CHAMBER ACTION

1 The Committee on Appropriations recommends the following:
2
3 **Committee Substitute**
4 Remove the entire bill and insert:
5 A bill to be entitled
6 An act relating to affordable health care; providing a
7 popular name; providing purpose; amending s. 381.026,
8 F.S.; requiring certain licensed facilities to provide
9 public Internet access to certain financial information;
10 providing a definition; amending s. 381.734, F.S.;
11 including participation by health care providers, small
12 businesses, and health insurers in the Healthy
13 Communities, Healthy People Program; requiring the
14 Department of Health to provide public Internet access to
15 certain public health programs; requiring the department
16 to monitor and assess the effectiveness of such programs;
17 requiring a report; requiring the Office of Program Policy
18 and Government Accountability to evaluate the
19 effectiveness of such programs; requiring a report;
20 amending s. 395.1041, F.S.; authorizing hospitals to
21 develop certain emergency room diversion programs;
22 amending s. 395.1055, F.S.; requiring licensed facilities
23 to make certain patient charge and performance outcome

24 data available on Internet websites; amending s. 395.1065,
25 F.S.; authorizing the Agency for Health Care
26 Administration to charge a fine for failure to provide
27 such information; amending s. 395.301, F.S.; requiring
28 certain licensed facilities to provide prospective
29 patients certain estimates of charges for services;
30 requiring such facilities to provide patients with certain
31 bill verification information; providing for a fine for
32 failure to provide such information; providing charge
33 limitations; requiring such facilities to establish a
34 patient question review and response methodology;
35 providing requirements; requiring certain licensed
36 facilities to provide public Internet access to certain
37 financial information; requiring posting of a notice of
38 the availability of such information; amending s. 408.061,
39 F.S.; requiring the Agency for Health Care Administration
40 to require health care facilities, health care providers,
41 and health insurers to submit certain information;
42 providing requirements; requiring the agency to adopt
43 certain risk and severity adjustment methodologies;
44 requiring the agency to adopt certain rules; requiring
45 certain information to be certified; amending s. 408.062,
46 F.S.; requiring the agency to conduct certain health care
47 costs and access research, analyses, and studies;
48 expanding the scope of such studies to include collection
49 of pharmacy retail price data, use of emergency
50 departments, physician information, and Internet patient
51 charge information availability; requiring a report;

52 requiring the agency to conduct additional data-based
53 studies and make recommendations to the Legislature;
54 requiring the agency to develop and implement a strategy
55 to adopt and use electronic health records; authorizing
56 the agency to develop rules to protect electronic records
57 confidentiality; requiring a report to the Governor and
58 Legislature; amending s. 408.05, F.S.; requiring the
59 agency to develop a plan to make performance outcome and
60 financial data available to consumers for health care
61 services comparison purposes; requiring submittal of the
62 plan to the Governor and Legislature; requiring the agency
63 to update the plan; requiring the agency to make the plan
64 available electronically; providing plan requirements;
65 amending s. 409.9066, F.S.; requiring the agency to
66 provide certain information relating to the Medicare
67 prescription discount program; amending s. 408.7056, F.S.;
68 renaming the Statewide Provider and Subscriber Assistance
69 Program as the Subscriber Assistance Program; revising
70 provisions to conform; expanding certain records
71 availability provisions; revising membership provisions
72 relating to a subscriber grievance hearing panel; revising
73 a list of grievances the panel may consider; providing
74 hearing procedures; amending s. 641.3154, F.S., to conform
75 to the renaming of the Subscriber Assistance Program;
76 amending s. 641.511, F.S., to conform to the renaming of
77 the Subscriber Assistance Program; adopting and
78 incorporating by reference the Employee Retirement Income
79 Security Act of 1974, as implemented by federal

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80 regulations; amending s. 641.58, F.S., to conform to the
81 renaming of the Subscriber Assistance Program; amending s.
82 408.909, F.S.; expanding a definition of "health flex plan
83 entity" to include public-private partnerships; making a
84 pilot health flex plan program apply permanently
85 statewide; providing additional program requirements;
86 creating s. 381.0271, F.S.; providing definitions;
87 creating the Florida Patient Safety Corporation;
88 authorizing the corporation to create additional not-for-
89 profit corporate subsidiaries for certain purposes;
90 specifying application of public records and public
91 meetings requirements; exempting the corporation and
92 subsidiaries from public procurement provisions; providing
93 purposes; providing for a board of directors; providing
94 for membership; authorizing the corporation to establish
95 certain advisory committees; providing for organization of
96 the corporation; providing for meetings; providing powers
97 and duties of the corporation; requiring the corporation
98 to collect, analyze, and evaluate patient safety data and
99 related information; requiring the corporation to
100 establish a reporting system to identify and report near
101 misses relating to patient safety; requiring the
102 corporation to work with state agencies to develop
103 electronic health records; providing for an active library
104 of evidence-based medicine and patient safety practices;
105 requiring the corporation to develop and recommend core
106 competencies in patient safety and public education
107 programs; requiring an annual report; providing report

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108 requirements; authorizing the corporation to seek funding
109 and apply for grants; requiring the Office of Program
110 Policy Analysis and Government Accountability, the
111 Department of Health, and the Agency for Health Care
112 Administration to develop performance standards to
113 evaluate the corporation; amending s. 409.91255, F.S.;
114 expanding assistance to certain health centers to include
115 community emergency room diversion programs and urgent
116 care services; amending s. 627.410, F.S.; requiring
117 insurers to file certain rates with the Office of
118 Insurance Regulation; creating s. 627.64872, F.S.;
119 providing legislative intent; creating the Florida Health
120 Insurance Plan for certain purposes; providing
121 definitions; providing exclusions; providing requirements
122 for operation of the plan; providing for a board of
123 directors; providing for appointment of members; providing
124 for terms; specifying service without compensation;
125 providing for travel and per diem expenses; requiring a
126 plan of operation; providing requirements; providing for
127 powers of the plan; requiring reports to the Governor and
128 Legislature; providing for an actuarial study; providing
129 certain immunity from liability for plan obligations;
130 authorizing the board to provide for indemnification of
131 certain costs; requiring an annually audited financial
132 statement; providing for eligibility for coverage under
133 the plan; providing criteria, requirements, and
134 limitations; specifying certain activity as an unfair
135 trade practice; providing for a plan administrator;

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136 providing criteria; providing requirements; providing term
137 limits for the plan administrator; providing duties;
138 providing for paying the administrator; providing for
139 premium rates for plan coverage; providing rate
140 limitations; providing for sources of additional revenue;
141 specifying benefits under the plan; providing criteria,
142 requirements, and limitations; providing for
143 nonduplication of benefits; providing for annual and
144 maximum lifetime benefits; providing for tax exempt
145 status; providing for abolition of the Florida
146 Comprehensive Health Association upon implementation of
147 the plan; providing for continued operation of the Florida
148 Comprehensive Health Association until adoption of a plan
149 of operation for the Florida Health Insurance Plan;
150 providing for enrollment in the plan of persons enrolled
151 in the association; requiring insurers to pay certain
152 assessments to the board for certain purposes; providing
153 criteria, requirements, and limitations for such
154 assessments; providing for repeal of ss. 627.6488,
155 627.6489, 627.649, 627.6492, 627.6494, 627.6496, and
156 627.6498, F.S., relating to the Florida Comprehensive
157 Health Association, upon implementation of the plan;
158 amending s. 627.662, F.S.; providing for application of
159 certain claim payment methodologies to certain types of
160 insurance; providing for certain actions relating to
161 inappropriate utilization of emergency care; amending s.
162 627.6699, F.S.; revising provisions requiring small
163 employer carriers to offer certain health benefit plans;

