By Senator Saunders

25-2397-02

1 A bill to be entitled
2 An act relating to health regulation; amending
3 s. 20.43, F.S.; updating a reference to provide
4 the name of a regulatory board under the
5 Division of Medical Quality Assurance;
6 eliminating the Department of Health's
7 authority to enter into a contract with the
8 Agency for Health Care Administration for
9 consumer complaint services, investigations,
10 and prosecutorial services; repealing s.
11 456.047, F.S.; terminating the standardized
12 credentialing program for health care
13 practitioners; prohibiting the refund of moneys
14 collected through the credentialing program;
15 amending ss. 456.039, 456.0391, 456.077, F.S.;
16 removing references, to conform; amending s.
17 456.072, F.S.; revising provisions governing
18 grounds for discipline; amending s. 458.309,
19 F.S.; requiring accreditation of physician
20 offices in which surgery is performed; amending
21 s. 459.005, F.S.; requiring accreditation of
22 osteopathic physician offices in which surgery
23 is performed; amending s. 456.004, F.S.,
24 relating to powers and duties of the
25 department; requiring performance measures for
26 certain entities; amending s. 456.009, F.S.;
27 requiring performance measures for certain
28 legal and investigative services and annual
29 review of such services to determine whether
30 such performance measures are being met;
31 amending s. 456.011, F.S.; requiring regulatory

1 board committee meetings, including probable
2 cause panels, to be held electronically unless
3 certain conditions are met; amending s.
4 456.026, F.S.; requiring inclusion of
5 performance measures for certain entities in
6 the department's annual report to the
7 Legislature; creating s. 458.3093, F.S.;
8 requiring submission of credentials for initial
9 physician licensure to a national licensure
10 verification service; requiring verification of
11 such credentials by that service or an
12 equivalent program; creating s. 459.0053, F.S.;
13 requiring submission of credentials for initial
14 osteopathic physician licensure to a national
15 licensure verification service; requiring
16 verification of such credentials by that
17 service, a specified association, or an
18 equivalent program; amending ss. 458.331,
19 459.015, F.S.; revising the definition of the
20 term "repeated malpractice" for purposes of
21 disciplinary action against physicians and
22 osteopaths; increasing the monetary limits of
23 claims against certain health care providers
24 which result in investigation; amending s.
25 627.912, F.S.; raising the malpractice closed
26 claims reporting requirement amount; amending
27 s. 456.025, F.S.; eliminating certain
28 restrictions on the setting of licensure
29 renewal fees for health care practitioners;
30 creating s. 456.0165, F.S.; restricting the
31 costs that may be charged by educational

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1 institutions hosting health care practitioner
2 licensure examinations; amending s. 468.302,
3 F.S.; authorizing certified nuclear medicine
4 technologists to administer X radiation from
5 certain devices under certain circumstances;
6 exempting certain persons from radiologic
7 technologist certification and providing
8 certain training requirements for such
9 exemption; amending s. 468.352, F.S.; revising
10 and providing definitions applicable to the
11 regulation of respiratory therapy; amending s.
12 468.355, F.S.; revising provisions relating to
13 respiratory therapy licensure and testing
14 requirements; amending s. 468.368, F.S.;
15 revising exemptions from respiratory therapy
16 licensure requirements; repealing s. 468.356,
17 F.S., relating to the approval of educational
18 programs; repealing s. 468.357, F.S., relating
19 to licensure by examination; renumbering ss.
20 381.0602, 381.6021, 381.6022, 381.6023,
21 381.6024, 381.6026, F.S., and renumbering and
22 amending ss. 381.60225, 381.6025, F.S., to move
23 provisions relating to organ and tissue
24 procurement, donation, and transplantation to
25 part V, ch. 765, F.S., relating to anatomical
26 gifts; conforming cross-references; amending
27 ss. 395.2050, 409.815, 765.5216, 765.522, F.S.;
28 conforming cross-references; amending s.
29 395.002, F.S.; defining the term "medically
30 unnecessary procedure"; amending s. 395.0161,
31 F.S.; requiring the Agency for Health Care

1 Administration to adopt rules governing the
2 conduct of inspections or investigations;
3 amending s. 395.0197, F.S.; revising provisions
4 governing the internal risk management program;
5 amending s. 456.0375, F.S.; redefining the term
6 "clinic"; amending s. 465.019, F.S.; redefining
7 the term "Class II institutional pharmacies";
8 amending s. 631.57, F.S.; exempting medical
9 professional liability insurance premiums from
10 an assessment; amending s. 766.101, F.S.;
11 redefining the term "medical review committee";
12 providing an appropriation for a feasibility
13 study; amending s. 393.064, F.S.; transferring
14 to the Department of Health the responsibility
15 for managing the Raymond C. Philips Research
16 and Education Unit; amending s. 627.6425, F.S.,
17 relating to renewability of individual
18 coverage; providing for circumstances relating
19 to nonrenewal or discontinuance of coverage;
20 amending s. 627.638, F.S.; revising
21 requirements relating to direct payment of
22 benefits to specified providers under certain
23 circumstances; amending s. 381.003, F.S.;
24 requiring the Department of Health to adopt
25 certain standards applicable to all
26 public-sector employers; requiring the
27 compilation and maintenance of certain
28 information by the department for use by
29 employers; amending ss. 765.510, 765.512,
30 765.516, 765.517, F.S.; amending the
31 declaration of legislative intent with respect

1 to certain anatomical gifts; prohibiting
2 modification of a donor's intent; providing
3 that a donor document is legally binding;
4 authorizing specified persons to furnish
5 donors' medical records upon request; revising
6 procedures by which the terms of an anatomical
7 gift may be amended or the gift may be revoked;
8 revising rights and duties with respect to the
9 disposition of a body at death; proscribing
10 legal liability; amending s. 381.0034, F.S.;
11 providing a requirement for instruction of
12 certain health care licensees on conditions
13 caused by nuclear, biological, and chemical
14 terrorism, as a condition of initial licensure,
15 and, in lieu of the requirement for instruction
16 on HIV and AIDS, as a condition of relicensure;
17 amending s. 381.0035, F.S.; providing a
18 requirement for instruction of employees at
19 certain health care facilities on conditions
20 caused by nuclear, biological, and chemical
21 terrorism, upon initial employment, and, in
22 lieu of the requirement of instruction on HIV
23 and AIDS, as biennial continuing education;
24 amending s. 401.23, F.S.; redefining the terms
25 "advanced life support" and "basic life
26 support"; defining the term "emergency medical
27 condition"; amending s. 401.27, F.S.; providing
28 that the course on conditions caused by
29 nuclear, biological, and chemical terrorism
30 shall count toward the total required hours for
31 biennial recertification of emergency medical

1 technicians and paramedics; amending s.
2 456.033, F.S.; providing a requirement for
3 instruction of certain health care
4 practitioners on conditions caused by nuclear,
5 biological, and chemical terrorism, as a
6 condition of initial licensure, and, in lieu of
7 the requirement for instruction on HIV and
8 AIDS, as part of biennial relicensure; creating
9 s. 456.0345, F.S.; providing continuing
10 education credits to health care practitioners
11 for certain life support training; amending ss.
12 458.319, 459.008, F.S.; conforming provisions
13 relating to exceptions to continuing education
14 requirements for physicians and osteopathic
15 physicians; amending ss. 401.2715, 633.35,
16 943.135, F.S.; authorizing the substitution of
17 a specified number of hours of qualifying
18 terrorism-response training for a like number
19 of hours of training required for
20 certification; creating s. 381.0421, F.S.;
21 requiring that individuals enrolled in a
22 postsecondary educational institution be
23 provided information regarding meningococcal
24 meningitis and hepatitis B vaccines and, if
25 residing in on-campus housing, provide
26 documentation of vaccination against
27 meningococcal meningitis and hepatitis B, or a
28 statement declining such vaccination; amending
29 s. 394.4574, F.S.; requiring publicly announced
30 meetings with respect to certain mental health
31 residents in assisted living; specifying

1 additional requirements for district plans;
2 amending s. 394.74, F.S.; authorizing the
3 Department of Children and Family Services to
4 use case rates or per-capita contracts in
5 contracting for the provision of services for
6 local substance abuse and mental health
7 programs; specifying additional requirements
8 relating to such contracts; amending s.
9 400.141, F.S.; revising requirements for
10 licensed nursing home facilities; amending s.
11 400.147, F.S.; revising reporting requirements;
12 requiring the Agency for Health Care
13 Administration to report to the Governor and
14 the Legislature concerning nursing homes;
15 amending s. 499.007, F.S.; redefining
16 circumstances that cause a drug or device to be
17 considered misbranded; amending s. 627.357,
18 F.S.; revising provisions governing medical
19 malpractice self-insurance; amending s. 631.54,
20 F.S.; redefining the term "member insurer";
21 transferring to the Department of Health the
22 powers, duties, functions, and assets that
23 relate to the consumer complaint services,
24 investigations, and prosecutorial services
25 performed by the Agency for Health Care
26 Administration under contract with the
27 department; transferring full-time equivalent
28 positions and the practitioner regulation
29 component from the agency to the department;
30 amending s. 408.7056, F.S.; redesignating the
31 Statewide Provider and Subscriber Assistance

1 Program as the Subscriber Assistance Program;
2 requiring the Subscriber Assistance Panel to
3 hold the record of a grievance hearing open for
4 a specified period after the hearing; revising
5 the Agency for Health Care Administration's
6 authority to obtain records associated with
7 subscriber grievances; requiring the Agency for
8 Health Care Administration to impose a fine for
9 each violation relating to the production of
10 records from a health care provider or managed
11 care entity; specifying procedures for handling
12 a tie vote by the Subscriber Assistance Panel;
13 specifying circumstances under which the agency
14 or the Department of Insurance may delay
15 issuance of a proposed final order or emergency
16 order recommended by the panel; requiring that
17 the Agency for Health Care Administration
18 develop a training program for panel members;
19 amending ss. 641.3154, 641.511, 641.58, F.S.;
20 redesignating the Statewide Provider and
21 Subscriber Assistance Panel as the Subscriber
22 Assistance Panel; requiring that a subscriber
23 or the provider acting on behalf of a
24 subscriber be notified of the right to submit a
25 written grievance if a case is unresolved;
26 amending s. 400.925, F.S.; eliminating the
27 regulation of certain home medical equipment by
28 the Agency for Health Care Administration;
29 amending s. 766.302, F.S.; defining the terms
30 "family member" and "family residential or
31 custodial care"; amending s. 766.31, F.S.;

1 authorizing compensation awards for
2 professional or family residential or custodial
3 care; amending s. 766.314, F.S.; revising
4 requirements for assessments used for certain
5 supervised personnel; amending s. 627.6475,
6 F.S.; revising criteria for reinsuring
7 individuals under an individual health
8 reinsurance program; amending s. 627.667, F.S.;
9 deleting an exception to an
10 extension-of-benefits application provision for
11 out-of-state group policies; amending s.
12 627.6692, F.S.; extending a time period for
13 premium payment for continuation of coverage;
14 amending s. 627.6699, F.S.; redefining terms;
15 authorizing certain small employers to enroll
16 with alternate carriers under certain
17 circumstances; revising certain criteria of the
18 small-employer health reinsurance program;
19 requiring the Insurance Commissioner to appoint
20 a health benefit plan committee to modify the
21 standard and basic health benefit plans;
22 amending s. 627.911, F.S.; including health
23 maintenance organizations under certain
24 information-reporting requirements; amending s.
25 627.9175, F.S.; revising health insurance
26 reporting requirements for insurers; amending
27 s. 627.9403, F.S.; clarifying application of
28 exceptions to certain long-term-care insurance
29 policy requirements for certain limited-benefit
30 policies; amending s. 641.31, F.S.; exempting
31 contracts of group health maintenance

1 organizations covering a specified number of
2 persons from the requirements of filing with
3 the department; specifying the standards for
4 department approval and disapproval of a change
5 in rates by a health maintenance organization;
6 amending s. 641.3111, F.S.; revising
7 extension-of-benefits requirements for group
8 health maintenance contracts; providing
9 legislative findings and intent; providing for
10 construction of laws enacted at the 2002
11 Regular Session in relation to this act;
12 providing effective dates.
13
14 Be It Enacted by the Legislature of the State of Florida:
15
16 Section 1. Paragraph (g) of subsection (3) of section
17 20.43, Florida Statutes, is amended to read:
18 20.43 Department of Health.--There is created a
19 Department of Health.
20 (3) The following divisions of the Department of
21 Health are established:
22 (g) Division of Medical Quality Assurance, which is
23 responsible for the following boards and professions
24 established within the division:
25 1. The Board of Acupuncture, created under chapter
26 457.
27 2. The Board of Medicine, created under chapter 458.
28 3. The Board of Osteopathic Medicine, created under
29 chapter 459.
30 4. The Board of Chiropractic Medicine, created under
31 chapter 460.

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5. The Board of Podiatric Medicine, created under chapter 461.

6. Naturopathy, as provided under chapter 462.

7. The Board of Optometry, created under chapter 463.

8. The Board of Nursing, created under part I of chapter 464.

9. Nursing assistants, as provided under part II of chapter 464.

10. The Board of Pharmacy, created under chapter 465.

11. The Board of Dentistry, created under chapter 466.

12. Midwifery, as provided under chapter 467.

13. The Board of Speech-Language Pathology and Audiology, created under part I of chapter 468.

14. The Board of Nursing Home Administrators, created under part II of chapter 468.

15. The Board of Occupational Therapy, created under part III of chapter 468.

16. The Board of Respiratory Care ~~therapy~~, created ~~as provided~~ under part V of chapter 468.

17. Dietetics and nutrition practice, as provided under part X of chapter 468.

18. The Board of Athletic Training, created under part XIII of chapter 468.

19. The Board of Orthotists and Prosthetists, created under part XIV of chapter 468.

20. Electrolysis, as provided under chapter 478.

21. The Board of Massage Therapy, created under chapter 480.

22. The Board of Clinical Laboratory Personnel, created under part III of chapter 483.

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23. Medical physicists, as provided under part IV of chapter 483.

24. The Board of Opticianry, created under part I of chapter 484.

25. The Board of Hearing Aid Specialists, created under part II of chapter 484.

26. The Board of Physical Therapy Practice, created under chapter 486.

27. The Board of Psychology, created under chapter 490.

28. School psychologists, as provided under chapter 490.

29. The Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, created under chapter 491.

~~The department may contract with the Agency for Health Care Administration who shall provide consumer complaint, investigative, and prosecutorial services required by the Division of Medical Quality Assurance, councils, or boards, as appropriate.~~

Section 2. Section 456.047, Florida Statutes, is repealed.

Section 3. All revenues associated with section 456.047, Florida Statutes, and collected by the Department of Health on or before July 1, 2002, shall remain in the Medical Quality Assurance Trust Fund, and no refunds shall be given.

Section 4. Paragraph (d) of subsection (4) of section 456.039, Florida Statutes, is amended to read:

456.039 Designated health care professionals; information required for licensure.--

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1 (4)
2 (d) Any applicant for initial licensure or renewal of
3 licensure as a health care practitioner who submits to the
4 Department of Health a set of fingerprints or information
5 required for the criminal history check required under this
6 section shall not be required to provide a subsequent set of
7 fingerprints or other duplicate information required for a
8 criminal history check to the Agency for Health Care
9 Administration, the Department of Juvenile Justice, or the
10 Department of Children and Family Services for employment or
11 licensure with such agency or department if the applicant has
12 undergone a criminal history check as a condition of initial
13 licensure or licensure renewal as a health care practitioner
14 with the Department of Health or any of its regulatory boards,
15 notwithstanding any other provision of law to the contrary. In
16 lieu of such duplicate submission, the Agency for Health Care
17 Administration, the Department of Juvenile Justice, and the
18 Department of Children and Family Services shall obtain
19 criminal history information for employment or licensure of
20 health care practitioners by such agency and departments from
21 the Department of <u>Health</u> ~~Health's health care practitioner~~
22 ~~credentialing system~~.
23 Section 5. Paragraph (d) of subsection (4) of section
24 456.0391, Florida Statutes, is amended to read:
25 456.0391 Advanced registered nurse practitioners;
26 information required for certification.--
27 (4)
28 (d) Any applicant for initial certification or renewal
29 of certification as an advanced registered nurse practitioner
30 who submits to the Department of Health a set of fingerprints
31 and information required for the criminal history check

required under this section shall not be required to provide a subsequent set of fingerprints or other duplicate information required for a criminal history check to the Agency for Health Care Administration, the Department of Juvenile Justice, or the Department of Children and Family Services for employment or licensure with such agency or department, if the applicant has undergone a criminal history check as a condition of initial certification or renewal of certification as an advanced registered nurse practitioner with the Department of Health, notwithstanding any other provision of law to the contrary. In lieu of such duplicate submission, the Agency for Health Care Administration, the Department of Juvenile Justice, and the Department of Children and Family Services shall obtain criminal history information for employment or licensure of persons certified under s. 464.012 by such agency or department from the Department of Health ~~Health's health care practitioner credentialing system~~.

Section 6. Paragraphs (e), (v), (aa), and (bb) of subsection (1) of section 456.072, Florida Statutes, are amended to read:

456.072 Grounds for discipline; penalties; enforcement.--

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(e) Failing to comply with the educational course requirements for conditions caused by nuclear, biological, and chemical terrorism or for human immunodeficiency virus and acquired immune deficiency syndrome. As used in this paragraph, the term "terrorism" has the same meaning as in s. 775.30.

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(v) Failing to comply with the requirements for profiling ~~and credentialing~~, including, but not limited to, failing to provide initial information, failing to timely provide updated information, or making misleading, untrue, deceptive, or fraudulent representations on a profile~~, credentialing,~~ or initial or renewal licensure application.

(aa) Performing ~~or attempting to perform~~ health care services on the wrong patient, a wrong-site procedure, a wrong procedure, or an unauthorized procedure or a procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition. For the purposes of this paragraph, performing ~~or attempting to perform~~ health care services includes the preparation of the patient.

(bb) Leaving a foreign body in a patient, such as a sponge, clamp, forceps, surgical needle, or other paraphernalia commonly used in surgical, examination, or other diagnostic procedures, unless leaving the foreign body is medically indicated and documented in the patient record. For the purposes of this paragraph, it shall be legally presumed that retention of a foreign body is not in the best interest of the patient and is not within the standard of care of the profession, unless medically indicated and documented in the patient record ~~regardless of the intent of the professional~~.

Section 7. Subsection (2) of section 456.077, Florida Statutes, is amended to read:

456.077 Authority to issue citations.--

(2) The board, or the department if there is no board, shall adopt rules designating violations for which a citation may be issued. Such rules shall designate as citation violations those violations for which there is no substantial threat to the public health, safety, and welfare. Violations

for which a citation may be issued shall include violations of continuing education requirements; failure to timely pay required fees and fines; failure to comply with the requirements of ss. 381.026 and 381.0261 regarding the dissemination of information regarding patient rights; failure to comply with advertising requirements; failure to timely update practitioner profile ~~and credentialing~~ files; failure to display signs, licenses, and permits; failure to have required reference books available; and all other violations that do not pose a direct and serious threat to the health and safety of the patient.

