1 A bill to be entitled
2 An act relating to affordable health care; providing a
3 popular name; providing purposes; amending s. 381.026,
4 F.S.; requiring certain licensed facilities to provide
5 public Internet access to certain financial information;
6 expanding the Florida Patient's Bill of Rights and
7 Responsibilities to include a right to certain price and
8 procedure comparison information; amending s. 381.734,
9 F.S.; including participation by health care providers,
10 small businesses, and health insurers in the Healthy
11 Communities, Healthy People Program; requiring the
12 Department of Health to provide public Internet access to
13 certain public health programs; requiring the department
14 to monitor and assess the effectiveness of such programs;
15 requiring a report; requiring the Auditor General to
16 investigate the effectiveness of such programs; requiring
17 a report; requiring the department to develop certain
18 community emergency room diversion programs; authorizing
19 the department to provide certain private sector
20 incentives for certain purposes; amending s. 395.1041,
21 F.S.; authorizing hospitals to develop certain emergency
22 room diversion programs; amending s. 395.301, F.S.;
23 requiring certain licensed facilities to provide public
24 Internet access to certain financial information;
25 requiring certain licensed facilities to provide
26 prospective patients certain estimates of charges for
27 services; amending s. 408.061, F.S.; requiring the Agency
28 for Health Care Administration to require health care
29 facilities, health care providers, and health insurers to

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30 submit certain information; requiring health care
31 facilities and health insurers to provide certain
32 information quarterly; deleting an onsite inspection
33 authorization requirement; amending s. 408.062, F.S.;
34 requiring the agency to conduct certain health care costs
35 and access research, analyses, and studies; expanding the
36 scope of such studies to include use of emergency
37 departments and Internet patient charge information
38 availability; requiring a report; requiring the agency to
39 conduct additional data-based studies and make
40 recommendations to the Legislature; amending s. 408.7056,
41 F.S.; renaming the Statewide Provider and Subscriber
42 Assistance Program as the Subscriber Assistance Program;
43 revising provisions to conform; expanding certain records
44 availability provisions; revising membership provisions
45 relating to a subscriber grievance hearing panel;
46 providing hearing procedures; amending s. 641.3154, F.S.,
47 to conform to the renaming of the Subscriber Assistance
48 Program; amending s. 641.511, F.S., to conform to the
49 renaming of the Subscriber Assistance Program; adopting
50 and incorporating by reference the Employee Retirement
51 Income Security Act of 1974, as implemented by federal
52 regulations; amending s. 641.58, F.S., to conform to the
53 renaming of the Subscriber Assistance Program; amending s.
54 408.909, F.S.; expanding a definition of "health flex plan
55 entity" to include public-private partnerships; making a
56 pilot health flex plan program apply permanently
57 statewide; providing additional program requirements;
58 creating s. 408.919, F.S.; creating the Statewide

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59 Electronic Medical Records Advisory Council for certain
60 purposes; requiring the agency to provide staff support;
61 authorizing the agency to contract to assist the council
62 in creating an electronic medical records system;
63 providing for appointment of council members and meetings;
64 providing responsibilities of the council; requiring an
65 annual status report to the Governor and Legislature;
66 specifying service without compensation; providing for per
67 diem and travel expenses; providing for future repeal;
68 creating the Statewide Evidenced-based Medicine Panel for
69 certain purposes; requiring the Agency for Health Care
70 Administration to provide staff support; authorizing the
71 agency to contract to assist the panel in creating a
72 statewide evidence-based medicine program; providing for
73 appointment of panel members and meetings; providing
74 responsibilities of the panel; requiring an annual status
75 report to the Governor and Legislature; specifying service
76 without compensation; providing for per diem and travel
77 expenses; providing for future abolition of the panel;
78 amending s. 409.91255, F.S.; expanding assistance to
79 certain health centers to include urgent care services;
80 amending s. 627.410, F.S.; requiring insurers to file
81 certain rates with the Office of Insurance Regulation;
82 amending s. 627.6487, F.S.; revising a definition;
83 creating s. 627.64872, F.S.; providing legislative intent;
84 creating the Florida Health Insurance Plan for certain
85 purposes; providing definitions; providing requirements
86 for operation of the plan; providing for a board of
87 directors; providing for appointment of members; providing

88 for terms; specifying service without compensation;
89 providing for travel and per diem expenses; requiring a
90 plan of operation; providing requirements; providing for
91 powers of the plan; requiring reports to the Governor and
92 Legislature; providing certain immunity from liability for
93 plan obligations; authorizing the board to provide for
94 indemnification of certain costs; requiring an annually
95 audited financial statement; providing for eligibility for
96 coverage under the plan; providing criteria; requirements,
97 and limitations; specifying certain activity as an unfair
98 trade practice; providing for a plan administrator;
99 providing criteria; providing requirements; providing term
100 limits for the plan administrator; providing duties;
101 providing for paying the administrator; providing for
102 funding mechanisms of the plan; specifying benefits under
103 the plan; providing criteria, requirements, and
104 limitations; providing for nonduplication of benefits;
105 providing for annual and maximum lifetime benefits;
106 providing for tax exempt status; providing for abolition
107 of the Florida Comprehensive Health Association upon
108 implementation of the plan; providing for enrollment in
109 the plan of persons enrolled in the association; requiring
110 insurers to pay certain assessments to the board for
111 certain purposes; providing criteria, requirements, and
112 limitations for such assessments; providing for repeal of
113 ss. 627.6488, 627.6489, 627.649, 627.6492, 627.6494,
114 627.6496, 627.6498, and 627.6499, F.S., relating to the
115 Florida Comprehensive Health Association, upon
116 implementation of the plan; amending s. 627.662, F.S.;

117 providing for application of certain claim payment
118 methodologies to certain types of insurance; amending s.
119 627.6699, F.S.; revising provisions requiring small
120 employer carriers to offer certain health benefit plans;
121 requiring small employer carriers to file and provide
122 coverage under certain high deductible plans; including
123 high deductible plans under certain required plan
124 provisions; creating the Small Employers Access Program;
125 providing legislative intent; providing definitions;
126 providing participation eligibility requirements and
127 criteria; requiring the Office of Insurance Regulation to
128 administer the program by selecting an insurer through
129 competitive bidding; providing requirements; specifying
130 insurer qualifications; providing duties of the insurer;
131 providing a contract term; providing insurer reporting
132 requirements; providing application requirements;
133 providing for benefits under the program; requiring the
134 office to annually report to the Governor and Legislature;
135 authorizing health insurers to require higher copayments
136 for certain uses of emergency departments; amending s.
137 627.9175, F.S.; requiring certain health insurers to
138 annually report certain coverage information to the
139 office; providing requirements; deleting certain reporting
140 requirements; amending s. 636.003, F.S.; revising the
141 definition of "prepaid limited health service
142 organization" to exclude provision of discounted medical
143 service programs; creating ss. 627.6410 and 627.66912,
144 F.S.; requiring certain insurers to provide for additional
145 coverage for certain additional disorders; providing for

146 additional premiums; providing limitations and exceptions;
147 amending s. 641.31, F.S.; providing for application of
148 certain claim payment methodologies to certain types of
149 insurance; requiring health maintenance contracts to
150 provide for additional coverage for certain additional
151 disorders; providing for additional premiums; providing
152 limitations and exceptions; amending s. 626.015, F.S.;
153 defining insurance advisor; amending ss. 626.016, 626.342,
154 626.536, 626.561, 626.572, and 626.601, F.S., to include
155 application of such provisions to insurance advisors;
156 providing penalties; amending ss. 626.171, 626.191, and
157 626.201, F.S.; clarifying certain application
158 requirements; amending s. 626.6115, F.S.; providing
159 additional grounds for adverse actions against insurance
160 agency licensure; amending ss. 624.509, 626.7845, 626.292,
161 and 626.321, F.S.; correcting cross references; preserving
162 certain rights to enrollment in certain health benefit
163 coverage for certain groups under certain circumstances;
164 repealing s. 408.02, F.S., relating to the development,
165 endorsement, implementation, and evaluation of patient
166 management practice parameters by the Agency for Health
167 Care Administration; providing appropriations; providing
168 an effective date.
169
170 WHEREAS, according to the Kaiser Family Foundation, eight
171 out of ten uninsured Americans are workers or dependents of
172 workers and nearly eight out of ten uninsured Americans have
173 family incomes above the poverty level, and
174 WHEREAS, fifty-five percent of those who do not have

175 insurance state the reason they don't have insurance is lack of
176 affordability, and
177 WHEREAS, average health insurance premium increases for the
178 last two years have been in the range of ten to twenty percent
179 for Florida's employers, and
180 WHEREAS, an increasing number of employers are opting to
181 cease providing insurance coverage to their employees due to the
182 high cost, and
183 WHEREAS, an increasing number of employers who continue
184 providing coverage are forced to shift more premium cost to
185 their employees, thus diminishing the value of employee wage
186 increases, and
187 WHEREAS, according to studies, the rate of avoidable
188 hospitalization is fifty to seventy percent lower for the
189 insured versus the uninsured, and
190 WHEREAS, according to Florida Cancer Registry data, the
191 uninsured have a seventy percent greater chance of a late
192 diagnosis, thus decreasing the chances of a positive health
193 outcome, and
194 WHEREAS, according to the Agency for Health Care
195 Administration's 2002 financial data, uncompensated care in
196 Florida's hospitals is growing at the rate of twelve to thirteen
197 percent per year, and, at $4.3 billion in 2001, this cost, when
198 shifted to Floridians who remain insured, is not sustainable,
199 and
200 WHEREAS, the Florida Legislature, through the creation of
201 Health Flex, has already identified the need for lower cost
202 alternatives, and
203 WHEREAS, it is of vital importance and in the best

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204 interests of the people of the State of Florida that the issue
205 of available, affordable health care insurance be addressed in a
206 cohesive and meaningful manner, and
207 WHEREAS, there is general recognition that the issues
208 surrounding the problem of access to affordable health insurance
209 are complicated and multifaceted, and
210 WHEREAS, on August 14, 2003, Speaker Johnnie Byrd created
211 the Select Committee on Affordable Health Care for Floridians
212 effort to address the issue of affordable and accessible
213 employment-based insurance, and
214 WHEREAS, the Select Committee on Affordable Health Care for
215 Floridians held public hearings with predetermined themes around
216 the state, specifically, in Orlando, Miami, Jacksonville, Tampa,
217 Pensacola, Boca Raton, and Tallahassee, from October through
218 November 2003 to effectively probe the operation of the private
219 insurance marketplace, to understand the health insurance market
220 trends, to learn from past policy initiatives, and to identify,
221 explore, and debate new ideas for change, and
222 WHEREAS, recommendations from the Select Committee on
223 Affordable Health Care were adopted on February 4, 2004, to
224 address the multifaceted issues attributed to the increase in
225 health care cost, and
226 WHEREAS, these recommendations were presented to the
227 Speaker of the House of Representatives in a final report from
228 the committee on February 18, 2004, and subsequent legislation
229 was drafted creating the "The 2004 Affordable Health Care for
230 Floridians Act," NOW, THEREFORE,
231
232 Be It Enacted by the Legislature of the State of Florida:

233

234 Section 1. This act may be referred to by the popular name
235 "The 2004 Affordable Health Care for Floridians Act."
236 Section 2. The purpose of this act is to address the
237 underlying cause of the double-digit increases in health
238 insurance premiums by mitigating the overall growth in health
239 care costs.
240 Section 3. Paragraph (c) of subsection (4) and subsection
241 (6) of section 381.026, Florida Statutes, are amended to read:
242 381.026 Florida Patient's Bill of Rights and
243 Responsibilities.--
244 (4) RIGHTS OF PATIENTS.--Each health care facility or
245 provider shall observe the following standards:
246 (c) Financial information and disclosure.--
247 1. A patient has the right to be given, upon request, by
248 the responsible provider, his or her designee, or a
249 representative of the health care facility full information and
250 necessary counseling on the availability of known financial
251 resources for the patient's health care.
252 2. A health care provider or a health care facility shall,
253 upon request, disclose to each patient who is eligible for
254 Medicare, in advance of treatment, whether the health care
255 provider or the health care facility in which the patient is
256 receiving medical services accepts assignment under Medicare
257 reimbursement as payment in full for medical services and
258 treatment rendered in the health care provider's office or
259 health care facility.
260 3. A health care provider or a health care facility shall,
261 upon request, furnish a patient, prior to provision of medical

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262 services, a reasonable estimate of charges for such services.
263 Such reasonable estimate shall not preclude the health care
264 provider or health care facility from exceeding the estimate or
265 making additional charges based on changes in the patient's
266 condition or treatment needs.
267 4. Each licensed facility not operated by the state shall
268 make available to the public on its Internet website or by other
269 electronic means package prices for each of the top 50 most
270 utilized elective inpatient and outpatient procedures. The
271 package pricing shall include all hospital-related services, and
272 shall include separate estimates of costs for professional fees
273 charged by independent contractor physicians or physician
274 groups. The licensed facilities shall also make available to the
275 public on its Internet website or by other electronic means each
276 of the top 50 most utilized inpatient and outpatient procedures.
277 Such list shall be updated quarterly. The facility shall place a
278 notice in the reception areas that such information is available
279 electronically and the website address. The licensed facility
280 may indicate that the package pricing is based on a compilation
281 of charges for the average patient and that each patient's bill
282 may vary from the average depending upon the severity of illness
283 and individual resources consumed. The licensed facility may
284 also indicate that the package pricing is negotiable based upon
285 the patient's health plan and the ability to pay. The agency
286 shall develop rules for implementation of a uniform mechanism
287 for reporting this information on the facility's website.
288 5.~~4.~~ A patient has the right to receive a copy of an
289 itemized bill upon request. A patient has a right to be given an
290 explanation of charges upon request.

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291 (6) SUMMARY OF RIGHTS AND RESPONSIBILITIES.--Any health
292 care provider who treats a patient in an office or any health
293 care facility licensed under chapter 395 that provides emergency
294 services and care or outpatient services and care to a patient,
295 or admits and treats a patient, shall adopt and make available
296 to the patient, in writing, a statement of the rights and
297 responsibilities of patients, including the following:
298
299 SUMMARY OF THE FLORIDA PATIENT'S BILL
300 OF RIGHTS AND RESPONSIBILITIES
301
302 Florida law requires that your health care provider or
303 health care facility recognize your rights while you are
304 receiving medical care and that you respect the health care
305 provider's or health care facility's right to expect certain
306 behavior on the part of patients. You may request a copy of the
307 full text of this law from your health care provider or health
308 care facility. A summary of your rights and responsibilities
309 follows:
310 A patient has the right to be treated with courtesy and
311 respect, with appreciation of his or her individual dignity, and
312 with protection of his or her need for privacy.
313 A patient has the right to a prompt and reasonable response
314 to questions and requests.
315 A patient has the right to know who is providing medical
316 services and who is responsible for his or her care.
317 A patient has the right to know what patient support
318 services are available, including whether an interpreter is
319 available if he or she does not speak English.

320 A patient has the right to know what rules and regulations
321 apply to his or her conduct.
322 A patient has the right to be given by the health care
323 provider information concerning diagnosis, planned course of
324 treatment, alternatives, risks, and prognosis.
325 A patient has the right to refuse any treatment, except as
326 otherwise provided by law.
327 A patient has the right to be given, upon request, full
328 information and necessary counseling on the availability of
329 known financial resources for his or her care.
330 A patient who is eligible for Medicare has the right to
331 know, upon request and in advance of treatment, whether the
332 health care provider or health care facility accepts the
333 Medicare assignment rate.
334 A patient has the right to receive, upon request, prior to
335 treatment, a reasonable estimate of charges for medical care.
336 A patient has the right to receive, upon request, prior to
337 treatment, a reasonable estimate of charges for proposed
338 service.
339 A patient has the right to receive a copy of a reasonably
340 clear and understandable, itemized bill and, upon request, to
341 have the charges explained.
342 A patient has the right to impartial access to medical
343 treatment or accommodations, regardless of race, national
344 origin, religion, handicap, or source of payment.
345 A patient has the right to treatment for any emergency
346 medical condition that will deteriorate from failure to provide
347 treatment.

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348 A patient has the right to know if medical treatment is for
349 purposes of experimental research and to give his or her consent
350 or refusal to participate in such experimental research.
351 A patient has the right to express grievances regarding any
352 violation of his or her rights, as stated in Florida law,
353 through the grievance procedure of the health care provider or
354 health care facility which served him or her and to the
355 appropriate state licensing agency.
356 A patient is responsible for providing to the health care
357 provider, to the best of his or her knowledge, accurate and
358 complete information about present complaints, past illnesses,
359 hospitalizations, medications, and other matters relating to his
360 or her health.
361 A patient is responsible for reporting unexpected changes
362 in his or her condition to the health care provider.
363 A patient is responsible for reporting to the health care
364 provider whether he or she comprehends a contemplated course of
365 action and what is expected of him or her.
366 A patient is responsible for following the treatment plan
367 recommended by the health care provider.
368 A patient is responsible for keeping appointments and, when
369 he or she is unable to do so for any reason, for notifying the
370 health care provider or health care facility.
371 A patient is responsible for his or her actions if he or
372 she refuses treatment or does not follow the health care
373 provider's instructions.
374 A patient is responsible for assuring that the financial
375 obligations of his or her health care are fulfilled as promptly
376 as possible.