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164 preserving a right to open enrollment for certain small
165 groups; requiring small employer carriers to file and
166 provide coverage under certain high deductible plans;
167 including high deductible plans and health reimbursement
168 arrangements under certain required plan provisions;
169 creating the Small Employers Access Program; providing
170 legislative intent; providing definitions; providing
171 participation eligibility requirements and criteria;
172 requiring the Office of Insurance Regulation to administer
173 the program by selecting an insurer through competitive
174 bidding; providing requirements; specifying insurer
175 qualifications; providing duties of the insurer; providing
176 a contract term; providing insurer reporting requirements;
177 providing application requirements; providing for benefits
178 under the program; requiring the office to annually report
179 to the Governor and Legislature; creating ss. 627.6405 and
180 641.31097, F.S.; providing for decreasing inappropriate
181 use of emergency care; providing legislative findings and
182 intent; requiring health maintenance organizations and
183 providers to provide certain information electronically
184 and develop community emergency department diversion
185 programs; authorizing health maintenance organizations to
186 require higher copayments for certain uses of emergency
187 departments; amending s. 627.9175, F.S.; requiring certain
188 health insurers to annually report certain coverage
189 information to the office; providing requirements;
190 deleting certain reporting requirements; retitling ch.
191 636, F.S.; designating ss. 636.002-636.067, F.S., as pt. I

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192 of ch. 636, F.S.; providing a part title; amending s.
193 636.003, F.S.; revising the definition of "prepaid limited
194 health service organization" to exclude discount medical
195 plan organizations; creating pt. II of ch. 636, F.S.,
196 consisting of ss. 636.202-636.244, F.S.; providing a part
197 title; providing definitions; providing for regulation and
198 operation of discount medical plan organizations;
199 requiring corporate licensure before doing business as a
200 discount medical plan; specifying application
201 requirements; requiring license fees; providing for
202 expiration and renewal of licenses; requiring such
203 organizations to establish an Internet website; requiring
204 publication of certain information on the website;
205 specifying collection and deposit of the licensing fee;
206 authorizing the office to examine or investigate the
207 business affairs of such organizations; requiring
208 examinations and investigations; authorizing the office to
209 order production of documents and take statements;
210 requiring organizations to pay certain expenses;
211 specifying grounds for denial or revocation under certain
212 circumstances; authorizing discount medical plan
213 organizations to charge certain fees under certain
214 circumstances; providing reimbursement requirements;
215 prohibiting certain activities; requiring certain
216 disclosures to prospective members; requiring provider
217 agreements to provide services under a medical discount
218 plan; providing agreement requirements; requiring forms
219 and rates to be filed with the office; requiring annual

220 reports to be filed with the office; providing
221 requirements; providing for fines and administrative
222 sanctions for failing to file annual reports; establishing
223 minimum capital requirements; providing for suspension or
224 revocation of licenses under certain circumstances;
225 providing for suspension of enrollment of new members
226 under certain circumstances; providing terms of
227 suspensions; requiring notice of any change of an
228 organization's name; requiring discount medical plan
229 organizations to maintain provider names listings;
230 specifying marketing requirements of discount medical
231 plans; providing limitations; specifying fee disclosure
232 requirements for bundling discount medical plans with
233 other insurance products; authorizing the commission to
234 adopt rules; applying insurer service of process
235 requirements on discount medical plan organizations;
236 requiring a security deposit; prohibiting levy on certain
237 deposit assets or securities under certain circumstances;
238 providing criminal penalties; authorizing the office to
239 seek certain injunctive relief under certain
240 circumstances; providing limitations; providing for civil
241 actions for damages for certain violations; providing for
242 awards of court costs and attorney fees; specifying
243 application of unauthorized insurer provisions of law to
244 unlicensed discount medical plan organizations; creating
245 ss. 627.65626 and 627.6402, F.S.; providing for insurance
246 rebates for healthy lifestyles; providing for rebate of
247 certain premiums for participation in health wellness,

248 maintenance, or improvement programs under certain
249 circumstances; providing requirements; amending s. 641.31,
250 F.S.; authorizing health maintenance organizations
251 offering certain point-of-service riders to offer such
252 riders to certain employers for certain employees;
253 providing requirements and limitations; providing for
254 application of certain claim payment methodologies to
255 certain types of insurance; providing for rebate of
256 certain premiums for participation in health wellness,
257 maintenance, or improvement programs under certain
258 circumstances; providing requirements; creating s.
259 626.593, F.S.; providing fee and commission limitations
260 for health insurance agents; requiring a written contract
261 for compensation; providing contract requirements;
262 requiring a rebate of commission under certain
263 circumstances; amending ss. 626.191 and 626.201, F.S.;
264 clarifying certain application requirements; preserving
265 certain rights to enrollment in certain health benefit
266 coverage programs for certain groups under certain
267 circumstances; creating s. 465.0244, F.S.; requiring each
268 pharmacy to make available on its Internet website a link
269 to certain performance outcome and financial data of the
270 Agency for Health Care Administration and a notice of the
271 availability of such information; amending s. 627.6499,
272 F.S.; requiring each health insurer to make available on
273 its Internet website a link to certain performance outcome
274 and financial data of the Agency for Health Care
275 Administration and a notice in policies of the

276 availability of such information; amending s. 641.54,
277 F.S.; requiring health maintenance organizations to make
278 certain insurance financial information available to
279 subscribers; requiring health maintenance organizations to
280 make available on its Internet website a link to certain
281 performance outcome and financial data of the Agency for
282 Health Care Administration and a notice in policies of the
283 availability of such information; repealing s. 408.02,
284 F.S., relating to the development, endorsement,
285 implementation, and evaluation of patient management
286 practice parameters by the Agency for Health Care
287 Administration; providing appropriations; providing
288 effective dates.
289
290 WHEREAS, according to the Kaiser Family Foundation, eight
291 out of ten uninsured Americans are workers or dependents of
292 workers and nearly eight out of ten uninsured Americans have
293 family incomes above the poverty level, and
294 WHEREAS, fifty-five percent of those who do not have
295 insurance state the reason they don't have insurance is lack of
296 affordability, and
297 WHEREAS, average health insurance premium increases for the
298 last two years have been in the range of ten to twenty percent
299 for Florida's employers, and
300 WHEREAS, an increasing number of employers are opting to
301 cease providing insurance coverage to their employees due to the
302 high cost, and

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303 WHEREAS, an increasing number of employers who continue
304 providing coverage are forced to shift more premium cost to
305 their employees, thus diminishing the value of employee wage
306 increases, and
307 WHEREAS, according to studies, the rate of avoidable
308 hospitalization is fifty to seventy percent lower for the
309 insured versus the uninsured, and
310 WHEREAS, according to Florida Cancer Registry data, the
311 uninsured have a seventy percent greater chance of a late
312 diagnosis, thus decreasing the chances of a positive health
313 outcome, and
314 WHEREAS, according to the Agency for Health Care
315 Administration's 2002 financial data, uncompensated care in
316 Florida's hospitals is growing at the rate of twelve to thirteen
317 percent per year, and, at $4.3 billion in 2001, this cost, when
318 shifted to Floridians who remain insured, is not sustainable,
319 and
320 WHEREAS, the Florida Legislature, through the creation of
321 Health Flex, has already identified the need for lower cost
322 alternatives, and
323 WHEREAS, it is of vital importance and in the best
324 interests of the people of the State of Florida that the issue
325 of available, affordable health care insurance be addressed in a
326 cohesive and meaningful manner, and
327 WHEREAS, there is general recognition that the issues
328 surrounding the problem of access to affordable health insurance
329 are complicated and multifaceted, and

330 WHEREAS, on August 14, 2003, Speaker Johnnie Byrd created
331 the Select Committee on Affordable Health Care for Floridians in
332 an effort to address the issue of affordable and accessible
333 employment-based insurance, and
334 WHEREAS, the Select Committee on Affordable Health Care for
335 Floridians held public hearings with predetermined themes around
336 the state, specifically, in Orlando, Miami, Jacksonville, Tampa,
337 Pensacola, Boca Raton, and Tallahassee, from October through
338 November 2003 to effectively probe the operation of the private
339 insurance marketplace, to understand the health insurance market
340 trends, to learn from past policy initiatives, and to identify,
341 explore, and debate new ideas for change, and
342 WHEREAS, recommendations from the Select Committee on
343 Affordable Health Care were adopted on February 4, 2004, to
344 address the multifaceted issues attributed to the increase in
345 health care cost, and
346 WHEREAS, these recommendations were presented to the
347 Speaker of the House of Representatives in a final report from
348 the committee on February 18, 2004, and subsequent legislation
349 was drafted creating the "The 2004 Affordable Health Care for
350 Floridians Act," NOW, THEREFORE,
351
352 Be It Enacted by the Legislature of the State of Florida:
353
354 Section 1. <u>This act may be referred to by the popular name</u>
355 <u>"The 2004 Affordable Health Care for Floridians Act."</u>
356 Section 2. <u>The purpose of this act is to address the</u>
357 <u>underlying cause of the double-digit increases in health</u>