Section 8. Subsection (3) of section 458.309, Florida Statutes, is amended to read:

458.309 Authority to make rules.--

(3) All physicians who perform level 2 procedures lasting more than 5 minutes and all level 3 surgical procedures in an office setting must register the office with the department unless that office is licensed as a facility pursuant to chapter 395. Each office that is required under this subsection to be registered must be ~~The department shall inspect the physician's office annually unless the office is~~ accredited by a nationally recognized accrediting agency approved by the Board of Medicine by rule or an accrediting organization ~~subsequently~~ approved by the Board of Medicine by rule. Each office registered but not accredited as required by this subsection must achieve full and unconditional accreditation no later than July 1, 2003, and must maintain unconditional accreditation as long as procedures described in this subsection which require the office to be registered and accredited are performed. Accreditation reports shall be submitted to the department. The actual costs for registration

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1 and ~~inspection or~~ accreditation shall be paid by the person
2 seeking to register and operate the office setting in which
3 office surgery is performed. <u>The board may adopt rules</u>
4 <u>pursuant to ss. 120.536(1) and 120.54 to implement this</u>
5 <u>subsection.</u>
6 Section 9. Subsection (2) of section 459.005, Florida
7 Statutes, is amended to read:
8 459.005 Rulemaking authority.--
9 (2) All <u>osteopathic</u> physicians who perform level 2
10 procedures lasting more than 5 minutes and all level 3
11 surgical procedures in an office setting must register the
12 office with the department unless that office is licensed as a
13 facility pursuant to chapter 395. <u>Each office that is</u>
14 <u>required under this subsection to be registered must be</u> ~~The~~
15 ~~department shall inspect the physician's office annually~~
16 ~~unless the office is~~ accredited by a nationally recognized
17 accrediting agency <u>approved by the Board of Medicine or the</u>
18 <u>Board of Osteopathic Medicine by rule</u> or an accrediting
19 organization ~~subsequently~~ approved by <u>the Board of Medicine or</u>
20 the Board of Osteopathic Medicine <u>by rule. Each office</u>
21 <u>registered but not accredited as required by this subsection</u>
22 <u>must achieve full and unconditional accreditation no later</u>
23 <u>than July 1, 2003, and must maintain unconditional</u>
24 <u>accreditation as long as procedures described in this</u>
25 <u>subsection which require the office to be registered and</u>
26 <u>accredited are performed. Accreditation reports shall be</u>
27 <u>submitted to the department</u>. The actual costs for registration
28 ~~and inspection~~ or accreditation shall be paid by the person
29 seeking to register and operate the office setting in which
30 office surgery is performed. <u>The Board of Osteopathic</u>
31

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Medicine may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this subsection.

Section 10. Subsection (11) is added to section 456.004, Florida Statutes, to read:

456.004 Department; powers and duties.--The department, for the professions under its jurisdiction, shall:

(11) Require objective performance measures for all bureaus, units, boards, contracted entities, and board executive directors which reflect the expected quality and quantity of services.

Section 11. Subsection (1) of section 456.009, Florida Statutes, is amended to read:

456.009 Legal and investigative services.--

(1) The department shall provide board counsel for boards within the department by contracting with the Department of Legal Affairs, by retaining private counsel pursuant to s. 287.059, or by providing department staff counsel. The primary responsibility of board counsel shall be to represent the interests of the citizens of the state. A board shall provide for the periodic review and evaluation of the services provided by its board counsel. Fees and costs of such counsel shall be paid from a trust fund used by the department to implement this chapter, subject to the provisions of s. 456.025. All contracts for independent counsel shall provide for periodic review and evaluation by the board and the department of services provided. All legal and investigative services shall be reviewed by the department annually to determine if such services are meeting the performance measures specified in law and in the contract. All contracts for legal and investigative services must include

1 objective performance measures that reflect the expected
2 quality and quantity of the contracted services.
3 Section 12. Subsection (6) is added to section
4 456.011, Florida Statutes, to read:
5 456.011 Boards; organization; meetings; compensation
6 and travel expenses.--
7 (6) Meetings of board committees, including probable
8 cause panels, shall be conducted electronically unless held
9 concurrently with, or on the day immediately before or after,
10 a regularly scheduled in-person board meeting. However, if a
11 particular committee meeting is expected to last more than 5
12 hours and cannot be held before or after the in-person board
13 meeting, the chair of the committee may request special
14 permission from the director of the Division of Medical
15 Quality Assurance to hold an in-person committee meeting in
16 Tallahassee.
17 Section 13. Subsection (11) is added to section
18 456.026, Florida Statutes, to read:
19 456.026 Annual report concerning finances,
20 administrative complaints, disciplinary actions, and
21 recommendations.--The department is directed to prepare and
22 submit a report to the President of the Senate and the Speaker
23 of the House of Representatives by November 1 of each year. In
24 addition to finances and any other information the Legislature
25 may require, the report shall include statistics and relevant
26 information, profession by profession, detailing:
27 (11) The performance measures for all bureaus, units,
28 boards, and contracted entities required by the department to
29 reflect the expected quality and quantity of services, and a
30 description of any effort to improve the performance of such
31 services.

1 Section 14. Section 458.3093, Florida Statutes, is
2 created to read:
3 458.3093 Licensure credentials verification.--All
4 applicants for initial physician licensure pursuant to this
5 chapter must submit their credentials to the Federation of
6 State Medical Boards. Effective January 1, 2003, the board
7 and the department shall only consider applications for
8 initial physician licensure pursuant to this chapter which
9 have been verified by the Federation of State Medical Boards
10 Credentials Verification Service or an equivalent program
11 approved by the board.
12 Section 15. Section 459.0053, Florida Statutes, is
13 created to read:
14 459.0053 Licensure credentials verification.--All
15 applicants for initial osteopathic physician licensure
16 pursuant to this chapter must submit their credentials to the
17 Federation of State Medical Boards. Effective January 1,
18 2003, the board and the department shall only consider
19 applications for initial osteopathic physician licensure
20 pursuant to this chapter which have been verified by the
21 Federation of State Medical Boards Credentials Verification
22 Service, the American Osteopathic Association, or an
23 equivalent program approved by the board.
24 Section 16. Paragraph (t) of subsection (1) and
25 subsection (6) of section 458.331, Florida Statutes, are
26 amended to read:
27 458.331 Grounds for disciplinary action; action by the
28 board and department.--
29 (1) The following acts constitute grounds for denial
30 of a license or disciplinary action, as specified in s.
31 456.072(2):

(t) Gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances. The board shall give great weight to the provisions of s. 766.102 when enforcing this paragraph. As used in this paragraph, "repeated malpractice" includes, but is not limited to, three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of $50,000 ~~$25,000~~ each to the claimant in a judgment or settlement and which incidents involved negligent conduct by the physician. As used in this paragraph, "gross malpractice" or "the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances," shall not be construed so as to require more than one instance, event, or act. Nothing in this paragraph shall be construed to require that a physician be incompetent to practice medicine in order to be disciplined pursuant to this paragraph.

(6) Upon the department's receipt from an insurer or self-insurer of a report of a closed claim against a physician pursuant to s. 627.912 or from a health care practitioner of a report pursuant to s. 456.049, or upon the receipt from a claimant of a presuit notice against a physician pursuant to s. 766.106, the department shall review each report and determine whether it potentially involved conduct by a licensee that is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply. However, if it is reported that a physician has had three or more claims with

1 indemnities exceeding $50,000 ~~$25,000~~ each within the previous
2 5-year period, the department shall investigate the
3 occurrences upon which the claims were based and determine
4 whether ~~if~~ action by the department against the physician is
5 warranted.
6 Section 17. Paragraph (x) of subsection (1) and
7 subsection (6) of section 459.015, Florida Statutes, are
8 amended to read:
9 459.015 Grounds for disciplinary action; action by the
10 board and department.--
11 (1) The following acts constitute grounds for denial
12 of a license or disciplinary action, as specified in s.
13 456.072(2):
14 (x) Gross or repeated malpractice or the failure to
15 practice osteopathic medicine with that level of care, skill,
16 and treatment which is recognized by a reasonably prudent
17 similar osteopathic physician as being acceptable under
18 similar conditions and circumstances. The board shall give
19 great weight to the provisions of s. 766.102 when enforcing
20 this paragraph. As used in this paragraph, "repeated
21 malpractice" includes, but is not limited to, three or more
22 claims for medical malpractice within the previous 5-year
23 period resulting in indemnities being paid in excess of
24 $50,000 ~~$25,000~~ each to the claimant in a judgment or
25 settlement and which incidents involved negligent conduct by
26 the osteopathic physician. As used in this paragraph, "gross
27 malpractice" or "the failure to practice osteopathic medicine
28 with that level of care, skill, and treatment which is
29 recognized by a reasonably prudent similar osteopathic
30 physician as being acceptable under similar conditions and
31 circumstances" shall not be construed so as to require more

than one instance, event, or act. Nothing in this paragraph
shall be construed to require that an osteopathic physician be
incompetent to practice osteopathic medicine in order to be
disciplined pursuant to this paragraph. A recommended order
by an administrative law judge or a final order of the board
finding a violation under this paragraph shall specify whether
the licensee was found to have committed "gross malpractice,"
"repeated malpractice," or "failure to practice osteopathic
medicine with that level of care, skill, and treatment which
is recognized as being acceptable under similar conditions and
circumstances," or any combination thereof, and any
publication by the board shall so specify.

(6) Upon the department's receipt from an insurer or
self-insurer of a report of a closed claim against an
osteopathic physician pursuant to s. 627.912 or from a health
care practitioner of a report pursuant to s. 456.049, or upon
the receipt from a claimant of a presuit notice against an
osteopathic physician pursuant to s. 766.106, the department
shall review each report and determine whether it potentially
involved conduct by a licensee that is subject to disciplinary
action, in which case the provisions of s. 456.073 shall
apply. However, if it is reported that an osteopathic
physician has had three or more claims with indemnities
exceeding $50,000 ~~$25,000~~ each within the previous 5-year
period, the department shall investigate the occurrences upon
which the claims were based and determine whether ~~if~~ action by
the department against the osteopathic physician is warranted.

Section 18. Subsection (1) of section 627.912, Florida
Statutes, is amended to read:

627.912 Professional liability claims and actions;
reports by insurers.--

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

(1) Each self-insurer authorized under s. 627.357 and each insurer or joint underwriting association providing professional liability insurance to a practitioner of medicine licensed under chapter 458, to a practitioner of osteopathic medicine licensed under chapter 459, to a podiatric physician licensed under chapter 461, to a dentist licensed under chapter 466, to a hospital licensed under chapter 395, to a crisis stabilization unit licensed under part IV of chapter 394, to a health maintenance organization certificated under part I of chapter 641, to clinics included in chapter 390, to an ambulatory surgical center as defined in s. 395.002, or to a member of The Florida Bar shall report in duplicate to the Department of Insurance any claim or action for damages for personal injuries claimed to have been caused by error, omission, or negligence in the performance of such insured's professional services or based on a claimed performance of professional services without consent, if the claim resulted in:

(a) A final judgment in any amount.

(b) A settlement in any amount.

Reports shall be filed with the Department of Insurance.~~and,~~ If the insured party is licensed under chapter 458, chapter 459, or chapter 461, ~~or chapter 466,~~with the Department of Health, and the final judgment or settlement was in an amount exceeding $50,000, the report shall also be filed with the Department of Health. If the insured is licensed under chapter 466 and the final judgment or settlement was in an amount exceeding $25,000, the report shall also be filed with the Department of Health. Reports must be filed no later than 30 days following the occurrence of any event listed in this

subsection ~~paragraph (a) or paragraph (b)~~. The Department of Health shall review each report and determine whether any of the incidents that resulted in the claim potentially involved conduct by the licensee that is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply. The Department of Health, as part of the annual report required by s. 456.026, shall publish annual statistics, without identifying licensees, on the reports it receives, including final action taken on such reports by the Department of Health or the appropriate regulatory board.

Section 19. Subsection (1) of section 456.025, Florida Statutes, is amended to read:

456.025 Fees; receipts; disposition.--

(1) It is the intent of the Legislature that all costs of regulating health care professions and practitioners shall be borne solely by licensees and licensure applicants. It is also the intent of the Legislature that fees should be reasonable and not serve as a barrier to licensure. Moreover, it is the intent of the Legislature that the department operate as efficiently as possible and regularly report to the Legislature additional methods to streamline operational costs. Therefore, the boards in consultation with the department, or the department if there is no board, shall, by rule, set renewal fees which:

(a) Shall be based on revenue projections prepared using generally accepted accounting procedures;

(b) Shall be adequate to cover all expenses relating to that board identified in the department's long-range policy plan, as required by s. 456.005;

(c) Shall be reasonable, fair, and not serve as a barrier to licensure;

(d) Shall be based on potential earnings from working under the scope of the license;

(e) Shall be similar to fees imposed on similar licensure types; and

~~(f) Shall not be more than 10 percent greater than the fee imposed for the previous biennium;~~

~~(g) Shall not be more than 10 percent greater than the actual cost to regulate that profession for the previous biennium; and~~

(f)~~(h)~~ Shall be subject to challenge pursuant to chapter 120.

Section 20. Section 456.0165, Florida Statutes, is created to read:

456.0165 Examination location.--A college, university, or vocational school in this state may serve as the host school for a health care practitioner licensure examination. However, the college, university, or vocational school may not charge the department for rent, space, reusable equipment, utilities, or janitorial services. The college, university, or vocational school may charge the department only the actual cost of nonreusable supplies provided by the school at the request of the department.

Section 21. Effective July 1, 2003, paragraph (g) of subsection (3) and paragraph (c) of subsection (6) of section 468.302, Florida Statutes, are amended to read:

468.302 Use of radiation; identification of certified persons; limitations; exceptions.--

(3)

(g) A person holding a certificate as a nuclear medicine technologist may only:

1. Conduct in vivo and in vitro measurements of radioactivity and administer radiopharmaceuticals to human beings for diagnostic and therapeutic purposes.

2. Administer X radiation from a combination nuclear medicine-computed tomography device if that radiation is administered as an integral part of a nuclear medicine procedure that uses an automated computed tomography protocol and the person has received device-specific training on the combination device.

However, the authority of a nuclear medicine technologist under this paragraph excludes radioimmunoassay and other clinical laboratory testing regulated pursuant to chapter 483.

(6) Requirement for certification does not apply to:

(c) A person who is a registered nurse licensed under part I of chapter 464, a respiratory therapist licensed under part V of chapter 468, or a cardiovascular technologist or cardiopulmonary technologist with active certification as a registered cardiovascular invasive specialist from a nationally recognized credentialing organization, or future equivalent should such credentialing be subsequently modified, each of whom is trained and skilled in invasive cardiovascular ~~cardiopulmonary~~ technology, including the radiologic technology duties associated with such procedures,and who provides invasive cardiovascular ~~cardiopulmonary~~ technology services at the direction, and under the direct supervision, of a licensed practitioner. A person requesting this exemption must have successfully completed a didactic and clinical training program in the following areas before performing radiologic technology duties under the direct supervision of a licensed practitioner:

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1. Principles of X-ray production and equipment operation.
2. Biological effects of radiation.
3. Radiation exposure and monitoring.
4. Radiation safety and protection.
5. Evaluation of radiographic equipment and accessories.
6. Radiographic exposure and technique factors.
7. Film processing.
8. Image quality assurance.
9. Patient positioning.
10. Administration and complications of contrast media.
11. Specific fluoroscopic and digital X-ray imaging procedures related to invasive cardiovascular technology.

Section 22. Section 468.352, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 468.352, F.S., for present text.)

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

(1) "Board" means the Board of Respiratory Care.

(2) "Certified respiratory therapist" means any person licensed pursuant to this part who is certified by the National Board for Respiratory Care or its successor; who is employed to deliver respiratory care services, under the order of a physician licensed pursuant to chapter 458 or chapter 459, in accordance with protocols established by a hospital or other health care provider or the board; and who functions in situations of unsupervised patient contact requiring individual judgment.

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1 (3) "Critical care" means care given to a patient in
2 any setting involving a life-threatening emergency.
3 (4) "Department" means the Department of Health.
4 (5) "Direct supervision" means practicing under the
5 direction of a licensed, registered, or certified respiratory
6 therapist who is physically on the premises and readily
7 available, as defined by the board.
8 (6) "Physician supervision" means supervision and
9 control by a physician licensed under chapter 458 or chapter
10 459 who assumes the legal liability for the services rendered
11 by the personnel employed in his or her office. Except in the
12 case of an emergency, physician supervision requires the easy
13 availability of the physician within the office or the
14 physical presence of the physician for consultation and
15 direction of the actions of the persons who deliver
16 respiratory care services.
17 (7) "Practice of respiratory care" or "respiratory
18 therapy" means the allied health specialty associated with the
19 cardiopulmonary system that is practiced under the orders of a
20 physician licensed under chapter 458 or chapter 459 and in
21 accordance with protocols, policies, and procedures
22 established by a hospital or other health care provider or the
23 board, including the assessment, diagnostic evaluation,
24 treatment, management, control, rehabilitation, education, and
25 care of patients.
26 (8) "Registered respiratory therapist" means any
27 person licensed under this part who is registered by the
28 National Board for Respiratory Care or its successor, and who
29 is employed to deliver respiratory care services under the
30 order of a physician licensed under chapter 458 or chapter
31 459, in accordance with protocols established by a hospital or

1 other health care provider or the board, and who functions in
2 situations of unsupervised patient contact requiring
3 individual judgment.
4 (9) "Respiratory care practitioner" means any person
5 licensed under this part who is employed to deliver
6 respiratory care services, under direct supervision, pursuant
7 to the order of a physician licensed under chapter 458 or
8 chapter 459.
9 (10) "Respiratory care services" includes:
10 (a) Evaluation and disease management.
11 (b) Diagnostic and therapeutic use of respiratory
12 equipment, devices, or medical gas.
13 (c) Administration of drugs, as duly ordered or
14 prescribed by a physician licensed under chapter 458 or
15 chapter 459 and in accordance with protocols, policies, and
16 procedures established by a hospital or other health care
17 provider or the board.
18 (d) Initiation, management, and maintenance of
19 equipment to assist and support ventilation and respiration.
20 (e) Diagnostic procedures, research, and therapeutic
21 treatment and procedures, including measurement of ventilatory
22 volumes, pressures, and flows; specimen collection and
23 analysis of blood for gas transport and acid/base
24 determinations; pulmonary-function testing; and other related
25 physiological monitoring of cardiopulmonary systems.
26 (f) Cardiopulmonary rehabilitation.
27 (g) Cardiopulmonary resuscitation, advanced cardiac
28 life support, neonatal resuscitation, and pediatric advanced
29 life support, or equivalent functions.
30 (h) Insertion and maintenance of artificial airways
31 and intravascular catheters.

