HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1629 w/CS Affordable Health Care
SPONSOR(S): Farkas
TIED BILLS: HB 1887 **IDEN./SIM. BILLS:** CS/CS/SB 2910

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care	22 Y, 0 N w/CS	Rawlins	Collins
2) Insurance	15 Y, 0 N w/CS	Callaway	Cooper
3) Appropriations	38 Y, 0 N w/CS	Speir	Baker
4)			
5)			

SUMMARY ANALYSIS

Speaker Johnnie Byrd created the Select Committee on Affordable Health Care for Floridians (Select Committee) in an effort to address the issue of affordable and accessible employment-based insurance. The Select Committee conducted public hearings with predetermined themes around the state from October through November 2003 to seek opinions of a wide range of stakeholders.

This bill creates the 2004 Affordable Health Care for Floridians Act and represents many of the recommendations of the Select Committee. Significant provisions affecting the health insurance markets include:

- ✓ Creation of the Florida Health Insurance Plan as the high risk pool for uninsurable medical risks, replacing the Florida Comprehensive Health Care Association.
- ✓ Expansion of the Health Flex Program statewide.
- ✓ Modification of the Small Employers Health Access Act to eliminate one-life groups, contingent on the Florida Health Insurance Plan accepting new enrollment.
- ✓ Creation of the Small Employers Access Program to provide additional options for small businesses of up to 25 employees, specified entities of rural communities, and nursing homes.
- ✓ Requirement that certain plans providing discount medical services be licensed as prepaid health plans.
- ✓ Updating the ability of the Office of Insurance Regulation to regularly collect data from insurers describing the health insurance marketplace.
- ✓ Requirements that each health issuer make available on its Internet website a link to the performance outcome and financial data that is published by the Agency for Health Care Administration (ACHA).
- ✓ Authorizes “rebates” for employers and employees who maintain healthy lifestyles.
- ✓ Requires hospitals, insurers and federally qualified health centers to create emergency room diversion programs.
- ✓ Establishes the Florida Patient Safety Corporation
- ✓ Requires AHCA to post pricing information on procedures performed in Florida hospitals.

The bill appropriates $1.7 million from the General Revenue Fund and $2.4 million in total funds.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. DOES THE BILL:

1. Reduce government?	Yes[]	No[X]	N/A[]
2. Lower taxes?	Yes[]	No[X]	N/A[]
3. Expand individual freedom?	Yes[X]	No[]	N/A[]
4. Increase personal responsibility?	Yes[X]	No[]	N/A[]
5. Empower families?	Yes[X]	No[]	N/A[]

For any principle that received a "no" above, please explain:

This bill establishes licensing fees for discount medical plans.

The bill provides for the establishment of a private, not-for-profit, corporation to provide coordination and direction to patient safety improvement efforts in the state.

B. EFFECT OF PROPOSED CHANGES:

Present Situation

More than 240 million people in the United States have health insurance today through a variety of private and public sources. As of 2002, 12.2 million out of 16.1 million Florida residents had health insurance. Of those Floridians with insurance, more than eight million were covered by private insurance or self-insurance plans operated by large employers. Another 2.5 million were covered by Medicare, mainly elderly adults, and another 1.7 million low-income citizens were covered by Medicaid.

Select Committee on Affordable Health Care for Floridians

The double digit increase in health insurance premiums and rise in health care cost have contributed to the lack of accessibility to employment-based health insurance. This has prompted policymakers around the nation to propose a range of approaches for expanding health insurance coverage and reducing health care cost. In Florida, in an effort to address the issue of affordable and accessible employment-based insurance, on August 14, 2003, Speaker Johnnie Byrd created the Select Committee on Affordable Health Care for Floridians and appointed Representative Frank Farkas, D.C., Chairman.

To seek opinions of a wide range of stakeholders, public hearings with predetermined themes were conducted around the state, specifically in Orlando, Miami, Jacksonville, Tampa, Pensacola, Boca Raton, and Tallahassee from October through November, 2003. The challenge for the committee is to effectively probe the operation of the private insurance market place, to understand the health insurance market trends, to learn from past policy initiatives, and to identify, explore, and debate new ideas for change.

Florida Health Insurance Market

Florida residents and employers spent $12.5 billion in health insurance premiums, as reported in calendar year 2000. Spending for all privately and publicly funded personal health care services and products (e.g., hospital care, physician services, nursing home care, prescription drugs, etc.) exceeded $60 billion in 1998.

While health economists debate the overall effect of rising health expenditures, many believe that the national health care system is at a breaking point, including many stakeholders in Florida. Many agree

that the nation's health care system is too costly, inefficient, unfair and in need of an overhaul. Former U.S. Secretaries of Health warn that “the real inequities in the U.S. system -- which ranks first in the world in cost and 35th in overall efficiency, according to World Health Organization surveys -- aren't much closer to resolution than they were during the quarter of a century that they presided over it.”

The structure of the Florida health coverage market and the regulations that govern its operations are based on health plan type and size. For purposes of this analysis, and by Florida law, the types of health plans discussed in this analysis are categorized as:

- Self-insured plans;
- Large group health plans;
- Small group health plans;
- Individual health plans;
- Out-of-State Groups; and
- High-risk Pool.

Most fully-insured private health coverage in Florida is issued through an employer group – a small group, which is defined by Florida law as one to 50 employees, or a large group, 51 employees or more. Many larger Florida employers provide coverage by self-insuring and establishing contracts with private insurance companies to provide "stop loss" reinsurance and administrative services, thus taking advantage of the Employment Retirement Income Security Act (ERISA) protections from state laws. As a result, less than 30 percent of Florida’s population is governed by state insurance laws. In fact, of Florida’s 16.1 million residents in 2002:

- 4.8 million are in Florida insurance market (fully-insured plans, large groups, small groups, and individual plans);
- 4.3 million are governed by only federal law (ERISA, aka: self-insured plans);
- 1.7 million are enrolled in Medicaid;
- 2.5 million are enrolled in the Medicare program; and
- 2.8 million are uninsured.

Consequences of Lack of Health Insurance

Research has found that patients who are uninsured for even short periods of time are more likely to receive too little medical care and to receive it too late, to be sicker and to die sooner. They are reluctant to use health services, often waiting until there is a crisis. They receive fewer preventive services, less regular care for chronic disease, and poorer care in the hospital.

Not only does the lack of insurance affect the health and well being of U.S. and Florida residents, but there is a resounding rippling affect on the economy. In 2001, the cost of medical care for uninsured residents in the U.S. totaled $98.9 billion. The Florida Hospital Association reports that in 2002 cost for uncompensated care provided in Florida hospitals amounted to $1.51 billion.

Studies estimate that the potential economic value to be gained in better health outcomes from uninterrupted coverage for all Americans is estimated to be between $65 and $130 billion each year, which is currently being lost per year in lost productivity. Each uninsured U.S. resident loses between $1,645 and $3,280 per year in lost wages and benefits and in the value that improved quality of life and longer lifespan would provide.