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358 insurance premiums by mitigating the overall growth in health
359 care costs.
360 Section 3. Paragraph (c) of subsection (4) of section
361 381.026, Florida Statutes, is amended to read:
362 381.026 Florida Patient's Bill of Rights and
363 Responsibilities.--
364 (4) RIGHTS OF PATIENTS.--Each health care facility or
365 provider shall observe the following standards:
366 (c) Financial information and disclosure.--
367 1. A patient has the right to be given, upon request, by
368 the responsible provider, his or her designee, or a
369 representative of the health care facility full information and
370 necessary counseling on the availability of known financial
371 resources for the patient's health care.
372 2. A health care provider or a health care facility shall,
373 upon request, disclose to each patient who is eligible for
374 Medicare, in advance of treatment, whether the health care
375 provider or the health care facility in which the patient is
376 receiving medical services accepts assignment under Medicare
377 reimbursement as payment in full for medical services and
378 treatment rendered in the health care provider's office or
379 health care facility.
380 3. A health care provider or a health care facility shall,
381 upon request, furnish a person ~~patient~~, prior to provision of
382 medical services, a reasonable estimate of charges for such
383 services. Such reasonable estimate shall not preclude the health
384 care provider or health care facility from exceeding the

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385 estimate or making additional charges based on changes in the
386 patient's condition or treatment needs.
387 4. Each licensed facility not operated by the state shall
388 make available to the public on its Internet website or by other
389 electronic means a description of and a link to the performance
390 outcome and financial data that is published by the agency
391 pursuant to s. 408.05(3)(l). The facility shall place a notice
392 in the reception area that such information is available
393 electronically and the website address. The licensed facility
394 may indicate that the pricing information is based on a
395 compilation of charges for the average patient and that each
396 patient's bill may vary from the average depending upon the
397 severity of illness and individual resources consumed. The
398 licensed facility may also indicate that the price of service is
399 negotiable for eligible patients based upon the patient's
400 ability to pay.
401 5.~~4.~~ A patient has the right to receive a copy of an
402 itemized bill upon request. A patient has a right to be given an
403 explanation of charges upon request.
404 Section 4. Subsection (1) and paragraph (g) of subsection
405 (3) of section 381.734, Florida Statutes, are amended, and
406 subsections (4), (5), and (6) are added to said section, to
407 read:
408 381.734 Healthy Communities, Healthy People Program.--
409 (1) The department shall develop and implement the Healthy
410 Communities, Healthy People Program, a comprehensive and
411 community-based health promotion and wellness program. The
412 program shall be designed to reduce major behavioral risk

413 factors associated with chronic diseases, including those
414 chronic diseases identified in chapter 385, by enhancing the
415 knowledge, skills, motivation, and opportunities for
416 individuals, organizations, health care providers, small
417 businesses, health insurers, and communities to develop and
418 maintain healthy lifestyles.
419 (3) The program shall include:
420 (g) The establishment of a comprehensive program to inform
421 the public, health care professionals, health insurers, and
422 communities about the prevalence of chronic diseases in the
423 state; known and potential risks, including social and
424 behavioral risks; and behavior changes that would reduce risks.
425 (4) The department shall make available on its Internet
426 website, no later than October 1, 2004, and in a hard-copy
427 format upon request, a listing of age-specific, disease-
428 specific, and community-specific health promotion, preventive
429 care, and wellness programs offered and established under the
430 Healthy Communities, Healthy People Program. The website shall
431 also provide residents with information to identify behavior
432 risk factors that lead to diseases that are preventable by
433 maintaining a healthy lifestyle. The website shall allow
434 consumers to select by county or region disease-specific
435 statistical information.
436 (5) The department shall monitor and assess the
437 effectiveness of such programs. The department shall submit a
438 status report based on this monitoring and assessment to the
439 Governor, the Speaker of the House of Representatives, the
440 President of the Senate, and the substantive committees of each

441 house of the Legislature, with the first annual report due
442 January 31, 2005.
443 (6) The Office of Program Policy and Government
444 Accountability shall evaluate and report to the Governor, the
445 President of the Senate, and the Speaker of the House of
446 Representatives, by March 1, 2005, on the effectiveness of the
447 department's monitoring and assessment of the program's
448 effectiveness.
449 Section 5. Subsection (7) is added to section 395.1041,
450 Florida Statutes, to read:
451 395.1041 Access to emergency services and care.--
452 (7) EMERGENCY ROOM DIVERSION PROGRAMS.--Hospitals may
453 develop emergency room diversion programs, including, but not
454 limited to, an "Emergency Hotline" which allows patients to help
455 determine if emergency department services are appropriate or if
456 other health care settings may be more appropriate for care, and
457 a "Fast Track" program allowing nonemergency patients to be
458 treated at an alternative site. Alternative sites may include
459 health care programs funded with local tax revenue and federally
460 funded community health centers, county health departments, or
461 other nonhospital providers of health care services. The program
462 may include provisions for followup care and case management.
463 Section 6. Paragraph (h) is added to subsection (1) of
464 section 395.1055, Florida Statutes, to read:
465 395.1055 Rules and enforcement.--
466 (1) The agency shall adopt rules pursuant to ss.
467 120.536(1) and 120.54 to implement the provisions of this part,

468 which shall include reasonable and fair minimum standards for
469 ensuring that:
470 (h) Licensed facilities make available on their Internet
471 websites, no later than October 1, 2004, and in a hard-copy
472 format upon request, a description of and a link to the patient
473 charge and performance outcome data collected from licensed
474 facilities pursuant to s. 408.061.
475 Section 7. Subsection (7) is added to section 395.1065,
476 Florida Statutes, to read:
477 395.1065 Criminal and administrative penalties;
478 injunctions; emergency orders; moratorium.--
479 (7) The agency shall impose a fine of $500 for each
480 instance of the facility's failure to provide the information
481 required by rules adopted pursuant to s. 395.1055(1)(h).
482 Section 8. Subsections (1), (2), and (3) of section
483 395.301, Florida Statutes, are amended, and subsections (7),
484 (8), (9), and (10) are added to said section, to read:
485 395.301 Itemized patient bill; form and content prescribed
486 by the agency.--
487 (1) A licensed facility not operated by the state shall
488 notify each patient during admission and at discharge of his or
489 her right to receive an itemized bill upon request. Within 7
490 days following the patient's discharge or release from a
491 licensed facility not operated by the state, ~~or within 7 days~~
492 ~~after the earliest date at which the loss or expense from the~~
493 ~~service may be determined,~~ the licensed facility providing the
494 service shall, upon request, submit to the patient, or to the
495 patient's survivor or legal guardian as may be appropriate, an

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496 itemized statement detailing in language comprehensible to an
497 ordinary layperson the specific nature of charges or expenses
498 incurred by the patient, which in the initial billing shall
499 contain a statement of specific services received and expenses
500 incurred for such items of service, enumerating in detail the
501 constituent components of the services received within each
502 department of the licensed facility and including unit price
503 data on rates charged by the licensed facility, as prescribed by
504 the agency.
505 (2)(a) Each such statement submitted pursuant to this
506 section:
507 1.~~(a)~~ May not include charges of hospital-based physicians
508 if billed separately.
509 2.~~(b)~~ May not include any generalized category of expenses
510 such as "other" or "miscellaneous" or similar categories.
511 3.~~(c)~~ Shall list drugs by brand or generic name and not
512 refer to drug code numbers when referring to drugs of any sort.
513 4.~~(d)~~ Shall specifically identify therapy treatment as to
514 the date, type, and length of treatment when therapy treatment
515 is a part of the statement.
516 (b) Any person receiving a statement pursuant to this
517 section shall be fully and accurately informed as to each charge
518 and service provided by the institution preparing the statement.
519 (3) On each ~~such~~ itemized statement submitted pursuant to
520 subsection (1) there shall appear the words "A FOR-PROFIT (or
521 NOT-FOR-PROFIT or PUBLIC) HOSPITAL (or AMBULATORY SURGICAL
522 CENTER) LICENSED BY THE STATE OF FLORIDA" or substantially
523 similar words sufficient to identify clearly and plainly the