377 A patient is responsible for following health care facility
378 rules and regulations affecting patient care and conduct.
379 Section 4. Subsection (1) and paragraph (g) of subsection
380 (3) of section 381.734, Florida Statutes, are amended, and
381 subsections (4), (5), and (6) are added to said section, to
382 read:
383 381.734 Healthy Communities, Healthy People Program.--
384 (1) The department shall develop and implement the Healthy
385 Communities, Healthy People Program, a comprehensive and
386 community-based health promotion and wellness program. The
387 program shall be designed to reduce major behavioral risk
388 factors associated with chronic diseases, including those
389 chronic diseases identified in chapter 385, by enhancing the
390 knowledge, skills, motivation, and opportunities for
391 individuals, organizations, health care providers, small
392 businesses, health insurers, and communities to develop and
393 maintain healthy lifestyles.
394 (3) The program shall include:
395 (g) The establishment of a comprehensive program to inform
396 the public, health care professionals, health insurers, and
397 communities about the prevalence of chronic diseases in the
398 state; known and potential risks, including social and
399 behavioral risks; and behavior changes that would reduce risks.
400 (4) The department shall make available on its Internet
401 website, no later than October 1, 2004, and in a hard-copy
402 format upon request, a listing of age-specific, disease-
403 specific, and community-specific health promotion, preventive
404 care, and wellness programs offered and established under the
405 Healthy Communities, Health People Program. The website shall

406 also provide residents with information to identify behavior
407 risk factors that lead to preventable diseases by maintaining a
408 healthy lifestyle. The website shall allow consumers to select
409 by county or region disease-specific statistical information.
410 (5) The department shall monitor and assess the
411 effectiveness of such programs. The department shall submit a
412 status report based on this monitoring and assessment to the
413 Governor, the Speaker of the House of Representatives, the
414 President of the Senate, and the substantive legislative
415 committees of each house of the Legislature, with the first
416 annual report due January 31, 2005.
417 (6) The Auditor General's office shall investigate and
418 report to the President of the Senate and the Speaker of the
419 House of Representatives, by February 15, 2005, on the
420 effectiveness of such programs.
421 Section 5. Subsection (7) is added to section 395.1041,
422 Florida Statutes, to read:
423 395.1041 Access to emergency services and care.--
424 (7) Hospitals may develop emergency room diversion
425 programs, including, but not limited to, an "Emergency Hotline"
426 which allows patients to help determine if emergency department
427 services are appropriate or if other health care settings may be
428 more appropriate for care, and a "Fast Track" program allowing
429 nonemergency patients to be treated at an alternative site.
430 Alternative sites may include health care programs funded with
431 local tax revenue and federally funded community health centers,
432 county health departments, or other nonhospital providers of
433 health care services.

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434 Section 6. Subsections (7) and (8) are added to section
435 395.301, Florida Statutes, to read:
436 395.301 Itemized patient bill; form and content prescribed
437 by the agency.--
438 (7) Each licensed facility not operated by the state shall
439 make available to the public on its Internet website or by other
440 electronic means package prices and the Medicare reimbursement
441 rate for each of the top 50 most used elective inpatient and
442 outpatient procedures. The package pricing shall include all
443 hospital-related services and shall include separate estimates
444 of costs for professional fees charged by independent contractor
445 physicians or physician groups. The licensed facilities shall
446 also make available to the public on its Internet website or by
447 other electronic means the top 50 most used procedures in both
448 inpatient and outpatient settings. The list shall be updated
449 quarterly. The facility shall place a notice in reception areas
450 that such information is available electronically and the
451 website address. The licensed facility may indicate that the
452 package pricing is based on a compilation of charges for the
453 average patient and that each patient's bill may vary from the
454 average depending upon the severity of illness and individual
455 resources consumed. The licensed facility may also indicate that
456 the package pricing is negotiable based upon the patient's
457 health plan and the ability to pay. The agency shall develop
458 rules for implementation of a uniform mechanism for reporting
459 this information on the facility's website.
460 (8) Each licensed facility not operated by the state
461 shall, upon request of a prospective patient prior to the
462 provision of medical services, provide a reasonable estimate of

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463 charges for the proposed service. Such estimate shall not
464 preclude the actual charges from exceeding the estimate based on
465 changes in the patient's medical condition or the treatment
466 needs of the patient as determined by the attending and
467 consulting physicians.
468 Section 7. Subsection (1) of section 408.061, Florida
469 Statutes, is amended to read:
470 408.061 Data collection; uniform systems of financial
471 reporting; information relating to physician charges;
472 confidential information; immunity.--
473 (1) The agency shall ~~may~~ require the submission by health
474 care facilities, health care providers, and health insurers of
475 data necessary to carry out the agency's duties. Specifications
476 for data to be collected under this section shall be developed
477 by the agency with the assistance of technical advisory panels
478 including representatives of affected entities, consumers,
479 purchasers, and such other interested parties as may be
480 determined by the agency.
481 (a) Data shall ~~to~~ be submitted by health care facilities
482 quarterly for each preceding calendar quarter no later than
483 February 1, May 1, August 1, and November 1 of each year
484 commencing August 1, 2004. Such data shall ~~may~~ include, but are
485 not limited to: case-mix data, patient admission and ~~or~~
486 discharge data, outpatient data which shall include the number
487 of patients treated in the emergency department of a licensed
488 hospital reported by patient acuity level, morbidity rates, and
489 mortality rates for the top 50 diagnoses which are risk
490 adjusted, with patient and provider-specific identifiers
491 included, actual charge data by diagnostic groups, financial

492 data, accounting data, operating expenses, expenses incurred for
493 rendering services to patients who cannot or do not pay,
494 interest charges, depreciation expenses based on the expected
495 useful life of the property and equipment involved, and
496 demographic data. Data may be obtained from documents such as,
497 but not limited to: leases, contracts, debt instruments,
498 itemized patient bills, medical record abstracts, and related
499 diagnostic information.
500 (b) Data to be submitted by health care providers may
501 include, but are not limited to: Medicare and Medicaid
502 participation, types of services offered to patients, amount of
503 revenue and expenses of the health care provider, and such other
504 data which are reasonably necessary to study utilization
505 patterns.
506 (c) Data shall ~~to~~ be electronically submitted by health
507 insurers quarterly for each preceding calendar quarter no later
508 than February 1, May 1, August 1, and November 1 of each year
509 commencing August 1, 2004. Such data shall ~~may~~ include, but are
510 not limited to: claims paid data aggregated by current
511 procedural terminology (CPT) code or service and provider,
512 premium, administration, and financial information.
513 (d) Data submission requirements of ~~required to be~~
514 ~~submitted by~~ health care facilities, health care providers, or
515 health insurers shall ~~not~~ include specific provider contract
516 reimbursement information. However, such specific provider
517 reimbursement data ~~shall be reasonably available for onsite~~
518 ~~inspection by the agency as is necessary to carry out the~~
519 ~~agency's regulatory duties. Any such data~~ obtained by the agency
520 as a result of specified reporting requirements ~~onsite~~

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521 ~~inspections~~ may not be used by the state for purposes of direct
522 provider contracting and are confidential and exempt from the
523 provisions of s. 119.07(1) and s. 24(a), Art. I of the State
524 Constitution.
525 (e) A requirement to submit data shall be adopted by rule
526 if the submission of data is being required of all members of
527 any type of health care facility, health care provider, or
528 health insurer. Rules are not required, however, for the
529 submission of data for a special study mandated by the
530 Legislature or when information is being requested for a single
531 health care facility, health care provider, or health insurer.
532 Section 8. Subsections (1) and (4) of section 408.062,
533 Florida Statutes, are amended to read:
534 408.062 Research, analyses, studies, and reports.--
535 (1) The agency shall ~~have the authority to~~ conduct
536 research, analyses, and studies relating to health care costs
537 and access to and quality of health care services as access and
538 quality are affected by changes in health care costs. Such
539 research, analyses, and studies shall include, but not be
540 limited to~~, research and analysis relating to~~:
541 (a) The financial status of any health care facility or
542 facilities subject to the provisions of this chapter.
543 (b) The impact of uncompensated charity care on health
544 care facilities and health care providers.
545 (c) The state's role in assisting to fund indigent care.
546 (d) In conjunction with the Office of Insurance
547 Regulation, the availability and affordability of health
548 insurance for small businesses.

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549 (e) Total health care expenditures in the state according
550 to the sources of payment and the type of expenditure.
551 (f) The quality of health services, using techniques such
552 as small area analysis, severity adjustments, and risk-adjusted
553 mortality rates.
554 (g) The development of physician payment systems which are
555 capable of taking into account the amount of resources consumed
556 and the outcomes produced in the delivery of care.
557 (h) The impact of subacute admissions on hospital revenues
558 and expenses for purposes of calculating adjusted admissions as
559 defined in s. 408.07.
560 (i) The utilization of emergency department services by
561 patient acuity level and the implication of increasing hospital
562 cost by providing nonurgent care in emergency departments. The
563 agency shall submit an annual report based on this monitoring
564 and assessment to the Governor, the Speaker of the House of
565 Representatives, the President of the Senate, and the
566 substantive legislative committees with the first annual report
567 due January 1, 2005.
568 (j) The making available on its Internet website no later
569 than October 1, 2004, and in a hard-copy format upon request, of
570 patient charge information by provider aggregated by claims data
571 submitted by insurers and performance outcome data collected
572 from health care facilities pursuant to s. 408.061(1)(a) and (d)
573 for not less than 100 inpatient and outpatient diagnostic and
574 therapeutic conditions and procedures and the volume of
575 inpatient and outpatient procedures by Medicare discharge
576 referral experience. The website shall also provide an
577 interactive search that allows consumers to view and compare the

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578 information for specific facilities, a map that allows consumers
579 to select a county or region, definitions of all of the data,
580 descriptions of each procedure, and an explanation about why the
581 data may differ from facility to facility. Such public data
582 shall be updated quarterly. The agency shall submit an annual
583 report based on this monitoring and assessment to the Governor,
584 the Speaker of the House of Representatives, the President of
585 the Senate, and the substantive legislative committees with the
586 first annual report due January 1, 2005.
587 (4)(a) The agency shall ~~may~~ conduct data-based studies and
588 evaluations and make recommendations to the Legislature and the
589 Governor concerning exemptions, the effectiveness of limitations
590 of referrals, restrictions on investment interests and
591 compensation arrangements, and the effectiveness of public
592 disclosure. Such analysis shall ~~may~~ include, but need not be
593 limited to, utilization of services, cost of care, quality of
594 care, and access to care. The agency may require the submission
595 of data necessary to carry out this duty, which may include, but
596 need not be limited to, data concerning ownership, Medicare and
597 Medicaid, charity care, types of services offered to patients,
598 revenues and expenses, patient-encounter data, and other data
599 reasonably necessary to study utilization patterns and the
600 impact of health care provider ownership interests in health-
601 care-related entities on the cost, quality, and accessibility of
602 health care.
603 (b) The agency may collect such data from any health
604 facility or licensed health care provider as a special study.
605 Section 9. Section 408.7056, Florida Statutes, is amended
606 to read:

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607 408.7056 ~~Statewide Provider and~~ Subscriber Assistance
608 Program.--
609 (1) As used in this section, the term:
610 (a) "Agency" means the Agency for Health Care
611 Administration.
612 (b) "Department" means the Department of Financial
613 Services.
614 (c) "Grievance procedure" means an established set of
615 rules that specify a process for appeal of an organizational
616 decision.
617 (d) "Health care provider" or "provider" means a state-
618 licensed or state-authorized facility, a facility principally
619 supported by a local government or by funds from a charitable
620 organization that holds a current exemption from federal income
621 tax under s. 501(c)(3) of the Internal Revenue Code, a licensed
622 practitioner, a county health department established under part
623 I of chapter 154, a prescribed pediatric extended care center
624 defined in s. 400.902, a federally supported primary care
625 program such as a migrant health center or a community health
626 center authorized under s. 329 or s. 330 of the United States
627 Public Health Services Act that delivers health care services to
628 individuals, or a community facility that receives funds from
629 the state under the Community Alcohol, Drug Abuse, and Mental
630 Health Services Act and provides mental health services to
631 individuals.
632 (e) "Managed care entity" means a health maintenance
633 organization or a prepaid health clinic certified under chapter
634 641, a prepaid health plan authorized under s. 409.912, or an
635 exclusive provider organization certified under s. 627.6472.

636 (f) "Office" means the Office of Insurance Regulation of
637 the Financial Services Commission.
638 (g) "Panel" means a ~~statewide provider and~~ subscriber
639 assistance panel selected as provided in subsection (11).
640 (2) The agency shall adopt and implement a program to
641 provide assistance to subscribers ~~and providers~~, including those
642 whose grievances are not resolved by the managed care entity to
643 the satisfaction of the subscriber ~~or provider~~. The program
644 shall consist of one or more panels that meet as often as
645 necessary to timely review, consider, and hear grievances and
646 recommend to the agency or the office any actions that should be
647 taken concerning individual cases heard by the panel. The panel
648 shall hear every grievance filed by subscribers ~~and providers~~ on
649 behalf of subscribers, unless the grievance:
650 (a) Relates to a managed care entity's refusal to accept a
651 provider into its network of providers;
652 (b) Is part of an internal grievance in a Medicare managed
653 care entity or a reconsideration appeal through the Medicare
654 appeals process which does not involve a quality of care issue;
655 (c) Is related to a health plan not regulated by the state
656 such as an administrative services organization, third-party
657 administrator, or federal employee health benefit program;
658 (d) Is related to appeals by in-plan suppliers and
659 providers, unless related to quality of care provided by the
660 plan;
661 (e) Is part of a Medicaid fair hearing pursued under 42
662 C.F.R. ss. 431.220 et seq.;
663 (f) Is the basis for an action pending in state or federal
664 court;

665 (g) Is related to an appeal by nonparticipating providers,
666 unless related to the quality of care provided to a subscriber
667 by the managed care entity and the provider is involved in the
668 care provided to the subscriber;
669 (h) Was filed before the subscriber ~~or provider~~ completed
670 the entire internal grievance procedure of the managed care
671 entity, the managed care entity has complied with its timeframes
672 for completing the internal grievance procedure, and the
673 circumstances described in subsection (6) do not apply;
674 (i) Has been resolved to the satisfaction of the
675 subscriber ~~or provider~~ who filed the grievance, unless the
676 managed care entity's initial action is egregious or may be
677 indicative of a pattern of inappropriate behavior;
678 (j) Is limited to seeking damages for pain and suffering,
679 lost wages, or other incidental expenses, including accrued
680 interest on unpaid balances, court costs, and transportation
681 costs associated with a grievance procedure;
682 (k) Is limited to issues involving conduct of a health
683 care provider or facility, staff member, or employee of a
684 managed care entity which constitute grounds for disciplinary
685 action by the appropriate professional licensing board and is
686 not indicative of a pattern of inappropriate behavior, and the
687 agency, office, or department has reported these grievances to
688 the appropriate professional licensing board or to the health
689 facility regulation section of the agency for possible
690 investigation; or
691 (l) Is withdrawn by the subscriber ~~or provider~~. Failure of
692 the subscriber ~~or the provider~~ to attend the hearing shall be
693 considered a withdrawal of the grievance.

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694 (3) The agency shall review all grievances within 60 days
695 after receipt and make a determination whether the grievance
696 shall be heard. Once the agency notifies the panel, the
697 subscriber ~~or provider~~, and the managed care entity that a
698 grievance will be heard by the panel, the panel shall hear the
699 grievance either in the network area or by teleconference no
700 later than 120 days after the date the grievance was filed. The
701 agency shall notify the parties, in writing, by facsimile
702 transmission, or by phone, of the time and place of the hearing.
703 The panel may take testimony under oath, request certified
704 copies of documents, and take similar actions to collect
705 information and documentation that will assist the panel in
706 making findings of fact and a recommendation. The panel shall
707 issue a written recommendation, supported by findings of fact,
708 to the ~~provider or~~ subscriber, to the managed care entity, and
709 to the agency or the office no later than 15 working days after
710 hearing the grievance. If at the hearing the panel requests
711 additional documentation or additional records, the time for
712 issuing a recommendation is tolled until the information or
713 documentation requested has been provided to the panel. The
714 proceedings of the panel are not subject to chapter 120.
715 (4) If, upon receiving a proper patient authorization
716 along with a properly filed grievance, the agency requests
717 ~~medical~~ records from a health care provider or managed care
718 entity, the health care provider or managed care entity that has
719 custody of the records has 10 days to provide the records to the
720 agency. Records include medical records, communication logs
721 associated with the grievance both to and from the subscriber,
722 contracts, and any other contents of the internal grievance file

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723 associated with the complaint filed with the Subscriber
724 Assistance Program. Failure to provide requested ~~medical~~ records
725 may result in the imposition of a fine of up to $500. Each day
726 that records are not produced is considered a separate
727 violation.
728 (5) Grievances that the agency determines pose an
729 immediate and serious threat to a subscriber's health must be
730 given priority over other grievances. The panel may meet at the
731 call of the chair to hear the grievances as quickly as possible
732 but no later than 45 days after the date the grievance is filed,
733 unless the panel receives a waiver of the time requirement from
734 the subscriber. The panel shall issue a written recommendation,
735 supported by findings of fact, to the office or the agency
736 within 10 days after hearing the expedited grievance.
737 (6) When the agency determines that the life of a
738 subscriber is in imminent and emergent jeopardy, the chair of
739 the panel may convene an emergency hearing, within 24 hours
740 after notification to the managed care entity and to the
741 subscriber, to hear the grievance. The grievance must be heard
742 notwithstanding that the subscriber has not completed the
743 internal grievance procedure of the managed care entity. The
744 panel shall, upon hearing the grievance, issue a written
745 emergency recommendation, supported by findings of fact, to the
746 managed care entity, to the subscriber, and to the agency or the
747 office for the purpose of deferring the imminent and emergent
748 jeopardy to the subscriber's life. Within 24 hours after receipt
749 of the panel's emergency recommendation, the agency or office
750 may issue an emergency order to the managed care entity. An
751 emergency order remains in force until:

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752 (a) The grievance has been resolved by the managed care
753 entity;
754 (b) Medical intervention is no longer necessary; or
755 (c) The panel has conducted a full hearing under
756 subsection (3) and issued a recommendation to the agency or the
757 office, and the agency or office has issued a final order.
758 (7) After hearing a grievance, the panel shall make a
759 recommendation to the agency or the office which may include
760 specific actions the managed care entity must take to comply
761 with state laws or rules regulating managed care entities.
762 (8) A managed care entity, subscriber, or provider that is
763 affected by a panel recommendation may within 10 days after
764 receipt of the panel's recommendation, or 72 hours after receipt
765 of a recommendation in an expedited grievance, furnish to the
766 agency or office written evidence in opposition to the
767 recommendation or findings of fact of the panel.
768 (9) No later than 30 days after the issuance of the
769 panel's recommendation and, for an expedited grievance, no later
770 than 10 days after the issuance of the panel's recommendation,
771 the agency or the office may adopt the panel's recommendation or
772 findings of fact in a proposed order or an emergency order, as
773 provided in chapter 120, which it shall issue to the managed
774 care entity. The agency or office may issue a proposed order or
775 an emergency order, as provided in chapter 120, imposing fines
776 or sanctions, including those contained in ss. 641.25 and
777 641.52. The agency or the office may reject all or part of the
778 panel's recommendation. All fines collected under this
779 subsection must be deposited into the Health Care Trust Fund.