The state’s budget is also strained by increasing numbers of uninsured. The Medicaid Enrollment and Expenditure Estimating Conference estimates that Florida’s Medicaid expenditures will approach $14 billion in FY 2004-05, resulting in a $526 million deficit in general revenue for that year.

As state budgets are stretched, funding care for Florida residents falls on the local communities where care is provided. Counties are mandated by state law to contribute to the state Medicaid program. For

fiscal year 2002-2003, counties contributed approximately $162 million. Counties are required to pay for eligible Medicaid recipients' inpatient hospital stay from day 11 through day 45, with this responsibility being increased by the state several years ago. Counties are currently funding inpatient hospital days at approximately $115 million statewide.

Cost Drivers Increasing Health Expenditures

The health policy research literature suggests that the growth in health care spending in the mid-1990s was a collective result of three factors: 1) inefficiencies in the provision of health services; 2) continued large returns to providers; and 3) investment in new technology. But the public testimony presented to the Select Committee and the independent research reviewed by the Health Care Committee staff identified other factors that many experts said had a more significant effect on health care costs than these three concepts.

During public testimony, the Select Committee was presented with a significant amount of data and research on what are considered the most influential cost drivers of health care expenditures, such as:

Consumer Demand.

The increase in demand from consumers is attributed to the increase of utilization of health care services. In the 1990s, trends in managed care began eroding its ability to restrain costs, further increasing national health care spending. Consumer demand called for less restrictive managed care options and an erosion of plans' ability to negotiate steep price discounts. Increased consumer demand for prescription medications, particularly new products, is the primary factor behind managed care plans' increased drug spending, according to a review of the literature. Consumer demand induced by drug manufacturer advertising is cited as a major contributing factor to the increases in prescription drug use.

New Technology.

Advancements in medical science, such as new drugs, medical devices, biologicals, and new medical and surgical procedures have contributed to increased life expectancy, decreased mortality and improved quality of life. However, these new advancements have greatly contributed to the nation's rapidly rising health care cost. One analysis showed that the availability of new diagnostic and therapeutic approaches, and increased use of established approaches, account for one half to two-thirds of the annual increase in U.S. health care spending that is not attributable to inflation in the economy as a whole.

Other cost drivers of health care expenditures may be categorized as:

- Drugs, Medical Devices, and Medical Advances;
- General Price Inflation (Consumer Price Index);
- Rising Provider Expenses;
- Government Mandates and Regulation;
- Increased Consumer Demand;
- Litigation and Risk Management; and
- Other Categories (Fraud and Abuse, Miscellaneous).

Cost Savers

There were several cost savers identified through health care committee staff research and public testimony given to the Select Committee. Of these, the promotion of evidence-based medicine to guide clinical practice, and the use of cost containment strategies were identified as some of the best ways to increase affordability in the employment-based market.

However, the most significant cost saver identified, and virtually unanimously agreed to by both stakeholders and researchers, was the need to establish "transparency" back into the health coverage system. The argument is that the current system blocks the real cost of health care utilization from the direct consumer, the patient/employee. The employment-based coverage system subsidizes this utilization so that consumer demand is disconnected to an awareness of true costs. Advocates of transparency believe that finding ways to make the full cost of health care open and apparent to each consumer would help them make better choices and reduce overall costs. When taken to the extreme, the advocates suggest making each individual more responsible for their utilization and consequences of over utilization, through pricing of health insurance products, and incentives for healthier lifestyles.

Final Recommendations

After seven public hearings held throughout the state and three committee meetings, 88 policy options were examined and reviewed by the members of the Select Committee. The "Policy Options -- Pros and Cons" section of the report provides a narrative regarding each of the options. Many of the recommendations fell outside the charge of the committee and members were able to narrow the list of policy options from 88 to a list of 13 (that list was a consolidation of approximately 28 options).

The Select Committee met on February 4, 2004, and considered the narrowed list of options and voted unanimously to forward the recommendations to the Speaker. The recommendations are crafted as both short and long term-approaches in providing choice and competition in the marketplace, while controlling health insurance cost.

The recommendations of the Select Committee on Affordable Health Care for Floridians are incorporated into this bill.

HB 1629

This bill creates "The 2004 Affordable Health Care for Floridians Act," to address the underlying cause of the double-digit increases in health insurance premiums by mitigating the overall growth in health care costs.

TRANSPARENCIES

Consumers are demanding more accountability from their health care providers across the nation. Many states have taken measures to provide more "transparencies" in the health care industry. For example, The Alliance for Quality Health Care (AQHC) and Niagara Health Quality Coalition (NHQC) have released Indicators of Inpatient Care in New York State Hospitals, 2001, which report hospital performance. The report provides consumers with reliable and comparable data on hospitals throughout the state. Nearly 300 hospitals are included in this hospitalization database. Hospitals in the same metropolitan area are grouped together. Links to additional explanatory information are provided throughout the report, which is accessible through the World Wide Web.

Currently, hospitals and ambulatory surgical centers are required to submit discharge data on a quarterly basis to the Agency for Health Care Administration. The State Center for Health Statistics collects three types of discharge information from 261 inpatient healthcare facilities and Ambulatory Patient Data is collected from 526 freestanding ambulatory surgical centers, lithotripsy centers, cardiac catheterization laboratories, and short-term acute care hospitals. The data is used for information guides and research by many that are interested in the health of Florida residents.

In an effort to create a more transparent health care system in Florida, this bill revises many provisions of law governing hospitals, insurers, and the analysis of the data collected by the Agency for Health Care Administration to provide consumers with useful information. The bill specifies that:

- ✓ Each licensed facility not operated by the state shall provide, prior to provision of any medical services, an estimate of charges for the proposed service upon request of a prospective patient who does not have insurance coverage or whose insurer or health maintenance organization does not have a contract with the hospital and an emergency medical condition does not exist or the service is not a covered service.

- ✓ The Agency adopts the 3M All Patient Refined DRG software risk and severity adjustment methodology to adjust data submitted.

- ✓ Data shall be reported electronically and certified by the facility's chief executive officer or other representative.

- ✓ Insurers report percentage of claims denied, percentage of claims meeting prompt pay requirements, and medical and administrative loss ratios. Data reported by insurers must be certified by a qualified insurer representative.

- ✓ The Agency make available information regarding patient charges, volume, length of stay and performance outcome data for medical conditions and specifies considerations for determining which medical conditions may be used.

- ✓ The Agency shall collect and report on its website by 10/1/05 a statistically valid sample of data on retail prices charged by pharmacies for a 30-day supply at a standard dose for the 50 most frequently prescribed medicines for licensed pharmacies to provide comparative information.

- ✓ The Agency provides an interactive website allowing consumer to view and compare information, with a map that allows consumer to select information based on geographical region.

- ✓ The Agency may collect information from licensed health care providers for special study.

- ✓ The Agency make available on its Internet website no later than October 1, 2004 and in a hard-copy format upon request, patient charge, volumes, length of stay, and performance outcome indicators collected from health care facilities pursuant to s. 408.061(1) (a), F.S., for specific medical conditions, surgeries, and procedures provided in inpatient and outpatient facilities as determined by the agency.