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1 (i) Performing sleep-disorder studies.
2 (j) Education of patients, families, the public, or
3 other health care providers, including disease process and
4 management programs and smoking prevention and cessation
5 programs.
6 (k) Initiation and management of hyperbaric oxygen.
7 Section 23. Section 468.355, Florida Statutes, is
8 amended to read:
9 (Substantial rewording of section. See
10 s. 468.355, F.S., for present text.)
11 468.355 Licensure requirements.--To be eligible for
12 licensure by the board, an applicant must be certified as a
13 "Certified Respiratory Therapist" or be registered as a
14 "Registered Respiratory Therapist" by the National Board for
15 Respiratory Care, or its successor.
16 Section 24. Section 468.368, Florida Statutes, is
17 amended to read:
18 (Substantial rewording of section. See
19 s. 468.368, F.S., for present text.)
20 468.368 Exemptions.--This part may not be construed to
21 prevent or restrict the practice, service, or activities of:
22 (1) Any person licensed in this state by any other law
23 from engaging in the profession or occupation for which he or
24 she is licensed.
25 (2) Any legally qualified person in the state or
26 another state or territory who is employed by the United
27 States Government or any agency thereof while such person is
28 discharging his or her official duties.
29 (3) A friend or family member who is providing
30 respiratory care services to an ill person and who does not
31

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1 represent himself or herself to be a respiratory care
2 practitioner or respiratory therapist.
3 (4) An individual providing respiratory care services
4 in an emergency who does not represent himself or herself as a
5 respiratory care practitioner or respiratory therapist.
6 (5) Any individual employed to deliver, assemble, set
7 up, or test equipment for use in a home, upon the order of a
8 physician licensed pursuant to chapter 458 or chapter 459.
9 This subsection does not, however, authorize the practice of
10 respiratory care without a license.
11 (6) Any individual credentialed by the Board of
12 Registered Polysomnographic Technologists as a registered
13 polysomnographic technologist, as related to the diagnosis and
14 evaluation of treatment for sleep disorders.
15 (7) Any individual certified or registered as a
16 pulmonary function technologist who is credentialed by the
17 National Board for Respiratory Care for performing
18 cardiopulmonary diagnostic studies.
19 (8) Any student who is enrolled in an accredited
20 respiratory care program approved by the board, while
21 performing respiratory care as an integral part of a required
22 course.
23 (9) The delivery of incidental respiratory care to
24 noninstitutionalized persons by surrogate family members who
25 do not represent themselves as registered or certified
26 respiratory care therapists.
27 (10) Any individual credentialed by the Underseas
28 Hyperbaric Society in hyperbaric medicine or its equivalent as
29 determined by the board, while performing related duties. This
30 subsection does not, however, authorize the practice of
31 respiratory care without a license.

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1 Section 25. Sections 468.356 and 468.357, Florida
2 Statutes, are repealed.
3 Section 26. Sections 381.0602, 381.6021, 381.6022,
4 381.6023, 381.6024, and 381.6026, Florida Statutes, are
5 renumbered as sections 765.53, 765.541, 765.542, 765.544,
6 765.545, and 765.547, Florida Statutes, respectively.
7 Section 27. Section 381.60225, Florida Statutes, is
8 renumbered as section 765.543, Florida Statutes, and is
9 amended to read:
10 765.543 381.60225 Background screening.--
11 (1) Each applicant for certification must comply with
12 the following requirements:
13 (a) Upon receipt of a completed, signed, and dated
14 application, the Agency for Health Care Administration shall
15 require background screening, in accordance with the level 2
16 standards for screening set forth in chapter 435, of the
17 managing employee, or other similarly titled individual
18 responsible for the daily operation of the organization,
19 agency, or entity, and financial officer, or other similarly
20 titled individual who is responsible for the financial
21 operation of the organization, agency, or entity, including
22 billings for services. The applicant must comply with the
23 procedures for level 2 background screening as set forth in
24 chapter 435, as well as the requirements of s. 435.03(3).
25 (b) The Agency for Health Care Administration may
26 require background screening of any other individual who is an
27 applicant if the Agency for Health Care Administration has
28 probable cause to believe that he or she has been convicted of
29 a crime or has committed any other offense prohibited under
30 the level 2 standards for screening set forth in chapter 435.
31

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1 (c) Proof of compliance with the level 2 background
2 screening requirements of chapter 435 which has been submitted
3 within the previous 5 years in compliance with any other
4 health care licensure requirements of this state is acceptable
5 in fulfillment of the requirements of paragraph (a).
6 (d) A provisional certification may be granted to the
7 organization, agency, or entity when each individual required
8 by this section to undergo background screening has met the
9 standards for the Department of Law Enforcement background
10 check, but the agency has not yet received background
11 screening results from the Federal Bureau of Investigation, or
12 a request for a disqualification exemption has been submitted
13 to the agency as set forth in chapter 435, but a response has
14 not yet been issued. A standard certification may be granted
15 to the organization, agency, or entity upon the agency's
16 receipt of a report of the results of the Federal Bureau of
17 Investigation background screening for each individual
18 required by this section to undergo background screening which
19 confirms that all standards have been met, or upon the
20 granting of a disqualification exemption by the agency as set
21 forth in chapter 435. Any other person who is required to
22 undergo level 2 background screening may serve in his or her
23 capacity pending the agency's receipt of the report from the
24 Federal Bureau of Investigation. However, the person may not
25 continue to serve if the report indicates any violation of
26 background screening standards and a disqualification
27 exemption has not been requested of and granted by the agency
28 as set forth in chapter 435.
29 (e) Each applicant must submit to the agency, with its
30 application, a description and explanation of any exclusions,
31 permanent suspensions, or terminations of the applicant from

1 the Medicare or Medicaid programs. Proof of compliance with
2 the requirements for disclosure of ownership and control
3 interests under the Medicaid or Medicare programs shall be
4 accepted in lieu of this submission.
5 (f) Each applicant must submit to the agency a
6 description and explanation of any conviction of an offense
7 prohibited under the level 2 standards of chapter 435 by a
8 member of the board of directors of the applicant, its
9 officers, or any individual owning 5 percent or more of the
10 applicant. This requirement does not apply to a director of a
11 not-for-profit corporation or organization if the director
12 serves solely in a voluntary capacity for the corporation or
13 organization, does not regularly take part in the day-to-day
14 operational decisions of the corporation or organization,
15 receives no remuneration for his or her services on the
16 corporation or organization's board of directors, and has no
17 financial interest and has no family members with a financial
18 interest in the corporation or organization, provided that the
19 director and the not-for-profit corporation or organization
20 include in the application a statement affirming that the
21 director's relationship to the corporation satisfies the
22 requirements of this paragraph.
23 (g) The agency may not certify any organization,
24 agency, or entity if any applicant or managing employee has
25 been found guilty of, regardless of adjudication, or has
26 entered a plea of nolo contendere or guilty to, any offense
27 prohibited under the level 2 standards for screening set forth
28 in chapter 435, unless an exemption from disqualification has
29 been granted by the agency as set forth in chapter 435.
30 (h) The agency may deny or revoke certification of any
31 organization, agency, or entity if the applicant:

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1 1. Has falsely represented a material fact in the
2 application required by paragraph (e) or paragraph (f), or has
3 omitted any material fact from the application required by
4 paragraph (e) or paragraph (f); or
5 2. Has had prior action taken against the applicant
6 under the Medicaid or Medicare program as set forth in
7 paragraph (e).
8 (i) An application for renewal of certification must
9 contain the information required under paragraphs (e) and (f).
10 (2) An organ procurement organization, tissue bank, or
11 eye bank certified by the Agency for Health Care
12 Administration in accordance with ss. 765.541 ~~381.6021~~ and
13 765.542 ~~381.6022~~ is not subject to the requirements of this
14 section if the entity has no direct patient care
15 responsibilities and does not bill patients or insurers
16 directly for services under the Medicare or Medicaid programs,
17 or for privately insured services.
18 Section 28. Section 381.6025, Florida Statutes, is
19 renumbered as section 765.546, Florida Statutes, and amended
20 to read:
21 765.546 ~~381.6025~~ Physician supervision of cadaveric
22 organ and tissue procurement coordinators.--Organ procurement
23 organizations, tissue banks, and eye banks may employ
24 coordinators, who are registered nurses, physician's
25 assistants, or other medically trained personnel who meet the
26 relevant standards for organ procurement organizations, tissue
27 banks, or eye banks as adopted by the Agency for Health Care
28 Administration under s. 765.541 ~~381.6021~~, to assist in the
29 medical management of organ donors or in the surgical
30 procurement of cadaveric organs, tissues, or eyes for
31 transplantation or research. A coordinator who assists in the

1 medical management of organ donors or in the surgical
2 procurement of cadaveric organs, tissues, or eyes for
3 transplantation or research must do so under the direction and
4 supervision of a licensed physician medical director pursuant
5 to rules and guidelines to be adopted by the Agency for Health
6 Care Administration. With the exception of organ procurement
7 surgery, this supervision may be indirect supervision. For
8 purposes of this section, the term "indirect supervision"
9 means that the medical director is responsible for the medical
10 actions of the coordinator, that the coordinator is operating
11 under protocols expressly approved by the medical director,
12 and that the medical director or his or her physician designee
13 is always available, in person or by telephone, to provide
14 medical direction, consultation, and advice in cases of organ,
15 tissue, and eye donation and procurement. Although indirect
16 supervision is authorized under this section, direct physician
17 supervision is to be encouraged when appropriate.
18 Section 29. Subsection (2) of section 395.2050,
19 Florida Statutes, is amended to read:
20 395.2050 Routine inquiry for organ and tissue
21 donation; certification for procurement activities.--
22 (2) Every hospital licensed under this chapter that is
23 engaged in the procurement of organs, tissues, or eyes shall
24 comply with the certification requirements of ss.
25 765.541-765.547 ~~381.6021-381.6026~~.
26 Section 30. Paragraph (e) of subsection (2) of section
27 409.815, Florida Statutes, is amended to read:
28 409.815 Health benefits coverage; limitations.--
29 (2) BENCHMARK BENEFITS.--In order for health benefits
30 coverage to qualify for premium assistance payments for an
31 eligible child under ss. 409.810-409.820, the health benefits

1 coverage, except for coverage under Medicaid and Medikids,
2 must include the following minimum benefits, as medically
3 necessary.
4 (e) Organ transplantation services.--Covered services
5 include pretransplant, transplant, and postdischarge services
6 and treatment of complications after transplantation for
7 transplants deemed necessary and appropriate within the
8 guidelines set by the Organ Transplant Advisory Council under
9 s. 765.53 ~~381.0602~~ or the Bone Marrow Transplant Advisory
10 Panel under s. 627.4236.
11 Section 31. Subsection (2) of section 765.5216,
12 Florida Statutes, is amended to read:
13 765.5216 Organ and tissue donor education panel.--
14 (2) There is created within the Agency for Health Care
15 Administration a statewide organ and tissue donor education
16 panel, consisting of 12 members, to represent the interests of
17 the public with regard to increasing the number of organ and
18 tissue donors within the state. The panel and the Organ and
19 Tissue Procurement and Transplantation Advisory Board
20 established in s. 765.544 ~~381.6023~~ shall jointly develop,
21 subject to the approval of the Agency for Health Care
22 Administration, education initiatives pursuant to s. 765.5215
23 ~~732.9215~~, which the agency shall implement. The membership
24 must be balanced with respect to gender, ethnicity, and other
25 demographic characteristics so that the appointees reflect the
26 diversity of the population of this state. The panel members
27 must include:
28 (a) A representative from the Agency for Health Care
29 Administration, who shall serve as chairperson of the panel.
30 (b) A representative from a Florida licensed organ
31 procurement organization.

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1 (c) A representative from a Florida licensed tissue
2 bank.
3 (d) A representative from a Florida licensed eye bank.
4 (e) A representative from a Florida licensed hospital.
5 (f) A representative from the Division of Driver
6 Licenses of the Department of Highway Safety and Motor
7 Vehicles, who possesses experience and knowledge in dealing
8 with the public.
9 (g) A representative from the family of an organ,
10 tissue, or eye donor.
11 (h) A representative who has been the recipient of a
12 transplanted organ, tissue, or eye, or is a family member of a
13 recipient.
14 (i) A representative who is a minority person as
15 defined in s. 381.81.
16 (j) A representative from a professional association
17 or public relations or advertising organization.
18 (k) A representative from a community service club or
19 organization.
20 (l) A representative from the Department of Education.
21 Section 32. Subsection (5) of section 765.522, Florida
22 Statutes, is amended to read:
23 765.522 Duty of certain hospital administrators;
24 liability of hospital administrators, organ procurement
25 organizations, eye banks, and tissue banks.--
26 (5) There shall be no civil or criminal liability
27 against any organ procurement organization, eye bank, or
28 tissue bank certified under s. 765.542 ~~381.6022~~, or against
29 any hospital or hospital administrator or designee, when
30 complying with the provisions of this part and the rules of
31 the Agency for Health Care Administration or when, in the

1 exercise of reasonable care, a request for organ donation is
2 inappropriate and the gift is not made according to this part
3 and the rules of the Agency for Health Care Administration.
4 Section 33. Present subsections (11) through (33) of
5 section 395.002, Florida Statutes, are renumbered as
6 subsections (12) through (34), respectively, and a new
7 subsection (11) is added to that section, to read:
8 395.002 Definitions.--As used in this chapter:
9 (11) "Medically unnecessary procedure" means a
10 surgical or other invasive procedure that a physician, acting
11 according to the prevailing professional standard of care as
12 defined in s. 766.102(1), would not deem to be indicated,
13 based on the patient's history and available diagnostic
14 information, to treat, cure, or palliate the patient's
15 condition or disease.
16 Section 34. Subsection (5) is added to section
17 395.0161, Florida Statutes, to read:
18 395.0161 Licensure inspection.--
19 (5)(a) The agency shall adopt rules governing the
20 conduct of inspections or investigations it initiates in
21 response to:
22 1. Reports filed pursuant to s. 395.0197.
23 2. Complaints alleging violations of state or federal
24 emergency access laws.
25 3. Complaints made by the public alleging violations
26 of law by licensed facilities or personnel.
27 (b) The rules must set forth the procedures to be used
28 in the investigations or inspections in order to protect the
29 due process rights of licensed facilities and personnel and to
30 minimize, to the greatest reasonable extent possible, the
31

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disruption of facility operations and the cost to facilities resulting from those investigations.

Section 35. Subsections (2), (14), and (16) of section 395.0197, Florida Statutes, are amended to read:

395.0197 Internal risk management program.--

(2) The internal risk management program is the responsibility of the governing board of the health care facility. Each licensed facility shall use the services of ~~hire~~ a risk manager, licensed under s. 395.10974, who is responsible for implementation and oversight of such facility's internal risk management program as required by this section. ~~A risk manager must not be made responsible for more than four internal risk management programs in separate licensed facilities, unless the facilities are under one corporate ownership or the risk management programs are in rural hospitals.~~

(14) The agency shall have access, as set forth in rules adopted under s. 395.0161(5), to all licensed facility records necessary to carry out the provisions of this section. The records obtained by the agency under subsection (6), subsection (8), or subsection (10) are not available to the public under s. 119.07(1), nor shall they be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board, nor shall records obtained pursuant to s. 456.071 be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency or the appropriate regulatory board. However, the agency or the appropriate regulatory board shall make available, upon written request by a health care professional against whom probable cause has

1 been found, any such records which form the basis of the
2 determination of probable cause, except that, with respect to
3 medical review committee records, s. 766.101 controls.
4 (16) The agency shall review, as part of its licensure
5 inspection process, the internal risk management program at
6 each licensed facility regulated by this section to determine
7 whether the program meets standards established in statutes
8 and rules, whether the program is being conducted in a manner
9 designed to reduce adverse incidents, and whether the program
10 is appropriately reporting incidents under this section. Only
11 a risk manager, licensed under s. 395.10974 and employed by
12 the Agency for Health Care Administration has the authority to
13 conduct inspections necessary to determine whether a program
14 meets the requirements of this section. A determination must
15 be based on the care, skill, and judgment which, in light of
16 all relevant surrounding circumstances, is recognized as
17 acceptable and appropriate by reasonably prudent similar
18 licensed risk managers. By July 1, 2004, the Agency for Health
19 Care Administration shall employ a minimum of three licensed
20 risk managers in each district to conduct inspections as
21 provided in this subsection.
22 Section 36. Paragraph (b) of subsection (1) of section
23 456.0375, Florida Statutes, is amended to read:
24 456.0375 Registration of certain clinics;
25 requirements; discipline; exemptions.--
26 (1)
27 (b) For purposes of this section, the term "clinic"
28 does not include and the registration requirements herein do
29 not apply to:
30 1. Entities licensed or registered by the state
31 pursuant to chapter 390, chapter 394, chapter 395, chapter

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1 397, chapter 400, chapter 463, chapter 465, chapter 466,
2 chapter 478, chapter 480, or chapter 484.
3 2. Entities exempt from federal taxation under 26
4 U.S.C. s. 501(c)(3) and community college and university
5 clinics.
6 3. Sole proprietorships, group practices,
7 partnerships, or corporations that provide health care
8 services by licensed health care practitioners pursuant to
9 chapters 457, 458, 459, 460, 461, 462, 463, 466, 467, 484,
10 486, 490, 491, or part I, part III, part X, part XIII, or part
11 XIV of chapter 468, or s. 464.012, which are wholly owned by
12 licensed health care practitioners or the licensed health care
13 practitioner and the spouse, parent, or child of a licensed
14 health care practitioner, so long as one of the owners who is
15 a licensed health care practitioner is supervising the
16 services performed therein and is legally responsible for the
17 entity's compliance with all federal and state laws. However,
18 no health care practitioner may supervise the delivery of
19 health care services beyond the scope of the practitioner's
20 license. This section does not prohibit a health care
21 practitioner from providing administrative or managerial
22 supervision for personnel purposes.
23 Section 37. Paragraph (b) of subsection (2) of section
24 465.019, Florida Statutes, is amended to read:
25 465.019 Institutional pharmacies; permits.--
26 (2) The following classes of institutional pharmacies
27 are established:
28 (b) "Class II institutional pharmacies" are those
29 institutional pharmacies which employ the services of a
30 registered pharmacist or pharmacists who, in practicing
31 institutional pharmacy, shall provide dispensing and

1 consulting services on the premises to patients of that
2 institution <u>and to patients receiving care in a hospice</u>
3 <u>licensed under part VI of chapter 400 which is located or</u>
4 <u>providing services on the premises of that institution</u>, for
5 use on the premises of that institution. However, an
6 institutional pharmacy located in an area or county included
7 in an emergency order or proclamation of a state of emergency
8 declared by the Governor may provide dispensing and consulting
9 services to individuals who are not patients of the
10 institution. However, a single dose of a medicinal drug may be
11 obtained and administered to a patient on a valid physician's
12 drug order under the supervision of a physician or charge
13 nurse, consistent with good institutional practice procedures.
14 The obtaining and administering of such single dose of a
15 medicinal drug shall be pursuant to drug-handling procedures
16 established by a consultant pharmacist. Medicinal drugs may
17 be dispensed in a Class II institutional pharmacy, but only in
18 accordance with the provisions of this section.
19 Section 38. Subsection (7) is added to section 631.57,
20 Florida Statutes, to read:
21 631.57 Powers and duties of the association.--
22 <u>(7) Notwithstanding any other provision of law, the</u>
23 <u>net direct written premiums of medical malpractice insurance</u>
24 <u>are not subject to assessment under this section to cover</u>
25 <u>claims and administrative costs for the type of insurance</u>
26 <u>defined in s. 624.604.</u>
27 Section 39. Paragraph (a) of subsection (1) of section
28 766.101, Florida Statutes, is amended to read:
29 766.101 Medical review committee, immunity from
30 liability.--
31 (1) As used in this section:

1 (a) The term "medical review committee" or "committee"
2 means:
3 1.a. A committee of a hospital or ambulatory surgical
4 center licensed under chapter 395 or a health maintenance
5 organization certificated under part I of chapter 641,
6 b. A committee of a physician-hospital organization, a
7 provider-sponsored organization, or an integrated delivery
8 system,
9 c. A committee of a state or local professional
10 society of health care providers,
11 d. A committee of a medical staff of a licensed
12 hospital or nursing home, provided the medical staff operates
13 pursuant to written bylaws that have been approved by the
14 governing board of the hospital or nursing home,
15 e. A committee of the Department of Corrections or the
16 Correctional Medical Authority as created under s. 945.602, or
17 employees, agents, or consultants of either the department or
18 the authority or both,
19 f. A committee of a professional service corporation
20 formed under chapter 621 or a corporation organized under
21 chapter 607 or chapter 617, which is formed and operated for
22 the practice of medicine as defined in s. 458.305(3), and
23 which has at least 25 health care providers who routinely
24 provide health care services directly to patients,
25 g. A committee of a mental health treatment facility
26 licensed under chapter 394 or a community mental health center
27 as defined in s. 394.907, provided the quality assurance
28 program operates pursuant to the guidelines which have been
29 approved by the governing board of the agency,
30 h. A committee of a substance abuse treatment and
31 education prevention program licensed under chapter 397

provided the quality assurance program operates pursuant to the guidelines which have been approved by the governing board of the agency,

i. A peer review or utilization review committee organized under chapter 440,

j. A committee of the Department of Health, a county health department, healthy start coalition, or certified rural health network, when reviewing quality of care, or employees of these entities when reviewing mortality records, ~~or~~

k. A continuous quality improvement committee of a pharmacy licensed pursuant to chapter 465,

l. A committee established by a university board of trustees, or

m. A committee comprised of faculty, residents, students, and administrators of an accredited college of medicine, nursing, or other health care discipline,

which committee is formed to evaluate and improve the quality of health care rendered by providers of health service or to determine that health services rendered were professionally indicated or were performed in compliance with the applicable standard of care or that the cost of health care rendered was considered reasonable by the providers of professional health services in the area; or

2. A committee of an insurer, self-insurer, or joint underwriting association of medical malpractice insurance, or other persons conducting review under s. 766.106.