780 (10) In determining any fine or sanction to be imposed,
781 the agency and the office may consider the following factors:
782 (a) The severity of the noncompliance, including the
783 probability that death or serious harm to the health or safety
784 of the subscriber will result or has resulted, the severity of
785 the actual or potential harm, and the extent to which provisions
786 of chapter 641 were violated.
787 (b) Actions taken by the managed care entity to resolve or
788 remedy any quality-of-care grievance.
789 (c) Any previous incidents of noncompliance by the managed
790 care entity.
791 (d) Any other relevant factors the agency or office
792 considers appropriate in a particular grievance.
793 (11)(a) The panel shall consist of the Insurance Consumer
794 Advocate, or designee thereof, established by s. 627.0613; at
795 least two members employed by the agency and at least two
796 members employed by the department, chosen by their respective
797 agencies; a consumer appointed by the Governor; a physician
798 appointed by the Governor, as a standing member; and, if
799 necessary, physicians who have expertise relevant to the case to
800 be heard, on a rotating basis. The agency may contract with a
801 medical director, ~~and~~ a primary care physician, or both, who
802 shall provide additional technical expertise to the panel but
803 shall not be voting members of the panel. The medical director
804 shall be selected from a health maintenance organization with a
805 current certificate of authority to operate in Florida.
806 (b) A majority of those panel members required under
807 paragraph (a) shall constitute a quorum for any meeting or
808 hearing of the panel. A grievance may not be heard or voted upon

809 at any panel meeting or hearing unless a quorum is present,
810 except that a minority of the panel may adjourn a meeting or
811 hearing until a quorum is present. A panel convened for the
812 purpose of hearing a subscriber's grievance in accordance with
813 subsections (2) and (3) shall not consist of more than 11
814 members.
815 (12) Every managed care entity shall submit a quarterly
816 report to the agency, the office, and the department listing the
817 number and the nature of all subscribers' and providers'
818 grievances which have not been resolved to the satisfaction of
819 the subscriber or provider after the subscriber or provider
820 follows the entire internal grievance procedure of the managed
821 care entity. The agency shall notify all subscribers and
822 providers included in the quarterly reports of their right to
823 file an unresolved grievance with the panel.
824 (13) A proposed order issued by the agency or office which
825 only requires the managed care entity to take a specific action
826 under subsection (7) is subject to a summary hearing in
827 accordance with s. 120.574, unless all of the parties agree
828 otherwise. If the managed care entity does not prevail at the
829 hearing, the managed care entity must pay reasonable costs and
830 attorney's fees of the agency or the office incurred in that
831 proceeding.
832 (14)(a) Any information that identifies a subscriber which
833 is held by the panel, agency, or department pursuant to this
834 section is confidential and exempt from the provisions of s.
835 119.07(1) and s. 24(a), Art. I of the State Constitution.
836 However, at the request of a subscriber or managed care entity
837 involved in a grievance procedure, the panel, agency, or

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838 department shall release information identifying the subscriber
839 involved in the grievance procedure to the requesting subscriber
840 or managed care entity.
841 (b) Meetings of the panel shall be open to the public
842 unless the provider or subscriber whose grievance will be heard
843 requests a closed meeting or the agency or the department
844 determines that information which discloses the subscriber's
845 medical treatment or history or information relating to internal
846 risk management programs as defined in s. 641.55(5)(c), (6), and
847 (8) may be revealed at the panel meeting, in which case that
848 portion of the meeting during which a subscriber's medical
849 treatment or history or internal risk management program
850 information is discussed shall be exempt from the provisions of
851 s. 286.011 and s. 24(b), Art. I of the State Constitution. All
852 closed meetings shall be recorded by a certified court reporter.
853 Section 10. Paragraph (c) of subsection (4) of section
854 641.3154, Florida Statutes, is amended to read:
855 641.3154 Organization liability; provider billing
856 prohibited.--
857 (4) A provider or any representative of a provider,
858 regardless of whether the provider is under contract with the
859 health maintenance organization, may not collect or attempt to
860 collect money from, maintain any action at law against, or
861 report to a credit agency a subscriber of an organization for
862 payment of services for which the organization is liable, if the
863 provider in good faith knows or should know that the
864 organization is liable. This prohibition applies during the
865 pendency of any claim for payment made by the provider to the
866 organization for payment of the services and any legal

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867 proceedings or dispute resolution process to determine whether
868 the organization is liable for the services if the provider is
869 informed that the ~~such~~ proceedings are taking place. It is
870 presumed that a provider does not know and should not know that
871 an organization is liable unless:
872 (c) The office or agency makes a final determination that
873 the organization is required to pay for such services subsequent
874 to a recommendation made by the ~~Statewide Provider and~~
875 Subscriber Assistance Panel pursuant to s. 408.7056; or
876 Section 11. Subsection (1), paragraphs (b) and (e) of
877 subsection (3), paragraph (d) of subsection (4), subsection (5),
878 paragraph (g) of subsection (6), and subsections (9), (10), and
879 (11) of section 641.511, Florida Statutes, are amended to read:
880 641.511 Subscriber grievance reporting and resolution
881 requirements.--
882 (1) Every organization must have a grievance procedure
883 available to its subscribers for the purpose of addressing
884 complaints and grievances. Every organization must notify its
885 subscribers that a subscriber must submit a grievance within 1
886 year after the date of occurrence of the action that initiated
887 the grievance, and may submit the grievance for review to the
888 ~~Statewide Provider and~~ Subscriber Assistance Program panel as
889 provided in s. 408.7056 after receiving a final disposition of
890 the grievance through the organization's grievance process. An
891 organization shall maintain records of all grievances and shall
892 report annually to the agency the total number of grievances
893 handled, a categorization of the cases underlying the
894 grievances, and the final disposition of the grievances.

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895 (3) Each organization's grievance procedure, as required
896 under subsection (1), must include, at a minimum:
897 (b) The names of the appropriate employees or a list of
898 grievance departments that are responsible for implementing the
899 organization's grievance procedure. The list must include the
900 address and the toll-free telephone number of each grievance
901 department, the address of the agency and its toll-free
902 telephone hotline number, and the address of the ~~Statewide~~
903 ~~Provider and~~ Subscriber Assistance Program and its toll-free
904 telephone number.
905 (e) A notice that a subscriber may voluntarily pursue
906 binding arbitration in accordance with the terms of the contract
907 if offered by the organization, after completing the
908 organization's grievance procedure and as an alternative to the
909 ~~Statewide Provider and~~ Subscriber Assistance Program. Such
910 notice shall include an explanation that the subscriber may
911 incur some costs if the subscriber pursues binding arbitration,
912 depending upon the terms of the subscriber's contract.
913 (4)
914 (d) In any case when the review process does not resolve a
915 difference of opinion between the organization and the
916 subscriber or the provider acting on behalf of the subscriber,
917 the subscriber or the provider acting on behalf of the
918 subscriber may submit a written grievance to the ~~Statewide~~
919 ~~Provider and~~ Subscriber Assistance Program.
920 (5) Except as provided in subsection (6), the organization
921 shall resolve a grievance within 60 days after receipt of the
922 grievance, or within a maximum of 90 days if the grievance
923 involves the collection of information outside the service area.

924 These time limitations are tolled if the organization has
925 notified the subscriber, in writing, that additional information
926 is required for proper review of the grievance and that such
927 time limitations are tolled until such information is provided.
928 After the organization receives the requested information, the
929 time allowed for completion of the grievance process resumes.
930 The Employee Retirement Income Security Act of 1974, as
931 implemented by 29 C.F.R. 2560.503-1, is adopted and incorporated
932 by reference as applicable to all organizations that administer
933 small and large group health plans that are subject to 29 C.F.R.
934 2560.503-1. The claims procedures of the regulations of the
935 Employee Retirement Income Security Act of 1974 as implemented
936 by 29 C.F.R. 2560.503-1 shall be the minimum standards for
937 grievance processes for claims for benefits for small and large
938 group health plans that are subject to 29 C.F.R. 2560.503-1.
939 (6)
940 (g) In any case when the expedited review process does not
941 resolve a difference of opinion between the organization and the
942 subscriber or the provider acting on behalf of the subscriber,
943 the subscriber or the provider acting on behalf of the
944 subscriber may submit a written grievance to the Statewide
945 Provider and Subscriber Assistance Program.
946 (9)(a) The agency shall advise subscribers with grievances
947 to follow their organization's formal grievance process for
948 resolution prior to review by the Statewide Provider and
949 Subscriber Assistance Program. The subscriber may, however,
950 submit a copy of the grievance to the agency at any time during
951 the process.

952 (b) Requiring completion of the organization's grievance
953 process before the ~~Statewide Provider and~~ Subscriber Assistance
954 Program panel's review does not preclude the agency from
955 investigating any complaint or grievance before the organization
956 makes its final determination.
957 (10) Each organization must notify the subscriber in a
958 final decision letter that the subscriber may request review of
959 the organization's decision concerning the grievance by the
960 ~~Statewide Provider and~~ Subscriber Assistance Program, as
961 provided in s. 408.7056, if the grievance is not resolved to the
962 satisfaction of the subscriber. The final decision letter must
963 inform the subscriber that the request for review must be made
964 within 365 days after receipt of the final decision letter, must
965 explain how to initiate such a review, and must include the
966 addresses and toll-free telephone numbers of the agency and the
967 ~~Statewide Provider and~~ Subscriber Assistance Program.
968 (11) Each organization, as part of its contract with any
969 provider, must require the provider to post a consumer
970 assistance notice prominently displayed in the reception area of
971 the provider and clearly noticeable by all patients. The
972 consumer assistance notice must state the addresses and toll-
973 free telephone numbers of the Agency for Health Care
974 Administration, the ~~Statewide Provider and~~ Subscriber Assistance
975 Program, and the Department of Financial Services. The consumer
976 assistance notice must also clearly state that the address and
977 toll-free telephone number of the organization's grievance
978 department shall be provided upon request. The agency may adopt
979 rules to implement this section.

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980 Section 12. Subsection (4) of section 641.58, Florida
981 Statutes, is amended to read:
982 641.58 Regulatory assessment; levy and amount; use of
983 funds; tax returns; penalty for failure to pay.--
984 (4) The moneys received and deposited into the Health Care
985 Trust Fund shall be used to defray the expenses of the agency in
986 the discharge of its administrative and regulatory powers and
987 duties under this part, including conducting an annual survey of
988 the satisfaction of members of health maintenance organizations;
989 contracting with physician consultants for the ~~Statewide~~
990 ~~Provider and~~ Subscriber Assistance Panel; maintaining offices
991 and necessary supplies, essential equipment, and other
992 materials, salaries and expenses of required personnel; and
993 discharging the administrative and regulatory powers and duties
994 imposed under this part.
995 Section 13. Paragraph (f) of subsection (2) and
996 subsections (3) and (9) of section 408.909, Florida Statutes,
997 are amended to read:
998 408.909 Health flex plans.--
999 (2) DEFINITIONS.--As used in this section, the term:
1000 (f) "Health flex plan entity" means a health insurer,
1001 health maintenance organization, health-care-provider-sponsored
1002 organization, local government, health care district, ~~or~~ other
1003 public or private community-based organization<u>, or public-</u>
1004 <u>private partnership</u> that develops and implements an approved
1005 health flex plan and is responsible for administering the health
1006 flex plan and paying all claims for health flex plan coverage by
1007 enrollees of the health flex plan.

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1008 (3) ~~PILOT~~ PROGRAM.--The agency and the office shall each
1009 approve or disapprove health flex plans that provide health care
1010 coverage for eligible participants ~~who reside in the three areas~~
1011 ~~of the state that have the highest number of uninsured persons,~~
1012 ~~as identified in the Florida Health Insurance Study conducted by~~
1013 ~~the agency and in Indian River County~~. A health flex plan may
1014 limit or exclude benefits otherwise required by law for insurers
1015 offering coverage in this state, may cap the total amount of
1016 claims paid per year per enrollee, may limit the number of
1017 enrollees, or may take any combination of those actions. A
1018 health flex plan offering may include the option of a
1019 catastrophic plan supplementing the health flex plan.
1020 (a) The agency shall develop guidelines for the review of
1021 applications for health flex plans and shall disapprove or
1022 withdraw approval of plans that do not meet or no longer meet
1023 minimum standards for quality of care and access to care. The
1024 agency shall ensure that the health flex plans follow
1025 standardized grievance procedures similar to those required of
1026 health maintenance organizations.
1027 (b) The office shall develop guidelines for the review of
1028 health flex plan applications and provide regulatory oversight
1029 of health flex plan advertisement and marketing procedures. The
1030 office shall disapprove or shall withdraw approval of plans
1031 that:
1032 1. Contain any ambiguous, inconsistent, or misleading
1033 provisions or any exceptions or conditions that deceptively
1034 affect or limit the benefits purported to be assumed in the
1035 general coverage provided by the health flex plan;

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1036 2. Provide benefits that are unreasonable in relation to
1037 the premium charged or contain provisions that are unfair or
1038 inequitable or contrary to the public policy of this state, that
1039 encourage misrepresentation, or that result in unfair
1040 discrimination in sales practices; or
1041 3. Cannot demonstrate that the health flex plan is
1042 financially sound and that the applicant is able to underwrite
1043 or finance the health care coverage provided.
1044 (c) The agency and the Financial Services Commission may
1045 adopt rules as needed to administer this section.
1046 (9) PROGRAM EVALUATION.--The agency and the office shall
1047 evaluate the pilot program and its effect on the entities that
1048 seek approval as health flex plans, on the number of enrollees,
1049 and on the scope of the health care coverage offered under a
1050 health flex plan; shall provide an assessment of the health flex
1051 plans and their potential applicability in other settings; shall
1052 use health flex plans to gather more information to evaluate
1053 low-income consumer driven benefit packages; and shall, by
1054 January 1, 2005 ~~2004~~, jointly submit a report to the Governor,
1055 the President of the Senate, and the Speaker of the House of
1056 Representatives.
1057 Section 14. Section 408.919, Florida Statutes, is created
1058 to read:
1059 408.919 Statewide Electronic Medical Records Advisory
1060 Council.--
1061 (1) There is hereby created a Statewide Electronic Medical
1062 Records Advisory Council to serve as a body of experts to guide
1063 the Agency for Health Care Administration in the development of
1064 policy related to electronic medical records and the technology

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1065 required for sharing clinical information among caregivers.
1066 (2) The agency shall provide staff support to the council
1067 and may enter into contracts as are necessary or proper to carry
1068 out the provisions and purposes of this act in assisting the
1069 advisory council in creating an electronic medical records
1070 system.
1071 (3) The advisory council shall be appointed by the
1072 Governor, the President of the Senate, and the Speaker of the
1073 House of Representatives. The advisory council shall consist of
1074 nine members, with three members appointed by the Governor,
1075 three members appointed by the President of the Senate, and
1076 three members appointed by the Speaker of the House of
1077 Representatives.
1078 (4) The council shall meet at least quarterly and advise
1079 the Governor, the Legislature, and the agency regarding:
1080 (a) Public and private sector initiatives related to
1081 electronic medical records and communication systems for the
1082 sharing of clinical information among caregivers.
1083 (b) Regulatory barriers that interfere with the sharing of
1084 clinical information among caregivers.
1085 (c) Investment incentives to promote the use of
1086 recommended technologies by health care providers.
1087 (d) Educational strategies to promote the use of
1088 recommended technologies by health care providers.
1089 (e) Standards for public access to facilitate transparency
1090 in pricing, costs, and quality.
1091 (5) By November 30, 2004, and annually thereafter, the
1092 advisory council shall provide to the Executive Office of the
1093 Governor, the Speaker of the House of Representatives, and the