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524 ownership status of the licensed facility. Each itemized
525 statement must prominently display the phone number of the
526 medical facility's patient liaison who is responsible for
527 expediting the resolution of any billing dispute between the
528 patient, or his or her representative, and the billing
529 department.
530 (7) Each licensed facility not operated by the state shall
531 provide, prior to provision of any nonemergency medical
532 services, a written good-faith estimate of reasonably
533 anticipated charges for the facility to treat the patient's
534 condition upon written request of a prospective patient. The
535 estimate shall be provided to the prospective patient within 7
536 business days after the receipt of the request. The estimate may
537 be the average charges for that diagnosis related group or the
538 average charges for that procedure. Upon request, the facility
539 shall notify the patient of any revision to the good-faith
540 estimate. Such estimate shall not preclude the actual charges
541 from exceeding the estimate. The facility shall place a notice
542 in the reception area that such information is available.
543 Failure to provide the estimate within the provisions
544 established pursuant to this section shall result in a fine of
545 $500 for each instance of the facility's failure to provide the
546 requested information.
547 (8) A licensed facility shall make available to a patient
548 all records necessary for verification of the accuracy of the
549 patient's bill within 30 business days after the request for
550 such records. The verification information must be made
551 available in the facility's offices. Such records shall be

552 available to the patient prior to and after payment of the bill
553 or claim. The facility may not charge the patient for making
554 such verification records available; however, the facility may
555 charge its usual fee for providing copies of records as
556 specified in s. 395.3025.
557 (9) Each facility shall establish a method for reviewing
558 and responding to questions from patients concerning the
559 patient's itemized bill. Such response shall be provided within
560 30 days after the date a question is received. If the patient is
561 not satisfied with the response, the facility must provide the
562 patient with the address of the agency to which the issue may be
563 sent for review.
564 (10) Each licensed facility shall make available on its
565 Internet website a link to the performance outcome and financial
566 data that is published by the Agency for Health Care
567 Administration pursuant to s. 408.05(3)(l). The facility shall
568 place a notice in the reception area that the information is
569 available electronically and the facility's Internet website
570 address.
571 Section 9. Subsection (1) of section 408.061, Florida
572 Statutes, is amended to read:
573 408.061 Data collection; uniform systems of financial
574 reporting; information relating to physician charges;
575 confidential information; immunity.--
576 (1) The agency shall ~~may~~ require the submission by health
577 care facilities, health care providers, and health insurers of
578 data necessary to carry out the agency's duties. Specifications
579 for data to be collected under this section shall be developed

580 by the agency with the assistance of technical advisory panels
581 including representatives of affected entities, consumers,
582 purchasers, and such other interested parties as may be
583 determined by the agency.
584 (a) Data ~~to be~~ submitted by health care facilities,
585 including the facilities as defined in chapter 395, shall ~~may~~
586 include, but are not limited to: case-mix data, patient
587 admission and ~~or~~ discharge data, hospital emergency department
588 data which shall include the number of patients treated in the
589 emergency department of a licensed hospital reported by patient
590 acuity level, data on hospital-acquired infections as specified
591 by rule, data on complications as specified by rule, data on
592 readmissions as specified by rule, with patient and provider-
593 specific identifiers included, actual charge data by diagnostic
594 groups, financial data, accounting data, operating expenses,
595 expenses incurred for rendering services to patients who cannot
596 or do not pay, interest charges, depreciation expenses based on
597 the expected useful life of the property and equipment involved,
598 and demographic data. The agency shall adopt nationally
599 recognized risk adjustment methodologies or software consistent
600 with the standards of the Agency for Healthcare Research and
601 Quality and as selected by the agency for all data submitted as
602 required by this section. Data may be obtained from documents
603 such as, but not limited to: leases, contracts, debt
604 instruments, itemized patient bills, medical record abstracts,
605 and related diagnostic information. Reported data elements shall
606 be reported electronically in accordance with Rule 59E-7.012,
607 Florida Administrative Code. Data submitted shall be certified

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608 by the chief executive officer or an appropriate and duly
609 authorized representative or employee of the licensed facility
610 that the information submitted is true and accurate.
611 (b) Data to be submitted by health care providers may
612 include, but are not limited to: Medicare and Medicaid
613 participation, types of services offered to patients, amount of
614 revenue and expenses of the health care provider, and such other
615 data which are reasonably necessary to study utilization
616 patterns. Data submitted shall be certified by the appropriate
617 duly authorized representative or employee of the health care
618 provider that the information submitted is true and accurate.
619 (c) Data to be submitted by health insurers may include,
620 but are not limited to: claims, premium, administration, and
621 financial information. Data submitted shall be certified by the
622 chief financial officer, an appropriate and duly authorized
623 representative, or an employee of the insurer that the
624 information submitted is true and accurate.
625 (d) Data required to be submitted by health care
626 facilities, health care providers, or health insurers shall not
627 include specific provider contract reimbursement information.
628 However, such specific provider reimbursement data shall be
629 reasonably available for onsite inspection by the agency as is
630 necessary to carry out the agency's regulatory duties. Any such
631 data obtained by the agency as a result of onsite inspections
632 may not be used by the state for purposes of direct provider
633 contracting and are confidential and exempt from the provisions
634 of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

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635 (e) A requirement to submit data shall be adopted by rule
636 if the submission of data is being required of all members of
637 any type of health care facility, health care provider, or
638 health insurer. Rules are not required, however, for the
639 submission of data for a special study mandated by the
640 Legislature or when information is being requested for a single
641 health care facility, health care provider, or health insurer.
642 Section 10. Subsections (1) and (4) of section 408.062,
643 Florida Statutes, are amended, and subsection (5) is added to
644 said section, to read:
645 408.062 Research, analyses, studies, and reports.--
646 (1) The agency shall ~~have the authority to~~ conduct
647 research, analyses, and studies relating to health care costs
648 and access to and quality of health care services as access and
649 quality are affected by changes in health care costs. Such
650 research, analyses, and studies shall include, but not be
651 limited to~~, research and analysis relating to~~:
652 (a) The financial status of any health care facility or
653 facilities subject to the provisions of this chapter.
654 (b) The impact of uncompensated charity care on health
655 care facilities and health care providers.
656 (c) The state's role in assisting to fund indigent care.
657 (d) In conjunction with the Office of Insurance
658 Regulation, the availability and affordability of health
659 insurance for small businesses.
660 (e) Total health care expenditures in the state according
661 to the sources of payment and the type of expenditure.