- ✓ The Agency submit an annual status report on the collection of data and publication of performance outcome indicators to the Governor, the Speaker of the House of Representatives, the President of the Senate, and the substantive legislative committees with the first status report due January 1, 2005.

- ✓ Each health insurance issuer shall make available on its Internet website a link to the performance outcome and financial data that is published by the Agency for Health Care Administration pursuant to s. 408.05(3) (m), F.S.

- ✓ A penalty of $500/ instance is assessed for each of a facility's failure to provide requested information to consumers.

- ✓ The Agency must develop and implement a strategy for the adoption and use of electronic health records and report to the Governor and Legislature.

- ✓ A facility must make available to a patient upon request all of the patient's records necessary for verification of the accuracy of the patients bill. The bill provides a time frame for disclosure.

- ✓ All facilities must establish a method for reviewing a patient's billing question. The bill provides a time frame for the facility to review and respond to a billing question.

PATIENT SAFETY CORPORATION

In 1999, the National Institute of Medicine reported that medical errors are estimated to be responsible for injury in as many as 1 out of every 25 hospital patients. Medical errors are estimated to be the eighth leading cause of death in this country; higher than motor vehicle accidents. According to the Institute of Medicine, preventable health care-related injuries cost the economy from $17 to $29 billion annually, of which half are health care costs.

Examples of medical errors include: a patient inadvertently given the wrong medication; a clinician misreading the results of a test; and a person with ambiguous symptoms (shortness of breath, abdominal pain, and dizziness) whose heart attack is not diagnosed by emergency room staff.

The health care industry is estimated to be a decade or more behind other high-risk industries in its attention to ensuring basic safety. Aviation has focused extensively on building safe systems, and has been doing so since World War II. Between 1990 and 1994, the U.S. airline fatality rate was less than one-third the rate experienced in mid century. According to the Institute report, although health care may never achieve aviation's impressive record, there is clearly room for improvement. The increase in error rates, whether in providing patient treatment or flying an airplane, creates an increase in production cost or the cost of providing service. When the rate of error in providing medical care decreases, it is generally accepted that the cost of providing services will decrease correspondingly.

This bill creates s. 381.0271, F.S., to establish the not-for-profit, Florida Patient Safety Corporation, to provide coordination to and direction to efforts in the state to improve the quality and safety of health care, and reduce harm to patients. The corporation is not a state agency and shall not regulate health care providers in the state. It must work collaboratively with state agencies in the development of electronic health records.

The bill establishes the corporation with a board composed of representatives of a broad cross section of health care interests with patient safety experience, who are appointed by their respective organizations. The bill also provides for advisory committees to address issues including: scientific research, technology, provider patient safety culture, consumers, interagency coordination, and tort alternatives.

The powers and duties of the corporation include:

- ✓ Collecting and analyzing patient safety data, medical malpractice closed claims, and adverse incidents already reported to the Agency for Health Care Administration (AHCA) and the Department of Health (DOH);
- ✓ A three year pilot project of a voluntary and anonymous, "near-miss," patient safety reporting system, to: identify potential systemic problems that could lead to adverse incidents; enable publication of system-wide alerts of potential harm; and facilitate development of both facility-specific and statewide options to avoid adverse incidents and improve patient safety;
- ✓ Foster development of a statewide electronic infrastructure, including electronic medical records, that may be implemented in phases over a multiyear period; and
- ✓ Provide for access to an active library of evidence-based medicine and patient safety practices, available to health care practitioners, health care facilities, and the public.

HEALTH INSURANCE

Significant provisions affecting the health insurance markets include:

- ✓ Creation of the Florida Health Insurance Plan as the high risk pool for uninsurable medical risks, replacing the Florida Comprehensive Health Care Association;
- ✓ Expansion of the Health Flex Program statewide;
- ✓ Modification of the Small Employers Health Access Act to eliminate one-life groups, contingent on the Florida Health Insurance Plan accepting new enrollment;
- ✓ Creation of the Small Employers Access Program to provide additional options for small businesses of up to 25 employees;
- ✓ Requirement that certain plans providing discount medical services to be licensed as prepaid health plans;
- ✓ Modification of health insurance agent's ability to collect a consulting fee; and
- ✓ Updating the ability of the Office of Insurance Regulation to regularly collect data from insurers describing the health insurance marketplace.

HEALTH FLEX PLANS

The 2002 Legislature passed SB 46-E (chapter 2002-389, L.O.F.), which became effective July 1, 2002, creating the Health Flex Plan Pilot Program. The Legislature found a significant proportion of the residents of Florida are unable to obtain affordable health insurance coverage. Therefore, it was the intent of the Legislature to expand the availability of health options for low-income, uninsured Florida residents by encouraging health insurers, health maintenance organizations, health care provider sponsored organizations, local governments, health care districts or other public or private community-sponsored organizations to develop alternative approaches to traditional health insurance which emphasize coverage for basic and preventive health care services. The 2003 Legislature expanded the Health Flex Program to allow the plans to be sold to groups.

The bill expands eligibility statewide by eliminating the "pilot" status and permits public-private partnerships to participate in the program. The bill requires an offering of a catastrophic insurance plan option and requires OIR to oversee health flex plan advertisement and marketing procedures. The bill requires AHCA and OIR to report on Health Flex progress to the Governor and legislature by January 1, 2005 and annually thereafter.

FLORIDA HEALTH INSURANCE PLAN

A segment of the Florida insurance market includes persons in the state's high-risk pool. A high-risk pool is a state-created, nonprofit residual market that is generally subsidized through a tax assessment on all of a state's health insurers, both individual and group plans, by state funds, or a combination of funding. Theoretically, the concept of the high-risk pool is to spread the cost of providing health services to a sicker population across a larger group of insured people, instead of relying on the relatively small individual market to cover the chronically ill. Risk pools by design are the safety net for the medically uninsurable individual.

Nationally, high-risk pools have been around since 1976, and most follow the model designed by the National Association of Insurance Commissioners. While originally designed to provide access to health care for the uninsurable population, many states offering a high-risk pool also use their high-risk pools to guarantee coverage to eligible people entering the individual market from group coverage as required by HIPAA. Only Alabama operates its high-risk pool exclusively for those eligible under HIPAA. Twenty-six of the 29 state high-risk pools cover those eligible under HIPAA. Federal regulations require all states to waive preexisting conditions exclusions periods for this class of enrollees.

To support the cost of the high-risk pools, most states assess health insurers. While other states fund all or part of the pool directly from general revenues, those states allow insurers to offset the assessment against their corporate income tax liability, in effect, also fund the high-risk pool from general revenues. A few states use other earmarked funds (such as tobacco funds) to finance their high-risk pools exclusively or in addition to general revenues.