1094 President of the Senate a status report to include any
1095 recommendations and an implementation plan to include, but not
1096 be limited to, estimated costs, capital investment requirements,
1097 recommended investment incentives, initial committed provider
1098 participation by region, standards of functionality and
1099 features, a marketing plan, and implementation schedules for key
1100 components.
1101 (6) Members of the advisory council shall serve without
1102 compensation but shall be entitled to receive reimbursement for
1103 per diem and travel expenses as provided in s. 112.061.
1104 (7) Unless otherwise reenacted by the Legislature, the
1105 advisory council is abolished effective July 1, 2007.
1106 Section 15. (1) The Statewide Evidence-based Medicine
1107 Panel is created to serve as a body of experts to guide the
1108 Agency for Health Care Administration and the Department of
1109 Health in the development of policy related to evidence-based
1110 medicine and the technology required for sharing information
1111 among caregivers.
1112 (2) The agency shall provide staff support to the panel
1113 and may enter into contracts as are necessary or proper to carry
1114 out the provisions and purposes of this section in assisting the
1115 panel in creating a statewide evidence-based medicine program.
1116 (3) The panel shall consist of nine members, with three
1117 members appointed by the Governor, three members appointed by
1118 the President of the Senate, and three members appointed by the
1119 Speaker of the House of Representatives.
1120 (4) The panel shall meet at least quarterly and advise the
1121 Governor, the President of the Senate, the Speaker of the House
1122 of Representatives, and the agency regarding:

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1123 (a) The ability to join or support efforts for the use of
1124 evidence-based medicine already underway, such as those of the
1125 Leapfrog Group, the international group Bandolier, and the
1126 Healthy Florida Foundation.
1127 (b) The means by which to promote university-based or
1128 medical-school-based research using Medicaid and other data
1129 collected by the Agency for Health Care Administration to
1130 identify and quantify the most cost-effective treatment and
1131 interventions, including disease management programs.
1132 (c) The means by which to encourage development of systems
1133 to measure and reward providers who implement evidence-based
1134 medical practices.
1135 (d) The evaluation and identification of ways to tie a
1136 health care provider's use of evidence-based medical practice to
1137 medical malpractice liability.
1138 (e) The review of other state and private initiatives and
1139 published literature for promising approaches and the
1140 dissemination of information about them to providers.
1141 (f) The encouragement of the Florida Medical Association
1142 and other health care associations to regularly publish findings
1143 related to the cost-effectiveness of disease-specific evidence-
1144 based standards.
1145 (g) Public and private sector initiatives related to
1146 evidence-based medicine and communication systems for the
1147 sharing of clinical information among caregivers.
1148 (h) Regulatory barriers that interfere with the sharing of
1149 clinical information among caregivers.
1150 (5) By November 30, 2004, and annually thereafter, the
1151 panel shall provide to the Office of the Governor, the Speaker

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1152 of the House of Representatives, and the President of the Senate
1153 a status report including any recommendations and an
1154 implementation plan to include, but not be limited to, estimated
1155 costs, capital investment requirements, recommended investment
1156 incentives, initial committed provider participation by region,
1157 standards of functionality and features, a marketing plan, and
1158 implementation schedules for key components.
1159 (6) Members of the panel shall serve without compensation
1160 but shall be entitled to receive reimbursement for per diem and
1161 travel expenses as provided in s. 112.061, Florida Statutes.
1162 (7) Unless otherwise reestablished by the Legislature, the
1163 panel is abolished effective July 1, 2007.
1164 Section 16. Subsection (3) of section 409.91255, Florida
1165 Statutes, is amended to read:
1166 409.91255 Federally qualified health center access
1167 program.--
1168 (3) ASSISTANCE TO FEDERALLY QUALIFIED HEALTH CENTERS.--The
1169 Department of Health shall develop a program for the expansion
1170 of federally qualified health centers for the purpose of
1171 providing comprehensive primary and preventive health care and
1172 urgent care services~~, including~~ services that may reduce the
1173 morbidity, mortality, and cost of care among the uninsured
1174 population of the state. The program shall provide for
1175 distribution of financial assistance to federally qualified
1176 health centers that apply and demonstrate a need for such
1177 assistance in order to sustain or expand the delivery of primary
1178 and preventive health care services. In selecting centers to
1179 receive this financial assistance, the program:

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1180 (a) Shall give preference to communities that have few or
1181 no community-based primary care services or in which the current
1182 services are unable to meet the community's needs.
1183 (b) Shall require that primary care services be provided
1184 to the medically indigent using a sliding fee schedule based on
1185 income.
1186 (c) Shall allow innovative and creative uses of federal,
1187 state, and local health care resources.
1188 (d) Shall require that the funds provided be used to pay
1189 for operating costs of a projected expansion in patient
1190 caseloads or services or for capital improvement projects.
1191 Capital improvement projects may include renovations to existing
1192 facilities or construction of new facilities, provided that an
1193 expansion in patient caseloads or services to a new patient
1194 population will occur as a result of the capital expenditures.
1195 The department shall include in its standard contract document a
1196 requirement that any state funds provided for the purchase of or
1197 improvements to real property are contingent upon the contractor
1198 granting to the state a security interest in the property at
1199 least to the amount of the state funds provided for at least 5
1200 years from the date of purchase or the completion of the
1201 improvements or as further required by law. The contract must
1202 include a provision that, as a condition of receipt of state
1203 funding for this purpose, the contractor agrees that, if it
1204 disposes of the property before the department's interest is
1205 vacated, the contractor will refund the proportionate share of
1206 the state's initial investment, as adjusted by depreciation.
1207 (e) May require in-kind support from other sources.

1208 (f) May encourage coordination among federally qualified
1209 health centers, other private-sector providers, and publicly
1210 supported programs.
1211 (g) Shall allow the development of community diversion
1212 programs in conjunction with local resources, providing extended
1213 hours of operation to urgent care patients.
1214 Section 17. Paragraph (a) of subsection (6) of section
1215 627.410, Florida Statutes, is amended to read:
1216 627.410 Filing, approval of forms.--
1217 (6)(a) An insurer shall not deliver or issue for delivery
1218 or renew in this state any health insurance policy form until it
1219 has filed with the office a copy of every applicable rating
1220 manual, rating schedule, change in rating manual, and change in
1221 rating schedule; if rating manuals and rating schedules are not
1222 applicable, the insurer must file with the office ~~order~~
1223 applicable premium rates and any change in applicable premium
1224 rates. This paragraph does not apply to group health insurance
1225 policies, effectuated and delivered in this state, insuring
1226 groups of 51 or more persons, except for Medicare supplement
1227 insurance, long-term care insurance, and any coverage under
1228 which the increase in claim costs over the lifetime of the
1229 contract due to advancing age or duration is prefunded in the
1230 premium.
1231 Section 18. Paragraph (b) of subsection (3) of section
1232 627.6487, Florida Statutes, is amended to read:
1233 627.6487 Guaranteed availability of individual health
1234 insurance coverage to eligible individuals.--
1235 (3) For the purposes of this section, the term "eligible
1236 individual" means an individual:

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1237 (b) Who is not eligible for coverage under:
1238 1. A group health plan, as defined in s. 2791 of the
1239 Public Health Service Act;
1240 2. A conversion policy or contract issued by an authorized
1241 insurer or health maintenance organization under s. 627.6675 or
1242 s. 641.3921, respectively, offered to an individual who is no
1243 longer eligible for coverage under either an insured or self-
1244 insured employer plan;
1245 3. Part A or part B of Title XVIII of the Social Security
1246 Act; ~~or~~
1247 4. A state plan under Title XIX of such act, or any
1248 successor program, and does not have other health insurance
1249 coverage; or
1250 5. The Florida Health Insurance Plan as specified in s.
1251 627.64872 and such plan is accepting new enrollment;
1252 Section 19. Section 627.64872, Florida Statutes, is
1253 created to read:
1254 627.64872 Uninsurable risk assumption plan.--
1255 (1) LEGISLATIVE INTENT; FLORIDA HEALTH INSURANCE PLAN.--
1256 (a) The Legislature recognizes that to secure a more
1257 stable and orderly health insurance market, the establishment of
1258 a plan to assume risks deemed uninsurable by the private
1259 marketplace is required.
1260 (b) The Florida Health Insurance Plan is created. The plan
1261 shall make coverage available to individuals who have no other
1262 option for similar coverage, at a premium that is commensurate
1263 with the risk and benefits provided, and with benefit designs
1264 that are reasonable in relation to the general market. While
1265 plan operations may include supplementary funding, the plan

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1266 shall fundamentally operate on sound actuarial principles, using
1267 basic insurance management techniques to ensure that the plan is
1268 run in an economical, cost-efficient, and sound manner,
1269 conserving plan resources to serve the maximum number of people
1270 possible in a sustainable fashion.
1271 (2) DEFINITIONS.--As used in this section:
1272 (a) "Board" means the board of directors of the plan.
1273 (b) "Governor" means the Governor of this state.
1274 (c) "Office" means the Office of Insurance Regulation of
1275 the Financial Services Commission.
1276 (d) "Dependent" means a resident spouse or resident
1277 unmarried child under the age of 19 years, a child who is a
1278 student under the age of 25 years and who is financially
1279 dependent upon the parent, or a child of any age who is disabled
1280 and dependent upon the parent.
1281 (e) "Director" means the director of the Office of
1282 Insurance Regulation.
1283 (f) "Health insurance" means any hospital or medical
1284 expense incurred policy, health maintenance organization
1285 subscriber contract pursuant to chapter 627 or chapter 641, or
1286 any other health care plan or arrangement that pays for or
1287 furnishes medical or health care services, whether by insurance
1288 or otherwise. The term does not include short term, accident,
1289 dental-only, vision-only, fixed indemnity, limited benefit, or
1290 credit insurance, coverage issued as a supplement to liability
1291 insurance, insurance arising out of a workers' compensation or
1292 similar law, automobile medical payment insurance, or insurance
1293 under which benefits are payable with or without regard to fault
1294 and which is statutorily required to be contained in any

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1295 liability insurance policy or equivalent selfinsurance.
1296 (g) "Implementation" means the enrollment of eligible
1297 individuals in the plan and provision of the benefits described
1298 in this section.
1299 (h) "Insurer" means any entity that provides health
1300 insurance in this state. For purposes of this section, insurer
1301 includes an insurance company with a valid certificate in
1302 accordance with chapter 624, a health maintenance organization
1303 with a valid certificate of authority in accordance with part I
1304 or part III of chapter 641, a prepaid health clinic authorized
1305 to transact business in this state pursuant to part II of
1306 chapter 641, multiple employer welfare arrangements authorized
1307 to transact business in this state pursuant to ss. 624.436-
1308 624.45, or a fraternal benefit society providing health benefits
1309 to its members as authorized pursuant to chapter 632.
1310 (i) "Medicare" means coverage under both Parts A and B of
1311 Title XVIII of the Social Security Act, 42 USC 1395 et seq., as
1312 amended.
1313 (j) "Medicaid" means coverage under Title XIX of the
1314 Social Security Act.
1315 (k) "Participating insurer" means any insurer providing
1316 health insurance to citizens of this state.
1317 (l) "Provider" means any physician, hospital, or other
1318 institution, organization, or person that furnishes health care
1319 services and is licensed or otherwise authorized to practice in
1320 the state.
1321 (m) "Plan" means the Florida Health Insurance Plan created
1322 in subsection (1).
1323 (n) "Plan of operation" means the articles, bylaws, and

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1324 operating rules and procedures adopted by the board pursuant to
1325 this section.
1326 (o) "Resident" means an individual who has been legally
1327 domiciled in this state for a period of at least 30 days.
1328 (3) BOARD OF DIRECTORS.--
1329 (a) The plan shall operate subject to the supervision and
1330 control of the board. The board shall consist of the director or
1331 his or her designated representative, who shall serve as a
1332 member of the board and shall be its chair, and an additional
1333 eight members, four of whom shall be appointed by the Governor,
1334 two of whom shall be appointed by the President of the Senate,
1335 and two of whom shall be appointed by the Speaker of the House
1336 of Representatives. A majority of the board shall be composed of
1337 individuals who are not representatives of insurers or health
1338 care providers.
1339 (b) The initial board members shall be appointed as
1340 follows: one-third of the members to serve a term of 2 years;
1341 one-third of the members to serve a term of 4 years; and one-
1342 third of the members to serve a term of 6 years. Subsequent
1343 board members shall serve for a term of 3 years. A board
1344 member's term shall continue until his or her successor is
1345 appointed.
1346 (c) Vacancies in the board shall be filled by the
1347 appointing authority, such authority being the Governor, the
1348 President of the Senate, or the Speaker of the House of
1349 Representatives. Board members may be removed by the appointing
1350 authority for cause.
1351 (d) The board shall conduct its first meeting by December
1352 1, 2004.

1353 (e) Members shall not be compensated in their capacity as
1354 board members but shall be reimbursed for reasonable expenses
1355 incurred in the necessary performance of their duties in
1356 accordance with s. 112.061.
1357 (f) The board shall submit to the Governor a plan of
1358 operation for the plan and any amendments thereto necessary or
1359 suitable to ensure the fair, reasonable, and equitable
1360 administration of the plan. The plan of operation shall ensure
1361 that the plan qualifies to apply for any available funding from
1362 the Federal Government that adds to the financial viability of
1363 the plan. The plan of operation shall become effective upon
1364 approval in writing by the Governor consistent with the date on
1365 which the coverage under this section must be made available. If
1366 the board fails to submit a suitable plan of operation within
1367 180 days after the appointment of the board of directors, or at
1368 any time thereafter fails to submit suitable amendments to the
1369 plan of operation, the office shall adopt such rules as are
1370 necessary or advisable to effectuate the provisions of this
1371 section. Such rules shall continue in force until modified by
1372 the office or superseded by a plan of operation submitted by the
1373 board and approved by the Governor.
1374 (4) PLAN OF OPERATION.--The plan of operation shall:
1375 (a) Establish procedures for operation of the plan.
1376 (b) Establish procedures for selecting an administrator in
1377 accordance with subsection (11).
1378 (c) Establish procedures to create a fund, under
1379 management of the board, for administrative expenses.
1380 (d) Establish procedures for the handling, accounting, and
1381 auditing of assets, moneys, and claims of the plan and the plan

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1382 administrator.

1383 (e) Develop and implement a program to publicize the
1384 existence of the plan, plan eligibility requirements, and
1385 procedures for enrollment and maintain public awareness of the
1386 plan.

1387 (f) Establish procedures under which applicants and
1388 participants may have grievances reviewed by a grievance
1389 committee appointed by the board. The grievances shall be
1390 reported to the board after completion of the review, with the
1391 committee's recommendation for grievance resolution. The board
1392 shall retain all written grievances regarding the plan for at
1393 least 3 years.

1394 (g) Provide for other matters as may be necessary and
1395 proper for the execution of the board's powers, duties, and
1396 obligations under this section.

1397 (5) POWERS OF THE PLAN.--The plan shall have the general
1398 powers and authority granted under the laws of this state to
1399 health insurers and, in addition thereto, the specific authority
1400 to:

1401 (a) Enter into such contracts as are necessary or proper
1402 to carry out the provisions and purposes of this section,
1403 including the authority, with the approval of the Governor, to
1404 enter into contracts with similar plans of other states for the
1405 joint performance of common administrative functions, or with
1406 persons or other organizations for the performance of
1407 administrative functions.

1408 (b) Take any legal actions necessary or proper to recover
1409 or collect assessments due the plan.

