state board and regional boards of the alliance; authorizing the Office of the Auditor General to audit and inspect the alliance; prohibiting state agencies from

providing certain funds to the alliance without specific legislative approval; amending s. 408.703, F.S.; providing eligibility requirements for small employer members of the alliance; amending s. 408.704, F.S.; providing responsibilities for the Agency for Health Care Administration; amending s. 408.7045, F.S.; revising marketing requirements of the alliance; amending s. 627.6699, F.S.; revising restrictions related to premium rates for small employer health benefit plans; repealing ss. 408.7041, 408.7042, 408.7055, 408.706, F.S., relating to anti-trust protection, relating to purchasing coverage for state employees and Medicaid recipients through community health purchasing alliances, relating to the establishment of practitioner advisory groups by the Agency for Health Care Administration, and relating to requirements for accountable health partnerships; providing an effective date.