Section 40. The Office of Legislative Services shall contract for a business case study of the feasibility of outsourcing the administrative, investigative, legal, and prosecutorial functions and other tasks and services that are

1 necessary to carry out the regulatory responsibilities of the
2 Board of Dentistry, employing its own executive director and
3 other staff, and obtaining authority over collections and
4 expenditures of funds paid by professions regulated by the
5 board into the Medical Quality Assurance Trust Fund. This
6 feasibility study must include a business plan and an
7 assessment of the direct and indirect costs associated with
8 outsourcing these functions. The sum of $50,000 is
9 appropriated from the Board of Dentistry account within the
10 Medical Quality Assurance Trust Fund to the Office of
11 Legislative Services for the purpose of contracting for the
12 study. The Office of Legislative Services shall submit the
13 completed study to the Governor, the President of the Senate,
14 and the Speaker of the House of Representatives by January 1,
15 2003.
16 Section 41. Subsection (5) of section 393.064, Florida
17 Statutes, is amended to read:
18 393.064 Prevention.--
19 (5) The Department of Health Children and Family
20 Services shall have the authority, within available resources,
21 to contract for the supervision and management of the Raymond
22 C. Philips Research and Education Unit, and such contract
23 shall include specific program objectives.
24 Section 42. Paragraph (a) of subsection (2) of section
25 627.6425, Florida Statutes, is amended to read:
26 627.6425 Renewability of individual coverage.--
27 (2) An insurer may nonrenew or discontinue health
28 insurance coverage of an individual in the individual market
29 based only on one or more of the following:
30 (a) The individual has failed to pay premiums, or
31 contributions, or a required copayment payable to the insurer

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1 in accordance with the terms of the health insurance coverage
2 or the insurer has not received timely premium payments. When
3 the copayment is payable to the insurer and exceeds $300 the
4 insurer shall allow the insured up to ninety days from the
5 date of the procedure to pay the required copayment. The
6 insurer shall print in 10 point type on the Declaration of
7 Benefits page notification that the insured could be
8 terminated for failure to make any required copayment to the
9 insurer.
10 Section 43. Subsection (2) of section 627.638, Florida
11 Statutes, is amended to read:
12 627.638 Direct payment for hospital, medical
13 services.--
14 (2) Whenever, in any health insurance claim form, an
15 insured specifically authorizes payment of benefits directly
16 to any recognized hospital or physician, the insurer shall
17 make such payment to the designated provider of such services,
18 unless otherwise provided in the insurance contract. However,
19 if:
20 (a) The benefit is determined to be covered under the
21 terms of the policy;
22 (b) The claim is limited to treatment of mental health
23 or substance abuse, including drug and alcohol abuse; and
24 (c) The insured authorizes the insurer, in writing, as
25 part of the claim to make direct payment of benefits to a
26 recognized hospital, physician, or other licensed provider,
27
28 payments shall be made directly to the recognized hospital,
29 physician, or other licensed provider, notwithstanding any
30 contrary provisions in the insurance contract.
31

Section 44. Subsection (3) is added to section 381.003, Florida Statutes, to read:

381.003 Communicable disease and AIDS prevention and control.--

(3) The department shall by rule adopt the blood-borne-pathogen standard set forth in subpart Z of 29 C.F.R. part 1910, as amended by Pub. L. No. 106-430, which shall apply to all public-sector employers. The department shall compile and maintain a list of existing needleless systems and sharps with engineered sharps-injury protection which shall be available to assist employers, including the department and the Department of Corrections, in complying with the applicable requirements of the blood-borne-pathogen standard. The list may be developed from existing sources of information, including, without limitation, the United States Food and Drug Administration, the Centers for Disease Control and Prevention, the Occupational Safety and Health Administration, and the United States Department of Veterans Affairs.

Section 45. Section 765.510, Florida Statutes, is amended to read:

765.510 Legislative declaration.--Because ~~of the rapid medical progress in the fields of tissue and organ preservation, transplantation of tissue, and tissue culture, and because~~ it is in the public interest to aid the medical developments in the ~~these~~ fields of organ and tissue recovery and transplantation, and in order to promote the general welfare, save lives, and reduce sickness, pain, suffering, disabilities, and medical costs of persons with organ and tissue impairment, and to help alleviate the shortage of organs and tissues available for transplantation and research,

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the Legislature in enacting this part intends to encourage and aid the development of reconstructive medicine and surgery and the development of medical research by facilitating premortem and postmortem authorizations for donations of tissue and organs. It is the purpose of this part to regulate the gift of a body or parts of a body, the gift to be made after the death of a donor.

Section 46. Subsections (1), (2), and (6) of section 765.512, Florida Statutes, are amended to read:

765.512 Persons who may make an anatomical gift.--

(1) Any person who may make a will may give all or part of his or her body for any purpose specified in s. 765.510, the gift to take effect upon death. An anatomical gift made by an adult donor and not revoked by the donor as provided in s. 765.516 is irrevocable ~~and does not require the consent or concurrence of any person~~ after the donor's death. A family member, guardian, representative ad litem, or health care surrogate of a decedent who has made an anatomical gift may not modify the decedent's wishes or deny or prevent the anatomical gift from being made.

(2) If the decedent has executed an agreement concerning an anatomical gift, by ~~including~~ signing an organ and tissue donor card, by expressing his or her wish to donate in a living will or advance directive, or by signifying his or her intent to donate on his or her driver's license or in some other written form has indicated his or her wish to make an anatomical gift, and in the absence of actual notice of contrary indications by the decedent, the document is evidence of legally sufficient informed consent to donate an anatomical gift and is legally binding. Any surrogate designated by the decedent pursuant to part II of this chapter may give all or

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any part of the decedent's body for any purpose specified in s. 765.510.

(6) A gift of all or part of a body authorizes:

(a) Any examination necessary to assure medical acceptability of the gift for the purposes intended; and~~.~~

(b) The decedent's medical provider, family, or a third party to furnish medical records requested concerning the decedent's medical and social history.

Section 47. Section 765.516, Florida Statutes, is amended to read:

765.516 Amendment of the terms of or the revocation of the gift.--

(1) A donor may amend the terms of or revoke an anatomical gift by:

(a) The execution and delivery to the donee of a signed statement.

(b) An oral statement that is~~:~~

~~1. Made to the donor's spouse; or~~

~~2.~~ made in the presence of two persons, other than the donor's spouse, and communicated to the donor's family or attorney or to the donee.

(c) A statement during a terminal illness or injury addressed to an attending physician, who must communicate the revocation of the gift to the procurement organization that is certified by the state.

(d) A signed document found on or about the donor's person ~~or in the donor's effects~~.

(2) The terms of any gift made by a will may ~~also~~ be amended or the gift may be revoked in the manner provided for the amendment or revocation of wills or as provided in subsection (1).

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Section 48. Subsections (1) and (5) of section 765.517, Florida Statutes, are amended to read:

765.517 Rights and duties at death.--

(1) The donee, as specified under the provisions of s. 765.515(2), may accept or reject the gift. If the donee accepts a gift of the entire body or a part of the body to be used for scientific purposes other than a transplant, the donee may authorize embalming and the use of the body in funeral services, subject to the terms of the gift. ~~If the gift is of a part of the body, the donee shall cause the part to be removed without unnecessary mutilation upon the death of the donor and before or after embalming.~~After removal of the part, ~~custody of the remainder of~~ the body <u>shall be made available to</u> ~~vests in~~ the surviving spouse, next of kin, or other persons under obligation to dispose of the body.

(5) A person <u>or entity that</u> ~~who~~ acts <u>or attempts to act</u> in good faith and without negligence in <u>accordance</u> ~~accord~~ with the terms of this part or under the anatomical gift laws of another state or a foreign country is not liable for damages in any civil action or subject to prosecution for his or her acts in any criminal proceeding. <u>Neither an individual who makes an anatomical gift nor the individual's estate is liable for any injury or damage that results from the making or the use of the anatomical gift.</u>

Section 49. Section 381.0034, Florida Statutes, is amended to read:

381.0034 Requirement for instruction <u>on conditions caused by nuclear, biological, and chemical terrorism and</u> on human immunodeficiency virus and acquired immune deficiency syndrome.--

(1) ~~As of July 1, 1991,~~The Department of Health shall require each person licensed or certified under chapter 401, chapter 467, part IV of chapter 468, or chapter 483, as a condition of biennial relicensure, to complete an educational course approved by the department on conditions caused by nuclear, biological, and chemical terrorism. The course shall consist of education on diagnosis and treatment,~~the~~ modes of transmission, infection control procedures, and clinical management. Such course shall also include information on reporting suspected cases of conditions caused by nuclear, biological, or chemical terrorism to the appropriate health and law enforcement authorities~~, and prevention of human immunodeficiency virus and acquired immune deficiency syndrome. Such course shall include information on current Florida law on acquired immune deficiency syndrome and its impact on testing, confidentiality of test results, and treatment of patients~~. Each such licensee or certificateholder shall submit confirmation of having completed said course, on a form provided by the department, when submitting fees or application for each biennial renewal.

(2) Failure to complete the requirements of this section shall be grounds for disciplinary action contained in the chapters specified in subsection (1). In addition to discipline by the department, the licensee or certificateholder shall be required to complete the required ~~said~~ course or courses.

(3) The department shall require, as a condition of granting a license under the chapters specified in subsection (1), that an applicant making initial application for licensure complete respective ~~an~~ educational courses ~~course~~ acceptable to the department on conditions caused by nuclear,

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1 <u>biological, and chemical terrorism and on</u> human
2 immunodeficiency virus and acquired immune deficiency
3 syndrome. An applicant who has not taken <u>such courses</u> ~~a~~
4 ~~course~~ at the time of licensure shall, upon an affidavit
5 showing good cause, be allowed 6 months to complete this
6 requirement.
7 (4) The department shall have the authority to adopt
8 rules to carry out the provisions of this section.
9 (5) Any professional holding two or more licenses or
10 certificates subject to the provisions of this section shall
11 be permitted to show proof of having taken one
12 department-approved course on <u>conditions caused by nuclear,</u>
13 <u>biological, and chemical terrorism</u> ~~human immunodeficiency~~
14 ~~virus and acquired immune deficiency syndrome~~, for purposes of
15 relicensure or recertification for the additional licenses.
16 <u>(6) As used in this section, the term "terrorism" has</u>
17 <u>the same meaning as in s. 775.30.</u>
18 Section 50. Section 381.0035, Florida Statutes, is
19 amended to read:
20 381.0035 Educational <u>courses</u> ~~course~~ on human
21 immunodeficiency virus and acquired immune deficiency syndrome
22 <u>and on conditions caused by nuclear, biological, and chemical</u>
23 <u>terrorism</u>; employees and clients of certain health care
24 facilities.--
25 (1)<u>(a)</u> The Department of Health shall require all
26 ~~employees and~~ clients of facilities licensed under chapters
27 393, 394, and 397 ~~and employees of facilities licensed under~~
28 ~~chapter 395 and parts II, III, IV, and VI of chapter 400~~ to
29 complete, biennially, a continuing educational course on the
30 modes of transmission, infection control procedures, clinical
31 management, and prevention of human immunodeficiency virus and

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1 acquired immune deficiency syndrome with an emphasis on
2 appropriate behavior and attitude change. Such instruction
3 shall include information on current Florida law and its
4 impact on testing, confidentiality of test results, and
5 treatment of patients and any protocols and procedures
6 applicable to human immunodeficiency counseling and testing,
7 reporting, the offering of HIV testing to pregnant women, and
8 partner notification issues pursuant to ss. 381.004 and
9 384.25.
10 (b) The department shall require all employees of
11 facilities licensed under chapters 393, 394, 395, and 397 and
12 parts II, III, IV, and VI of chapter 400 to complete,
13 biennially, a continuing educational course on conditions
14 caused by nuclear, biological, and chemical terrorism. The
15 course shall consist of education on diagnosis and treatment,
16 modes of transmission, infection control procedures, and
17 clinical management. Such course shall also include
18 information on reporting suspected cases of conditions caused
19 by nuclear, biological, or chemical terrorism to the
20 appropriate health and law enforcement authorities.
21 (2) New employees of facilities licensed under
22 chapters 393, 394, 395, and 397 and parts II, III, IV, and VI
23 of chapter 400 shall be required to complete a course on human
24 immunodeficiency virus and acquired immune deficiency
25 syndrome, with instruction to include information on current
26 Florida law and its impact on testing, confidentiality of test
27 results, and treatment of patients. New employees of such
28 facilities shall also be required to complete a course on
29 conditions caused by nuclear, biological, and chemical
30 terrorism, with instruction to include information on
31

1 reporting suspected cases to the appropriate health and law
2 enforcement authorities.
3 (3) Facilities licensed under chapters 393, 394, 395,
4 and 397, and parts II, III, IV, and VI of chapter 400 shall
5 maintain a record of employees and dates of attendance at
6 ~~human immunodeficiency virus and acquired immune deficiency~~
7 ~~syndrome~~ educational courses on human immunodeficiency virus
8 and acquired immune deficiency syndrome and on conditions
9 caused by nuclear, biological, and chemical terrorism.
10 (4) The department shall have the authority to review
11 the records of each facility to determine compliance with the
12 requirements of this section. The department may adopt rules
13 to carry out the provisions of this section.
14 (5) As used in this section, the term "terrorism" has
15 the same meaning as in s. 775.30.
16 Section 51. Section 401.23, Florida Statutes, is
17 amended to read:
18 401.23 Definitions.--As used in this part, the term:
19 (1) "Advanced life support" means the use of skills
20 and techniques described in the most recent U.S. DOT National
21 Standard Paramedic Curriculum by a paramedic under the
22 supervision of a licensee's medical director as required by
23 rules of the department. The term "advanced life support" also
24 includes other techniques which have been approved and are
25 performed under conditions specified by rules of the
26 department. The term "advanced life support" also includes
27 provision of care by a paramedic under the supervision of a
28 licensee's medical director to one experiencing an emergency
29 medical condition as defined herein.~~treatment of~~
30 ~~life-threatening medical emergencies through the use of~~
31 ~~techniques such as endotracheal intubation, the administration~~

1 ~~of drugs or intravenous fluids, telemetry, cardiac monitoring,~~
2 ~~and cardiac defibrillation by a qualified person, pursuant to~~
3 ~~rules of the department.~~
4 (2) "Advanced life support service" means any
5 emergency medical transport or nontransport service which uses
6 advanced life support techniques.
7 (3) "Air ambulance" means any fixed-wing or
8 rotary-wing aircraft used for, or intended to be used for, air
9 transportation of sick or injured persons requiring or likely
10 to require medical attention during transport.
11 (4) "Air ambulance service" means any publicly or
12 privately owned service, licensed in accordance with the
13 provisions of this part, which operates air ambulances to
14 transport persons requiring or likely to require medical
15 attention during transport.
16 (5) "Ambulance" or "emergency medical services
17 vehicle" means any privately or publicly owned land or water
18 vehicle that is designed, constructed, reconstructed,
19 maintained, equipped, or operated for, and is used for, or
20 intended to be used for, land or water transportation of sick
21 or injured persons requiring or likely to require medical
22 attention during transport.
23 (6) "Ambulance driver" means any person who meets the
24 requirements of s. 401.281.
25 (7) "Basic life support" means <u>the use of skills and</u>
26 <u>techniques described in the most recent U.S. DOT National</u>
27 <u>Standard EMT-Basic Curriculum by an emergency medical</u>
28 <u>technician or paramedic under the supervision of a licensee's</u>
29 <u>medical director as required by rules of the department. The</u>
30 <u>term "basic life support" also includes other techniques which</u>
31 <u>have been approved and are performed under conditions</u>

1 specified by rules of the department. The term "basic life
2 support" also includes provision of care by a paramedic or
3 emergency medical technician under the supervision of a
4 licensee's medical director to one experiencing an emergency
5 medical condition as defined herein.treatment of medical
6 emergencies by a qualified person through the use of
7 techniques such as patient assessment, cardiopulmonary
8 resuscitation (CPR), splinting, obstetrical assistance,
9 bandaging, administration of oxygen, application of medical
10 antishock trousers, administration of a subcutaneous injection
11 using a premeasured autoinjector of epinephrine to a person
12 suffering an anaphylactic reaction, and other techniques
13 described in the Emergency Medical Technician Basic Training
14 Course Curriculum of the United States Department of
15 Transportation. The term "basic life support" also includes
16 other techniques which have been approved and are performed
17 under conditions specified by rules of the department.
18 (8) "Basic life support service" means any emergency
19 medical service which uses only basic life support techniques.
20 (9) "Certification" means any authorization issued
21 pursuant to this part to a person to act as an emergency
22 medical technician or a paramedic.
23 (10) "Department" means the Department of Health.
24 (11) "Emergency medical condition" means:
25 (a) A medical condition manifesting itself by acute
26 symptoms of sufficient severity, which may include severe
27 pain, psychiatric disturbances, symptoms of substance abuse,
28 or other acute symptoms, such that the absence of immediate
29 medical attention could reasonably be expected to result in
30 any of the following:
31

1 1. Serious jeopardy to patient health, including a
2 pregnant woman or fetus.
3 2. Serious impairment to bodily functions.
4 3. Serious dysfunction of any bodily organ or part.
5 (b) With respect to a pregnant woman, that there is
6 evidence of the onset and persistence of uterine contractions
7 or rupture of the membranes.
8 (c) With respect to a person exhibiting acute
9 psychiatric disturbance or substance abuse, that the absence
10 of immediate medical attention could reasonably be expected to
11 result in:
12 1. Serious jeopardy to the health of a patient; or
13 2. Serious jeopardy to the health of others.
14 (12)~~(11)~~ "Emergency medical technician" means a person
15 who is certified by the department to perform basic life
16 support pursuant to this part.
17 (13)~~(12~~) "Interfacility transfer" means the
18 transportation by ambulance of a patient between two
19 facilities licensed under chapter 393, chapter 395, or chapter
20 400, pursuant to this part.
21 (14)~~(13)~~ "Licensee" means any basic life support
22 service, advanced life support service, or air ambulance
23 service licensed pursuant to this part.
24 (15)~~(14)~~ "Medical direction" means direct supervision
25 by a physician through two-way voice communication or, when
26 such voice communication is unavailable, through established
27 standing orders, pursuant to rules of the department.
28 (16)~~(15)~~ "Medical director" means a physician who is
29 employed or contracted by a licensee and who provides medical
30 supervision, including appropriate quality assurance but not
31

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including administrative and managerial functions, for daily operations and training pursuant to this part.