1410 (c) Take such legal action as is necessary to:

1411 1. Avoid payment of improper claims against the plan or
1412 the coverage provided by or through the plan;
1413 2. Recover any amounts erroneously or improperly paid by
1414 the plan;
1415 3. Recover any amounts paid by the plan as a result of
1416 mistake of fact or law; or
1417 4. Recover other amounts due the plan.
1418 (d) Establish, and modify as appropriate, rates, rate
1419 schedules, rate adjustments, expense allowances, agents'
1420 referral fees, claim reserve formulas, and any other actuarial
1421 functions appropriate to the operation of the plan. Rates and
1422 rate schedules may be adjusted for appropriate factors such as
1423 age, sex, and geographic variation in claim cost and shall take
1424 into consideration appropriate factors in accordance with
1425 established actuarial and underwriting practices.
1426 (e) Issue policies of insurance in accordance with the
1427 requirements of this section.
1428 (f) Appoint appropriate legal, actuarial, investment, and
1429 other committees as necessary to provide technical assistance in
1430 the operation of the plan and develop and educate its
1431 policyholders regarding health savings accounts, policy and
1432 contract design, and any other function within the authority of
1433 the plan.
1434 (g) Borrow money to effectuate the purposes of the plan.
1435 Any notes or other evidence of indebtedness of the plan not in
1436 default shall be legal investments for insurers and may be
1437 carried as admitted assets.
1438 (h) Employ and fix the compensation of employees.
1439 (i) Prepare and distribute certificate of eligibility

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1440 forms and enrollment instruction forms to insurance producers
1441 and to the general public.
1442 (j) Provide for reinsurance of risks incurred by the plan.
1443 (k) Provide for and employ cost-containment measures and
1444 requirements, including, but not limited to, preadmission
1445 screening, second surgical opinion, concurrent utilization
1446 review, and individual case management for the purpose of making
1447 the plan more cost-effective.
1448 (l) Design, use, contract, or otherwise arrange for the
1449 delivery of cost-effective health care services, including, but
1450 not limited to, establishing or contracting with preferred
1451 provider organizations, health maintenance organizations, and
1452 other limited network provider arrangements.
1453 (m) Adopt such bylaws, policies, and procedures as may be
1454 necessary or convenient for the implementation of this section
1455 and the operation of the plan.
1456 (6) ANNUAL REPORT.--No later than December 1, 2005, and
1457 annually thereafter, the board shall submit to the Governor, the
1458 President of the Senate, and the Speaker of the House of
1459 Representatives a report which includes an independent actuarial
1460 study to determine, including, but not be limited to:
1461 (a) The impact the creation of the plan has on the small
1462 group insurance market, specifically on the premiums paid by
1463 insureds. This shall include an estimate of the total
1464 anticipated aggregate savings for all small employers in the
1465 state.
1466 (b) The actual number of individuals covered at the
1467 current funding and benefit level, the projected number of
1468 individuals that may seek coverage in the forthcoming fiscal

1469 year, and the projected funding needed to cover anticipated
1470 increase or decrease in plan participation.
1471 (c) A recommendation as to the best source of funding for
1472 the anticipated deficits of the pool.
1473 (d) A summarization of the activities of the plan in the
1474 preceding calendar year, including the net written and earned
1475 premiums, plan enrollment, the expense of administration, and
1476 the paid and incurred losses.
1477 (e) A review of the operation of the plan as to whether
1478 the plan has met the intent of this section.
1479 (7) LIABILITY OF THE PLAN.--Neither the board nor its
1480 employees shall be liable for any obligations of the plan. No
1481 member or employee of the board shall be liable, and no cause of
1482 action of any nature may arise against a member or employee of
1483 the board, for any act or omission related to the performance of
1484 any powers and duties under this section, unless such act or
1485 omission constitutes willful or wanton misconduct. The board may
1486 provide in its bylaws or rules for indemnification of, and legal
1487 representation for, its members and employees.
1488 (8) AUDITED FINANCIAL STATEMENT.--No later than June 1
1489 following the close of each calendar year, the plan shall submit
1490 to the Governor an audited financial statement prepared in
1491 accordance with statutory accounting principles as adopted by
1492 the National Association of Insurance Commissioners.
1493 (9) ELIGIBILITY.--
1494 (a) Any individual person who is and continues to be a
1495 resident of this state shall be eligible for coverage under the
1496 plan if:
1497 1. Evidence is provided that the person received:

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1498 a. A notice of rejection or refusal to issue substantially
1499 similar insurance for health reasons by one insurer; or
1500 b. A refusal by an insurer to issue insurance except at a
1501 rate exceeding the plan rate.
1502
1503 A rejection or refusal by an insurer offering only stoploss,
1504 excess of loss, or reinsurance coverage with respect to the
1505 applicant shall not be sufficient evidence under this paragraph.
1506 2. The person is eligible for individual coverage in
1507 accordance with s. 627.6487.
1508 3. The person is enrolled in the Florida Comprehensive
1509 Health Association as of the date the plan is implemented.
1510 (b) The board may provide a list of medical or health
1511 conditions for which a person shall be eligible for coverage
1512 under the plan without applying for health insurance pursuant to
1513 paragraph (a). A person who can demonstrate the existence or
1514 history of any medical or health conditions on the list provided
1515 by the board shall not be required to provide the evidence
1516 specified in paragraph (a). The list shall be effective on the
1517 first day of the operation of the plan and may be amended as
1518 appropriate.
1519 (c) Each resident dependent of a person who is eligible
1520 for coverage under the plan shall also be eligible for such
1521 coverage.
1522 (d) A person shall not be eligible for coverage under the
1523 plan if:
1524 1. The person has or obtains health insurance coverage
1525 substantially similar to or more comprehensive than a plan
1526 policy, or would be eligible to obtain such coverage, unless a

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1527 person may maintain other coverage for the period of time the
1528 person is satisfying any preexisting condition waiting period
1529 under a plan policy or may maintain plan coverage for the period
1530 of time the person is satisfying a preexisting condition waiting
1531 period under another health insurance policy intended to replace
1532 the plan policy.
1533 2. The person is determined to be eligible for health care
1534 benefits under Medicaid, the state's children's health insurance
1535 program, or any other federal, state, or local government
1536 program that provides health benefits;
1537 3. The person has previously terminated plan coverage
1538 unless 12 months have elapsed since such termination;
1539 4. The person is an inmate or resident of a public
1540 institution; or
1541 5. The person's premiums are paid for or reimbursed under
1542 any government-sponsored program or by any government agency or
1543 health care provider, except as an otherwise qualifying fulltime
1544 employee, or dependent thereof, of a government agency or health
1545 care provider.
1546 (e) Coverage shall cease:
1547 1. On the date a person is no longer a resident of this
1548 state;
1549 2. On the date a person requests coverage to end;
1550 3. Upon the death of the covered person;
1551 4. On the date state law requires cancellation of the
1552 policy; or
1553 5. At the option of the plan, 30 days after the plan makes
1554 any inquiry concerning the person's eligibility or place of
1555 residence to which the person does not reply.

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1556 (f) Except under the circumstances described in this
1557 subsection, coverage of a person who ceases to meet the
1558 eligibility requirements of this subsection may be terminated at
1559 the end of the policy period for which the necessary premiums
1560 have been paid.
1561 (10) UNFAIR REFERRAL TO PLAN.--It is an unfair trade
1562 practice for the purposes of part IX of chapter 626, Florida
1563 Statutes, or s. 641.3901 for an insurer, health maintenance
1564 organization insurance agent, insurance broker, or third-party
1565 administrator to refer an individual employee to the plan, or
1566 arrange for an individual employee to apply to the plan, for the
1567 purpose of separating that employee from group health insurance
1568 coverage provided in connection with the employee's employment.
1569 (11) PLAN ADMINISTRATOR.--The board shall select through a
1570 competitive bidding process a plan administrator to administer
1571 the plan. The board shall evaluate bids submitted based on
1572 criteria established by the board, which shall include:
1573 (a) The plan administrator's proven ability to handle
1574 health insurance coverage to individuals.
1575 (b) The efficiency and timeliness of the plan
1576 administrator's claim processing procedures.
1577 (c) An estimate of total charges for administering the
1578 plan.
1579 (d) The plan administrator's ability to apply effective
1580 cost-containment programs and procedures and to administer the
1581 plan in a cost-efficient manner.
1582 (e) The financial condition and stability of the plan
1583 administrator.
1584

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1585 The administrator shall be an insurer, a health maintenance
1586 organization, or a third-party administrator, or another
1587 organization duly authorized to provide insurance pursuant to
1588 the Florida Insurance Code.
1589 (12) ADMINISTRATOR TERM LIMITS.--The plan administrator
1590 shall serve for a period specified in the contract between the
1591 plan and the plan administrator subject to removal for cause and
1592 subject to any terms, conditions, and limitations of the
1593 contract between the plan and the plan administrator. At least 1
1594 year prior to the expiration of each period of service by a plan
1595 administrator, the board shall invite eligible entities,
1596 including the current plan administrator, to submit bids to
1597 serve as the plan administrator. Selection of the plan
1598 administrator for each succeeding period shall be made at least
1599 6 months prior to the end of the current period.
1600 (13) DUTIES OF THE PLAN ADMINISTRATOR.--
1601 (a) The plan administrator shall perform such functions
1602 relating to the plan as may be assigned to it, including, but
1603 not limited to:
1604 1. Determination of eligibility.
1605 2. Payment of claims.
1606 3. Establishment of a premium billing procedure for
1607 collection of premiums from persons covered under the plan.
1608 4. Other necessary functions to ensure timely payment of
1609 benefits to covered persons under the plan.
1610 (b) The plan administrator shall submit regular reports to
1611 the board regarding the operation of the plan. The frequency,
1612 content, and form of the reports shall be specified in the
1613 contract between the board and the plan administrator.

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1614 (c) On March 1 following the close of each calendar year,
1615 the plan administrator shall determine net written and earned
1616 premiums, the expense of administration, and the paid and
1617 incurred losses for the year and report this information to the
1618 board and the Governor on a form prescribed by the Governor.
1619 (14) PAYMENT OF THE PLAN ADMINISTRATOR.--The plan
1620 administrator shall be paid as provided in the contract between
1621 the plan and the plan administrator.
1622 (15) FUNDING OF THE PLAN.--
1623 (a) Premiums.--
1624 1. The plan shall establish premium rates for plan
1625 coverage as provided in subparagraph (5)(a)4. Separate schedules
1626 of premium rates based on age, sex, and geographical location
1627 may apply for individual risks. Premium rates and schedules
1628 shall be submitted to the office for approval prior to use.
1629 2. Initial rates for plan coverage shall be capped at 200
1630 percent of rates established as applicable for individual
1631 standard risks as specified in s. 627.6653. The plan shall also
1632 develop a sliding scale premium surcharge based upon the
1633 insured's income. Subject to the limits provided in this
1634 paragraph, subsequent rates shall be established to provide
1635 fully for the expected costs of claims, including recovery of
1636 prior losses, expenses of operation, investment income of claim
1637 reserves, and any other cost factors subject to the limitations
1638 described herein.
1639 (b) Sources of additional revenue.--Any deficit incurred
1640 by the plan shall be funded through amounts appropriated by the
1641 Legislature from general revenue sources, including, but not
1642 limited to, a portion of the annual growth in existing net

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1643 insurance premium taxes. The board shall operate the plan in
1644 such a manner that the estimated cost of providing health
1645 insurance during any fiscal year will not exceed total income
1646 the plan expects to receive from policy premiums and funds
1647 appropriated by the Legislature, including any interest on
1648 investments. After determining the amount of funds appropriated
1649 to the board for a fiscal year, the board shall estimate the
1650 number of new policies it believes the plan has the financial
1651 capacity to insure during that year so that costs do not exceed
1652 income. The board shall take steps necessary to ensure that plan
1653 enrollment does not exceed the number of residents it has
1654 estimated it has the financial capacity to insure.
1655 (16) BENEFITS.--
1656 (a) The benefits provided shall be the same as the
1657 standard and basic plans for small employers as outlined in s.
1658 627.6699. The board may also establish an option of alternative
1659 coverage such as catastrophic coverage that includes a minimum
1660 level of primary care coverage.
1661 (b) In establishing the plan coverage, the board shall
1662 take into consideration the levels of health insurance provided
1663 in the state and such medical economic factors as may be deemed
1664 appropriate and adopt benefit levels, deductibles, copayments,
1665 coinsurance factors, exclusions, and limitations determined to
1666 be generally reflective of and commensurate with health
1667 insurance provided through a representative number of large
1668 employers in the state.
1669 (c) The board may adjust any deductibles and coinsurance
1670 factors annually according to the medical component of the
1671 Consumer Price Index.

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1672 (d)1. Plan coverage shall exclude charges or expenses
1673 incurred during the first 6 months following the effective date
1674 of coverage for any condition for which medical advice, care, or
1675 treatment was recommended or received for such condition during
1676 the 6-month period immediately preceding the effective date of
1677 coverage.
1678 2. Such preexisting condition exclusions shall be waived
1679 to the extent that similar exclusions, if any, have been
1680 satisfied under any prior health insurance coverage which was
1681 involuntarily terminated, provided application for pool coverage
1682 is made not later than 63 days following such involuntary
1683 termination. In such case, coverage under the plan shall be
1684 effective from the date on which such prior coverage was
1685 terminated and the applicant is not eligible for continuation or
1686 conversion rights that would provide coverage substantially
1687 similar to plan coverage.
1688 (17) NONDUPLICATION OF BENEFITS.--
1689 (a) The plan shall be payor of last resort of benefits
1690 whenever any other benefit or source of third-party payment is
1691 available. Benefits otherwise payable under plan coverage shall
1692 be reduced by all amounts paid or payable through any other
1693 health insurance, by all hospital and medical expense benefits
1694 paid or payable under any workers' compensation coverage,
1695 automobile medical payment, or liability insurance, whether
1696 provided on the basis of fault or nonfault, and by any hospital
1697 or medical benefits paid or payable under or provided pursuant
1698 to any state or federal law or program.
1699 (b) The plan shall have a cause of action against an
1700 eligible person for the recovery of the amount of benefits paid

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1701 that are not for covered expenses. Benefits due from the plan
1702 may be reduced or refused as a setoff against any amount
1703 recoverable under this paragraph.
1704 (18) ANNUAL AND MAXIMUM BENEFITS.--Maximum benefits under
1705 the plan shall be determined by the board.
1706 (19) TAXATION.--The plan is exempt from any tax imposed by
1707 this state. The plan shall apply for federal tax exemption
1708 status.
1709 (20) COMBINING MEMBERSHIP OF THE FLORIDA COMPREHENSIVE
1710 HEALTH ASSOCIATION.--
1711 (a)1. Upon implementation of the plan, the Florida
1712 Comprehensive Health Association is abolished and all high-risk
1713 individuals actively enrolled in the Florida Comprehensive
1714 Health Association shall be enrolled in the plan subject to its
1715 rules and requirements.
1716 2. Persons formerly enrolled in the Florida Comprehensive
1717 Health Association are only eligible for the benefits authorized
1718 under subsection (18).
1719 (b)1. As a condition of doing business in this state, an
1720 insurer shall pay an assessment to the board in the amount
1721 prescribed by this paragraph. For operating losses incurred on
1722 or after July 1, 2004, by persons previously enrolled in the
1723 Florida Comprehensive Health Association, each insurer shall
1724 annually be assessed by the board in the following calendar year
1725 a portion of such incurred operating losses of the plan. Such
1726 portion shall be determined by multiplying such operating losses
1727 by a fraction, the numerator of which equals the insurer's
1728 earned premium pertaining to direct writings of health insurance
1729 in the state during the calendar year proceeding that for which

1730 the assessment is levied, and the denominator of which equals
1731 the total of all such premiums earned by participating insurers
1732 in the state during such calendar year.
1733 2. The total of all assessments under this paragraph upon
1734 a participating insurer shall not exceed 1 percent of such
1735 insurer's health insurance premium earned in this state during
1736 the calendar year preceeding the year for which the assessments
1737 were levied.
1738 3. All rights, title, and interest in the assessment funds
1739 collected under this paragraph shall vest in this state.
1740 However, all of such funds and interest earned shall be used by
1741 the plan to pay claims and administrative expenses.
1742 (c) If assessments and other receipts by the plan, board,
1743 or plan administrator exceed the actual losses and
1744 administrative expenses of the plan, the excess shall be held in
1745 interest and used by the board to offset future losses. As used
1746 in this subsection, the term "future losses" includes reserves
1747 for claims incurred but not reported.
1748 (d) Each insurer's assessment shall be determined annually
1749 by the board or plan administrator based on annual statements
1750 and other reports deemed necessary by the board or plan
1751 administrator and filed with the board or plan administrator by
1752 the insurer. Any deficit incurred under the plan by persons
1753 previously enrolled in the Florida Comprehensive Health
1754 Association shall be recouped by the assessments against
1755 participating insurers by the board or plan administrator in the
1756 manner provided in paragraph (b), and the insurers may recover
1757 the assessment in the normal course of their respective
1758 businesses without time limitation.

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1759 (e) If a person enrolled in the Florida Comprehensive
1760 Health Association as of July 1, 2004, loses eligibility for
1761 participation in the plan, such person shall not be included in
1762 the calculation of incurred operational losses as described in
1763 paragraph (b) if the person later regains eligibility for
1764 participation in the plan.
1765 (f) After all persons enrolled in the Florida
1766 Comprehensive Health Association as of July 1, 2004, are no
1767 longer eligible for participation in the plan, the plan, board,
1768 or plan administrator shall no longer be allowed to assess
1769 insurers in this state for incurred losses as described in
1770 paragraph (b).
1771 Section 20. Upon implementation, as defined in s.
1772 627.64872(2), Florida Statutes, and provided in s.
1773 627.64872(22), Florida Statutes, of the Florida Health Benefit
1774 Plan created under s. 627.64872, Florida Statutes, sections
1775 627.6488, 627.6489, 627.649, 627.6492, 627.6494, 627.6496,
1776 627.6498, and 627.6499, Florida Statutes, are repealed.
1777 Section 21. Subsection (12) is added to section 627.662,
1778 Florida Statutes, to read:
1779 627.662 Other provisions applicable.--The following
1780 provisions apply to group health insurance, blanket health
1781 insurance, and franchise health insurance:
1782 (12) Section 627.6044, relating to the use of specific
1783 methodology for payment of claims.
1784 Section 22. Paragraphs (c) and (d) of subsection (5),
1785 paragraph (b) of subsection (6), and subsection (12) of section
1786 627.6699, Florida Statutes, are amended, subsections (15) and
1787 (16) of said section are renumbered as subsections (16) and

1788 (17), respectively, present subsection (15) of said section is
1789 amended, and new subsections (15) and (18) are added to said
1790 section, to read:
1791 627.6699 Employee Health Care Access Act.--
1792 (5) AVAILABILITY OF COVERAGE.--
1793 (c) Every small employer carrier must, as a condition of
1794 transacting business in this state:
1795 1. Offer and issue all small employer health benefit plans
1796 on a guaranteed-issue basis to every eligible small employer,
1797 with 2 to 50 eligible employees, that elects to be covered under
1798 such plan, agrees to make the required premium payments, and
1799 satisfies the other provisions of the plan. A rider for
1800 additional or increased benefits may be medically underwritten
1801 and may only be added to the standard health benefit plan. The
1802 increased rate charged for the additional or increased benefit
1803 must be rated in accordance with this section.
1804 2. Depending upon the absence of the availability of new
1805 enrollment into the Florida Health Insurance Plan, offer and
1806 issue basic and standard small employer health benefit plans on
1807 a guaranteed-issue basis, during a 31-day open enrollment period
1808 of August 1 through August 31 of each year, to every eligible
1809 small employer, with fewer than two eligible employees, which
1810 small employer is not formed primarily for the purpose of buying
1811 health insurance and which elects to be covered under such plan,
1812 agrees to make the required premium payments, and satisfies the
1813 other provisions of the plan. Coverage provided under this
1814 subparagraph shall begin on October 1 of the same year as the
1815 date of enrollment, unless the small employer carrier and the
1816 small employer agree to a different date. A rider for additional

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1817 or increased benefits may be medically underwritten and may only
1818 be added to the standard health benefit plan. The increased rate
1819 charged for the additional or increased benefit must be rated in
1820 accordance with this section. For purposes of this subparagraph,
1821 a person, his or her spouse, and his or her dependent children
1822 constitute a single eligible employee if that person and spouse
1823 are employed by the same small employer and either that person
1824 or his or her spouse has a normal work week of less than 25
1825 hours.