A heavy reliance on funding sources other than assessments can cause a recurring crisis for the high-risk pool if the revenue base does not expand with growth in health care costs. Affordability and sustainability are paramount among the difficult issues that high-risk pools raise for consumers and states. Several states subsidize the participation of those with low incomes in the high-risk pool, but even in these states, the subsidized premiums remain high, relative to income. While all states need broad funding for the high-risk pool, those without an earmarked (and therefore, relatively narrow) revenue base may find it difficult to maintain support for the high-risk pool when budgets become tight. Efforts to control plan costs by severely limiting coverage obviously defeat the purpose and usefulness of a high-risk pool, but also illustrate the dilemma many states face in maintaining adequate funding.

Some states have adopted innovative strategies to maintain adequate benefits and better affordability of their high-risk pool by augmenting their assessments on insurers with a surcharge on provider revenues, despite obvious opposition from providers. Other states have broadened these pools' conventional funding base by assessing covered lives rather than insurer premiums or by including stop-loss premiums with the traditionally assessed premiums. ERISA's provisions preempt state taxation of self-insured employer plans for the purpose of high-risk pool financing.

The bill establishes the Florida Health Insurance Plan (FHIP) as the state's high risk pool. The FHIP is run by a nine person Board of Directors and chaired by the OIR Director. There are five Governor appointees; one Senate appointee; one House appointee; and one CFO appointee. The bill requires that a majority of the board must be composed of individuals who are not representatives of insurers or health care providers without further definition. By December 1, 2004, the board must provide to the Governor, Senate President and Speaker of the House an actuarial study regarding funding of the FHIP and impact of the FHIP on small employers. The bill requires the initial meeting of the board to occur no later than September 1, 2004. However, prior to opening the FHIP, the actuarial study must be completed with identified funding needs.

Eligible Individuals

Residents deemed medically uninsurable by the marketplace (2 notices of rejection) and current FCHA enrollees.

Benefit Plans

Standard and basic benefit plans as described in s. 627.6699, F.S. with an additional alternative catastrophic coverage as determined by the board.

Funding

Funding of the high risk pool is accomplished through two mechanisms:

(1) Premiums, initially capped at 300 percent of standard risk rate, subject to a sliding surcharge based on the insured's income.
(2) General revenue to cover deficits incurred in excess of new enrollees in the plan.

The Financial Services Commission is given authority to give final approval of the operational plan of the Florida Health Insurance Plan. Upon the opening of the FHIP, the Florida Comprehensive Health Association is statutorily repealed.

SMALL GROUP MARKET REFORMS

There are several reforms to the small group market designed to enhance flexibility of the coverages offered. The bill requires:

- ✓ the offering of a high deductible plan that meets the federal requirements of a health savings account or health reimbursement accounts; and
- ✓ a limit of the allowable variation from the approved rate for cumulative use of health status and claims experience rating factors to 4 percent.

The bill creates the Small Employers Access Program to allow the development of distinctive, innovative, and flexible benefit plans exclusively offered in defined geographical areas to small businesses up to 25 employees; any municipality, county, school district, or hospital located in a rural community; and any nursing home employer.

The bill allows health insurers to require higher co-payments for nonemergency use of emergency rooms.

ONE LIFE GROUPS

The Health Insurance Portability and Accountability Act of 1996, known as HIPAA, includes important limited protections for millions of working Americans and their families. HIPAA specifies that a group health plan (federally defined as a group of 2-50 individuals), and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on Health Status.

Currently, Florida law defines small group coverage as an employer with 1-50 employees. The bill amends s. 627.6487, F.S., making individuals (one-life groups) ineligible for guaranteed issue in the small group market if the Florida Health Insurance Plan is accepting new enrollment.

DATA COLLECTION

The bill amends s. 627.9175, F.S., authorizing the annual collection of market data from health insurers, prepaid plans, and HMO's and provides the Department of Financial Services with rulemaking authority governing the submission of such information.

DISCOUNT PLANS

As health insurance premiums have risen at double-digit rates in recent years, employers and individuals who have sought to purchase more affordable coverage have fallen prey to certain entities that may offer attractively priced premiums but do not fulfill the expectations of those buying health insurance. These unauthorized entities—also known as bogus entities or scams—may not meet the financial and benefit requirements typically associated with health insurance products or other arrangements that are authorized, licensed, and regulated by the state.

Discount health care plans are not insurance, but as their name implies offer discounts for medical services from hospitals and doctors. Often, the plans are offered without concern about pre-existing conditions. The problem with this type of plan is that often, they are not what they have been advertised to be and in addition, if something should go wrong, such as insolvency; consumers have no recourse and no help available to pay claims.

The bill establishes a comprehensive regulatory scheme for discount medical plan organizations. It involves the creation of a new license, forms and rate filings and approval, procedures for examinations and investigations by the Office, prohibited activities, required disclosures to plan members, better tracking of providers, annual report filing, minimum capital requirements, a process for suspension and revocation of licenses, sale by licensed agents only, service of process through the Department, security deposits, criminal penalties, injunctive relief by the Office, civil remedies, and unlicensed activities by the plans.

The bill allows insurance agents to shop for the best plan available for the consumer. The insurance agents will be compensated for their efforts with a consultation fee.

PRACTICE PARAMETERS

The Health Care Reform Act of 1993 required AHCA to develop and implement scientifically sound practice parameters. At the time of its passage, national standards were limited to specialized provider and practitioner groups and were not generally available to payers, purchasers or consumers.

Today, the National Guideline Clearinghouse is available as a public resource for evidence-based clinical practice guidelines. This is sponsored by the Agency for Health Care Research and Quality (AHRQ) and the U.S. Department of Health and Human Services sponsors, in partnership with the American Medical Association and the American Association of Health Plans-Health Insurance Association of America.

The National Guideline Clearinghouse is accessible on the Internet at: www.guideline.gov. The medical community would be able to access and use the dynamically updated parameters of the National Guideline Clearinghouse.

The bill repeals the requirement that AHCA develop practice parameters, thus eliminating the duplicative and costly development of practice parameters that are now widely available to the medical community.

STATEWIDE PROVIDE AND SUBSCRIBER ASSISTANCE PROGRAM

The current program title "Statewide Provider and Subscriber Assistance Program" (Program) is misleading to subscribers and providers, and causes particular confusion among providers, who incorrectly believe that their billing problems can be resolved by the program. The Program title "Subscriber Assistance Program" more accurately portrays the purpose and function of the program, and is more user friendly. Thus, the bill changes the title of the Program from "Statewide Provider and Subscriber Assistance Program" to "Subscriber Assistance Program."

Currently, the Program has authority to require managed care plans to provide only "medical" records within a specified time frame; yet the panel frequently requires other records, in addition to the medical records, to arrive at its conclusion and make its recommendation The bill incorporates grievance file and other requested records with the medical records, and more importantly, would permit fines to be applied when records other than medical records are not supplied as requested, i.e., telephone logs, correspondence, grievance hearing records, billing statements, premium/rate change notices, formulary lists, contracts, etc.

Flexibility in the numbers and makeup of the panel members from the agency and the department will ensure a balance of perspective regarding subscribers' issues heard by the panel.

This bill amends Section 408.7056, Florida Statutes, as follows:

- ✓ Clarifies of the use of a physician with expertise only as necessary.
- ✓ Clarifies that the panel may contract with a medical director and/or a primary care physician.
- ✓ Clarifies that a contracted medical director or primary care physician is not a voting panel member.