(17)~~(16)~~ "Mutual aid agreement" means a written agreement between two or more entities whereby the signing parties agree to lend aid to one another under conditions specified in the agreement and as sanctioned by the governing body of each affected county.

(18)~~(17)~~ "Paramedic" means a person who is certified by the department to perform basic and advanced life support pursuant to this part.

(19)~~(18)~~ "Permit" means any authorization issued pursuant to this part for a vehicle to be operated as a basic life support or advanced life support transport vehicle or an advanced life support nontransport vehicle providing basic or advanced life support.

(20)~~(19)~~ "Physician" means a practitioner who is licensed under the provisions of chapter 458 or chapter 459. For the purpose of providing "medical direction" as defined in subsection (14) for the treatment of patients immediately prior to or during transportation to a United States Department of Veterans Affairs medical facility, "physician" also means a practitioner employed by the United States Department of Veterans Affairs.

(21)~~(20)~~ "Registered nurse" means a practitioner who is licensed to practice professional nursing pursuant to part I of chapter 464.

(22)~~(21)~~ "Secretary" means the Secretary of Health.

(23)~~(22)~~ "Service location" means any permanent location in or from which a licensee solicits, accepts, or conducts business under this part.

1 Section 52. Subsection (6) of section 401.27, Florida
2 Statutes, is amended to read:
3 401.27 Personnel; standards and certification.--
4 (6)(a) The department shall establish by rule a
5 procedure for biennial renewal certification of emergency
6 medical technicians. Such rules must require a United States
7 Department of Transportation refresher training program of at
8 least 30 hours as approved by the department every 2 years.
9 Completion of the course required by s. 381.0034(1) shall
10 count toward the 30 hours.The refresher program may be
11 offered in multiple presentations spread over the 2-year
12 period. The rules must also provide that the refresher course
13 requirement may be satisfied by passing a challenge
14 examination.
15 (b) The department shall establish by rule a procedure
16 for biennial renewal certification of paramedics. Such rules
17 must require candidates for renewal to have taken at least 30
18 hours of continuing education units during the 2-year period.
19 Completion of the course required by s. 381.0034(1) shall
20 count toward the 30 hours.The rules must provide that the
21 continuing education requirement may be satisfied by passing a
22 challenge examination.
23 Section 53. Section 456.033, Florida Statutes, is
24 amended to read:
25 456.033 Requirement for instruction for certain
26 licensees on conditions caused by nuclear, biological, and
27 chemical terrorism and on HIV and AIDS.--
28 (1) The appropriate board shall require each person
29 licensed or certified under chapter 457; chapter 458; chapter
30 459; chapter 460; chapter 461; chapter 463; part I of chapter
31 464; chapter 465; chapter 466; part II, part III, part V, or

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part X of chapter 468; or chapter 486 to complete a continuing educational course, approved by the board, on conditions caused by nuclear, biological, and chemical terrorism ~~human immunodeficiency virus and acquired immune deficiency syndrome~~ as part of biennial relicensure or recertification. The course shall consist of education on diagnosis and treatment,~~the~~ modes of transmission, infection control procedures, and clinical management. Such course shall also include information on reporting suspected cases of conditions caused by nuclear, biological, or chemical terrorism to the appropriate health and law enforcement authorities~~, and prevention of human immunodeficiency virus and acquired immune deficiency syndrome. Such course shall include information on current Florida law on acquired immune deficiency syndrome and its impact on testing, confidentiality of test results, treatment of patients, and any protocols and procedures applicable to human immunodeficiency virus counseling and testing, reporting, the offering of HIV testing to pregnant women, and partner notification issues pursuant to ss. 381.004 and 384.25~~.

(2) Each such licensee or certificateholder shall submit confirmation of having completed said course, on a form as provided by the board, when submitting fees for each biennial renewal.

(3) The board shall have the authority to approve additional equivalent courses that may be used to satisfy the requirements in subsection (1). Each licensing board that requires a licensee to complete an educational course pursuant to this section may count the hours required for completion of the course included in the total continuing educational requirements as required by law.

(4) Any person holding two or more licenses subject to the provisions of this section shall be permitted to show proof of having taken one board-approved course on conditions caused by nuclear, biological, and chemical terrorism ~~human immunodeficiency virus and acquired immune deficiency syndrome~~, for purposes of relicensure or recertification for additional licenses.

(5) Failure to comply with the ~~above~~ requirements of this section shall constitute grounds for disciplinary action under each respective licensing chapter and s. 456.072(1)(e). In addition to discipline by the board, the licensee shall be required to complete the required course or courses.

(6) The board shall require as a condition of granting a license under the chapters and parts specified in subsection (1) that an applicant making initial application for licensure complete respective ~~an~~ educational courses ~~course~~ acceptable to the board on conditions caused by nuclear, biological, and chemical terrorism and on human immunodeficiency virus and acquired immune deficiency syndrome. An applicant who has not taken such courses ~~a course~~ at the time of licensure shall, upon an affidavit showing good cause, be allowed 6 months to complete this requirement.

(7) The board shall have the authority to adopt rules to carry out the provisions of this section.

(8) The board shall report to the Legislature by March 1 of each year as to the implementation and compliance with the requirements of this section.

(9)(a) In lieu of completing a course as required in subsection (1), the licensee may complete a course on ~~in~~ end-of-life care and palliative health care or a course on HIV/AIDS, so long as the licensee completed an approved

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1 ~~AIDS/HIV~~ course on conditions caused by nuclear, biological,
2 and chemical terrorism in the immediately preceding biennium.
3 (b) In lieu of completing a course as required by
4 subsection (1), a person licensed under chapter 466 ~~who has~~
5 ~~completed an approved AIDS/HIV course in the immediately~~
6 ~~preceding 2 years~~ may complete a course approved by the Board
7 of Dentistry.
8 (10) As used in this section, the term "terrorism" has
9 the same meaning as in s. 775.30.
10 Section 54. Section 456.0345, Florida Statutes, is
11 created to read:
12 456.0345 Life support training.--Health care
13 practitioners who obtain training in advanced cardiac life
14 support, cardiopulmonary resuscitation, or emergency first aid
15 shall receive an equivalent number of continuing education
16 course credits which may be applied toward licensure renewal
17 requirements.
18 Section 55. Subsection (4) of section 458.319, Florida
19 Statutes, is amended to read:
20 458.319 Renewal of license.--
21 (4) Notwithstanding the provisions of s. 456.033, a
22 physician may complete continuing education on end-of-life
23 care and palliative care in lieu of continuing education in
24 conditions caused by nuclear, biological, and chemical
25 terrorism ~~AIDS/HIV~~, if that physician has completed the
26 ~~AIDS/HIV~~ continuing education in conditions caused by nuclear,
27 biological, and chemical terrorism in the immediately
28 preceding biennium. As used in this subsection, the term
29 "terrorism" has the same meaning as in s. 775.30.
30 Section 56. Subsection (5) of section 459.008, Florida
31 Statutes, is amended to read:

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1 459.008 Renewal of licenses and certificates.--
2 (5) Notwithstanding the provisions of s. 456.033, an
3 osteopathic physician may complete continuing education on
4 end-of-life and palliative care in lieu of continuing
5 education in conditions caused by nuclear, biological, and
6 chemical terrorism ~~AIDS/HIV~~, if that physician has completed
7 the ~~AIDS/HIV~~ continuing education in conditions caused by
8 nuclear, biological, and chemical terrorism in the immediately
9 preceding biennium. As used in this subsection, the term
10 "terrorism" has the same meaning as in s. 775.30.
11 Section 57. Subsection (4) is added to section
12 401.2715, Florida Statutes, to read:
13 401.2715 Recertification training of emergency medical
14 technicians and paramedics.--
15 (4) Any certified emergency medical technician or
16 paramedic may, as a condition of recertification, complete up
17 to 8 hours of training to respond to terrorism, as defined in
18 s. 775.30, and such hours completed may be substituted on a
19 hour-for-hour basis for any other areas of training required
20 for recertification. The department may adopt rules necessary
21 to administer this subsection.
22 Section 58. Subsection (1) of section 633.35, Florida
23 Statutes, is amended to read:
24 633.35 Firefighter training and certification.--
25 (1) The division shall establish a firefighter
26 training program of not less than 360 hours, administered by
27 such agencies and institutions as it approves for the purpose
28 of providing basic employment training for firefighters. Any
29 firefighter may, as a condition of certification, complete up
30 to 8 hours of training to respond to terrorism, as defined in
31 s. 775.30, and such hours completed may be substituted on a

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1 hour-for-hour basis for any other areas of training required
2 for certification. The division may adopt rules necessary to
3 administer this subsection. Nothing herein shall require a
4 public employer to pay the cost of such training.
5 Section 59. Subsection (1) of section 943.135, Florida
6 Statutes, is amended to read:
7 943.135 Requirements for continued employment.--
8 (1) The commission shall, by rule, adopt a program
9 that requires all officers, as a condition of continued
10 employment or appointment as officers, to receive periodic
11 commission-approved continuing training or education. Such
12 continuing training or education shall be required at the rate
13 of 40 hours every 4 years, and up to 8 hours which may consist
14 of training to respond to terrorism as defined in s. 775.30.
15 No officer shall be denied a reasonable opportunity by the
16 employing agency to comply with this section. The employing
17 agency must document that the continuing training or education
18 is job-related and consistent with the needs of the employing
19 agency. The employing agency must maintain and submit, or
20 electronically transmit, the documentation to the commission,
21 in a format approved by the commission. The rule shall also
22 provide:
23 (a) Assistance to an employing agency in identifying
24 each affected officer, the date of his or her employment or
25 appointment, and his or her most recent date for successful
26 completion of continuing training or education;
27 (b) A procedure for reactivation of the certification
28 of an officer who is not in compliance with this section; and
29 (c) A remediation program supervised by the training
30 center director within the geographic area for any officer who
31 is attempting to comply with the provisions of this subsection

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1 and in whom learning disabilities are identified. The officer
2 shall be assigned nonofficer duties, without loss of employee
3 benefits, and the program shall not exceed 90 days.
4 Section 60. Section 381.0421, Florida Statutes, is
5 created to read:
6 381.0421 Vaccination against meningococcal meningitis
7 and hepatitis B.--
8 (1) A postsecondary educational institution shall
9 provide detailed information concerning the risks associated
10 with meningococcal meningitis and hepatitis B and the
11 availability, effectiveness, and known contraindications of
12 any required or recommended vaccine to every student, or to
13 the student's parent or guardian if the student is a minor,
14 who has been accepted for admission.
15 (2) An individual enrolled in a postsecondary
16 educational institution who will be residing in on-campus
17 housing shall provide documentation of vaccinations against
18 meningococcal meningitis and hepatitis B unless the
19 individual, if the individual is 18 years of age or older, or
20 the individual's parent or guardian, if the individual is a
21 minor, declines the vaccinations by signing a separate waiver
22 for each of these vaccines, provided by the institution,
23 acknowledging receipt and review of the information provided.
24 (3) This section does not require any postsecondary
25 educational institution to provide or pay for vaccinations
26 against meningococcal meningitis and hepatitis B.
27 Section 61. Subsection (3) of section 394.4574,
28 Florida Statutes, is amended to read:
29 394.4574 Department responsibilities for a mental
30 health resident who resides in an assisted living facility
31 that holds a limited mental health license.--

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1 (3) The Secretary of Children and Family Services, in
2 consultation with the Agency for Health Care Administration,
3 shall annually require each district administrator to develop
4 and implement within a specific legislative appropriation for
5 this purpose, with community input, detailed plans that
6 demonstrate how the district will ensure the provision of
7 state-funded mental health and substance abuse treatment
8 services to residents of assisted living facilities that hold
9 a limited mental health license. Each district will hold a
10 publicly announced meeting for input from assisted living
11 facilities that hold a limited mental health license. The
12 district will record minutes of the meeting.These plans must
13 be consistent with the substance abuse and mental health
14 district plan developed pursuant to s. 394.75 and must address
15 case management services; access to consumer-operated drop-in
16 centers; access to services during evenings, weekends, and
17 holidays; supervision of the clinical needs of the residents;
18 and access to emergency psychiatric care. The state
19 headquarters office will hold an annual meeting to review the
20 district plans and will invite the Florida Assisted Living
21 Association, the Florida Council for Behavioral Healthcare,
22 the Florida Psychiatric Society, and the Alliance for the
23 Mentally Ill.
24 Section 62. Subsection (2) of section 394.74, Florida
25 Statutes, is amended, present subsections (4) and (5) of that
26 section are renumbered as subsections (5) and (6),
27 respectively, and a new subsection (4) is added to that
28 section to read:
29 394.74 Contracts for provision of local substance
30 abuse and mental health programs.--
31

1 (2)(a) Contracts for service shall be consistent with
2 the approved district plan.
3 (b) Notwithstanding s. 394.76(3)(a) and (c), the
4 department may use unit cost methods of payment in contracts
5 for purchasing mental health and substance abuse services. The
6 unit cost contracting system must account for those patient
7 fees that are paid on behalf of a specific client and those
8 that are earned and used by the provider for those services
9 funded in whole or in part by the department.
10 (c) The department may reimburse actual expenditures
11 for startup contracts and fixed capital outlay contracts in
12 accordance with contract specifications. The department is
13 authorized to use case rates or per-capita contracts. The
14 contract provider must report persons served and services
15 provided.
16 (4) Within existing statewide or district resources,
17 the department shall:
18 (a) Require that contract funds support individual
19 client treatment or service plans and clinical status.
20 (b) Develop proposed eligibility criteria and
21 associated benefits packages as a part of the 2004 state
22 master plan submitted pursuant to s. 394.75.
23 (c) Promote the use of electronic formats for contract
24 materials, including electronic signatures.
25 (d) Promote the use of web-enabled application
26 software products to simplify and expedite contract data
27 collection and billing.
28 (e) Ensure consumer choice among providers as provider
29 networks are created pursuant to s. 394.9082.
30 Section 63. Subsection (20) of section 400.141,
31 Florida Statutes, is amended to read:

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1 400.141 Administration and management of nursing home
2 facilities.--Every licensed facility shall comply with all
3 applicable standards and rules of the agency and shall:
4 (20) Maintain general and professional liability
5 insurance coverage that is in force at all times.
6
7 Facilities that have been awarded a Gold Seal under the
8 program established in s. 400.235 may develop a plan to
9 provide certified nursing assistant training as prescribed by
10 federal regulations and state rules and may apply to the
11 agency for approval of their program.
12 Section 64. Subsection (9) of section 400.147, Florida
13 Statutes, is amended to read:
14 400.147 Internal risk management and quality assurance
15 program.--
16 (9) By the 10th of each month each facility subject to
17 this section shall report ~~monthly~~ any notice received pursuant
18 to s. 400.0233(2) and each initial complaint that was filed
19 with the clerk of the court and served on the facility during
20 the previous month by a resident, family member, guardian,
21 conservator, or personal legal representative ~~liability claim~~
22 ~~filed against it~~. The report must include the name of the
23 resident, the date of birth, the Medicaid identification
24 number for persons eligible for Medicaid, the date or dates of
25 the incident leading to the claim, if applicable, the dates of
26 residency, and the type of injury or violation of rights
27 alleged to have occurred. Each facility shall also submit a
28 copy of the notices received pursuant to s. 400.0233(2) and
29 complaints filed with the clerk of the court. This report is
30 confidential as provided by law and is not discoverable or
31 admissible in any civil or administrative action, except in

1 such actions brought by the agency to enforce the provisions
2 of this part.
3 Section 65. (1) For the period beginning June 30,
4 2001, and ending June 30, 2005, the Agency for Health Care
5 Administration shall provide a report to the Governor, the
6 President of the Senate, and the Speaker of the House of
7 Representatives with respect to nursing homes. The first
8 report shall be submitted no later than December 30, 2002, and
9 every 6 months thereafter. The report shall identify:
10 (a) Facilities based on their ownership
11 characteristics, size, business structure, for-profit or
12 not-for-profit status, and any other characteristics the
13 agency determines useful in analyzing the varied segments of
14 the nursing home industry;
15 (b) The number of Notices of Intent to Litigate
16 received by each facility each month;
17 (c) The number of complaints on behalf of a resident
18 or resident's legal representative which were filed with the
19 clerk of the court each month;
20 (d) The month in which the injury that is the basis
21 for the suit occurred or was discovered or, if unavailable,
22 the dates of residency of the resident involved, beginning
23 with the date of initial admission and the latest discharge
24 date; and
25 (e) Information regarding deficiencies cited,
26 including information used to develop the Nursing Home Guide
27 pursuant to section 400.191, Florida Statutes, and applicable
28 rules; a summary of data generated on nursing homes by the
29 Centers for Medicare and Medicaid Services Nursing Home
30 Quality Information Project; and information collected
31

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1 pursuant to section 400.147(9), Florida Statutes, relating to
2 litigation.
3 (2) Facilities subject to this part must submit the
4 information necessary to compile this report each month on
5 existing forms, as modified, and provided by the agency.
6 (3) The agency shall delineate the available
7 information on a monthly basis.
8 Section 66. Subsection (2) of section 499.007, Florida
9 Statutes, is amended to read:
10 499.007 Misbranded drug or device.--A drug or device
11 is misbranded:
12 (2) Unless, if in package form, it bears a label
13 containing:
14 (a) The name and place of business of the manufacturer
15 or distributor~~; in addition, for a medicinal drug, as defined~~
16 ~~in s. 499.003, the label must contain the name and place of~~
17 ~~business of the manufacturer~~ of the finished dosage form of
18 the drug. For the purpose of this paragraph, the finished
19 dosage form of a medicinal drug is that form of the drug which
20 is, or is intended to be, dispensed or administered to the
21 patient and requires no further manufacturing or processing
22 other than packaging, reconstitution, and labeling; and
23 (b) An accurate statement of the quantity of the
24 contents in terms of weight, measure, or numerical count;
25 however, under this section, reasonable variations are
26 permitted, and the department shall establish by rule
27 exemptions for small packages.
28
29 A drug dispensed by filling or refilling a written or oral
30 prescription of a practitioner licensed by law to prescribe
31 such drug is exempt from the requirements of this section,