662 (f) The quality of health services, using techniques such
663 as small area analysis, severity adjustments, and risk-adjusted
664 mortality rates.
665 (g) The development of physician information ~~payment~~
666 systems which are capable of providing data for health care
667 consumers taking into account the amount of resources consumed,
668 including such information at licensed facilities as defined in
669 chapter 395, and the outcomes produced in the delivery of care.
670 (h) The collection of a statistically valid sample of data
671 on the retail prices charged by pharmacies for the 50 most
672 frequently prescribed medicines from any pharmacy licensed by
673 this state as a special study authorized by the Legislature to
674 be performed by the agency quarterly. If the drug is available
675 generically, price data shall be reported for the generic drug
676 and price data of a brand-named drug for which the generic drug
677 is the equivalent shall be reported. The agency shall make
678 available on its Internet website for each pharmacy, no later
679 than October 1, 2005, drug prices for a 30-day supply at a
680 standard dose. The data collected shall be reported for each
681 drug by pharmacy and by metropolitan statistical area or region
682 and updated quarterly ~~The impact of subacute admissions on~~
683 ~~hospital revenues and expenses for purposes of calculating~~
684 ~~adjusted admissions as defined in s. 408.07~~.
685 (i) The use of emergency department services by patient
686 acuity level and the implication of increasing hospital cost by
687 providing nonurgent care in emergency departments. The agency
688 shall submit an annual report based on this monitoring and
689 assessment to the Governor, the Speaker of the House of

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690 Representatives, the President of the Senate, and the
691 substantive legislative committees with the first report due
692 January 1, 2006.
693 (j) The making available on its Internet website no later
694 than October 1, 2004, and in a hard-copy format upon request, of
695 patient charge, volumes, length of stay, and performance outcome
696 indicators collected from health care facilities pursuant to s.
697 408.061(1)(a) for specific medical conditions, surgeries, and
698 procedures provided in inpatient and outpatient facilities as
699 determined by the agency. In making the determination of
700 specific medical conditions, surgeries, and procedures to
701 include, the agency shall consider such factors as volume,
702 severity of the illness, urgency of admission, individual and
703 societal costs, and whether the condition is acute or chronic.
704 Performance outcome indicators shall be risk adjusted or
705 severity adjusted, as applicable, using nationally recognized
706 risk adjustment methodologies or software consistent with the
707 standards of the Agency for Healthcare Research and Quality and
708 as selected by the agency. The website shall also provide an
709 interactive search that allows consumers to view and compare the
710 information for specific facilities, a map that allows consumers
711 to select a county or region, definitions of all of the data,
712 descriptions of each procedure, and an explanation about why the
713 data may differ from facility to facility. Such public data
714 shall be updated quarterly. The agency shall submit an annual
715 status report on the collection of data and publication of
716 performance outcome indicators to the Governor, the Speaker of
717 the House of Representatives, the President of the Senate, and

718 <u>the substantive legislative committees with the first status</u>
719 <u>report due January 1, 2005.</u>
720 (4)(a) The agency <u>shall</u> ~~may~~ conduct data-based studies and
721 evaluations and make recommendations to the Legislature and the
722 Governor concerning exemptions, the effectiveness of limitations
723 of referrals, restrictions on investment interests and
724 compensation arrangements, and the effectiveness of public
725 disclosure. Such analysis <u>shall</u> ~~may~~ include, but need not be
726 limited to, utilization of services, cost of care, quality of
727 care, and access to care. The agency may require the submission
728 of data necessary to carry out this duty, which may include, but
729 need not be limited to, data concerning ownership, Medicare and
730 Medicaid, charity care, types of services offered to patients,
731 revenues and expenses, patient-encounter data, and other data
732 reasonably necessary to study utilization patterns and the
733 impact of health care provider ownership interests in health-
734 care-related entities on the cost, quality, and accessibility of
735 health care.
736 (b) The agency may collect such data from any health
737 facility <u>or licensed health care provider</u> as a special study.
738 <u>(5) The agency shall develop and implement a strategy for</u>
739 <u>the adoption and use of electronic health records. The agency</u>
740 <u>may develop rules to facilitate the functionality and protect</u>
741 <u>the confidentiality of electronic health records. The agency</u>
742 <u>shall report to the Governor, the Speaker of the House of</u>
743 <u>Representatives, and the President of the Senate on legislative</u>
744 <u>recommendations to protect the confidentiality of electronic</u>
745 <u>health records.</u>

746 Section 11. Paragraph (l) is added to subsection (3) of
747 section 408.05, Florida Statutes, to read:
748 408.05 State Center for Health Statistics.--
749 (3) COMPREHENSIVE HEALTH INFORMATION SYSTEM.--In order to
750 produce comparable and uniform health information and
751 statistics, the agency shall perform the following functions:
752 (l) Develop, in conjunction with the State Comprehensive
753 Health Information System Advisory Council, and implement a
754 long-range plan for making available performance outcome and
755 financial data that will allow consumers to compare health care
756 services. The performance outcomes and financial data the agency
757 must make available shall include, but is not limited to,
758 pharmaceuticals, physicians, health care facilities, and health
759 plans and managed care entities. The agency shall submit the
760 initial plan to the Governor, the President of the Senate, and
761 the Speaker of the House of Representatives by March 1, 2005,
762 and shall update the plan and report on the status of its
763 implementation annually thereafter. The agency shall also make
764 the plan and status report available to the public on its
765 Internet website. As part of the plan, the agency shall identify
766 the process and timeframes for implementation, any barriers to
767 implementation, and recommendations of changes in the law that
768 may be enacted by the Legislature to eliminate the barriers. As
769 preliminary elements of the plan, the agency shall:
770 1. Make available performance outcome and patient charge
771 data collected from health care facilities pursuant to s.
772 408.061(1)(a) and (2). The agency shall determine which
773 conditions and procedures, performance outcomes, and patient

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774 charge data to disclose based upon input from the council. When
775 determining which conditions and procedures are to be disclosed,
776 the council and the agency shall consider variation in costs,
777 variation in outcomes, and magnitude of variations and other
778 relevant information. When determining which performance
779 outcomes to disclose, the agency:
780 a. Shall consider such factors as volume of cases; average
781 patient charges; average length of stay; complication rates;
782 mortality rates; and infection rates, among others, which shall
783 be adjusted for case mix and severity, if applicable.
784 b. May consider such additional measures that are adopted
785 by the Centers for Medicare and Medicaid Studies, National
786 Quality Forum, the Joint Commission on Accreditation of
787 Healthcare Organizations, the Agency for Healthcare Research and
788 Quality, or a similar national entity that establishes standards
789 to measure the performance of health care providers, or by other
790 states.
791
792 When determining which patient charge data to disclose, the
793 agency shall consider such measures as average charge, average
794 net revenue per adjusted patient day, average cost per adjusted
795 patient day, and average cost per admission, among others.
796 2. Make available performance measures, benefit design,
797 and premium cost data from health plans licensed pursuant to
798 chapter 627 or chapter 641. The agency shall determine which
799 performance outcome and member and subscriber cost data to
800 disclose, based upon input from the council. When determining
801 which data to disclose, the agency shall consider information

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802 that may be required by either individual or group purchasers to
803 assess the value of the product, which may include membership
804 satisfaction, quality of care, current enrollment or membership,
805 coverage areas, accreditation status, premium costs, plan costs,
806 premium increases, range of benefits, copayments and
807 deductibles, accuracy and speed of claims payment, credentials
808 of physicians, number of providers, names of network providers,
809 and hospitals in the network. Health plans shall make available
810 to the agency any such data or information that is not currently
811 reported to the agency or the office.
812 3. Determine the method and format for public disclosure
813 of data reported pursuant to this paragraph. The agency shall
814 make its determination based upon input from the Comprehensive
815 Health Information System Advisory Council. At a minimum, the
816 data shall be made available on the agency's Internet website in
817 a manner that allows consumers to conduct an interactive search
818 that allows them to view and compare the information for
819 specific providers. The website must include such additional
820 information as is determined necessary to ensure that the
821 website enhances informed decision making among consumers and
822 health care purchasers, which shall include, at a minimum,
823 appropriate guidance on how to use the data and an explanation
824 of why the data may vary from provider to provider. The data
825 specified in subparagraph 1. shall be released no later than
826 March 1, 2005. The data specified in subparagraph 2. shall be
827 released no later than March 1, 2006.
828 Section 12. Subsection (3) of section 409.9066, Florida
829 Statutes, is amended to read:

830 409.9066 Medicare prescription discount program.--
831 (3) The Agency for Health Care Administration shall
832 publish, on a free website available to the public, the most
833 recent average wholesale prices for the 200 drugs most
834 frequently dispensed ~~to the elderly~~ and~~, to the extent possible,~~
835 shall provide a mechanism that consumers may use to calculate
836 the retail price and the price that should be paid after the
837 discount required in subsection (1) is applied. The agency shall
838 provide retail information by geographic area and retail
839 information by provider within geographical areas.
840 Section 13. Section 408.7056, Florida Statutes, is amended
841 to read:
842 408.7056 ~~Statewide Provider and~~ Subscriber Assistance
843 Program.--
844 (1) As used in this section, the term:
845 (a) "Agency" means the Agency for Health Care
846 Administration.
847 (b) "Department" means the Department of Financial
848 Services.
849 (c) "Grievance procedure" means an established set of
850 rules that specify a process for appeal of an organizational
851 decision.
852 (d) "Health care provider" or "provider" means a state-
853 licensed or state-authorized facility, a facility principally
854 supported by a local government or by funds from a charitable
855 organization that holds a current exemption from federal income
856 tax under s. 501(c)(3) of the Internal Revenue Code, a licensed
857 practitioner, a county health department established under part

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858 I of chapter 154, a prescribed pediatric extended care center
859 defined in s. 400.902, a federally supported primary care
860 program such as a migrant health center or a community health
861 center authorized under s. 329 or s. 330 of the United States
862 Public Health Services Act that delivers health care services to
863 individuals, or a community facility that receives funds from
864 the state under the Community Alcohol, Drug Abuse, and Mental
865 Health Services Act and provides mental health services to
866 individuals.
867 (e) "Managed care entity" means a health maintenance
868 organization or a prepaid health clinic certified under chapter
869 641, a prepaid health plan authorized under s. 409.912, or an
870 exclusive provider organization certified under s. 627.6472.
871 (f) "Office" means the Office of Insurance Regulation of
872 the Financial Services Commission.
873 (g) "Panel" means a ~~statewide provider and~~ subscriber
874 assistance panel selected as provided in subsection (11).
875 (2) The agency shall adopt and implement a program to
876 provide assistance to subscribers ~~and providers~~, including those
877 whose grievances are not resolved by the managed care entity to
878 the satisfaction of the subscriber ~~or provider~~. The program
879 shall consist of one or more panels that meet as often as
880 necessary to timely review, consider, and hear grievances and
881 recommend to the agency or the office any actions that should be
882 taken concerning individual cases heard by the panel. The panel
883 shall hear every grievance filed by subscribers ~~and providers~~ on
884 behalf of subscribers, unless the grievance:

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885 (a) Relates to a managed care entity's refusal to accept a
886 provider into its network of providers;
887 (b) Is part of an internal grievance in a Medicare managed
888 care entity or a reconsideration appeal through the Medicare
889 appeals process which does not involve a quality of care issue;
890 (c) Is related to a health plan not regulated by the state
891 such as an administrative services organization, third-party
892 administrator, or federal employee health benefit program;
893 (d) Is related to appeals by in-plan suppliers and
894 providers, unless related to quality of care provided by the
895 plan;
896 (e) Is part of a Medicaid fair hearing pursued under 42
897 C.F.R. ss. 431.220 et seq.;
898 (f) Is the basis for an action pending in state or federal
899 court;
900 (g) Is related to an appeal by nonparticipating providers,
901 unless related to the quality of care provided to a subscriber
902 by the managed care entity and the provider is involved in the
903 care provided to the subscriber;
904 (h) Was filed before the subscriber ~~or provider~~ completed
905 the entire internal grievance procedure of the managed care
906 entity, the managed care entity has complied with its timeframes
907 for completing the internal grievance procedure, and the
908 circumstances described in subsection (6) do not apply;
909 (i) Has been resolved to the satisfaction of the
910 subscriber ~~or provider~~ who filed the grievance, unless the
911 managed care entity's initial action is egregious or may be
912 indicative of a pattern of inappropriate behavior;

913 (j) Is limited to seeking damages for pain and suffering,
914 lost wages, or other incidental expenses, including accrued
915 interest on unpaid balances, court costs, and transportation
916 costs associated with a grievance procedure;
917 (k) Is limited to issues involving conduct of a health
918 care provider or facility, staff member, or employee of a
919 managed care entity which constitute grounds for disciplinary
920 action by the appropriate professional licensing board and is
921 not indicative of a pattern of inappropriate behavior, and the
922 agency, office, or department has reported these grievances to
923 the appropriate professional licensing board or to the health
924 facility regulation section of the agency for possible
925 investigation; ~~or~~
926 (l) Is withdrawn by the subscriber ~~or provider~~. Failure of
927 the subscriber ~~or the provider~~ to attend the hearing shall be
928 considered a withdrawal of the grievance; or
929 (3) The agency shall review all grievances within 60 days
930 after receipt and make a determination whether the grievance
931 shall be heard. Once the agency notifies the panel, the
932 subscriber ~~or provider~~, and the managed care entity that a
933 grievance will be heard by the panel, the panel shall hear the
934 grievance either in the network area or by teleconference no
935 later than 120 days after the date the grievance was filed. The
936 agency shall notify the parties, in writing, by facsimile
937 transmission, or by phone, of the time and place of the hearing.
938 The panel may take testimony under oath, request certified
939 copies of documents, and take similar actions to collect
940 information and documentation that will assist the panel in

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941 making findings of fact and a recommendation. The panel shall
942 issue a written recommendation, supported by findings of fact,
943 to the ~~provider or~~ subscriber, to the managed care entity, and
944 to the agency or the office no later than 15 working days after
945 hearing the grievance. If at the hearing the panel requests
946 additional documentation or additional records, the time for
947 issuing a recommendation is tolled until the information or
948 documentation requested has been provided to the panel. The
949 proceedings of the panel are not subject to chapter 120.
950 (4) If, upon receiving a proper patient authorization
951 along with a properly filed grievance, the agency requests
952 ~~medical~~ records from a health care provider or managed care
953 entity, the health care provider or managed care entity that has
954 custody of the records has 10 days to provide the records to the
955 agency. Records include medical records, communication logs
956 associated with the grievance both to and from the subscriber,
957 and contracts. Failure to provide requested ~~medical~~ records may
958 result in the imposition of a fine of up to $500. Each day that
959 records are not produced is considered a separate violation.
960 (5) Grievances that the agency determines pose an
961 immediate and serious threat to a subscriber's health must be
962 given priority over other grievances. The panel may meet at the
963 call of the chair to hear the grievances as quickly as possible
964 but no later than 45 days after the date the grievance is filed,
965 unless the panel receives a waiver of the time requirement from
966 the subscriber. The panel shall issue a written recommendation,
967 supported by findings of fact, to the office or the agency
968 within 10 days after hearing the expedited grievance.

969 (6) When the agency determines that the life of a
970 subscriber is in imminent and emergent jeopardy, the chair of
971 the panel may convene an emergency hearing, within 24 hours
972 after notification to the managed care entity and to the
973 subscriber, to hear the grievance. The grievance must be heard
974 notwithstanding that the subscriber has not completed the
975 internal grievance procedure of the managed care entity. The
976 panel shall, upon hearing the grievance, issue a written
977 emergency recommendation, supported by findings of fact, to the
978 managed care entity, to the subscriber, and to the agency or the
979 office for the purpose of deferring the imminent and emergent
980 jeopardy to the subscriber's life. Within 24 hours after receipt
981 of the panel's emergency recommendation, the agency or office
982 may issue an emergency order to the managed care entity. An
983 emergency order remains in force until:
984 (a) The grievance has been resolved by the managed care
985 entity;
986 (b) Medical intervention is no longer necessary; or
987 (c) The panel has conducted a full hearing under
988 subsection (3) and issued a recommendation to the agency or the
989 office, and the agency or office has issued a final order.
990 (7) After hearing a grievance, the panel shall make a
991 recommendation to the agency or the office which may include
992 specific actions the managed care entity must take to comply
993 with state laws or rules regulating managed care entities.
994 (8) A managed care entity, subscriber, or provider that is
995 affected by a panel recommendation may within 10 days after
996 receipt of the panel's recommendation, or 72 hours after receipt

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997 of a recommendation in an expedited grievance, furnish to the
998 agency or office written evidence in opposition to the
999 recommendation or findings of fact of the panel.
1000 (9) No later than 30 days after the issuance of the
1001 panel's recommendation and, for an expedited grievance, no later
1002 than 10 days after the issuance of the panel's recommendation,
1003 the agency or the office may adopt the panel's recommendation or
1004 findings of fact in a proposed order or an emergency order, as
1005 provided in chapter 120, which it shall issue to the managed
1006 care entity. The agency or office may issue a proposed order or
1007 an emergency order, as provided in chapter 120, imposing fines
1008 or sanctions, including those contained in ss. 641.25 and
1009 641.52. The agency or the office may reject all or part of the
1010 panel's recommendation. All fines collected under this
1011 subsection must be deposited into the Health Care Trust Fund.
1012 (10) In determining any fine or sanction to be imposed,
1013 the agency and the office may consider the following factors:
1014 (a) The severity of the noncompliance, including the
1015 probability that death or serious harm to the health or safety
1016 of the subscriber will result or has resulted, the severity of
1017 the actual or potential harm, and the extent to which provisions
1018 of chapter 641 were violated.
1019 (b) Actions taken by the managed care entity to resolve or
1020 remedy any quality-of-care grievance.
1021 (c) Any previous incidents of noncompliance by the managed
1022 care entity.
1023 (d) Any other relevant factors the agency or office
1024 considers appropriate in a particular grievance.