1826 3. This paragraph does not limit a carrier's ability to
1827 offer other health benefit plans to small employers if the
1828 standard and basic health benefit plans are offered and
1829 rejected.

1830 (d) A small employer carrier must file with the office, in
1831 a format and manner prescribed by the committee, a standard
1832 health care plan, a high deductible plan that meets the federal
1833 requirements of a health savings account plan, and a basic
1834 health care plan to be used by the carrier.

1835 (6) RESTRICTIONS RELATING TO PREMIUM RATES.--

1836 (b) For all small employer health benefit plans that are
1837 subject to this section and are issued by small employer
1838 carriers on or after January 1, 1994, premium rates for health
1839 benefit plans subject to this section are subject to the
1840 following:

1841 1. Small employer carriers must use a modified community
1842 rating methodology in which the premium for each small employer
1843 must be determined solely on the basis of the eligible
1844 employee's and eligible dependent's gender, age, family
1845 composition, tobacco use, or geographic area as determined under

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1846 paragraph (5)(j) and in which the premium may be adjusted as
1847 permitted by this paragraph.
1848 2. Rating factors related to age, gender, family
1849 composition, tobacco use, or geographic location may be
1850 developed by each carrier to reflect the carrier's experience.
1851 The factors used by carriers are subject to office review and
1852 approval.
1853 3. Small employer carriers may not modify the rate for a
1854 small employer for 12 months from the initial issue date or
1855 renewal date, unless the composition of the group changes or
1856 benefits are changed. However, a small employer carrier may
1857 modify the rate one time prior to 12 months after the initial
1858 issue date for a small employer who enrolls under a previously
1859 issued group policy that has a common anniversary date for all
1860 employers covered under the policy if:
1861 a. The carrier discloses to the employer in a clear and
1862 conspicuous manner the date of the first renewal and the fact
1863 that the premium may increase on or after that date.
1864 b. The insurer demonstrates to the office that
1865 efficiencies in administration are achieved and reflected in the
1866 rates charged to small employers covered under the policy.
1867 4. A carrier may issue a group health insurance policy to
1868 a small employer health alliance or other group association with
1869 rates that reflect a premium credit for expense savings
1870 attributable to administrative activities being performed by the
1871 alliance or group association if such expense savings are
1872 specifically documented in the insurer's rate filing and are
1873 approved by the office. Any such credit may not be based on
1874 different morbidity assumptions or on any other factor related

1875 to the health status or claims experience of any person covered
1876 under the policy. Nothing in this subparagraph exempts an
1877 alliance or group association from licensure for any activities
1878 that require licensure under the insurance code. A carrier
1879 issuing a group health insurance policy to a small employer
1880 health alliance or other group association shall allow any
1881 properly licensed and appointed agent of that carrier to market
1882 and sell the small employer health alliance or other group
1883 association policy. Such agent shall be paid the usual and
1884 customary commission paid to any agent selling the policy.
1885 5. Any adjustments in rates for claims experience, health
1886 status, or duration of coverage may not be charged to individual
1887 employees or dependents. For a small employer's policy, such
1888 adjustments may not result in a rate for the small employer
1889 which deviates more than 15 percent from the carrier's approved
1890 rate. Any such adjustment must be applied uniformly to the rates
1891 charged for all employees and dependents of the small employer.
1892 A small employer carrier may make an adjustment to a small
1893 employer's renewal premium, not to exceed 10 percent annually,
1894 due to the claims experience, health status, or duration of
1895 coverage of the employees or dependents of the small employer.
1896 Semiannually, small group carriers shall report information on
1897 forms adopted by rule by the commission, to enable the office to
1898 monitor the relationship of aggregate adjusted premiums actually
1899 charged policyholders by each carrier to the premiums that would
1900 have been charged by application of the carrier's approved
1901 modified community rates. If the aggregate resulting from the
1902 application of such adjustment exceeds the premium that would
1903 have been charged by application of the approved modified

1904 community rate by 5 percent for the current reporting period,
1905 the carrier shall limit the application of such adjustments only
1906 to minus adjustments beginning not more than 60 days after the
1907 report is sent to the office. For any subsequent reporting
1908 period, if the total aggregate adjusted premium actually charged
1909 does not exceed the premium that would have been charged by
1910 application of the approved modified community rate by 2 ~~5~~
1911 percent, the carrier may apply both plus and minus adjustments.
1912 A small employer carrier may provide a credit to a small
1913 employer's premium based on administrative and acquisition
1914 expense differences resulting from the size of the group. Group
1915 size administrative and acquisition expense factors may be
1916 developed by each carrier to reflect the carrier's experience
1917 and are subject to office review and approval.

1918 6. A small employer carrier rating methodology may include
1919 separate rating categories for one dependent child, for two
1920 dependent children, and for three or more dependent children for
1921 family coverage of employees having a spouse and dependent
1922 children or employees having dependent children only. A small
1923 employer carrier may have fewer, but not greater, numbers of
1924 categories for dependent children than those specified in this
1925 subparagraph.

1926 7. Small employer carriers may not use a composite rating
1927 methodology to rate a small employer with fewer than 10
1928 employees. For the purposes of this subparagraph, a "composite
1929 rating methodology" means a rating methodology that averages the
1930 impact of the rating factors for age and gender in the premiums
1931 charged to all of the employees of a small employer.

1932 8.a. A carrier may separate the experience of small
1933 employer groups with less than 2 eligible employees from the
1934 experience of small employer groups with 2-50 eligible employees
1935 for purposes of determining an alternative modified community
1936 rating.
1937 b. If a carrier separates the experience of small employer
1938 groups as provided in sub-subparagraph a., the rate to be
1939 charged to small employer groups of less than 2 eligible
1940 employees may not exceed 150 percent of the rate determined for
1941 small employer groups of 2-50 eligible employees. However, the
1942 carrier may charge excess losses of the experience pool
1943 consisting of small employer groups with less than 2 eligible
1944 employees to the experience pool consisting of small employer
1945 groups with 2-50 eligible employees so that all losses are
1946 allocated and the 150-percent rate limit on the experience pool
1947 consisting of small employer groups with less than 2 eligible
1948 employees is maintained. Notwithstanding s. 627.411(1), the rate
1949 to be charged to a small employer group of fewer than 2 eligible
1950 employees, insured as of July 1, 2002, may be up to 125 percent
1951 of the rate determined for small employer groups of 2-50
1952 eligible employees for the first annual renewal and 150 percent
1953 for subsequent annual renewals.
1954 (12) STANDARD, BASIC, HIGH DEDUCTIBLE, AND LIMITED HEALTH
1955 BENEFIT PLANS.--
1956 (a)1. The Chief Financial Officer shall appoint a health
1957 benefit plan committee composed of four representatives of
1958 carriers which shall include at least two representatives of
1959 HMOs, at least one of which is a staff model HMO, two
1960 representatives of agents, four representatives of small

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1961 employers, and one employee of a small employer. The carrier
1962 members shall be selected from a list of individuals recommended
1963 by the board. The Chief Financial Officer may require the board
1964 to submit additional recommendations of individuals for
1965 appointment.
1966 2. The plans shall comply with all of the requirements of
1967 this subsection.
1968 3. The plans must be filed with and approved by the office
1969 prior to issuance or delivery by any small employer carrier.
1970 4. After approval of the revised health benefit plans, if
1971 the office determines that modifications to a plan might be
1972 appropriate, the Chief Financial Officer shall appoint a new
1973 health benefit plan committee in the manner provided in
1974 subparagraph 1. to submit recommended modifications to the
1975 office for approval.
1976 (b)1. Each small employer carrier issuing new health
1977 benefit plans shall offer to any small employer, upon request, a
1978 standard health benefit plan, ~~and~~ a basic health benefit plan,
1979 and a high deductible plan that meets the requirements of a
1980 health savings account plan as defined by federal law, that meet
1981 ~~meets~~ the criteria set forth in this section.
1982 2. For purposes of this subsection, the terms "standard
1983 health benefit plan," ~~and~~ "basic health benefit plan," and "high
1984 deductible plan" mean policies or contracts that a small
1985 employer carrier offers to eligible small employers that
1986 contain:
1987 a. An exclusion for services that are not medically
1988 necessary or that are not covered preventive health services;
1989 and

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1990 b. A procedure for preauthorization by the small employer
1991 carrier, or its designees.
1992 3. A small employer carrier may include the following
1993 managed care provisions in the policy or contract to control
1994 costs:
1995 a. A preferred provider arrangement or exclusive provider
1996 organization or any combination thereof, in which a small
1997 employer carrier enters into a written agreement with the
1998 provider to provide services at specified levels of
1999 reimbursement or to provide reimbursement to specified
2000 providers. Any such written agreement between a provider and a
2001 small employer carrier must contain a provision under which the
2002 parties agree that the insured individual or covered member has
2003 no obligation to make payment for any medical service rendered
2004 by the provider which is determined not to be medically
2005 necessary. A carrier may use preferred provider arrangements or
2006 exclusive provider arrangements to the same extent as allowed in
2007 group products that are not issued to small employers.
2008 b. A procedure for utilization review by the small
2009 employer carrier or its designees.
2010
2011 This subparagraph does not prohibit a small employer carrier
2012 from including in its policy or contract additional managed care
2013 and cost containment provisions, subject to the approval of the
2014 office, which have potential for controlling costs in a manner
2015 that does not result in inequitable treatment of insureds or
2016 subscribers. The carrier may use such provisions to the same
2017 extent as authorized for group products that are not issued to
2018 small employers.

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2019 4. The standard health benefit plan shall include:
2020 a. Coverage for inpatient hospitalization;
2021 b. Coverage for outpatient services;
2022 c. Coverage for newborn children pursuant to s. 627.6575;
2023 d. Coverage for child care supervision services pursuant
2024 to s. 627.6579;
2025 e. Coverage for adopted children upon placement in the
2026 residence pursuant to s. 627.6578;
2027 f. Coverage for mammograms pursuant to s. 627.6613;
2028 g. Coverage for handicapped children pursuant to s.
2029 627.6615;
2030 h. Emergency or urgent care out of the geographic service
2031 area; and
2032 i. Coverage for services provided by a hospice licensed
2033 under s. 400.602 in cases where such coverage would be the most
2034 appropriate and the most cost-effective method for treating a
2035 covered illness.
2036 5. The standard health benefit plan and the basic health
2037 benefit plan may include a schedule of benefit limitations for
2038 specified services and procedures. If the committee develops
2039 such a schedule of benefits limitation for the standard health
2040 benefit plan or the basic health benefit plan, a small employer
2041 carrier offering the plan must offer the employer an option for
2042 increasing the benefit schedule amounts by 4 percent annually.
2043 6. The basic health benefit plan shall include all of the
2044 benefits specified in subparagraph 4.; however, the basic health
2045 benefit plan shall place additional restrictions on the benefits
2046 and utilization and may also impose additional cost containment
2047 measures.

2048 7. Sections 627.419(2), (3), and (4), 627.6574, 627.6612,
2049 627.66121, 627.66122, 627.6616, 627.6618, 627.668, and 627.66911
2050 apply to the standard health benefit plan and to the basic
2051 health benefit plan. However, notwithstanding said provisions,
2052 the plans may specify limits on the number of authorized
2053 treatments, if such limits are reasonable and do not
2054 discriminate against any type of provider.
2055 8. The plan associated with a health savings account shall
2056 include all the benefits specified in subparagraph 4.
2057 9.~~8.~~ Each small employer carrier that provides for
2058 inpatient and outpatient services by allopathic hospitals may
2059 provide as an option of the insured similar inpatient and
2060 outpatient services by hospitals accredited by the American
2061 Osteopathic Association when such services are available and the
2062 osteopathic hospital agrees to provide the service.
2063 (c) If a small employer rejects, in writing, the standard
2064 health benefit plan, ~~and~~ the basic health benefit plan, and the
2065 high-deductible health savings account plan, the small employer
2066 carrier may offer the small employer a limited benefit policy or
2067 contract.
2068 (d)1. Upon offering coverage under a standard health
2069 benefit plan, a basic health benefit plan, or a limited benefit
2070 policy or contract for any small employer, the small employer
2071 carrier shall provide such employer group with a written
2072 statement that contains, at a minimum:
2073 a. An explanation of those mandated benefits and providers
2074 that are not covered by the policy or contract;
2075 b. An explanation of the managed care and cost control
2076 features of the policy or contract, along with all appropriate

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2077 mailing addresses and telephone numbers to be used by insureds
2078 in seeking information or authorization; and
2079 c. An explanation of the primary and preventive care
2080 features of the policy or contract.
2081
2082 Such disclosure statement must be presented in a clear and
2083 understandable form and format and must be separate from the
2084 policy or certificate or evidence of coverage provided to the
2085 employer group.
2086 2. Before a small employer carrier issues a standard
2087 health benefit plan, a basic health benefit plan, or a limited
2088 benefit policy or contract, it must obtain from the prospective
2089 policyholder a signed written statement in which the prospective
2090 policyholder:
2091 a. Certifies as to eligibility for coverage under the
2092 standard health benefit plan, basic health benefit plan, or
2093 limited benefit policy or contract;
2094 b. Acknowledges the limited nature of the coverage and an
2095 understanding of the managed care and cost control features of
2096 the policy or contract;
2097 c. Acknowledges that if misrepresentations are made
2098 regarding eligibility for coverage under a standard health
2099 benefit plan, a basic health benefit plan, or a limited benefit
2100 policy or contract, the person making such misrepresentations
2101 forfeits coverage provided by the policy or contract; and
2102 d. If a limited plan is requested, acknowledges that the
2103 prospective policyholder had been offered, at the time of
2104 application for the insurance policy or contract, the
2105 opportunity to purchase any health benefit plan offered by the

2106 carrier and that the prospective policyholder had rejected that
2107 coverage.
2108
2109 A copy of such written statement shall be provided to the
2110 prospective policyholder no later than at the time of delivery
2111 of the policy or contract, and the original of such written
2112 statement shall be retained in the files of the small employer
2113 carrier for the period of time that the policy or contract
2114 remains in effect or for 5 years, whichever period is longer.
2115 3. Any material statement made by an applicant for
2116 coverage under a health benefit plan which falsely certifies as
2117 to the applicant's eligibility for coverage serves as the basis
2118 for terminating coverage under the policy or contract.
2119 4. Each marketing communication that is intended to be
2120 used in the marketing of a health benefit plan in this state
2121 must be submitted for review by the office prior to use and must
2122 contain the disclosures stated in this subsection.
2123 (e) A small employer carrier may not use any policy,
2124 contract, form, or rate under this section, including
2125 applications, enrollment forms, policies, contracts,
2126 certificates, evidences of coverage, riders, amendments,
2127 endorsements, and disclosure forms, until the insurer has filed
2128 it with the office and the office has approved it under ss.
2129 627.410 and 627.411 and this section.
2130 (15) SMALL EMPLOYERS ACCESS PROGRAM.--
2131 (a) Popular name.--This subsection may be referred to by
2132 the popular name "The Small Employers Access Program."
2133 (b) Intent.--The Legislature finds that increased access
2134 to health care coverage for small employers with up to 25

2135 employees could improve employees' health and reduce the
2136 incidence and costs of illness and disabilities among residents
2137 in this state. Many employers do not offer health care benefits
2138 to their employees citing the increased cost of this benefit. It
2139 is the intent of the Legislature to create the Small Business
2140 Health Plan to provide small employers the option and ability to
2141 provide health care benefits to their employees at an affordable
2142 cost through the creation of purchasing pools for employers with
2143 up to 25 employees, and rural hospital employers and nursing
2144 home employers regardless of the number of employees.
2145 (c) Definitions.--For purposes of this subsection:
2146 1. "Fair commission" means a commission structure
2147 determined by the office and the insurers, which will carry out
2148 the intent of this subsection.
2149 2. "Insurer" means any entity that provides health
2150 insurance in this state. For purposes of this subsection,
2151 insurer includes an insurance company holding a certificate of
2152 authority pursuant to chapter 624 or a health maintenance
2153 organization holding a certificate of authority pursuant to
2154 chapter 641, which qualifies to provide coverage to small
2155 employer groups pursuant to this section.
2156 3. "Mutually supported benefit plan" means an optional
2157 alternative coverage plan developed within a defined geographic
2158 region which may include, but is not limited to, a minimum level
2159 of primary care coverage in which the percentage of the premium
2160 is distributed among the employer, the employee, and community-
2161 generated revenue either alone or in conjunction with federal
2162 matching funds.