1 except subsections (1), (8), (10), and (11) and the packaging
2 requirements of subsections (6) and (7), if the drug bears a
3 label that contains the name and address of the dispenser or
4 seller, the prescription number and the date the prescription
5 was written or filled, the name of the prescriber and the name
6 of the patient, and the directions for use and cautionary
7 statements. This exemption does not apply to any drug
8 dispensed in the course of the conduct of a business of
9 dispensing drugs pursuant to diagnosis by mail or to any drug
10 dispensed in violation of subsection (12). The department
11 may, by rule, exempt drugs subject to ss. 499.062-499.064 from
12 subsection (12) if compliance with that subsection is not
13 necessary to protect the public health, safety, and welfare.
14 Section 67. Effective upon this act becoming a law,
15 subsection (10) of section 627.357, Florida Statutes, is
16 amended to read:
17 627.357 Medical malpractice self-insurance.--
18 (10)<u>(a)1. An application to form a self-insurance fund</u>
19 <u>under this section must be filed with the department before</u>
20 <u>October 1, 2002. All self-insurance funds authorized under</u>
21 <u>this paragraph must apply for a certificate of authority to</u>
22 <u>become an authorized insurer by October 1, 2006. Any such fund</u>
23 <u>failing to obtain a certificate of authority as an authorized</u>
24 <u>insurer within 1 year of the date of application therefor</u>
25 <u>shall wind down its affairs and shall not issue coverage after</u>
26 <u>the expiration of the 1-year period.</u>
27 <u>2. Any self insurance fund established pursuant to</u>
28 <u>this section after April 1, 2002, shall also comply with ss.</u>
29 <u>624.460-624.489, notwithstanding s. 624.462(2)(a). In the</u>
30 <u>event of a conflict between the provisions of this section and</u>
31 <u>ss. 624.460-624.489, the latter sections shall govern. With</u>

1 respect to those sections, provisions solely applicable to
2 workers' compensation and employers liability insurance shall
3 not apply to medical malpractice funds ~~A self insurance may~~
4 ~~not be formed under this section after October 1, 1992~~.
5 Section 68. Subsection (7) of section 631.54, Florida
6 Statutes, is amended to read:
7 631.54 Definitions.--As used in this part:
8 (7) "Member insurer" means any person who writes any
9 kind of insurance to which this part applies under s. 631.52,
10 including the exchange of reciprocal or interinsurance
11 contracts and any medical malpractice self-insurance fund
12 authorized after April 1, 2002, under s. 627.357, and is
13 licensed to transact insurance in this state.
14 Section 69. (1) Effective July 1, 2002, all powers,
15 duties, functions, records, personnel, property, and
16 unexpended balances of appropriations, allocations, and other
17 funds of the Agency for Health Care Administration which
18 relate to consumer complaint services, investigations, and
19 prosecutorial services currently provided by the Agency for
20 Health Care Administration under a contract with the
21 Department of Health are transferred to the Department of
22 Health by a type two transfer, as defined in section 20.06(2),
23 Florida Statutes. This transfer of funds shall include all
24 advance payments made from the Medical Quality Assurance Trust
25 Fund to the Agency for Health Care Administration.
26 (2)(a) Effective July 1, 2002, 279 full-time
27 equivalent positions are eliminated from the Agency for Health
28 Care Administration's total number of authorized positions.
29 Effective July 1, 2002, 279 full-time equivalent positions are
30 authorized for the Department of Health, to be added to the
31 department's total number of authorized positions. However,

if the General Appropriations Act for fiscal year 2002-2003 reduces the number of positions from the practitioner regulation component at the Agency for Health Care Administration, that provision shall be construed to eliminate the full-time equivalent positions from the practitioner regulation component, which is hereby transferred to the Department of Health, thereby resulting in no more than 279 positions being eliminated from the agency and no more than 279 positions being authorized to the department.

(b) All records, personnel, and funds of the consumer complaint and investigative services units of the agency are transferred and assigned to the Division of Medical Quality Assurance of the Department of Health.

(c) All records, personnel, and funds of the health care practitioner prosecutorial unit of the agency are transferred and assigned to the Office of the General Counsel of the Department of Health.

(3) The Department of Health is deemed the successor in interest in all legal proceedings and contracts currently involving the Agency for Health Care Administration and relating to health care practitioner regulation. Except as provided herein, no legal proceeding shall be dismissed, nor any contract terminated, on the basis of this type two transfer. The interagency agreement between the Department of Health and the Agency for Health Care Administration shall terminate on June 30, 2002.

Section 70. Section 408.7056, Florida Statutes, is amended to read:

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

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

1 (a) "Agency" means the Agency for Health Care
2 Administration.
3 (b) "Department" means the Department of Insurance.
4 (c) "Grievance procedure" means an established set of
5 rules that specify a process for appeal of an organizational
6 decision.
7 (d) "Health care provider" or "provider" means a
8 state-licensed or state-authorized facility, a facility
9 principally supported by a local government or by funds from a
10 charitable organization that holds a current exemption from
11 federal income tax under s. 501(c)(3) of the Internal Revenue
12 Code, a licensed practitioner, a county health department
13 established under part I of chapter 154, a prescribed
14 pediatric extended care center defined in s. 400.902, a
15 federally supported primary care program such as a migrant
16 health center or a community health center authorized under s.
17 329 or s. 330 of the United States Public Health Services Act
18 that delivers health care services to individuals, or a
19 community facility that receives funds from the state under
20 the Community Alcohol, Drug Abuse, and Mental Health Services
21 Act and provides mental health services to individuals.
22 (e) "Managed care entity" means a health maintenance
23 organization or a prepaid health clinic certified under
24 chapter 641, a prepaid health plan authorized under s.
25 409.912, or an exclusive provider organization certified under
26 s. 627.6472.
27 (f) "Panel" means a ~~statewide provider and~~ subscriber
28 assistance panel selected as provided in subsection (11).
29 (2) The agency shall adopt and implement a program to
30 provide assistance to subscribers and providers, including
31 those whose grievances are not resolved by the managed care

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1 entity to the satisfaction of the subscriber or provider. The
2 program shall consist of one or more panels that meet as often
3 as necessary to timely review, consider, and hear grievances
4 and recommend to the agency or the department any actions that
5 should be taken concerning individual cases heard by the
6 panel. The panel shall hear every grievance filed by
7 subscribers and providers on behalf of subscribers, unless the
8 grievance:
9 (a) Relates to a managed care entity's refusal to
10 accept a provider into its network of providers;
11 (b) Is part of an internal grievance in a Medicare
12 managed care entity or a reconsideration appeal through the
13 Medicare appeals process which does not involve a quality of
14 care issue;
15 (c) Is related to a health plan not regulated by the
16 state such as an administrative services organization,
17 third-party administrator, or federal employee health benefit
18 program;
19 (d) Is related to appeals by in-plan suppliers and
20 providers, unless related to quality of care provided by the
21 plan;
22 (e) Is part of a Medicaid fair hearing pursued under
23 42 C.F.R. ss. 431.220 et seq.;
24 (f) Is the basis for an action pending in state or
25 federal court;
26 (g) Is related to an appeal by nonparticipating
27 providers, unless related to the quality of care provided to a
28 subscriber by the managed care entity and the provider is
29 involved in the care provided to the subscriber;
30 (h) Was filed before the subscriber or provider
31 completed the entire internal grievance procedure of the

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1 managed care entity, the managed care entity has complied with
2 its timeframes for completing the internal grievance
3 procedure, and the circumstances described in subsection (6)
4 do not apply;
5 (i) Has been resolved to the satisfaction of the
6 subscriber or provider who filed the grievance, unless the
7 managed care entity's initial action is egregious or may be
8 indicative of a pattern of inappropriate behavior;
9 (j) Is limited to seeking damages for pain and
10 suffering, lost wages, or other incidental expenses, including
11 accrued interest on unpaid balances, court costs, and
12 transportation costs associated with a grievance procedure;
13 (k) Is limited to issues involving conduct of a health
14 care provider or facility, staff member, or employee of a
15 managed care entity which constitute grounds for disciplinary
16 action by the appropriate professional licensing board and is
17 not indicative of a pattern of inappropriate behavior, and the
18 agency or department has reported these grievances to the
19 appropriate professional licensing board or to the health
20 facility regulation section of the agency for possible
21 investigation; or
22 (l) Is withdrawn by the subscriber or provider.
23 Failure of the subscriber or the provider to attend the
24 hearing shall be considered a withdrawal of the grievance.
25 (3) The agency shall review all grievances within 60
26 days after receipt and make a determination whether the
27 grievance shall be heard. Once the agency notifies the panel,
28 the subscriber or provider, and the managed care entity that a
29 grievance will be heard by the panel, the panel shall hear the
30 grievance either in the network area or by teleconference no
31 later than 120 days after the date the grievance was filed.

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1 The agency shall notify the parties, in writing, by facsimile
2 transmission, or by phone, of the time and place of the
3 hearing. The panel may take testimony under oath, request
4 certified copies of documents, and take similar actions to
5 collect information and documentation that will assist the
6 panel in making findings of fact and a recommendation. A
7 managed care entity, subscriber, or provider may within 5
8 working days after the hearing of the grievance submit
9 additional information to supplement the record before the
10 panel. Five working days after the hearing of the grievance,
11 the record shall be closed.The panel shall issue a written
12 recommendation, supported by findings of fact, to the provider
13 or subscriber, to the managed care entity, and to the agency
14 or the department no later than 10 ~~15~~ working days after the
15 record is closed ~~hearing the grievance~~. If at the hearing the
16 panel requests additional documentation or additional records,
17 the time for issuing a recommendation is tolled until the
18 information or documentation requested has been provided to
19 the panel. Except as provided in this section,the proceedings
20 of the panel are not subject to chapter 120. In the event of a
21 tie vote by the panel, the tie shall be decided by a second
22 vote and additional votes if necessary. In the event of a
23 deadlock, defined as three consecutive votes resulting in a
24 tie vote, such deadlock shall result in a recommendation by
25 the panel that no further action should be taken by the agency
26 or department.
27 (4) If, upon receiving a proper patient authorization
28 along with a properly filed grievance, the agency requests
29 medical records from a health care provider or managed care
30 entity, the health care provider or managed care entity that
31 has custody of the records has 10 days to provide the records

to the agency. Records include all medical records, all telephone communication logs associated with the grievance both to and from the subscriber, and any other contents of the internal grievance file associated with the complaint filed with the Subscriber Assistance Program. The agency must impose a fine of up to $500 for each day that the requested records are not produced.~~Failure to provide requested medical records may result in the imposition of a fine of up to $500.~~ Each day that records are not produced is considered a separate violation.

(5) Grievances that the agency determines pose an immediate and serious threat to a subscriber's health must be given priority over other grievances. The panel may meet at the call of the chair to hear the grievances as quickly as possible but no later than 45 days after the date the grievance is filed, unless the panel receives a waiver of the time requirement from the subscriber. The panel shall issue a written recommendation, supported by findings of fact, to the department or the agency within 10 days after hearing the expedited grievance.

(6) When the agency determines that the life of a subscriber is in imminent and emergent jeopardy, the chair of the panel may convene an emergency hearing, within 24 hours after notification to the managed care entity and to the subscriber, to hear the grievance. The grievance must be heard notwithstanding that the subscriber has not completed the internal grievance procedure of the managed care entity. The panel shall, upon hearing the grievance, issue a written emergency recommendation, supported by findings of fact, to the managed care entity, to the subscriber, and to the agency or the department for the purpose of deferring the imminent

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1 and emergent jeopardy to the subscriber's life. Within 24
2 hours after receipt of the panel's emergency recommendation,
3 the agency or department may issue an emergency order to the
4 managed care entity. An emergency order remains in force
5 until:
6 (a) The grievance has been resolved by the managed
7 care entity;
8 (b) Medical intervention is no longer necessary; or
9 (c) The panel has conducted a full hearing under
10 subsection (3) and issued a recommendation to the agency or
11 the department, and the agency or department has issued a
12 final order.
13 (7) After hearing a grievance, the panel shall make a
14 recommendation to the agency or the department which may
15 include specific actions the managed care entity must take to
16 comply with state laws or rules regulating managed care
17 entities.
18 (8) A managed care entity, subscriber, or provider
19 that is affected by a panel recommendation may within 10 days
20 after receipt of the panel's recommendation, or 72 hours after
21 receipt of a recommendation in an expedited grievance, furnish
22 to the agency or department written exceptions ~~evidence~~ in
23 opposition to the recommendation or findings of fact of the
24 panel.
25 (9) No later than 30 days after the issuance of the
26 panel's recommendation and, for an expedited grievance, no
27 later than 10 days after the issuance of the panel's
28 recommendation, the agency or the department shall issue ~~may~~
29 ~~adopt the panel's recommendation or findings of fact in~~ a
30 proposed final order or an emergency order, as provided in
31 chapter 120, which it shall issue to the managed care entity.

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1 However, the agency or department may delay issuance of a
2 proposed final order or emergency order if the agency or
3 department finds that additional investigative information is
4 needed to resolve the subscriber's grievance or if the agency
5 or department finds that the panel's recommendation or
6 findings of fact have been improvidently issued by the panel.
7 The agency or department may issue a proposed final order or
8 an emergency order, as provided in chapter 120, imposing fines
9 or sanctions, including those contained in ss. 641.25 and
10 641.52. The agency or the department may reject all or part
11 of the panel's recommendation or amend the panel's findings of
12 fact based upon:
13 (a) Written exceptions provided in opposition to the
14 panel's recommendation or findings of fact;
15 (b) Facts that the agency or department has discovered
16 at such times when additional investigative information is
17 required; or
18 (c) The agency's or department's finding that the
19 panel's recommendation or findings of fact have been
20 improvidently issued.
21
22 All fines collected under this subsection must be deposited
23 into the Health Care Trust Fund.
24 (10) In determining any fine or sanction to be
25 imposed, the agency and the department may consider the
26 following factors:
27 (a) The severity of the noncompliance, including the
28 probability that death or serious harm to the health or safety
29 of the subscriber will result or has resulted, the severity of
30 the actual or potential harm, and the extent to which
31 provisions of chapter 641 were violated.

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1 (b) Actions taken by the managed care entity to
2 resolve or remedy any quality-of-care grievance.
3 (c) Any previous incidents of noncompliance by the
4 managed care entity.
5 (d) Any other relevant factors the agency or
6 department considers appropriate in a particular grievance.
7 (11) The panel shall consist of members employed by
8 the agency and members employed by the department, chosen by
9 their respective agencies; a consumer appointed by the
10 Governor; a physician appointed by the Governor, as a standing
11 member; and physicians who have expertise relevant to the case
12 to be heard, on a rotating basis. The agency may contract with
13 a medical director and a primary care physician who shall
14 provide additional technical expertise to the panel. The
15 medical director shall be selected from a health maintenance
16 organization with a current certificate of authority to
17 operate in Florida. The agency shall develop a training
18 program for persons appointed to membership on the panel. The
19 program shall familiarize such persons with the substantive
20 and procedural laws and rules regarding their responsibilities
21 on the panel, including training with respect to the panel's
22 past recommendations and any subsequent agency action by the
23 agency or department in such cases.
24 (12) Every managed care entity shall submit a
25 quarterly report to the agency and the department listing the
26 number and the nature of all subscribers' and providers'
27 grievances that ~~which~~ have not been resolved to the
28 satisfaction of the subscriber or provider after the
29 subscriber or provider follows the entire internal grievance
30 procedure of the managed care entity. The agency shall notify
31 all subscribers and providers included in the quarterly

1 reports of their right to file an unresolved grievance with
2 the panel.
3 (13) Any information that ~~which~~ would identify a
4 subscriber or the spouse, relative, or guardian of a
5 subscriber and that ~~which~~ is contained in a report obtained by
6 the Department of Insurance pursuant to this section is
7 confidential and exempt from ~~the provisions of~~ s. 119.07(1)
8 and s. 24(a), Art. I of the State Constitution.
9 (14) A proposed final order issued by the agency or
10 department which only requires the managed care entity to take
11 a specific action under subsection (7) is subject to a summary
12 hearing in accordance with s. 120.574, unless all of the
13 parties agree otherwise. If the managed care entity does not
14 prevail at the hearing, the managed care entity must pay
15 reasonable costs and attorney's fees of the agency or the
16 department incurred in that proceeding.
17 (15)(a) Any information that ~~which~~ would identify a
18 subscriber or the spouse, relative, or guardian of a
19 subscriber and that ~~which~~ is contained in a document, report,
20 or record prepared or reviewed by the panel or obtained by the
21 agency pursuant to this section is confidential and exempt
22 from ~~the provisions of~~ s. 119.07(1) and s. 24(a), Art. I of
23 the State Constitution.
24 (b) Meetings of the panel shall be open to the public
25 unless the provider or subscriber whose grievance will be
26 heard requests a closed meeting or the agency or the
27 Department of Insurance determines that information of a
28 sensitive personal nature which discloses the subscriber's
29 medical treatment or history; or information that ~~which~~
30 constitutes a trade secret as defined by s. 812.081; or
31 information relating to internal risk-management ~~risk~~

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~~management~~ programs as defined in s. 641.55(5)(c), (6), and (8) may be revealed at the panel meeting, in which case that portion of the meeting during which such sensitive personal information, trade secret information, or internal risk-management-program ~~risk management program~~ information is discussed shall be exempt from ~~the provisions of~~ s. 286.011 and s. 24(b), Art. I of the State Constitution. All closed meetings shall be recorded by a certified court reporter.

This subsection is subject to the Open Government Sunset Review Act of 1995 in accordance with s. 119.15, and shall stand repealed on October 2, 2003, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 71. Subsection (4) of section 641.3154, Florida Statutes, is amended to read:

641.3154 Organization liability; provider billing prohibited.--

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

presumed that a provider does not know and should not know that an organization is liable unless:

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

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

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

Section 72. Subsection (1), paragraphs (b) and (e) of subsection (3), paragraph (d) of subsection (4), paragraph (g) of subsection (6), and subsections (9), (10), and (11) of section 641.511, Florida Statutes, are amended to read:

641.511 Subscriber grievance reporting and resolution requirements.--

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

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

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

(e) A notice that a subscriber may voluntarily pursue binding arbitration in accordance with the terms of the contract if offered by the organization, after completing the organization's grievance procedure and as an alternative to the ~~Statewide Provider and~~ Subscriber Assistance Program. Such notice shall include an explanation that the subscriber may incur some costs if the subscriber pursues binding arbitration, depending upon the terms of the subscriber's contract.

(4)

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

(6)

(g) In any case in which ~~when~~ the expedited review ~~process~~ does not resolve a difference of opinion between the organization and the subscriber or the provider acting on behalf of the subscriber, the subscriber or the provider

acting on behalf of the subscriber may submit a written grievance to the ~~Statewide Provider and~~ Subscriber Assistance Program. In the letter of final decision for any case in which the expedited review does not resolve a difference of opinion between the organization and the subscriber or the provider acting on behalf of the subscriber, the organization must notify the subscriber or the provider acting on behalf of the subscriber of the right to submit the written grievance to the Subscriber Assistance Program.

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

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

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

1 agency and the ~~Statewide Provider and~~ Subscriber Assistance
2 Program.
3 (11) Each organization, as part of its contract with
4 any provider, must require the provider to post a consumer
5 assistance notice prominently displayed in the reception area
6 of the provider and clearly noticeable by all patients. The
7 consumer assistance notice must state the addresses and
8 toll-free telephone numbers of the Agency for Health Care
9 Administration, the ~~Statewide Provider and~~ Subscriber
10 Assistance Program, and the Department of Insurance. The
11 consumer assistance notice must also clearly state that the
12 address and toll-free telephone number of the organization's
13 grievance department shall be provided upon request. The
14 agency may adopt ~~is authorized to promulgate~~ rules necessary
15 to administer ~~implement~~ this section.
16 Section 73. Subsection (4) of section 641.58, Florida
17 Statutes, is amended to read:
18 641.58 Regulatory assessment; levy and amount; use of
19 funds; tax returns; penalty for failure to pay.--
20 (4) The moneys received and deposited into the Health
21 Care Trust Fund shall be used to defray the expenses of the
22 agency in the discharge of its administrative and regulatory
23 powers and duties under this part, including conducting an
24 annual survey of the satisfaction of members of health
25 maintenance organizations; contracting with physician
26 consultants for the ~~Statewide Provider and~~ Subscriber
27 Assistance Panel; maintaining offices and necessary supplies,
28 essential equipment, and other materials, salaries and
29 expenses of required personnel; and discharging the
30 administrative and regulatory powers and duties imposed under
31 this part.