There is no statutory direction for conducting a panel hearing with less than full membership. Specific member attendance poses potential scheduling difficulties due to the probability of unavoidable last

minute absenteeism by some panel members. Last minute cancellation unnecessarily delays the grievance process and causes inconvenience for those scheduled and assembled for the hearing. This bill establishes a quorum to enhance the ability of the Panel to review the subscriber grievances in a timely manner as directed in section 408.7056, Florida Statutes.

HEALTHY LIFESTLYES

Studies show that poor health status leads to higher health care cost. For example, one study found that obesity has roughly the same association with chronic health conditions as does twenty years of aging. Another study showed that obesity is associated with a 36 percent increase in inpatient and outpatient spending and a 77 percent increase in use of medications. In addition, smoking leads to a 21 percent increase in inpatient and outpatient costs and a 28 percent increase in medication use. The rate of obesity has increased significantly during the last decade, while smoking rates have leveled at about 23 percent of the U.S. population.

Nearly two-thirds of American adults are overweight or obese. Equally alarming, the prevalence of obesity in children has nearly quadrupled since the 1960s. The obesity epidemic is fueling an unprecedented rise in type-2 diabetes, contributes to numerous other debilitating health conditions, and adds a growing economic burden to the health care system.

This bill addresses the importance of healthy lifestyles by providing educational material through the Healthy Communities program and providing financial incentives by giving rebates on health insurance for healthy lifestyles.

Healthy Communities, Healthy People Program

The Healthy Communities, Healthy People Program is a comprehensive community-based health promotion and wellness program. It is designed to encourage healthy lifestyles and behaviors to reduce the incidence of disease and increase life expectancy. Specific programs that contribute to the Healthy Communities, Healthy People Program include: Chronic Disease Health Promotion and Education Program; Heart Disease and Stroke Prevention Program; Obesity Prevention Program; Diabetes Education and Control Program; Arthritis Education Program; Comprehensive Cancer Control Program; and the Coordinated School Health Program.

This bill requires the DOH to include health care providers and small businesses and health insurers in the organizations that the Healthy Communities, Healthy People program serves. It requires DOH to provide information about DOH's health promotion and wellness programs and healthy lifestyle information on its Internet web page.

Rebates on Health Insurance for Healthy Lifestyles

The bill authorizes health insurers and health maintenance organizations to provide for an appropriate rebate of premiums paid in the last calendar year when the majority of members of a health plan have enrolled and maintained participation in any health wellness, maintenance, or improvement program offered by the employer.

The employer must provide evidence of demonstrative maintenance or improvement of the enrollees' health status as determined by assessments of agreed-upon health status indicators between the employer and the health insurer, including, but not limited to, reduction in weight, body mass index, and smoking cessation. Any rebate provided by the health insurer is presumed to be appropriate unless credible data demonstrates otherwise, but shall not exceed 10 percent of paid premiums.

EMERGENCY DEPARTMENT DIVISION PROGRAMS

Emergency departments (EDs) are misused and overused nationwide and Florida is no exception. The Center for Studying Health System Change reports that there was a 16.3 percent increase in emergency department visits between 1996-97 and 2000-01. During the same period, population increased by only 4.4 percent. Surprisingly, the majority of the increase in use is from insured patients. Inappropriate utilization of services, whether its ED usage or the demand for more expensive diagnostic treatments, contributes to the overall growth in health care spending.

It is of vital importance that emergency services and care be provided by hospitals and physicians to every person in need of such care, but with the double-digit increases in health insurance premiums, health care providers and insurers should encourage patients to assume responsibility for their treatment, including emergency care. Inappropriate utilization of emergency department services increase the overall cost of providing health care and these costs are ultimately borne by the hospital, the insured patients, and, many times, by the taxpayers of this state. The Legislature recognizes that the providers and insurers must share the responsibility of providing alternative treatment options to urgent care patients outside of the emergency department.

This bill address the inappropriate utilization of emergency department care on several levels; federally qualified health centers mission is expanded to include the provision of providing urgent care (explained in more detail below); statutorily, hospitals are encouraged to develop “fast track” programs; insurers are required to provide the insured with information regarding appropriate venues for care and a list of alternative care sites for non-emergent care; insurers are required to develop community emergency department diversion programs; insurers are authorized to charge higher copays for services that rendered for non-emergent care, insurers are required to provide information on their website about appropriate utilization of emergency care services.

Federally Qualified Community Health Centers

DOH serves informally as a liaison between health centers funded under Section 330 of the Public Health Service Act (42 U.S. C. 254b et seq) and the state. Commonly known as community health centers, these health centers provide primary health services to medically underserved populations. In calendar year 2002, the 30 federal grantees in Florida provided care to 501,193 patients, of whom 54.9 percent were uninsured and 24.6 percent were Medicaid patients. Seventy-six percent of the patients served during 2002 had incomes below 200 percent of the federal poverty level. Federal funds provided to the health centers do not flow through DOH or any other state agency, funds flow from the federal government directly to the community health centers.

DOH administers the Community Health Center Access Program Act (s. 409.91255, F.S.) passed by the Legislature in 2002 to provide state funding for centers that provide comprehensive primary and preventive care services to uninsured populations in Florida. The program currently funds nine community health centers providing services to 35,000 persons through a combination of state, local and Medicaid dollars that total $4,868,549.

The bill permits CHDs and community health centers to treat non-emergency patients in conjunction with local hospital emergency room diversion programs. The bill requires DOH to include “urgent care” in an expansion program for community health centers and permits the centers to participate in community diversion programs.

Monitoring Effectiveness

With the implementation of the provisions described above, it is important to determine if the policy decisions enacted will actually reduce the inappropriate use of emergency departments. This bill requires hospitals to report specific outpatient data and allows the Agency for Health Care Administration to use the data collected to determine and report the effectiveness of the policies implemented by this act.

APPROPRIATION

The bill provides a $1.7 million appropriation from General Revenue to AHCA for implementation of the Florida Patient Safety Corporation and implementing the provisions of this act relating to performance and cost data reporting. It appropriates $250,000 from the Insurance Regulatory Trust Fund for the required actuarial study by FHIP and $250,000 from the same trust fund for implementation of the Small Employers Access Program. $1,69,069 from the Insurance Regulatory Trust Fund is appropriated to regulate the Discount Medical Plan Organizations.

C. SECTION DIRECTORY:

Section 1. Creates a popular name for this act as "The 2004 Affordable Health Care for Floridians Act."

Section 2. Specifies the purpose of the act is to address lower health insurance premiums by mitigating overall health care costs.

Section 3. Amends s. 381.026, F.S., requiring certain licensed facilities to provide public Internet access to certain financial information; estimates shall be made to a "person" instead of a "patient."

Section 4. Amends s. 381.734, F.S., including the participation by health care providers, small businesses, and health insurers in the Healthy Communities, Healthy People Program; requiring the Department of Health to provide public Internet access to certain public health programs; requiring the department to monitor and assess the effectiveness of such programs; requiring a report; and requiring the Office of Program Policy and Government Accountability to evaluate the effectiveness of such programs and to report the findings to the Legislature and Governor.