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2163 4. "Office" means the Office of Insurance Regulation of
2164 the Department of Financial Services.
2165 5. "Participating insurer" means any insurer providing
2166 health insurance to small employers that has been selected by
2167 the office in accordance with this subsection for its designated
2168 region.
2169 6. "Program" means the Small Employer Access Program as
2170 created by this subsection.
2171 (d) Eligibility.--
2172 1. Any small employer group of up to 25 employees that has
2173 had no prior coverage for the last 6 months may participate.
2174 2. Rural hospital employers may participate.
2175 3. Nursing home employers may participate.
2176 4. Each dependent of a person eligible for coverage is
2177 also eligible to participate.
2178 5. Any small employer that is actively engaged in
2179 business, has its principal place of business in this state,
2180 employed up to 25 eligible employees on business days during the
2181 preceding calendar year, and employs at least 2 employees on the
2182 first day of the plan year may participate.
2183
2184 Coverage for a small employer group that ceases to meet the
2185 eligibility requirements of this section may be terminated at
2186 the end of the policy period for which the necessary premiums
2187 have been paid.
2188 (e) Administration.--
2189 1. The office shall by competitive bid, in accordance with
2190 current state law, select an insurer to provide coverage through
2191 the program to eligible small employers within an established

2192 geographical area of this state. The office may develop
2193 exclusive regions for the program similar to those used by the
2194 Healthy Kids Corporation. However the office is not precluded
2195 from developing, in conjunction with insurers, regions different
2196 from those used by the Healthy Kids Corporation if the office
2197 deems that such a region will carry out the intentions of this
2198 subsection.
2199 2. The office shall evaluate bids submitted based upon
2200 criteria established by the office, which shall include, but not
2201 be limited to:
2202 a. The insurer's proven ability to handle health insurance
2203 coverage to small employer groups.
2204 b. The efficiency and timeliness of the insurer's claim
2205 processing procedures.
2206 c. The insurer's ability to apply effective cost-
2207 containment programs and procedures and to administer the
2208 program in a cost-efficient manner.
2209 d. The financial condition and stability of the insurer.
2210 e. The insurer's ability to develop an optional mutually
2211 supported benefit plan.
2212
2213 The office may use any financial information available to it
2214 through its regulatory duties to make this evaluation.
2215 (f) Insurer qualifications.--The insurer shall be a duly
2216 authorized insurer or health maintenance organization.
2217 (g) Duties of the insurer.--The insurer shall:
2218 1. Develop and implement a program to publicize the
2219 existence of the program, program eligibility requirements, and

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2220 procedures for enrollment and maintain public awareness of the
2221 program.
2222 2. Maintain employer awareness of the program.
2223 3. Demonstrate the ability to use delivery of cost-
2224 effective health care services.
2225 4. Encourage, educate, advise, and administer the
2226 effective use of health savings accounts by covered employees
2227 and dependents.
2228 5. Serve for a period specified in the contract between
2229 the office and the insurer, subject to removal for cause and
2230 subject to any terms, conditions, and limitations of the
2231 contract between the office and the insurer as may be specified
2232 in the request for proposal.
2233 (h) Contract term.--The contract term shall not exceed 3
2234 years. At least 6 months prior to the expiration of each
2235 contract period, the office shall invite eligible entities,
2236 including the current insurer, to submit bids to serve as the
2237 insurer for a designated geographic area. Selection of the
2238 insurer for the succeeding period shall be made at least 3
2239 months prior to the end of the current period.
2240 (i) Insurer reporting requirements.--On March 1 following
2241 the close of each calendar year, the insurer shall determine net
2242 written and earned premiums, the expense of administration, and
2243 the paid and incurred losses for the year and report this
2244 information to the office on a form prescribed by the office.
2245 (j) Application requirements.--The insurer shall permit or
2246 allow any licensed and duly appointed health insurance agent
2247 residing in the designated region to submit applications for
2248 coverage, and such agent shall be paid a fair commission if

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2249 coverage is written. The agent must be appointed to at least one
2250 insurer.
2251 (k) Benefits.--The benefits provided by the plan shall be
2252 the same as the coverage required for small employers under
2253 subsection (12). Upon the approval of the office, the insurer
2254 may also establish an optional mutually supported benefit plan
2255 which is an alternative coverage plan developed within a defined
2256 geographic region of this state or any other such alternative
2257 coverage benefit plan which will carry out the intent of this
2258 subsection.
2259 (l) Annual reporting.--The office shall make an annual
2260 report to the Governor, the President of the Senate, and the
2261 Speaker of the House of Representatives. The report shall
2262 summarize the activities of the program in the preceding
2263 calendar year, including the net written and earned premiums,
2264 program enrollment, the expense of administration, and the paid
2265 and incurred losses. The report shall be submitted no later than
2266 March 15 following the close of the prior calendar year.
2267 (16) ~~(15)~~ APPLICABILITY OF OTHER STATE LAWS.--
2268 (a) Except as expressly provided in this section, a law
2269 requiring coverage for a specific health care service or
2270 benefit, or a law requiring reimbursement, utilization, or
2271 consideration of a specific category of licensed health care
2272 practitioner, does not apply to a standard or basic health
2273 benefit plan policy or contract, a small employer access
2274 program, or a limited benefit policy or contract offered or
2275 delivered to a small employer unless that law is made expressly
2276 applicable to such policies or contracts. A law restricting or
2277 limiting deductibles, coinsurance, copayments, or annual or

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2278 lifetime maximum payments does not apply to any health plan
2279 policy, including a standard or basic health benefit plan policy
2280 or contract, offered or delivered to a small employer unless
2281 such law is made expressly applicable to such policy or
2282 contract. However, every small employer carrier must offer to
2283 eligible small employers the standard benefit plan and the basic
2284 benefit plan, as required by subsection (5), as such plans have
2285 been approved by the office pursuant to subsection (12).
2286 (b) Except as provided in this section, a standard or
2287 basic health benefit plan policy or contract or limited benefit
2288 policy or contract offered to a small employer is not subject to
2289 any provision of this code which:
2290 1. Inhibits a small employer carrier from contracting with
2291 providers or groups of providers with respect to health care
2292 services or benefits;
2293 2. Imposes any restriction on a small employer carrier's
2294 ability to negotiate with providers regarding the level or
2295 method of reimbursing care or services provided under a health
2296 benefit plan; or
2297 3. Requires a small employer carrier to either include a
2298 specific provider or class of providers when contracting for
2299 health care services or benefits or to exclude any class of
2300 providers that is generally authorized by statute to provide
2301 such care.
2302 (c) Any second tier assessment paid by a carrier pursuant
2303 to paragraph (11)(j) may be credited against assessments levied
2304 against the carrier pursuant to s. 627.6494.
2305 (d) Notwithstanding chapter 641, a health maintenance
2306 organization is authorized to issue contracts providing benefits

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2307 equal to the standard health benefit plan, the basic health
2308 benefit plan, and the limited benefit policy authorized by this
2309 section.

2310 (17) ~~(16)~~ RULEMAKING AUTHORITY.--The commission may adopt
2311 rules to administer this section, including rules governing
2312 compliance by small employer carriers and small employers.

2313 (18) DECREASE IN INAPPROPRIATE UTILIZATION OF EMERGENCY
2314 CARE.--Health insurers may require higher copayments for
2315 nonemergency use of emergency departments and higher copayments
2316 for out-of-network emergency department use and are encouraged
2317 to create the development of emergency room diversion programs.

2318 Section 23. Subsection (1) of section 627.9175, Florida
2319 Statutes, is amended to read:

2320 627.9175 Reports of information on health and accident
2321 insurance.--

2322 (1) Each health insurer, prepaid limited health services
2323 organization, and health maintenance organization shall submit,
2324 no later than April 1 of each year, ~~annually~~ to the office
2325 information concerning health and accident insurance coverage
2326 and medical plans being marketed and currently in force in this
2327 state. The required information shall be described by market
2328 segment, to include, but not be limited to:

2329 (a) Issuing, servicing company, and entity contact
2330 information.

2331 (b) Information on all health and accident insurance
2332 policies and prepaid limited health service organizations and
2333 health maintenance organization contracts in force and issued in
2334 the previous year. Such information shall include, but not be
2335 limited to, direct premiums earned, direct losses incurred,

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2336 number of policies, number of certificates, and number of
2337 covered lives. ~~as to policies of individual health insurance:~~
2338 ~~(a) A summary of typical benefits, exclusions, and~~
2339 ~~limitations for each type of individual policy form currently~~
2340 ~~being issued in the state. The summary shall include, as~~
2341 ~~appropriate:~~
2342 ~~1. The deductible amount;~~
2343 ~~2. The coinsurance percentage;~~
2344 ~~3. The out-of-pocket maximum;~~
2345 ~~4. Outpatient~~ benefits;
2346 ~~5. Inpatient benefits; and~~
2347 ~~6. Any exclusions for preexisting conditions.~~
2348
2349 ~~The commission shall determine other appropriate benefits,~~
2350 ~~exclusions, and limitations to be reported for inclusion in the~~
2351 ~~consumer's guide published pursuant to this section.~~
2352 ~~(b) A schedule of rates for each type of individual policy~~
2353 ~~form reflecting typical variations by age, sex, region of the~~
2354 ~~state, or any other applicable factor which is in use and is~~
2355 ~~determined to be appropriate for inclusion by the commission.~~
2356
2357 The commission may establish rules governing ~~shall provide by~~
2358 ~~rule a uniform format for~~ the submission of ~~this~~ information
2359 described in this section, including the use of uniform formats
2360 and electronic data transmission ~~order to allow for meaningful~~
2361 ~~comparisons of premiums charged for comparable benefits. The~~
2362 ~~office shall provide this information to the department, which~~
2363 ~~shall publish annually a consumer's guide which summarizes and~~

2364 ~~compares the information required to be reported under this~~
2365 ~~subsection~~.
2366 Section 24. Subsection (7) of section 636.003, Florida
2367 Statutes, is amended to read:
2368 636.003 Definitions.--As used in this act, the term:
2369 (7) "Prepaid limited health service organization" means
2370 any person, corporation, partnership, or any other entity which,
2371 in return for a prepayment, undertakes to provide or arrange
2372 for, or provide access to, the provision of a limited health
2373 service to enrollees through an exclusive panel of providers <u>or</u>
2374 <u>undertakes to provide access to any discounted medical services</u>.
2375 Prepaid limited health service organization does not include:
2376 (a) An entity otherwise authorized pursuant to the laws of
2377 this state to indemnify for any limited health service;
2378 (b) A provider or entity when providing limited health
2379 services pursuant to a contract with a prepaid limited health
2380 service organization, a health maintenance organization, a
2381 health insurer, or a self-insurance plan; ~~or~~
2382 (c) Any person who, in exchange for fees, dues, charges or
2383 other consideration, provides access to a limited health service
2384 provider without assuming any responsibility for payment for the
2385 limited health service or any portion thereof<u>; or</u>
2386 <u>(d) Any plan or program of discounted medical services for</u>
2387 <u>which fees, dues, charges, or other consideration paid to the</u>
2388 <u>plan by consumers do not exceed $15 per month or $180 per year</u>
2389 <u>and which, in its advertising and contracts:</u>
2390 <u>1. Clearly indicates that the plan is not insurance, that</u>
2391 <u>the plan is not obligated to pay any portion of the discounted</u>
2392 <u>medical fees, and that the consumer is responsible for paying</u>

2393 the full amount of the discounted fees.
2394 2. Does not use the terms "affordable health care" or
2395 "coverage" or other terms which misrepresent the nature of the
2396 program.
2397 3. Requires a statement, together with the provider
2398 network, on the discount card alerting the network providers and
2399 facilities that the cardholder does not have insurance and is
2400 merely entitled to the network discount rate for services
2401 provided.
2402 Section 25. Section 627.6410, Florida Statutes, is created
2403 to read:
2404 627.6410 Optional coverage for speech, language,
2405 swallowing, and hearing disorders.--
2406 (1) Insurers issuing individual health insurance policies
2407 in this state shall make available to the policyholder as part
2408 of the application for any such policy of insurance, for an
2409 appropriate additional premium, the benefits or levels of
2410 benefits specified in the December 1999 Florida Medicaid Therapy
2411 Services Handbook for genetic or congenital disorders or
2412 conditions involving speech, language, swallowing, and hearing
2413 and a hearing aid and earmolds benefit at the level of benefits
2414 specified in the January 2001 Florida Medicaid Hearing Services
2415 Handbook.
2416 (2) This section does not apply to specified accident,
2417 specified disease, hospital indemnity, limited benefit,
2418 disability income, or long-term care insurance policies.
2419 (3) Such optional coverage is not required to be offered
2420 when substantially similar benefits are included in the policy
2421 of insurance issued to the policyholder.

2422 (4) This section does not require or prohibit the use of a
2423 provider network.
2424 (5) This section does not prohibit an insurer from
2425 requiring prior authorization for the benefits under this
2426 section.
2427 Section 26. Section 627.66912, Florida Statutes, is
2428 created to read:
2429 627.66912 Optional coverage for speech, language,
2430 swallowing, and hearing disorders.--
2431 (1) Insurers issuing group health insurance policies in
2432 this state shall make available to the policyholder as part of
2433 the application for any such policy of insurance, for an
2434 appropriate additional premium, the benefits or levels of
2435 benefits specified in the December 1999 Florida Medicaid Therapy
2436 Services Handbook for genetic or congenital disorders or
2437 conditions involving speech, language, swallowing, and hearing
2438 and a hearing aid and earmolds benefit at the level of benefits
2439 specified in the January 2001 Florida Medicaid Hearing Services
2440 Handbook.
2441 (2) This section does not apply to specified accident,
2442 specified disease, hospital indemnity, limited benefit,
2443 disability income, or long-term care insurance policies.
2444 (3) Such optional coverage is not required to be offered
2445 when substantially similar benefits are included in the policy
2446 of insurance issued to the policyholder.
2447 (4) This section does not require or prohibit the use of a
2448 provider network.
2449 (5) This section does not prohibit an insurer from
2450 requiring prior authorization for the benefits under this

2451 section.

2452 Section 27. Subsection (38) of section 641.31, Florida
2453 Statutes, is amended, and subsection (40) is added to said
2454 section, to read:

2455 641.31 Health maintenance contracts.--

2456 (38)(a) Notwithstanding any other provision of this part,
2457 a health maintenance organization that meets the requirements of
2458 paragraph (b) may, through a point-of-service rider to its
2459 contract providing comprehensive health care services, include a
2460 point-of-service benefit. Under such a rider, a subscriber or
2461 other covered person of the health maintenance organization may
2462 choose, at the time of covered service, a provider with whom the
2463 health maintenance organization does not have a health
2464 maintenance organization provider contract. The rider may not
2465 require a referral from the health maintenance organization for
2466 the point-of-service benefits.

2467 (b) A health maintenance organization offering a point-of-
2468 service rider under this subsection must have a valid
2469 certificate of authority issued under the provisions of the
2470 chapter, must have been licensed under this chapter for a
2471 minimum of 3 years, and must at all times that it has riders in
2472 effect maintain a minimum surplus of $5 million.

2473 (c) Premiums paid in for the point-of-service riders may
2474 not exceed 15 percent of total premiums for all health plan
2475 products sold by the health maintenance organization offering
2476 the rider. If the premiums paid for point-of-service riders
2477 exceed 15 percent, the health maintenance organization must
2478 notify the office and, once this fact is known, must immediately

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2479 cease offering such a rider until it is in compliance with the
2480 rider premium cap.
2481 (d) Notwithstanding the limitations of deductibles and
2482 copayment provisions in this part, a point-of-service rider may
2483 require the subscriber to pay a reasonable copayment for each
2484 visit for services provided by a noncontracted provider chosen
2485 at the time of the service. The copayment by the subscriber may
2486 either be a specific dollar amount or a percentage of the
2487 reimbursable provider charges covered by the contract and must
2488 be paid by the subscriber to the noncontracted provider upon
2489 receipt of covered services. The point-of-service rider may
2490 require that a reasonable annual deductible for the expenses
2491 associated with the point-of-service rider be met and may
2492 include a lifetime maximum benefit amount. The rider must
2493 include the language required by s. 627.6044 and must comply
2494 with copayment limits described in s. 627.6471. Section 641.3154
2495 does not apply to a point-of-service rider authorized under this
2496 subsection.
2497 (e) The point-of-service rider must contain provisions
2498 that comply with s. 627.6044.
2499 (f)~~(e)~~ The term "point of service" may not be used by a
2500 health maintenance organization except with riders permitted
2501 under this section or with forms approved by the office in which
2502 a point-of-service product is offered with an indemnity carrier.
2503 (g)~~(f)~~ A point-of-service rider must be filed and approved
2504 under ss. 627.410 and 627.411.
2505 (40) Health maintenance organizations shall make available
2506 to the contract holder as part of the application for any such
2507 contract, for an appropriate additional premium, the benefits or

2508 levels of benefits specified in the December 1999 Florida
2509 Medicaid Therapy Services Handbook for genetic or congenital
2510 disorders or conditions involving speech, language, swallowing,
2511 and hearing and a hearing aid and earmolds benefit at the level
2512 of benefits specified in the January 2001 Florida Medicaid
2513 Hearing Services Handbook.
2514 (a) Such optional coverage is not required to be offered
2515 when substantially similar benefits are included in
2516 the contract issued to the subscriber.
2517 (b) This section does not require or prohibit the use of a
2518 provider network.
2519 (c) This section does not prohibit an organization from
2520 requiring prior authorization for the benefits under this
2521 subsection.
2522 (d) This subsection does not apply to health maintenance
2523 organizations issuing individual coverage to fewer than 50,000
2524 members.
2525 Section 28. Subsection (2) of section 626.015, Florida
2526 Statutes, is amended, subsections (8) through (17) of said
2527 section are renumbered as subsections (9) through (18),
2528 respectively, and a new subsection (8) is added to said section,
2529 to read:
2530 626.015 Definitions.--As used in this part:
2531 (2) "Agent" means a general lines agent, life agent,
2532 health agent, or title agent, or all such agents, as indicated
2533 by context. The term "agent" includes an insurance producer or
2534 producer, but does not include a customer representative,
2535 limited customer representative, or service representative but
2536 does include an insurance advisor.