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Section 74. Effective upon this act becoming a law, subsection (8) of section 400.925, Florida Statutes, is amended to read:

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

(8) "Home medical equipment" includes any product as defined by the Federal Drug Administration's Drugs, Devices and Cosmetics Act, any products reimbursed under the Medicare Part B Durable Medical Equipment benefits, or any products reimbursed under the Florida Medicaid durable medical equipment program. Home medical equipment includes, but is not limited to, oxygen and related respiratory equipment; manual, motorized, or~~. Home medical equipment includes~~ customized wheelchairs and related seating and positioning, but does not include prosthetics or orthotics or any splints, braces, or aids custom fabricated by a licensed health care practitioner. ~~Home medical equipment includes assistive technology devices, including: manual wheelchairs, motorized wheelchairs, motorized scooters, voice-synthesized computer modules, optical scanners, talking software, braille printers, environmental control devices for use by person with quadriplegia, motor vehicle adaptive transportation aids, devices that enable persons with severe speech disabilities to in effect speak, personal transfer systems and specialty beds, including demonstrator, for use by a person with a medical need.~~

Section 75. Subsections (9) and (10) are added to section 766.302, Florida Statutes, to read:

766.302 Definitions; ss. 766.301-766.316.--As used in ss. 766.301-766.316, the term:

(9) "Family member" means a father, mother, or legal guardian.

1 (10) "Family residential or custodial care" means care
2 normally rendered by trained professional attendants which is
3 beyond the scope of child care duties, but which is provided
4 by family members. Family members who provide nonprofessional
5 residential or custodial care may not be compensated under
6 this act for care that falls within the scope of child care
7 duties and other services normally and gratuitously provided
8 by family members. Family residential or custodial care shall
9 be performed only at the direction and control of a physician
10 when such care is medically necessary. Reasonable charges for
11 expenses for family residential or custodial care provided by
12 a family member shall be determined as follows:
13 (a) If the family member is not employed, the per-hour
14 value equals the federal minimum hourly wage.
15 (b) If the family member is employed and elects to
16 leave that employment to provide such care, the per-hour value
17 of that care shall equal the rates established by Medicaid for
18 private-duty services provided by a home health aide. A family
19 member or a combination of family members providing care in
20 accordance with this definition may not be compensated for
21 more than a total of 10 hours per day. Family care is in lieu
22 of professional residential or custodial care, and no
23 professional residential or custodial care may be awarded for
24 the period of time during the day that family care is being
25 provided.
26 (c) The award of family residential or custodial care
27 as defined in this section shall not be included in the
28 current estimates for purposes of s. 766.314(9)(c).
29 Section 76. Paragraph (a) of subsection (1) of section
30 766.31, Florida Statutes, is amended to read:
31

1 766.31 Administrative law judge awards for
2 birth-related neurological injuries; notice of award.--
3 (1) Upon determining that an infant has sustained a
4 birth-related neurological injury and that obstetrical
5 services were delivered by a participating physician at the
6 birth, the administrative law judge shall make an award
7 providing compensation for the following items relative to
8 such injury:
9 (a) Actual expenses for medically necessary and
10 reasonable medical and hospital, habilitative and training,
11 <u>family residential or custodial care, professional</u>
12 residential, and custodial care and service, for medically
13 necessary drugs, special equipment, and facilities, and for
14 related travel. However, such expenses shall not include:
15 1. Expenses for items or services that the infant has
16 received, or is entitled to receive, under the laws of any
17 state or the Federal Government, except to the extent such
18 exclusion may be prohibited by federal law.
19 2. Expenses for items or services that the infant has
20 received, or is contractually entitled to receive, from any
21 prepaid health plan, health maintenance organization, or other
22 private insuring entity.
23 3. Expenses for which the infant has received
24 reimbursement, or for which the infant is entitled to receive
25 reimbursement, under the laws of any state or the Federal
26 Government, except to the extent such exclusion may be
27 prohibited by federal law.
28 4. Expenses for which the infant has received
29 reimbursement, or for which the infant is contractually
30 entitled to receive reimbursement, pursuant to the provisions
31

of any health or sickness insurance policy or other private insurance program.

Expenses included under this paragraph shall be limited to reasonable charges prevailing in the same community for similar treatment of injured persons when such treatment is paid for by the injured person.

Section 77. Paragraph (c) of subsection (4) of section 766.314, Florida Statutes, is amended to read:

766.314 Assessments; plan of operation.--

(4) The following persons and entities shall pay into the association an initial assessment in accordance with the plan of operation:

(c) On or before December 1, 1988, each physician licensed pursuant to chapter 458 or chapter 459 who wishes to participate in the Florida Birth-Related Neurological Injury Compensation Plan and who otherwise qualifies as a participating physician under ss. 766.301-766.316 shall pay an initial assessment of $5,000. However, if the physician is either a resident physician, assistant resident physician, or intern in an approved postgraduate training program, as defined by the Board of Medicine or the Board of Osteopathic Medicine by rule, and is supervised in accordance with program requirements established by the Accreditation Council for Graduate Medical Education by a physician who is participating in the plan, such resident physician, assistant resident physician, or intern is deemed to be a participating physician without the payment of the assessment. Participating physicians also include any employee of the Board of Regents who has paid the assessment required by this paragraph and paragraph (5)(a), and any certified nurse midwife supervised

1 by such employee. Participating physicians include any
2 certified nurse midwife who has paid 50 percent of the
3 physician assessment required by this paragraph and paragraph
4 (5)(a) and who is supervised by a participating physician who
5 has paid the assessment required by this paragraph and
6 paragraph (5)(a). Supervision shall require that the
7 supervising physician will be easily available and have a
8 prearranged plan of treatment for specified patient problems
9 which the supervised certified nurse midwife or physician may
10 carry out in the absence of any complicating features. Any
11 physician who elects to participate in such plan on or after
12 January 1, 1989, who was not a participating physician at the
13 time of such election to participate and who otherwise
14 qualifies as a participating physician under ss.
15 766.301-766.316 shall pay an additional initial assessment
16 equal to the most recent assessment made pursuant to this
17 paragraph, paragraph (5)(a), or paragraph (7)(b).
18 Section 78. Effective October 1, 2002, paragraphs (b),
19 (c), and (e) of subsection (7) of section 627.6475, Florida
20 Statutes, are amended to read:
21 627.6475 Individual reinsurance pool.--
22 (7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.--
23 (b) A reinsuring carrier may reinsure with the program
24 coverage of an eligible individual, subject to each of the
25 following provisions:
26 1. A reinsuring carrier may reinsure an eligible
27 individual within 90 ~~60~~ days after commencement of the
28 coverage of the eligible individual.
29 2. The program may not reimburse a participating
30 carrier with respect to the claims of a reinsured eligible
31 individual until the carrier has paid incurred claims of an

amount equal to the participating carrier's selected deductible level, as established by the board,~~at least $5,000~~ in a calendar year for benefits covered by the program. ~~In addition, the reinsuring carrier is responsible for 10 percent of the next $50,000 and 5 percent of the next $100,000 of incurred claims during a calendar year, and the program shall reinsure the remainder.~~

3. The board shall annually adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment may not be less than the annual change in the medical component of the "Commerce Price Index for All Urban Consumers" of the Bureau of Labor Statistics of the United States Department of Labor, unless the board proposes and the department approves a lower adjustment factor.

4. A reinsuring carrier may terminate reinsurance for all reinsured eligible individuals on any plan anniversary.

5. The premium rate charged for reinsurance by the program to a health maintenance organization that is approved by the Secretary of Health and Human Services as a federally qualified health maintenance organization pursuant to 42 U.S.C. s. 300e(c)(2)(A) and that, as such, is subject to requirements that limit the amount of risk that may be ceded to the program, which requirements are more restrictive than subparagraph 2., shall be reduced by an amount equal to that portion of the risk, if any, which exceeds the amount set forth in subparagraph 2., which may not be ceded to the program.

6. The board may consider adjustments to the premium rates charged for reinsurance by the program or carriers that

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1 use effective cost-containment measures, including high-cost
2 case management, as defined by the board.
3 7. A reinsuring carrier shall apply its
4 case-management and claims-handling techniques, including, but
5 not limited to, utilization review, individual case
6 management, preferred provider provisions, other managed-care
7 provisions, or methods of operation consistently with both
8 reinsured business and nonreinsured business.
9 (c)1. The board, as part of the plan of operation,
10 shall establish a methodology for determining premium rates to
11 be charged by the program for reinsuring eligible individuals
12 pursuant to this section. The methodology must include a
13 system for classifying individuals which reflects the types of
14 case characteristics commonly used by carriers in this state.
15 The methodology must provide for the development of basic
16 reinsurance premium rates, which shall be multiplied by the
17 factors set for them in this paragraph to determine the
18 premium rates for the program. The basic reinsurance premium
19 rates shall be established by the board, subject to the
20 approval of the department, and shall be set at levels that
21 reasonably approximate gross premiums charged to eligible
22 individuals for individual health insurance by health
23 insurance issuers. The premium rates set by the board may vary
24 by geographical area, as determined under this section, to
25 reflect differences in cost. ~~An eligible individual may be~~
26 ~~reinsured for a rate that is five times the rate established~~
27 ~~by the board.~~
28 2. The board shall periodically review the methodology
29 established, including the system of classification and any
30 rating factors, to ensure that it reasonably reflects the
31 claims experience of the program. The board may propose

1 changes to the rates that are subject to the approval of the
2 department.
3 (e)1. Before September ~~March~~ 1 of each calendar year,
4 the board shall determine and report to the department the
5 program net loss in the individual account for the previous
6 year, including administrative expenses for that year and the
7 incurred losses for that year, taking into account investment
8 income and other appropriate gains and losses.
9 2. Any net loss in the individual account for the year
10 shall be recouped by assessing the carriers as follows:
11 a. The operating losses of the program shall be
12 assessed in the following order subject to the specified
13 limitations. The first tier of assessments shall be made
14 against reinsuring carriers in an amount that may not exceed 5
15 percent of each reinsuring carrier's premiums for individual
16 health insurance. If such assessments have been collected and
17 additional moneys are needed, the board shall make a second
18 tier of assessments in an amount that may not exceed 0.5
19 percent of each carrier's health benefit plan premiums.
20 b. Except as provided in paragraph (f), risk-assuming
21 carriers are exempt from all assessments authorized pursuant
22 to this section. The amount paid by a reinsuring carrier for
23 the first tier of assessments shall be credited against any
24 additional assessments made.
25 c. The board shall equitably assess reinsuring
26 carriers for operating losses of the individual account based
27 on market share. The board shall annually assess each carrier
28 a portion of the operating losses of the individual account.
29 The first tier of assessments shall be determined by
30 multiplying the operating losses by a fraction, the numerator
31 of which equals the reinsuring carrier's earned premium

pertaining to direct writings of individual health insurance in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of all such premiums earned by reinsuring carriers in the state during that calendar year. The second tier of assessments shall be based on the premiums that all carriers, except risk-assuming carriers, earned on all health benefit plans written in this state. The board may levy interim assessments against reinsuring carriers to ensure the financial ability of the plan to cover claims expenses and administrative expenses paid or estimated to be paid in the operation of the plan for the calendar year prior to the association's anticipated receipt of annual assessments for that calendar year. Any interim assessment is due and payable within 30 days after receipt by a carrier of the interim assessment notice. Interim assessment payments shall be credited against the carrier's annual assessment. Health benefit plan premiums and benefits paid by a carrier that are less than an amount determined by the board to justify the cost of collection may not be considered for purposes of determining assessments.

d. Subject to the approval of the department, the board shall adjust the assessment formula for reinsuring carriers that are approved as federally qualified health maintenance organizations by the Secretary of Health and Human Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent, if any, that restrictions are placed on them which are not imposed on other carriers.

3. Before September ~~March~~ 1 of each year, the board shall determine and file with the department an estimate of the assessments needed to fund the losses incurred by the

1 program in the individual account for the previous calendar
2 year.
3 4. If the board determines that the assessments needed
4 to fund the losses incurred by the program in the individual
5 account for the previous calendar year will exceed the amount
6 specified in subparagraph 2., the board shall evaluate the
7 operation of the program and report its findings and
8 recommendations to the department in the format established in
9 s. 627.6699(11) for the comparable report for the small
10 employer reinsurance program.
11 Section 79. Effective October 1, 2002, subsection (6)
12 of section 627.667, Florida Statutes, is amended to read:
13 627.667 Extension of benefits.--
14 (6) This section also applies to holders of group
15 certificates which are renewed, delivered, or issued for
16 delivery to residents of this state under group policies
17 effectuated or delivered outside this state~~, unless a~~
18 ~~succeeding carrier under a group policy has agreed to assume~~
19 ~~liability for the benefits~~.
20 Section 80. Effective October 1, 2002, paragraph (e)
21 of subsection (5) of section 627.6692, Florida Statutes, as
22 amended by section 1 of chapter 2001-353, Laws of Florida, is
23 amended to read:
24 627.6692 Florida Health Insurance Coverage
25 Continuation Act.--
26 (5) CONTINUATION OF COVERAGE UNDER GROUP HEALTH
27 PLANS.--
28 (e)1. A covered employee or other qualified
29 beneficiary who wishes continuation of coverage must pay the
30 initial premium and elect such continuation in writing to the
31 insurance carrier issuing the employer's group health plan

within 63 ~~30~~ days after receiving notice from the insurance carrier under paragraph (d). Subsequent premiums are due by the grace period expiration date. The insurance carrier or the insurance carrier's designee shall process all elections promptly and provide coverage retroactively to the date coverage would otherwise have terminated. The premium due shall be for the period beginning on the date coverage would have otherwise terminated due to the qualifying event. The first premium payment must include the coverage paid to the end of the month in which the first payment is made. After the election, the insurance carrier must bill the qualified beneficiary for premiums once each month, with a due date on the first of the month of coverage and allowing a 30-day grace period for payment.

2. Except as otherwise specified in an election, any election by a qualified beneficiary shall be deemed to include an election of continuation of coverage on behalf of any other qualified beneficiary residing in the same household who would lose coverage under the group health plan by reason of a qualifying event. This subparagraph does not preclude a qualified beneficiary from electing continuation of coverage on behalf of any other qualified beneficiary.

Section 81. Effective October 1, 2002, paragraph (i) of subsection (3), paragraph (c) of subsection (5), paragraphs (f), (g), (h), and (j) of subsection (11), and paragraph (a) of subsection (12) of section 627.6699, Florida Statutes, are amended to read:

627.6699 Employee Health Care Access Act.--

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

(i) "Established geographic area" means the county or counties~~, or any portion of a county or counties,~~within which

1 the carrier provides or arranges for health care services to
2 be available to its insureds, members, or subscribers.
3 (5) AVAILABILITY OF COVERAGE.--
4 (c) Every small employer carrier must, as a condition
5 of transacting business in this state:
6 1. Beginning July 1, 2000, offer and issue all small
7 employer health benefit plans on a guaranteed-issue basis to
8 every eligible small employer, with 2 to 50 eligible
9 employees, that elects to be covered under such plan, agrees
10 to make the required premium payments, and satisfies the other
11 provisions of the plan. A rider for additional or increased
12 benefits may be medically underwritten and may only be added
13 to the standard health benefit plan. The increased rate
14 charged for the additional or increased benefit must be rated
15 in accordance with this section.
16 2. Beginning July 1, 2000, and until July 31, 2001,
17 offer and issue basic and standard small employer health
18 benefit plans on a guaranteed-issue basis to every eligible
19 small employer which is eligible for guaranteed renewal, has
20 less than two eligible employees, is not formed primarily for
21 the purpose of buying health insurance, elects to be covered
22 under such plan, agrees to make the required premium payments,
23 and satisfies the other provisions of the plan. A rider for
24 additional or increased benefits may be medically underwritten
25 and may be added only to the standard benefit plan. The
26 increased rate charged for the additional or increased benefit
27 must be rated in accordance with this section. For purposes of
28 this subparagraph, a person, his or her spouse, and his or her
29 dependent children shall constitute a single eligible employee
30 if that person and spouse are employed by the same small
31

1 employer and either one has a normal work week of less than 25
2 hours.
3 3.a. Beginning August 1, 2001, offer and issue basic
4 and standard small employer health benefit plans on a
5 guaranteed-issue basis, during a 31-day open enrollment period
6 of August 1 through August 31 of each year, to every eligible
7 small employer, with fewer than two eligible employees, which
8 small employer is not formed primarily for the purpose of
9 buying health insurance and which elects to be covered under
10 such plan, agrees to make the required premium payments, and
11 satisfies the other provisions of the plan. Coverage provided
12 under this subparagraph shall begin on October 1 of the same
13 year as the date of enrollment, unless the small employer
14 carrier and the small employer agree to a different date. A
15 rider for additional or increased benefits may be medically
16 underwritten and may only be added to the standard health
17 benefit plan. The increased rate charged for the additional
18 or increased benefit must be rated in accordance with this
19 section. For purposes of this subparagraph, a person, his or
20 her spouse, and his or her dependent children constitute a
21 single eligible employee if that person and spouse are
22 employed by the same small employer and either that person or
23 his or her spouse has a normal work week of less than 25
24 hours.
25 b. Notwithstanding the restrictions set forth in
26 sub-subparagraph a., when a small employer group is losing
27 coverage because a carrier is exercising the provisions of s.
28 627.6571(3)(b) or s. 641.31074(3)(b), the eligible small
29 employer, as defined in sub-subparagraph a., is entitled to
30 enroll with another carrier offering small employer coverage
31 within 63 days after the notice of termination or the

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1 termination date of the prior coverage, whichever is later.
2 Coverage provided under this sub-subparagraph begins
3 immediately upon enrollment, unless the small employer carrier
4 and the small employer agree to a different date.
5 4. This paragraph does not limit a carrier's ability
6 to offer other health benefit plans to small employers if the
7 standard and basic health benefit plans are offered and
8 rejected.
9 (11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.--
10 (f) The program has the general powers and authority
11 granted under the laws of this state to insurance companies
12 and health maintenance organizations licensed to transact
13 business, except the power to issue health benefit plans
14 directly to groups or individuals. In addition thereto, the
15 program has specific authority to:
16 1. Enter into contracts as necessary or proper to
17 carry out the provisions and purposes of this act, including
18 the authority to enter into contracts with similar programs of
19 other states for the joint performance of common functions or
20 with persons or other organizations for the performance of
21 administrative functions.
22 2. Sue or be sued, including taking any legal action
23 necessary or proper for recovering any assessments and
24 penalties for, on behalf of, or against the program or any
25 carrier.
26 3. Take any legal action necessary to avoid the
27 payment of improper claims against the program.
28 4. Issue reinsurance policies, in accordance with the
29 requirements of this act.
30 5. Establish rules, conditions, and procedures for
31 reinsurance risks under the program participation.