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1025 (11)(a) The panel shall consist of the Insurance Consumer
1026 Advocate, or designee thereof, established by s. 627.0613; at
1027 least two members employed by the agency and at least two
1028 members employed by the department, chosen by their respective
1029 agencies; a consumer appointed by the Governor; a physician
1030 appointed by the Governor, as a standing member; and, if
1031 necessary, physicians who have expertise relevant to the case to
1032 be heard, on a rotating basis. The agency may contract with a
1033 medical director, ~~and~~ a primary care physician, or both, who
1034 shall provide additional technical expertise to the panel but
1035 shall not be voting members of the panel. The medical director
1036 shall be selected from a health maintenance organization with a
1037 current certificate of authority to operate in Florida.
1038 (b) A majority of those panel members required under
1039 paragraph (a) shall constitute a quorum for any meeting or
1040 hearing of the panel. A grievance may not be heard or voted upon
1041 at any panel meeting or hearing unless a quorum is present,
1042 except that a minority of the panel may adjourn a meeting or
1043 hearing until a quorum is present. A panel convened for the
1044 purpose of hearing a subscriber's grievance in accordance with
1045 subsections (2) and (3) shall not consist of more than 11
1046 members.
1047 (12) Every managed care entity shall submit a quarterly
1048 report to the agency, the office, and the department listing the
1049 number and the nature of all subscribers' and providers'
1050 grievances which have not been resolved to the satisfaction of
1051 the subscriber or provider after the subscriber or provider
1052 follows the entire internal grievance procedure of the managed

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1053 care entity. The agency shall notify all subscribers and
1054 providers included in the quarterly reports of their right to
1055 file an unresolved grievance with the panel.
1056 (13) A proposed order issued by the agency or office which
1057 only requires the managed care entity to take a specific action
1058 under subsection (7) is subject to a summary hearing in
1059 accordance with s. 120.574, unless all of the parties agree
1060 otherwise. If the managed care entity does not prevail at the
1061 hearing, the managed care entity must pay reasonable costs and
1062 attorney's fees of the agency or the office incurred in that
1063 proceeding.
1064 (14)(a) Any information that identifies a subscriber which
1065 is held by the panel, agency, or department pursuant to this
1066 section is confidential and exempt from the provisions of s.
1067 119.07(1) and s. 24(a), Art. I of the State Constitution.
1068 However, at the request of a subscriber or managed care entity
1069 involved in a grievance procedure, the panel, agency, or
1070 department shall release information identifying the subscriber
1071 involved in the grievance procedure to the requesting subscriber
1072 or managed care entity.
1073 (b) Meetings of the panel shall be open to the public
1074 unless the provider or subscriber whose grievance will be heard
1075 requests a closed meeting or the agency or the department
1076 determines that information which discloses the subscriber's
1077 medical treatment or history or information relating to internal
1078 risk management programs as defined in s. 641.55(5)(c), (6), and
1079 (8) may be revealed at the panel meeting, in which case that
1080 portion of the meeting during which a subscriber's medical

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1081 treatment or history or internal risk management program
1082 information is discussed shall be exempt from the provisions of
1083 s. 286.011 and s. 24(b), Art. I of the State Constitution. All
1084 closed meetings shall be recorded by a certified court reporter.
1085 Section 14. Paragraph (c) of subsection (4) of section
1086 641.3154, Florida Statutes, is amended to read:
1087 641.3154 Organization liability; provider billing
1088 prohibited.--
1089 (4) A provider or any representative of a provider,
1090 regardless of whether the provider is under contract with the
1091 health maintenance organization, may not collect or attempt to
1092 collect money from, maintain any action at law against, or
1093 report to a credit agency a subscriber of an organization for
1094 payment of services for which the organization is liable, if the
1095 provider in good faith knows or should know that the
1096 organization is liable. This prohibition applies during the
1097 pendency of any claim for payment made by the provider to the
1098 organization for payment of the services and any legal
1099 proceedings or dispute resolution process to determine whether
1100 the organization is liable for the services if the provider is
1101 informed that such proceedings are taking place. It is presumed
1102 that a provider does not know and should not know that an
1103 organization is liable unless:
1104 (c) The office or agency makes a final determination that
1105 the organization is required to pay for such services subsequent
1106 to a recommendation made by the ~~Statewide Provider and~~
1107 Subscriber Assistance Panel pursuant to s. 408.7056; or

1108 Section 15. Subsection (1), paragraphs (b) and (e) of
1109 subsection (3), paragraph (d) of subsection (4), subsection (5),
1110 paragraph (g) of subsection (6), and subsections (9), (10), and
1111 (11) of section 641.511, Florida Statutes, are amended to read:
1112 641.511 Subscriber grievance reporting and resolution
1113 requirements.--
1114 (1) Every organization must have a grievance procedure
1115 available to its subscribers for the purpose of addressing
1116 complaints and grievances. Every organization must notify its
1117 subscribers that a subscriber must submit a grievance within 1
1118 year after the date of occurrence of the action that initiated
1119 the grievance, and may submit the grievance for review to the
1120 ~~Statewide Provider and~~ Subscriber Assistance Program panel as
1121 provided in s. 408.7056 after receiving a final disposition of
1122 the grievance through the organization's grievance process. An
1123 organization shall maintain records of all grievances and shall
1124 report annually to the agency the total number of grievances
1125 handled, a categorization of the cases underlying the
1126 grievances, and the final disposition of the grievances.
1127 (3) Each organization's grievance procedure, as required
1128 under subsection (1), must include, at a minimum:
1129 (b) The names of the appropriate employees or a list of
1130 grievance departments that are responsible for implementing the
1131 organization's grievance procedure. The list must include the
1132 address and the toll-free telephone number of each grievance
1133 department, the address of the agency and its toll-free
1134 telephone hotline number, and the address of the ~~Statewide~~

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1135 ~~Provider and~~ Subscriber Assistance Program and its toll-free
1136 telephone number.
1137 (e) A notice that a subscriber may voluntarily pursue
1138 binding arbitration in accordance with the terms of the contract
1139 if offered by the organization, after completing the
1140 organization's grievance procedure and as an alternative to the
1141 ~~Statewide Provider and~~ Subscriber Assistance Program. Such
1142 notice shall include an explanation that the subscriber may
1143 incur some costs if the subscriber pursues binding arbitration,
1144 depending upon the terms of the subscriber's contract.
1145 (4)
1146 (d) In any case when the review process does not resolve a
1147 difference of opinion between the organization and the
1148 subscriber or the provider acting on behalf of the subscriber,
1149 the subscriber or the provider acting on behalf of the
1150 subscriber may submit a written grievance to the ~~Statewide~~
1151 ~~Provider and~~ Subscriber Assistance Program.
1152 (5) Except as provided in subsection (6), the organization
1153 shall resolve a grievance within 60 days after receipt of the
1154 grievance, or within a maximum of 90 days if the grievance
1155 involves the collection of information outside the service area.
1156 These time limitations are tolled if the organization has
1157 notified the subscriber, in writing, that additional information
1158 is required for proper review of the grievance and that such
1159 time limitations are tolled until such information is provided.
1160 After the organization receives the requested information, the
1161 time allowed for completion of the grievance process resumes.
1162 The Employee Retirement Income Security Act of 1974, as