Section 5. Amends s. 395.1041, F.S., to authorize hospitals to develop emergency room diversion programs.

Section 6. Amends s. 395.1055, F.S., to require licensed facilities to provide on their Internet website access to certain financial and performance outcome information; to require license facilities to provide hard-copies upon request.

Section 7. Amends s. 395.1065, F.S., requiring AHCA to impose a fine on facilities that fail to provide the information required in Section 6 of this act.

Section 8. Amends s. 395.301, F.S., requiring an estimate of charges to be provided to a prospective patient within seven days of a written request from prospective patient; requiring facilities to provide patient's access to the records necessary to verify the accuracy of the patient's bill; establishing methods for responding to questions concerning the itemized bill; requiring an Internet link to performance outcome and financial data published by AHCA.

Section 9. Amends s. 408.061, F.S., requiring health care facilities, health care providers, and health insurers to submit certain information; specifying information to be included in emergency department data; and requiring certification of data.

Section 10. Amends s. 408.062, F.S., requires the agency to conduct certain health care costs and access research, analyses, and studies; expands the scope of such studies to include collection of pharmacy retail price data, use of emergency departments, and Internet patient charge information availability; requires a report; requires the agency to conduct additional data-based studies and make recommendations to the Legislature; authorizes the agency to develop and implement a strategy for the use of electronic health records.

Section 11. Amends s. 408.05, F.S., requires agency to develop a plan to make performance outcome and financial data available to consumers for health care services comparison purposes; requires

submittal of the plan to the Governor and Legislature; requires the agency to update the plan; requires the agency to make the plan available electronically; and provides plan requirements; establishes deadlines for publication of data.

Section 12. Amends s. 409.9066, F.S., requires the agency to provide certain information relating to the Medicare prescription discount program.

Section 13. Amends s. 408.7056, F.S., renames the Statewide Provider and Subscriber Assistance Program as the Subscriber Assistance Program; revises provisions to conform; expands certain records availability provisions; revises membership provisions relating to a subscriber grievance hearing panel; and provides hearing procedures.

Sections 14-15. Amend s. 641.3154, F.S., to conform to the renaming of the Subscriber Assistance Program; amend s. 641.511, F.S., to conform to the renaming of the Subscriber Assistance Program; and adopt and incorporate by reference the Employee Retirement Income Security Act of 1974, as implemented by federal regulations.

Sections 16. Amends s. 641.58, F.S., to conform to the renaming of the Subscriber Assistance Panel.

Section 17. Amends s. 408.909, F.S., expands a definition of "health flex plan entity" to include public-private partnerships; makes a pilot health flex plan program apply permanently statewide; and provides an offering of a catastrophic plan with the offering of a health flex plan.

Section 18. Creates s. 381.0271, F.S., provides definitions, creates the Florida Patient Safety Corporation; authorizes the corporation to create additional not-for-profit corporate subsidiaries for certain purposes; specifies application of public records and public meetings requirements; exempts the corporation and subsidiaries from public procurement provisions; provides purposes; provides for a board of directors; provides for membership; authorizes the corporation to establish certain advisory committees; provides for organization of the corporation; provides for meetings; provides powers and duties of the corporation; requires the corporation to collect, analyze, and evaluate patient safety data and related information; requires the corporation to establish a pilot project to identify and report near misses relating to patient safety; provides requirements; provides for an active library of evidence-based medicine and patient safety practices; requires the corporation to develop and recommend core competencies in patient safety and public education programs; requires an annual report; provides report requirements; authorizes the corporation to seek funding and apply for grants; and requires AHCA, the Office of Program Policy Analysis and Government Accountability, and the Department of Health to develop performance standards to evaluate the corporation.

Section 19. Amends s. 409.91255, F.S., expands the requirements of federally quality health centers to include urgent care services; allows the development of community emergency room diversion programs.

Section 20. Amends s. 627.410, F.S., requires insurers to file certain rates with the Office of Insurance Regulation.

Section 21. Creates s. 627.64872, F.S., provides legislative intent; creates the Florida Health Insurance Plan for certain purposes; provides definitions; provides requirements for operation of the plan; provides for a board of directors; provides for appointment of members; provides for terms; specifies service without compensation; provides for travel and per diem expenses; requires a plan of operation; requires an actuarial study; provides for powers of the plan; requires reports to the Governor and Legislature; provides certain immunity from liability for plan obligations; authorizes the board to provide for indemnification of certain costs; requires an annually audited financial statement; provides for eligibility for coverage under the plan; provides criteria; requirements, and limitations; specifies certain activity as an unfair trade practice; provides for a plan administrator; provides criteria; provides requirements; provides term limits for the plan administrator; provides duties; provides for paying the

administrator; provides for funding mechanisms of the plan; provides for premium rates for plan coverage; provides rate limitations; provides for assessing certain insurers providing coverage for persons under the Health Insurance Portability and Accountability Act; specifies benefits under the plan; provides criteria, requirements, and limitations; provides for non-duplication of benefits; provides for annual and maximum lifetime benefits; provides for tax exempt status; provides for abolition of the Florida Comprehensive Health Association upon implementation of the plan; provides for enrollment in the plan of persons enrolled in the association; requires insurers to pay certain assessments to the board for certain purposes; and provides criteria, requirements, and limitations for such assessments.

Section 22. Provides for repeal of ss. 627.6488, 627.6489, 627.649, 627.6492, 627.6494, 627.6496, and 627.6498, F.S., relating to the Florida Comprehensive Health Association, upon implementation of the Florida Health Insurance Plan.

Section 23. Amends s. 627.662, F.S., provides for application of certain claim payment methodologies to certain types of insurance.

Section 24. Amends s. 627.6699, F.S., revises provisions requiring small employer carriers to offer certain health benefit plans; preserves a right to open enrollment for certain small groups; requires small employer carriers to file and provide coverage under certain high deductible plans; includes high deductible plans under certain required plan provisions; creates the Small Employers Access Program; provides legislative intent; provides definitions; provides participation eligibility requirements and criteria; requires the Office of Insurance Regulation to administer the program by selecting an insurer through competitive bidding; provides requirements; specifies insurer qualifications; provides duties of the insurer; provides a contract term; provides insurer reporting requirements; provides application requirements; provides for benefits under the program; requires the office to annually report to the Governor and Legislature; provides for decreases in inappropriate use of emergency care; provides legislative intent; requires health insurers to provide certain information electronically and develop community emergency department diversion programs; and authorizes health insurers to require higher co-payments for certain uses of emergency departments.

Section 25: Creates s. 627.6405, F.S.; provides legislative intent regarding inappropriate care of emergency department services; requires health insurers to provide information on their website about appropriate use of emergency services; requires health insurers to develop community emergency department diversion programs; allows higher co-payments for use of emergency departments for non-emergency care.