1 6. Establish actuarial functions as appropriate for
2 the operation of the program.
3 7. Assess participating carriers in accordance with
4 paragraph (j), and make advance interim assessments as may be
5 reasonable and necessary for organizational and interim
6 operating expenses. Interim assessments shall be credited as
7 offsets against any regular assessments due following the
8 close of the calendar year.
9 8. Appoint appropriate legal, actuarial, and other
10 committees as necessary to provide technical assistance in the
11 operation of the program, and in any other function within the
12 authority of the program.
13 9. Borrow money to effect the purposes of the program.
14 Any notes or other evidences of indebtedness of the program
15 which are not in default constitute legal investments for
16 carriers and may be carried as admitted assets.
17 10. To the extent necessary, increase the $5,000
18 deductible reinsurance requirement to adjust for the effects
19 of inflation. The program may evaluate the desirability of
20 establishing differing levels of deductibles. If differing
21 levels of deductibles are established, such levels and the
22 resulting premiums must be approved by the department.
23 (g) A reinsuring carrier may reinsure with the program
24 coverage of an eligible employee of a small employer, or any
25 dependent of such an employee, subject to each of the
26 following provisions:
27 1. With respect to a standard and basic health care
28 plan, the program may ~~must~~ reinsure the level of coverage
29 provided; and, with respect to any other plan, the program may
30 ~~must~~ reinsure the coverage up to, but not exceeding, the level
31 of coverage provided under the standard and basic health care

1 plan. As an alternative to reinsuring the entire level of
2 coverage provided, the program may develop corridors of
3 reinsurance designed to coordinate with a reinsuring carrier's
4 existing reinsurance. The corridors of reinsurance and
5 resulting premiums must be approved by the department.
6 2. Except in the case of a late enrollee, a reinsuring
7 carrier may reinsure an eligible employee or dependent within
8 90 ~~60~~ days after the commencement of the coverage of the small
9 employer. A newly employed eligible employee or dependent of a
10 small employer may be reinsured within 90 ~~60~~ days after the
11 commencement of his or her coverage.
12 3. A small employer carrier may reinsure an entire
13 employer group within 90 ~~60~~ days after the commencement of the
14 group's coverage under the plan. The carrier may choose to
15 reinsure newly eligible employees and dependents of the
16 reinsured group pursuant to subparagraph 1.
17 4. The program may evaluate the option of allowing a
18 small employer carrier to reinsure an entire employer group or
19 an eligible employee at the first or subsequent renewal date.
20 Any such option and the resulting premium must be approved by
21 the department.
22 5.~~4.~~ The program may not reimburse a participating
23 carrier with respect to the claims of a reinsured employee or
24 dependent until the carrier has paid incurred claims of an
25 amount equal to the participating carrier's selected
26 deductible level ~~at least $5,000~~ in a calendar year for
27 benefits covered by the program. ~~In addition, the reinsuring~~
28 ~~carrier shall be responsible for 10 percent of the next~~
29 ~~$50,000 and 5 percent of the next $100,000 of incurred claims~~
30 ~~during a calendar year and the program shall reinsure the~~
31 ~~remainder.~~

6.~~5.~~ The board annually may ~~shall~~ adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the "Consumer Price Index for All Urban Consumers" of the Bureau of Labor Statistics of the Department of Labor, unless the board proposes and the department approves a lower adjustment factor.

7.~~6.~~ A small employer carrier may terminate reinsurance for all reinsured employees or dependents on any plan anniversary.

8.~~7.~~ The premium rate charged for reinsurance by the program to a health maintenance organization that is approved by the Secretary of Health and Human Services as a federally qualified health maintenance organization pursuant to 42 U.S.C. s. 300e(c)(2)(A) and that, as such, is subject to requirements that limit the amount of risk that may be ceded to the program, which requirements are more restrictive than subparagraph 4., shall be reduced by an amount equal to that portion of the risk, if any, which exceeds the amount set forth in subparagraph 4. which may not be ceded to the program.

9.~~8.~~ The board may consider adjustments to the premium rates charged for reinsurance by the program for carriers that use effective cost containment measures, including high-cost case management, as defined by the board.

10.~~9.~~ A reinsuring carrier shall apply its case-management and claims-handling techniques, including, but not limited to, utilization review, individual case management, preferred provider provisions, other managed care

provisions or methods of operation, consistently with both reinsured business and nonreinsured business.

(h)1. The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of basic reinsurance premium rates, which shall be multiplied by the factors set for them in this paragraph to determine the premium rates for the program. The basic reinsurance premium rates shall be established by the board, subject to the approval of the department, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard and basic health benefit plan. The premium rates set by the board may vary by geographical area, as determined under this section, to reflect differences in cost. ~~The multiplying factors must be established as follows:~~

~~a. The entire group may be reinsured for a rate that is 1.5 times the rate established by the board.~~

~~b. An eligible employee or dependent may be reinsured for a rate that is 5 times the rate established by the board.~~

2. The board periodically shall review the methodology established, including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the rates which shall be subject to the approval of the department.

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1 (j)1. Before September ~~March~~ 1 of each calendar year,
2 the board shall determine and report to the department the
3 program net loss for the previous year, including
4 administrative expenses for that year, and the incurred losses
5 for the year, taking into account investment income and other
6 appropriate gains and losses.
7 2. Any net loss for the year shall be recouped by
8 assessment of the carriers, as follows:
9 a. The operating losses of the program shall be
10 assessed in the following order subject to the specified
11 limitations. The first tier of assessments shall be made
12 against reinsuring carriers in an amount which shall not
13 exceed 5 percent of each reinsuring carrier's premiums from
14 health benefit plans covering small employers. If such
15 assessments have been collected and additional moneys are
16 needed, the board shall make a second tier of assessments in
17 an amount which shall not exceed 0.5 percent of each carrier's
18 health benefit plan premiums. Except as provided in paragraph
19 (n), risk-assuming carriers are exempt from all assessments
20 authorized pursuant to this section. The amount paid by a
21 reinsuring carrier for the first tier of assessments shall be
22 credited against any additional assessments made.
23 b. The board shall equitably assess carriers for
24 operating losses of the plan based on market share. The board
25 shall annually assess each carrier a portion of the operating
26 losses of the plan. The first tier of assessments shall be
27 determined by multiplying the operating losses by a fraction,
28 the numerator of which equals the reinsuring carrier's earned
29 premium pertaining to direct writings of small employer health
30 benefit plans in the state during the calendar year for which
31 the assessment is levied, and the denominator of which equals

1 the total of all such premiums earned by reinsuring carriers
2 in the state during that calendar year. The second tier of
3 assessments shall be based on the premiums that all carriers,
4 except risk-assuming carriers, earned on all health benefit
5 plans written in this state. The board may levy interim
6 assessments against carriers to ensure the financial ability
7 of the plan to cover claims expenses and administrative
8 expenses paid or estimated to be paid in the operation of the
9 plan for the calendar year prior to the association's
10 anticipated receipt of annual assessments for that calendar
11 year. Any interim assessment is due and payable within 30
12 days after receipt by a carrier of the interim assessment
13 notice. Interim assessment payments shall be credited against
14 the carrier's annual assessment. Health benefit plan premiums
15 and benefits paid by a carrier that are less than an amount
16 determined by the board to justify the cost of collection may
17 not be considered for purposes of determining assessments.
18 c. Subject to the approval of the department, the
19 board shall make an adjustment to the assessment formula for
20 reinsuring carriers that are approved as federally qualified
21 health maintenance organizations by the Secretary of Health
22 and Human Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to
23 the extent, if any, that restrictions are placed on them that
24 are not imposed on other small employer carriers.
25 3. Before <u>September</u> ~~March~~ 1 of each year, the board
26 shall determine and file with the department an estimate of
27 the assessments needed to fund the losses incurred by the
28 program in the previous calendar year.
29 4. If the board determines that the assessments needed
30 to fund the losses incurred by the program in the previous
31 calendar year will exceed the amount specified in subparagraph

1 2., the board shall evaluate the operation of the program and
2 report its findings, including any recommendations for changes
3 to the plan of operation, to the department within 240 ~~90~~ days
4 following the end of the calendar year in which the losses
5 were incurred. The evaluation shall include an estimate of
6 future assessments, the administrative costs of the program,
7 the appropriateness of the premiums charged and the level of
8 carrier retention under the program, and the costs of coverage
9 for small employers. If the board fails to file a report with
10 the department within 240 ~~90~~ days following the end of the
11 applicable calendar year, the department may evaluate the
12 operations of the program and implement such amendments to the
13 plan of operation the department deems necessary to reduce
14 future losses and assessments.
15 5. If assessments exceed the amount of the actual
16 losses and administrative expenses of the program, the excess
17 shall be held as interest and used by the board to offset
18 future losses or to reduce program premiums. As used in this
19 paragraph, the term "future losses" includes reserves for
20 incurred but not reported claims.
21 6. Each carrier's proportion of the assessment shall
22 be determined annually by the board, based on annual
23 statements and other reports considered necessary by the board
24 and filed by the carriers with the board.
25 7. Provision shall be made in the plan of operation
26 for the imposition of an interest penalty for late payment of
27 an assessment.
28 8. A carrier may seek, from the commissioner, a
29 deferment, in whole or in part, from any assessment made by
30 the board. The department may defer, in whole or in part, the
31 assessment of a carrier if, in the opinion of the department,

1 the payment of the assessment would place the carrier in a
2 financially impaired condition. If an assessment against a
3 carrier is deferred, in whole or in part, the amount by which
4 the assessment is deferred may be assessed against the other
5 carriers in a manner consistent with the basis for assessment
6 set forth in this section. The carrier receiving such
7 deferment remains liable to the program for the amount
8 deferred and is prohibited from reinsuring any individuals or
9 groups in the program if it fails to pay assessments.
10 (12) STANDARD, BASIC, AND LIMITED HEALTH BENEFIT
11 PLANS.--
12 (a)1. By May 15, 1993, the commissioner shall appoint
13 a health benefit plan committee composed of four
14 representatives of carriers which shall include at least two
15 representatives of HMOs, at least one of which is a staff
16 model HMO, two representatives of agents, four representatives
17 of small employers, and one employee of a small employer. The
18 carrier members shall be selected from a list of individuals
19 recommended by the board. The commissioner may require the
20 board to submit additional recommendations of individuals for
21 appointment.
22 2. The plans shall comply with all of the requirements
23 of this subsection.
24 3. The plans must be filed with and approved by the
25 department prior to issuance or delivery by any small employer
26 carrier.
27 4. <u>Before October 1, 2002, and in every 4th year</u>
28 <u>thereafter, the commissioner shall appoint a new health</u>
29 <u>benefit plan committee in the manner provided in subparagraph</u>
30 <u>1. to determine whether modifications to a plan might be</u>
31 <u>appropriate and to submit recommended modifications to the</u>

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department for approval. Such a determination must be based upon prevailing industry standards regarding managed care and cost-containment provisions and is to serve the purpose of ensuring that the benefit plans offered to small employers on a guaranteed-issue basis are consistent with the low-priced to mid-priced benefit plans offered in the large-group market. Each new health benefit plan committee shall evaluate the implementation of this act and its impact on the entities that provide the plans, the number of enrollees, the participants covered by the plans and their access to care, the scope of health care coverage offered under the plans, the difference in premiums between these plans and standard or basic plans, and an assessment of the plans. This determination shall be included in a report submitted to the President of the Senate and the Speaker of the House of Representatives annually by October 1.~~After approval of the revised health benefit plans, if the department determines that modifications to a plan might be appropriate, the commissioner shall appoint a new health benefit plan committee in the manner provided in subparagraph 1. to submit recommended modifications to the department for approval.~~

Section 82. Effective October 1, 2002, section 627.911, Florida Statutes, is amended to read:

627.911 Scope of this part.--Any insurer or health maintenance organization transacting insurance in this state shall report information as required by this part.

Section 83. Effective October 1, 2002, section 627.9175, Florida Statutes, is amended to read:

627.9175 Reports of information on health insurance.--

(1) Each authorized health insurer shall submit annually to the department information concerning health

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1 insurance coverage being issued or currently in force in this
2 state. The information must include information related to
3 premium, number of policies, and covered lives for such
4 policies and other information necessary for analyzing trends
5 in enrollment, premiums, and claim costs.~~as to policies of~~
6 ~~individual health insurance:~~
7 (a) The required information must be broken down by
8 market segment, to include:
9 1. Health insurance issuer company contact
10 information.
11 2. Information on all health insurance products issued
12 or in force. Such information must include:
13 a. Direct premiums earned.
14 b. Direct losses incurred.
15 c. Direct premiums earned for new business issued
16 during the year.
17 d. Number of policies.
18 e. Number of certificates.
19 f. Number of total covered lives.
20 ~~A summary of typical benefits, exclusions, and~~
21 ~~limitations for each type of individual policy form currently~~
22 ~~being issued in the state. The summary shall include, as~~
23 ~~appropriate:~~
24 ~~1. The deductible amount;~~
25 ~~2. The coinsurance percentage;~~
26 ~~3. The out-of-pocket maximum;~~
27 ~~4. Outpatient benefits;~~
28 ~~5. Inpatient benefits; and~~
29 ~~6. Any exclusions for preexisting conditions.~~
30
31

~~The department shall determine other appropriate benefits, exclusions, and limitations to be reported for inclusion in the consumer's guide published pursuant to this section.~~

(b) The department may adopt rules to administer this section, including, but not limited to, rules governing compliance and provisions implementing electronic methodologies for use in furnishing such records or documents. ~~A schedule of rates for each type of individual policy form reflecting typical variations by age, sex, region of the state, or any other applicable factor which is in use and is determined to be appropriate for inclusion by the department.~~

The department may ~~shall~~ provide by rule a uniform format for the submission of this information in order to allow for meaningful comparisons ~~of premiums charged for comparable benefits. The department shall publish annually a consumer's guide which summarizes and compares the information required to be reported under this subsection~~.

(2)~~(a)~~ The department shall publish annually a consumer's guide ~~Every insurer transacting health insurance in this state shall report annually to the department, not later than April 1, information relating to any measure the insurer has implemented or proposes to implement during the next calendar year for the purpose of containing health insurance costs or cost increases~~. ~~The reports shall identify each measure and the forms to which the measure is applied, shall provide an explanation as to how the measure is used, and shall provide an estimate of the cost effect of the measure.~~

~~(b) The department shall promulgate forms to be used by insurers in reporting information pursuant to this subsection and shall utilize such forms to analyze the effects~~

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1 ~~of health care cost containment programs used by health~~
2 ~~insurers in this state.~~
3 ~~(c) The department shall analyze the data reported~~
4 ~~under this subsection and shall annually make available to the~~
5 ~~public a summary of its findings as to the types of cost~~
6 ~~containment measures reported and the estimated effect of~~
7 ~~these measures.~~
8 Section 84. Effective October 1, 2002, section
9 627.9403, Florida Statutes, is amended to read:
10 627.9403 Scope.--The provisions of this part shall
11 apply to long-term care insurance policies delivered or issued
12 for delivery in this state, and to policies delivered or
13 issued for delivery outside this state to the extent provided
14 in s. 627.9406, by an insurer, a fraternal benefit society as
15 defined in s. 632.601, a health maintenance organization as
16 defined in s. 641.19, a prepaid health clinic as defined in s.
17 641.402, or a multiple-employer welfare arrangement as defined
18 in s. 624.437. A policy which is advertised, marketed, or
19 offered as a long-term care policy and as a Medicare
20 supplement policy shall meet the requirements of this part and
21 the requirements of ss. 627.671-627.675 and, to the extent of
22 a conflict, be subject to the requirement that is more
23 favorable to the policyholder or certificateholder. The
24 provisions of this part shall not apply to a continuing care
25 contract issued pursuant to chapter 651 and shall not apply to
26 guaranteed renewable policies issued prior to October 1, 1988.
27 Any limited benefit policy that limits coverage to care in a
28 nursing home or to one or more lower levels of care required
29 or authorized to be provided by this part or by department
30 rule must meet all requirements of this part that apply to
31 long-term care insurance policies, except ss. 627.9407(3)(c)

and (d), (9), (10)(f), and (12) and 627.94073(2). ~~If the limited benefit policy does not provide coverage for care in a nursing home, but does provide coverage for one or more lower levels of care, the policy shall also be exempt from the requirements of s. 627.9407(3)(d).~~

Section 85. Paragraphs (b) and (d) of subsection (3) of section 641.31, Florida Statutes, are amended to read:

641.31 Health maintenance contracts.--

(3)

(b) Any change in the rate is subject to paragraph (d) and requires at least 30 days' advance written notice to the subscriber. In the case of a group member, there may be a contractual agreement with the health maintenance organization to have the employer provide the required notice to the individual members of the group. This paragraph does not apply to a group contract covering 51 or more persons unless the rate is for any coverage under which the increase in claim costs over the lifetime of the contract due to advancing age or duration is prefunded in the premium.

(d) Any change in rates charged for the contract must be filed with the department not less than 30 days in advance of the effective date. At the expiration of such 30 days, the rate filing shall be deemed approved unless prior to such time the filing has been affirmatively approved or disapproved by ~~order of~~ the department pursuant to s. 627.411. The approval of the filing by the department constitutes a waiver of any unexpired portion of such waiting period. The department may extend by not more than an additional 15 days the period within which it may so affirmatively approve or disapprove any such filing, by giving notice of such extension before expiration of the initial 30-day period. At the expiration of

1 any such period as so extended, and in the absence of such
2 prior affirmative approval or disapproval, any such filing
3 shall be deemed approved.
4 Section 86. Effective October 1, 2002, subsections (1)
5 and (3) of section 641.3111, Florida Statutes, are amended to
6 read:
7 641.3111 Extension of benefits.--
8 (1) Every group health maintenance contract shall
9 provide that termination of the contract shall be without
10 prejudice to any continuous loss which commenced while the
11 contract was in force, but any extension of benefits beyond
12 the period the contract was in force may be predicated upon
13 the continuous total disability of the subscriber ~~and may be~~
14 ~~limited to payment for the treatment of a specific accident or~~
15 ~~illness incurred while the subscriber was a member~~. The
16 extension is required regardless of whether the group contract
17 holder or other entity secures replacement coverage from a new
18 insurer or health maintenance organization or foregoes the
19 provision of coverage. The required provision must provide for
20 continuation of contract benefits in connection with the
21 treatment of a specific accident or illness incurred while the
22 contract was in effect.Such extension of benefits may be
23 limited to the occurrence of the earliest of the following
24 events:
25 (a) The expiration of 12 months.
26 (b) Such time as the member is no longer totally
27 disabled.
28 (c) A succeeding carrier elects to provide replacement
29 coverage without limitation as to the disability condition.
30 (d) The maximum benefits payable under the contract
31 have been paid.

1 (3) In the case of maternity coverage, ~~when not~~
2 ~~covered by the succeeding carrier,~~a reasonable extension of
3 benefits or accrued liability provision is required, which
4 provision provides for continuation of the contract benefits
5 in connection with maternity expenses for a pregnancy that
6 commenced while the policy was in effect. The extension shall
7 be for the period of that pregnancy and shall not be based
8 upon total disability.
9 Section 87. <u>If any law that is amended by this act was</u>
10 <u>also amended by a law enacted at the 2002 Regular Session of</u>
11 <u>the Legislature, such laws shall be construed as if they had</u>
12 <u>been enacted at the same session of the Legislature, and full</u>
13 <u>effect should be given to each if that is possible.</u>
14 Section 88. Except as otherwise provided in this act,
15 this act shall take effect July 1, 2002.
16
17 ***
18 SENATE SUMMARY
19 Revises and creates provisions relating to a wide variety
20 of subjects relating to health care, health care
21 providers, and health care delivery. (See bill for details.)
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