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2537 (8) "Insurance advisor" means any person who, for money,
2538 fee, commission, or any other thing of value offers to examine
2539 or examines any policy of life, accident, or health insurance,
2540 any health benefit plan, or any annuity or pure endowment
2541 contract for the purpose of giving, or gives, or offers to give,
2542 any advice, counsel, recommendation, or information in respect
2543 to the terms, conditions, benefits, coverage, or premium of any
2544 such policy or contract, or in respect to the expediency or
2545 advisability of altering, changing, exchanging, converting,
2546 replacing, surrendering, continuing, or rejecting any such
2547 policy, plan, or contract, or of accepting or procuring any such
2548 policy, plan, or contract from any insurer or issuer of a health
2549 benefit plan, or who in or on advertisements, cards, signs,
2550 circulars, or letterheads, or elsewhere, or in any other way or
2551 manner by which public announcements are made, uses the title
2552 "insurance advisor," "insurance specialist," "insurance
2553 counselor," "insurance analyst," "policyholders' adviser,"
2554 "policyholders' counselor," or any other similar title, or any
2555 title indicating that the person gives, or is engaged in the
2556 business of giving advice, counsel, recommendation, or
2557 information to an insured, or a beneficiary, or any person
2558 having any interest in a life, accident, or health insurance
2559 contract, health benefit plan contract, annuity, or pure
2560 endowment contract. This definition is not intended to prevent a
2561 person who has obtained the professional designation of life
2562 underwriter, chartered financial consultant, or certified
2563 financial planner by completing a course of instruction
2564 recognized within the business of insurance from using that
2565 designation to indicate professional achievement.

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2566 Section 29. Subsection (1) of section 626.016, Florida
2567 Statutes, is amended to read:
2568 626.016 Powers and duties of department, commission, and
2569 office.--
2570 (1) The powers and duties of the Chief Financial Officer
2571 and the department specified in this part apply only with
2572 respect to insurance agents, insurance advisors, managing
2573 general agents, reinsurance intermediaries, viatical settlement
2574 brokers, customer representatives, service representatives, and
2575 agencies.
2576 Section 30. Section 626.171, Florida Statutes, is amended
2577 to read:
2578 626.171 Application for license.--
2579 (1) The department or office shall not issue a license as
2580 agent, insurance advisor, customer representative, adjuster,
2581 ~~insurance agency,~~ service representative, managing general
2582 agent, or reinsurance intermediary to any person except upon
2583 written application therefor filed with it, qualification
2584 therefor, and payment in advance of all applicable fees. Any
2585 such application shall be made under the oath of the applicant
2586 and be signed by the applicant. ~~Beginning November 1, 2002,~~ The
2587 department shall accept the uniform application for nonresident
2588 agent licensing. The department may adopt revised versions of
2589 the uniform application by rule.
2590 (2) In the application, the applicant shall set forth:
2591 (a) His or her full name, age, social security number,
2592 residence address, business address, and mailing address.
2593 (b) Proof that he or she has completed or is in the
2594 process of completing any required prelicensing course.

2595 (c) Whether he or she has been refused or has voluntarily
2596 surrendered or has had suspended or revoked a license to solicit
2597 insurance by the department or by the supervising officials of
2598 any state.
2599 (d) Whether any insurer or any managing general agent
2600 claims the applicant is indebted under any agency contract or
2601 otherwise and, if so, the name of the claimant, the nature of
2602 the claim, and the applicant's defense thereto, if any.
2603 (e) Proof that the applicant meets the requirements for
2604 the type of license for which he or she is applying.
2605 (f) Such other or additional information as the department
2606 or office may deem proper to enable it to determine the
2607 character, experience, ability, and other qualifications of the
2608 applicant to hold himself or herself out to the public as an
2609 insurance representative.
2610 ~~(3) An application for an insurance agency license shall~~
2611 ~~be signed by the owner or owners of the agency. If the agency is~~
2612 ~~incorporated, the application shall be signed by the president~~
2613 ~~and secretary of the corporation.~~
2614 (3)~~(4)~~ Each application shall be accompanied by payment of
2615 any applicable fee.
2616 (4)~~(5)~~ An application for a license as an agent, customer
2617 representative, adjuster, insurance agency, service
2618 representative, managing general agent, or reinsurance
2619 intermediary must be accompanied by a set of the individual
2620 applicant's fingerprints, or, if the applicant is not an
2621 individual, by a set of the fingerprints of the sole proprietor,
2622 majority owner, partners, officers, and directors, on a form
2623 adopted by rule of the department or commission and accompanied

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2624 by the fingerprint processing fee set forth in s. 624.501.
2625 Fingerprints shall be used to investigate the applicant's
2626 qualifications pursuant to s. 626.201. The fingerprints shall be
2627 taken by a law enforcement agency or other department-approved
2628 entity.
2629 (5)~~(6)~~ The application for license filing fee prescribed
2630 in s. 624.501 is not subject to refund.
2631 (6)~~(7)~~ Pursuant to the federal Personal Responsibility and
2632 Work Opportunity Reconciliation Act of 1996, each party is
2633 required to provide his or her social security number in
2634 accordance with this section. Disclosure of social security
2635 numbers obtained through this requirement shall be limited to
2636 the purpose of administration of the Title IV-D program for
2637 child support enforcement.
2638 Section 31. Section 626.191, Florida Statutes, is amended
2639 to read:
2640 626.191 Repeated applications.--The failure of an
2641 applicant to secure a license upon an application shall not
2642 preclude the applicant ~~him or her~~ from applying again as many
2643 times as desired, but the department or office shall not give
2644 consideration to or accept any further application by the same
2645 individual for a similar license dated or filed within 30 days
2646 subsequent to the date the department or office denied the last
2647 application, except as provided in s. 626.281.
2648 Section 32. Subsection (1) of section 626.201, Florida
2649 Statutes, is amended to read:
2650 626.201 Investigation.--
2651 (1) The department or office may propound any reasonable
2652 interrogatories in addition to those contained in the

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2653 application, to any applicant for license or appointment, or on
2654 any renewal, reinstatement, or continuation thereof, relating to
2655 the applicant's ~~his or her~~ qualifications, residence,
2656 prospective place of business, and any other matter which, in
2657 the opinion of the department or office, is deemed necessary or
2658 advisable for the protection of the public and to ascertain the
2659 applicant's qualifications.

2660 Section 33. Subsections (1) and (2) of section 626.342,
2661 Florida Statutes, are amended to read:

2662 626.342 Furnishing supplies to unlicensed life, health, or
2663 general lines agent prohibited; civil liability.--

2664 (1) An insurer, a managing general agent, an insurance
2665 advisor, or an agent, directly or through any representative,
2666 may not furnish to any agent any blank forms, applications,
2667 stationery, or other supplies to be used in soliciting,
2668 negotiating, or effecting contracts of insurance on its behalf
2669 unless such blank forms, applications, stationery, or other
2670 supplies relate to a class of business with respect to which the
2671 agent is licensed and appointed, whether for that insurer or
2672 another insurer.

2673 (2) Any insurer, general agent, insurance advisor, or
2674 agent who furnishes any of the supplies specified in subsection
2675 (1) to any agent or prospective agent not appointed to represent
2676 the insurer and who accepts from or writes any insurance
2677 business for such agent or agency is subject to civil liability
2678 to any insured of such insurer to the same extent and in the
2679 same manner as if such agent or prospective agent had been
2680 appointed or authorized by the insurer or such agent to act in
2681 its or his or her behalf. The provisions of this subsection do

2682 not apply to insurance risk apportionment plans under s.
2683 627.351.
2684 Section 34. Section 626.536, Florida Statutes, is amended
2685 to read:
2686 626.536 Reporting of actions.--An agent and insurance
2687 broker shall submit to the department, within 30 days after the
2688 final disposition of any administrative action taken against the
2689 agent by a governmental agency in this or any other state or
2690 jurisdiction relating to the business of insurance, the sale of
2691 securities, or activity involving fraud, dishonesty,
2692 trustworthiness, or breach of a fiduciary duty, a copy of the
2693 order, consent to order, or other relevant legal documents. The
2694 department may adopt rules implementing the provisions of this
2695 section.
2696 Section 35. Subsections (1) and (3) of section 626.561,
2697 Florida Statutes, are amended to read:
2698 626.561 Reporting and accounting for funds.--
2699 (1) All premiums, return premiums, or other funds
2700 belonging to insurers or others received by an insurance broker,
2701 agent, customer representative, or adjuster in transactions
2702 under a ~~his or her~~ license are trust funds received by the
2703 licensee in a fiduciary capacity. An agent or insurance advisor
2704 shall keep the funds belonging to each insurer for which an
2705 agent or insurance advisor ~~he or she~~ is not appointed, other
2706 than a surplus lines insurer, in a separate account so as to
2707 allow the department or office to properly audit such funds. The
2708 licensee in the applicable regular course of business shall
2709 account for and pay the same to the insurer, insured, or other
2710 person entitled thereto.

2711 (3) Any insurance advisor, agent, customer representative,
2712 or adjuster who, not being lawfully entitled thereto, either
2713 temporarily or permanently diverts or misappropriates such funds
2714 or any portion thereof or deprives the other person of a benefit
2715 therefrom commits the offense specified below:
2716 (a) If the funds diverted or misappropriated are $300 or
2717 less, a misdemeanor of the first degree, punishable as provided
2718 in s. 775.082 or s. 775.083.
2719 (b) If the funds diverted or misappropriated are more than
2720 $300, but less than $20,000, a felony of the third degree,
2721 punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
2722 (c) If the funds diverted or misappropriated are $20,000
2723 or more, but less than $100,000, a felony of the second degree,
2724 punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
2725 (d) If the funds diverted or misappropriated are $100,000
2726 or more, a felony of the first degree, punishable as provided in
2727 s. 775.082, s. 775.083, or s. 775.084.
2728 Section 36. Subsections (1) and (2) of section 626.572,
2729 Florida Statutes, are amended to read:
2730 626.572 Rebating; when allowed.--
2731 (1) No insurance advisor or agent shall rebate any portion
2732 of a ~~his or her~~ commission except as follows:
2733 (a) The rebate shall be available to all insureds in the
2734 same actuarial class.
2735 (b) The rebate shall be in accordance with a rebating
2736 schedule filed by the agent with the insurer issuing the policy
2737 to which the rebate applies.
2738 (c) The rebating schedule shall be uniformly applied in
2739 that all insureds who purchase the same policy through the agent

2740 for the same amount of insurance receive the same percentage
2741 rebate.
2742 (d) Rebates shall not be given to an insured with respect
2743 to a policy purchased from an insurer that prohibits its agents
2744 from rebating commissions.
2745 (e) The rebate schedule is prominently displayed in public
2746 view in the agent's place of doing business and a copy is
2747 available to insureds on request at no charge.
2748 (f) The age, sex, place of residence, race, nationality,
2749 ethnic origin, marital status, or occupation of the insured or
2750 location of the risk is not utilized in determining the
2751 percentage of the rebate or whether a rebate is available.
2752 (2) The insurance advisor or agent shall maintain a copy
2753 of all rebate schedules for the most recent 5 years and their
2754 effective dates.
2755 Section 37. Subsection (1) of section 626.601, Florida
2756 Statutes, is amended to read:
2757 626.601 Improper conduct; inquiry; fingerprinting.--
2758 (1) The department or office may, upon its own motion or
2759 upon a written complaint signed by any interested person and
2760 filed with the department or office, inquire into any alleged
2761 improper conduct of any licensed insurance advisor, agent,
2762 adjuster, service representative, managing general agent,
2763 customer representative, title insurance agent, title insurance
2764 agency, continuing education course provider, instructor, school
2765 official, or monitor group under this code. The department or
2766 office may thereafter initiate an investigation of any such
2767 licensee if it has reasonable cause to believe that the licensee
2768 has violated any provision of the insurance code. During the

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2769 course of its investigation, the department or office shall
2770 contact the licensee being investigated unless it determines
2771 that contacting such person could jeopardize the successful
2772 completion of the investigation or cause injury to the public.
2773 Section 38. Section 626.6115, Florida Statutes, is amended
2774 to read:
2775 626.6115 Grounds for compulsory refusal, suspension, or
2776 revocation of insurance agency license.--The department shall
2777 deny, suspend, revoke, or refuse to continue the license of any
2778 insurance agency if it finds, as to any insurance agency or as
2779 to any majority owner, partner, manager, director, officer, or
2780 other person who manages or controls such agency, that any
2781 ~~either one or both~~ of the following applicable grounds exist:
2782 (1) Lack by the agency of one or more of the
2783 qualifications for the license as specified in this code;~~.~~
2784 (2) Material misstatement, misrepresentation, or fraud in
2785 obtaining the license or in attempting to obtain the license;
2786 or~~.~~
2787 (3) Denial, suspension, or revocation of a license to
2788 practice or conduct any regulated profession, business, or
2789 vocation relating to the business of insurance by this state,
2790 any other state, any nation, any possession or district of the
2791 United States, any court, or any lawful agency thereof.
2792 Section 39. Paragraph (b) of subsection (5) of section
2793 624.509, Florida Statutes, is amended to read:
2794 624.509 Premium tax; rate and computation.--
2795 (5) There shall be allowed a credit against the net tax
2796 imposed by this section equal to 15 percent of the amount paid
2797 by the insurer in salaries to employees located or based within

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2798 this state and who are covered by the provisions of chapter 443.
2799 For purposes of this subsection:
2800 (b) The term "employees" does not include independent
2801 contractors or any person whose duties require that the person
2802 hold a valid license under the Florida Insurance Code, except
2803 persons defined in s. 626.015(1), (16)~~(15)~~, and (18)~~(17)~~.
2804 Section 40. Subsection (2) of section 626.7845, Florida
2805 Statutes, is amended to read:
2806 626.7845 Prohibition against unlicensed transaction of
2807 life insurance.--
2808 (2) Except as provided in s. 626.112(6), with respect to
2809 any line of authority specified in s. 626.015(12)~~(11)~~, no
2810 individual shall, unless licensed as a life agent:
2811 (a) Solicit insurance or annuities or procure
2812 applications; or
2813 (b) In this state, engage or hold himself or herself out
2814 as engaging in the business of analyzing or abstracting
2815 insurance policies or of counseling or advising or giving
2816 opinions to persons relative to insurance or insurance contracts
2817 other than:
2818 1. As a consulting actuary advising an insurer; or
2819 2. As to the counseling and advising of labor unions,
2820 associations, trustees, employers, or other business entities,
2821 the subsidiaries and affiliates of each, relative to their
2822 interests and those of their members or employees under
2823 insurance benefit plans.
2824 Section 41. Paragraph (c) of subsection (2) of section
2825 626.292, Florida Statutes, is amended to read:
2826 626.292 Transfer of license from another state.--

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2827 (2) To qualify for a license transfer, an individual
2828 applicant must meet the following requirements:
2829 (c) The individual shall submit a completed application
2830 for this state which is received by the department within 90
2831 days after the date the individual became a resident of this
2832 state, along with payment of the applicable fees set forth in s.
2833 624.501 and submission of the following documents:
2834 1. A certification issued by the appropriate official of
2835 the applicant's home state identifying the type of license and
2836 lines of authority under the license and stating that, at the
2837 time the license from the home state was canceled, the applicant
2838 was in good standing in that state or that the state's Producer
2839 Database records, maintained by the National Association of
2840 Insurance Commissioners, its affiliates, or subsidiaries,
2841 indicate that the agent is or was licensed in good standing for
2842 the line of authority requested.
2843 2. A set of the individual applicant's fingerprints in
2844 accordance with s. 626.171(4)~~(5)~~.
2845 Section 42. Paragraph (a) of subsection (2) of section
2846 626.321, Florida Statutes, is amended to read:
2847 626.321 Limited licenses.--
2848 (2) An entity applying for a license under this section is
2849 required to:
2850 (a) Submit only one application for a license under s.
2851 626.171. The requirements of s. 626.171(4)~~(5)~~ shall only apply
2852 to the officers and directors of the entity submitting the
2853 application.
2854 Section 43. Notwithstanding the amendment to s.
2855 627.6699(5)(c), Florida Statutes, by this act, any right to an

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2856 open enrollment offer of health benefit coverage for groups of
2857 fewer than two employees, pursuant to s. 627.6699(5)(c), Florida
2858 Statutes, as it existed immediately before the effective date of
2859 this act, shall remain in full force and effect until the
2860 enactment of s. 627.64872, Florida Statutes, and the subsequent
2861 date upon which such plan begins to accept new risks or members.
2862 Section 44. Section 408.02, Florida Statutes, is repealed.
2863 Section 45. The sum of $250,000 is appropriated from the
2864 Insurance Regulatory Trust Fund in the Department of Financial
2865 Services to the Office of Insurance Regulation for the purpose
2866 of implementing the provisions in this act related to the Small
2867 Business Health Plan.
2868 Section 46. There is hereby appropriated a sum of $2
2869 million from General Revenue to the Agency for Health Care
2870 Administration for funding activities relative to the Statewide
2871 Electronic Medical Records Advisory Council provided under s.
2872 408.919, Florida Statutes.
2873 Section 47. This act shall take effect October 1, 2004.

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