Section 26: Creates s. 641.31097, F.S.; provides legislative intent regarding inappropriate care of emergency department services; requires health maintenance organizations to provide information on their website about appropriate use of emergency services; requires health maintenance organizations to develop community emergency department diversion programs; allows higher co-payments for use of emergency departments for non-emergency care.

Section 27. Amends s. 627.9175, F.S.; requires certain health insurers to annually report certain coverage information to the office; provides requirements; and deletes certain reporting requirements.

Section 28: Amends the title of chapter 636 from “Prepaid Limited Health Service Organizations” to “Prepaid Limited Health Service Organizations and Discount Medical Plan Organizations.”

Section 29: Designates ss. 636.002 through 636.067, F.S. as Part I of chapter 636 and titled “Prepaid Limited Health Service Organizations.”

Section 30. Amends s. 636.003, F.S.; revises the definition of "prepaid limited health service organization" to exclude provision of discounted medical service programs.

Section 31. Creates ss. 636.202 through 636.244, F.S. and designates these sections Part II of chapter 636 and titled “Discount Medical Plan Organizations;” provides definitions; provides licensing requirements; provides licensing fees; authorizes OIR to examine and inspect discount medical plan organizations; provides permitted and prohibited activities of a discount medical plan organization; provides required disclosures to be made by the discount medical plan organization; provides better tracking of providers; provides form and rate filing; provides annual report filing; provides rulemaking authority to the Financial Services Commission; provides minimum capital requirements; provides a process for suspension and revocation of licenses; provides sale by licensed agents only; provides service of process through the Department; provides security deposits; provides criminal penalties; provides injunctive relief by OIR, provides civil remedies; and provides unlicensed activities by the plans.

Sections 32-33. Creates ss. 627.65626 and 627.6402, F.S., provide for insurance rebates for healthy lifestyles; provide for rebate of certain premiums for participation in health wellness, maintenance, or improvement programs under certain circumstances; and provide requirements.

Section 34. Amends s. 641.31, F.S., authorizes health maintenance organizations offering certain point-of-service riders to offer such riders to certain employers for certain employees; provides requirements and limitations; provides for application of certain claim payment methodologies to certain types of insurance; provides for rebate of certain premiums for participation in health wellness, maintenance, or improvement programs under certain circumstances; and provides requirements.

Sections 35-36. Amends ss. 626.191 and 626.201, F.S., to change “him or her” to “applicant.”

Section 37. Creates s. 626.593, F.S., provides fee and commission limitations for health insurance agents; requires a written contract for compensation; provides contract requirements.

Section 38. Preserves the right of groups of fewer than two employees to enroll in certain health benefit coverages.

Section 39. Creates s. 465.0244, F.S., requires each pharmacy to make available on its Internet website a link to certain performance outcome and financial data of the Agency for Health Care Administration and a notice of the availability of such information.

Section 40. Amends s. 627.6499, F.S., requires each health insurer to make available on its Internet website a link to certain performance outcome and financial data of the Agency for Health Care Administration and a notice in policies of the availability of such information.

Section 41. Amends s. 641.54, F.S., requires health maintenance organizations to make certain insurance financial information available to subscribers; and requires health maintenance organizations to make available on its Internet website a link to certain performance outcome and financial data of the Agency for Health Care Administration and a notice in policies of the availability of such information.

Section 42. Repeals s. 408.02, F.S., relating to the development, endorsement, implementation, and evaluation of patient management practice parameters by the Agency for Health Care Administration.

Section 43. Provides for an appropriation of $250,000 to implement the provisions in this act relating to the Small Employers Access Plan.

Section 44. Provides for an appropriation of $250,000 for an actuarial study by the Florida Health Insurance Plan.

Section 45. Appropriates $169,069 from the Insurance Regulatory Trust Fund to regulate the Discount Medical Plan Organizations.

Section 46. Provides $650,000 for the purpose of implementing the Florida Patient Safety Corporation.

Section 47. Provides $1,136,171 from the General Revenue Fund to AHCA to implement the reporting of performance and cost data for hospitals, physicians and pharmacies.

Section 48. Provides an effective date of July 1, 2004, unless otherwise specified.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   See information below.

2. Expenditures:

Fiscal Impact on the Department of Fiscal Services Office of Insurance Regulation:

Expenditures	FY 04-05	(FY 05 06)
Nonrecurring		
Insurance Regulatory Trust Fund	$513,683	$0
Recurring		
Insurance Regulatory Trust Fund	$155,386	$159,271
Total Estimated Expenditures	$669,069	$159,271

Fiscal Impact on the Department of Health

Expenditures	FY 04-05	(FY 05 06)
Administrative Trust Fund	$5,000	$5,000
Total Estimated Expenditures	$5,000	$5,000

Fiscal Impact on the Agency for Health Care Administration

Expenditures	FY 04-05	(FY 05 06)
Nonrecurring		
General Revenue Fund	$650,000	$0
Recurring		
General Revenue Fund	$1,136,171	$1,197,686
Total Estimated Expenditures	$3,165,026	$1,197,686

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Significant costs are associated with achieving licensing and solvency requirements required of specified discount medical plans.

The opening of the Florida Health Insurance Plan should allow small businesses to experience modest declines in future premium increases. One person groups may experience significant declines in medical premiums.

The uninsurables may find medical coverage available, potentially decreasing out of pocket expenditures for medical care.

Small businesses and the uninsured may find affordable coverage through the expansion of Health Flex program or the creation of the Small Employers Access Program.

The bill has a significant impact on health care facilities and health care providers. Many of the requirements in this bill are designed to increase competition among health providers.

Florida's uninsured population, small employer groups, rural hospitals, and nursing home employees are expected to benefit from both the establishment of the Florida Health Insurance Plan and the establishment of Purchasing pools. Health care providers and consumers will benefit from the Patient Safety Corporation.

This bill will increase consumer awareness regarding the cost of health care treatment in hospitals and to encourage comparison shopping. Employers and the general population may benefit from additional information about licensed hospital and ambulatory surgical center prices.

D. FISCAL COMMENTS:

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill provides rulemaking authority to Office of Insurance Regulation, Department of Financial Services, Agency for Health Care Administration, and the Department of Health necessary to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On March 18, 2004, the Committee on Health Care considered HB 1629 and reported the bill favorably with a committee substitute. The committee substitute differs from the original bill in that it:

- ✓ Creates the Patient Safety Corporation in lieu of having two advisory bodies to address the issues regarding an Electronic Medical Record and Evidenced-based Medicine.
- ✓ Specifies that the High-Risk Pool is authorized under the jurisdiction of the Office of Insurance Regulation rather than the Governor's Office.
- ✓ Creates an assessment of health insurers for the HIPAA eligibles that enter the high-risk pool.
- ✓ Requires the creation of ER diversion programs by health insures.
- ✓ Creates a rebate program for the purchase of health insurance for groups and individuals maintaining a healthy lifestyle.
- ✓ Specifies that the Agency shall report retail price information on pharmaceuticals.
- ✓ Removes requirements for a mandated offering of coverage for speech, language, swallowing, and hearing disorders.
- ✓ Requires insurers to provide consumers with specific plan information regarding contracted providers.
- ✓ Strengthens the directive to the Agency regarding the reporting of outcome and performance data.
- ✓ Requires insurers to report to AHCA the percentage of claims denied, percentage of claims meeting prompt pay requirements, and administrative and medical loss ratios.

On March 31, 2004, the Committee on Insurance reported the bill favorably with a strike-everything amendment sponsored by Rep. Farkas and other amendments. The strike-everything amendment made the following changes to the committee substitute reported by the Committee on Health Care:

Section 3. s. 381, F.S., Rights of a Patient:

- Authorizes the agency to fine licensed facilities on the grounds of not providing required information to consumers.

- Specifies that reporting of financial information must include the top 50 inpatient and outpatient procedures.

Section 6. s. 395.301, F.S., Itemized patient bill; form and content prescribed by the agency.

- Specifies failure to provide data upon request shall result in a fine of $500 for each instance of the facility's failure to provide the requested information.

- Incorporates the provision of HB 701 as it relates to estimate of charges.

Section 7. s. 408.061, F.S., Data Collection; uniform systems of financial reporting; information relating top physician charges; confidential information; immunity.

- Specifies that the Agency adopt the 3M All Patient Refined DRG software risk and severity adjustment methodology for all data submitted, in lieu of the agency adopting guidelines that may not be as effect as of the establish system.

- Requires that all data submitted be certified by the Chief Executive Officer or an appropriate and duly authorized representative or employee of the licensed facility.

Section 8. s. 408.062 Research, analyses, studies, and reports.—

- Authorizes the Agency to report the development of physician information systems which are capable of providing data for health care consumers taking into account the amount of resources consumed at licensed facilities as defined in Chapter 395 and the outcomes produced in the delivery of care.

- Clarifies that the pharmacy reporting information is on the price of a 30 day supply of medications.

- Authorizes the agency to report Performance outcome indicators which are risk-adjusted or severity adjusted as applicable using 3M All Patient Refined DRGs.

- Authorizes the Agency to develop and implement a strategy for the use of an electronic medical record.

Section 9. s. 408.05, F.S., State Center for Health Statistics.—

- Requires the publication of data to be released no later than March 1, 2006.

Section 11. s. 408.7056, F.S, Subscriber Assistance Panel.—

- Authorizes the Agency to delineate when a grievance of a subscriber may be heard by the panel based on if the grievance is specific to an exclusion, expressed limitation, or benefit or service not covered by the contract.

Section 16. s. 381.0271, F.S., Florida Patient Safety Corporation.—

- Increases the membership of the Board of directors to include person responsible for patient safety issues for an authorized Health Maintenance Organization, and an additional member form the Florida Hospital Association.

- Specifies that the physicians on an advisory committee must have experience in patient safety and evidenced-based medicine.

- Requires the Patient Safety Corporation to work collaboratively with state agencies.

- Expands the reporting requirement to assess the ability of the corporation to fulfill the duties specified. (SENATE CONFORMING LANGUAGE).

- Removes the requirements that the Patient Safety Corporation develop an advisory committee on electronic medical records.

Section 20. s. 627.64872 Florida Health Insurance Plan.

- Removes the HIPAA eligibles from the high risk pool and the assessment associated with this group.

- Requires that the Board be established no later than September 1, 2004 and changes the composition of the board to include an additional appointee by the Governor and an appointee by the Chief Financial Officer.

- Specifies that an actuarial study be completed by the Board prior to implementing the plan.

- Redefines the term “Health Insurance” to conform to the HIPAA definition of health insurance. (SENATE CONFORMING LANGUAGE).

- Requires eligibility determination to be made on the bases of at least two notices of rejection rather than one.

- Specifies that coverage ceases upon failure of the insured to pay for continued coverage.

- Specifies that maximum life time benefits for former enrollees of the FCHA shall not exceed the lifetime maximum benefit in the FHIP and services rendered while enrolled in FCHA goes toward the lifetime maximum of the FHIP.

- Specifies that FCHA will operate under the existing plan of operation without modification until the adoption of the new plan of operation for the Florida Health Insurance Plan.

Section 22. s. 627.662 F.S., Other provisions applicable for group health insurance, blanket health insurance, and franchise health insurance.

- Corrects a drafting error as it relates to the provisions aimed at decreasing the inappropriate utilization of emergency services to include all group health plans rather than just the small group market.

Section 23. s. 627.6699, F.S., Employee Health Care Access Act.

- SMALL EMPLOYERS ACCESS PROGRAM (Purchasing Pool) Authorizes any municipality, county, or school district located in a rural community to participate in purchasing pool.

- Requires any employer participating in the program must do so until the end of the term for which the carrier providing the coverage is obligated to provide such coverage to the program.

Sections 24 & 25. s. 627.6405. Decreasing inappropriate utilization of emergency care.

- Corrects a drafting error in that the provisions relating to decreasing the inappropriate use of emergency services which was originally only drafted to the small group. This provision extends the requirement into the group market and HMOs.

Sections 27- 54. Medical Discount Plans

- Establishes a comprehensive regulatory scheme for discount medical plan organizations. It involves the creation of a new license, forms and rate filings and approval, procedures for examinations and investigations by the Office, prohibited activities, required disclosures to plan members, better tracking of providers, annual report filing, minimum capital requirements, a process for suspension and revocation of licenses, sale by licensed agents only, service of process through the Department, security deposits, criminal penalties, injunctive relief by the Office, civil remedies, and unlicensed activities by the plans.

Section 78. Specifies that the appropriation of $2 million be for the electronic medical records provisions of the bill rather than the Patient Safety Corporation.

Section 79. Authorizes a $250,000 appropriation for the actuarial study for the high-risk pool.

Other amendments to HB 1629 w/CS adopted at the Committee on Insurance meeting on March 31, 2004, are summarized as follows:

- Deletes references to life and accident insurance in the insurance advisor sections of HB 1629 w/CS.

- Retains the current law's requirement that an application for insurance agency licensure be signed by the owner(s) or president and secretary of the insurance agency, depending on whether the insurance agency is incorporated.

- Retains the current law's provisions relating to grounds for compulsory refusal, suspension, or revocation of an insurance agency license.

- Retains the current law's provisions relating to transfer of an insurance agent license from another state and insurance agents' limited licenses.

- Clarifies that performance outcome and financial data allowing consumers to compare health care services is a duty for AHCA and the Comprehensive Health Information System Advisory Council.

- Changes the number of the Florida Health Insurance Plan Board of Directors from 10 to 9 members.

- Specifies the qualifications for licensure and authority of an insurance advisor.

- Provides for rebating to the insured any commission received by an insurance advisor in connection with the issuance of a health insurance policy.

- Removes a representative of an authorized medical malpractice insurer appointed by an insurer from the Patient Safety Corporation Board of Directors and replaces that representative with an authorized medical malpractice insurer appointed by the Florida Insurance Council.

On April 16, 2004, the Committee on Appropriations reported the bill favorably with a strike-everything amendment sponsored by Rep. Farkas. The bill analysis is written to the bill as amended.