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1163 implemented by 29 C.F.R. 2560.503-1, is adopted and incorporated
1164 by reference as applicable to all organizations that administer
1165 small and large group health plans that are subject to 29 C.F.R.
1166 2560.503-1. The claims procedures of the regulations of the
1167 Employee Retirement Income Security Act of 1974 as implemented
1168 by 29 C.F.R. 2560.503-1 shall be the minimum standards for
1169 grievance processes for claims for benefits for small and large
1170 group health plans that are subject to 29 C.F.R. 2560.503-1.
1171 (6)
1172 (g) In any case when the expedited review process does not
1173 resolve a difference of opinion between the organization and the
1174 subscriber or the provider acting on behalf of the subscriber,
1175 the subscriber or the provider acting on behalf of the
1176 subscriber may submit a written grievance to the Statewide
1177 Provider and Subscriber Assistance Program.
1178 (9)(a) The agency shall advise subscribers with grievances
1179 to follow their organization's formal grievance process for
1180 resolution prior to review by the Statewide Provider and
1181 Subscriber Assistance Program. The subscriber may, however,
1182 submit a copy of the grievance to the agency at any time during
1183 the process.
1184 (b) Requiring completion of the organization's grievance
1185 process before the Statewide Provider and Subscriber Assistance
1186 Program panel's review does not preclude the agency from
1187 investigating any complaint or grievance before the organization
1188 makes its final determination.
1189 (10) Each organization must notify the subscriber in a
1190 final decision letter that the subscriber may request review of

1191 the organization's decision concerning the grievance by the
1192 ~~Statewide Provider and~~ Subscriber Assistance Program, as
1193 provided in s. 408.7056, if the grievance is not resolved to the
1194 satisfaction of the subscriber. The final decision letter must
1195 inform the subscriber that the request for review must be made
1196 within 365 days after receipt of the final decision letter, must
1197 explain how to initiate such a review, and must include the
1198 addresses and toll-free telephone numbers of the agency and the
1199 ~~Statewide Provider and~~ Subscriber Assistance Program.
1200 (11) Each organization, as part of its contract with any
1201 provider, must require the provider to post a consumer
1202 assistance notice prominently displayed in the reception area of
1203 the provider and clearly noticeable by all patients. The
1204 consumer assistance notice must state the addresses and toll-
1205 free telephone numbers of the Agency for Health Care
1206 Administration, the ~~Statewide Provider and~~ Subscriber Assistance
1207 Program, and the Department of Financial Services. The consumer
1208 assistance notice must also clearly state that the address and
1209 toll-free telephone number of the organization's grievance
1210 department shall be provided upon request. The agency may adopt
1211 rules to implement this section.
1212 Section 16. Subsection (4) of section 641.58, Florida
1213 Statutes, is amended to read:
1214 641.58 Regulatory assessment; levy and amount; use of
1215 funds; tax returns; penalty for failure to pay.--
1216 (4) The moneys received and deposited into the Health Care
1217 Trust Fund shall be used to defray the expenses of the agency in
1218 the discharge of its administrative and regulatory powers and

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1219 duties under this part, including conducting an annual survey of
1220 the satisfaction of members of health maintenance organizations;
1221 contracting with physician consultants for the ~~Statewide~~
1222 ~~Provider and~~ Subscriber Assistance Panel; maintaining offices
1223 and necessary supplies, essential equipment, and other
1224 materials, salaries and expenses of required personnel; and
1225 discharging the administrative and regulatory powers and duties
1226 imposed under this part.
1227 Section 17. Paragraph (f) of subsection (2) and
1228 subsections (3) and (9) of section 408.909, Florida Statutes,
1229 are amended to read:
1230 408.909 Health flex plans.--
1231 (2) DEFINITIONS.--As used in this section, the term:
1232 (f) "Health flex plan entity" means a health insurer,
1233 health maintenance organization, health-care-provider-sponsored
1234 organization, local government, health care district, ~~or~~ other
1235 public or private community-based organization, or public-
1236 private partnership that develops and implements an approved
1237 health flex plan and is responsible for administering the health
1238 flex plan and paying all claims for health flex plan coverage by
1239 enrollees of the health flex plan.
1240 (3) ~~PILOT~~ PROGRAM.--The agency and the office shall each
1241 approve or disapprove health flex plans that provide health care
1242 coverage for eligible participants ~~who reside in the three areas~~
1243 ~~of the state that have the highest number of uninsured persons,~~
1244 ~~as identified in the Florida Health Insurance Study conducted by~~
1245 ~~the agency and in Indian River County~~. A health flex plan may
1246 limit or exclude benefits otherwise required by law for insurers

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1247 offering coverage in this state, may cap the total amount of
1248 claims paid per year per enrollee, may limit the number of
1249 enrollees, or may take any combination of those actions. A
1250 health flex plan offering may include the option of a
1251 catastrophic plan supplementing the health flex plan.
1252 (a) The agency shall develop guidelines for the review of
1253 applications for health flex plans and shall disapprove or
1254 withdraw approval of plans that do not meet or no longer meet
1255 minimum standards for quality of care and access to care. The
1256 agency shall ensure that the health flex plans follow
1257 standardized grievance procedures similar to those required of
1258 health maintenance organizations.
1259 (b) The office shall develop guidelines for the review of
1260 health flex plan applications and provide regulatory oversight
1261 of health flex plan advertisement and marketing procedures. The
1262 office shall disapprove or shall withdraw approval of plans
1263 that:
1264 1. Contain any ambiguous, inconsistent, or misleading
1265 provisions or any exceptions or conditions that deceptively
1266 affect or limit the benefits purported to be assumed in the
1267 general coverage provided by the health flex plan;
1268 2. Provide benefits that are unreasonable in relation to
1269 the premium charged or contain provisions that are unfair or
1270 inequitable or contrary to the public policy of this state, that
1271 encourage misrepresentation, or that result in unfair
1272 discrimination in sales practices; or

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1273 3. Cannot demonstrate that the health flex plan is
1274 financially sound and that the applicant is able to underwrite
1275 or finance the health care coverage provided.
1276 (c) The agency and the Financial Services Commission may
1277 adopt rules as needed to administer this section.
1278 (9) PROGRAM EVALUATION.--The agency and the office shall
1279 evaluate the pilot program and its effect on the entities that
1280 seek approval as health flex plans, on the number of enrollees,
1281 and on the scope of the health care coverage offered under a
1282 health flex plan; shall provide an assessment of the health flex
1283 plans and their potential applicability in other settings; shall
1284 use health flex plans to gather more information to evaluate
1285 low-income consumer driven benefit packages; and shall, by
1286 January 1, 2005, and annually thereafter ~~2004~~, jointly submit a
1287 report to the Governor, the President of the Senate, and the
1288 Speaker of the House of Representatives.
1289 Section 18. Section 381.0271, Florida Statutes, is created
1290 to read:
1291 381.0271 Florida Patient Safety Corporation.--
1292 (1) DEFINITIONS.--As used in this section, the term:
1293 (a) "Adverse incident" has the same meanings provided in
1294 ss. 395.0197, 458.351, and 459.026.
1295 (b) "Corporation" means the Florida Patient Safety
1296 Corporation.
1297 (c) "Patient safety data" has the same meaning provided in
1298 s. 766.1016.
1299 (2) CREATION.--

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1300 (a) The Florida Patient Safety Corporation is created as a
1301 not-for-profit corporation and shall be registered,
1302 incorporated, organized, and operated in compliance with chapter
1303 617. The corporation may create not-for-profit corporate
1304 subsidiaries that are organized under the provisions of chapter
1305 617, upon the prior approval of the board of directors, as
1306 necessary, to fulfill its mission.
1307 (b) The corporation and any authorized and approved
1308 subsidiary are not an agency as defined in s. 20.03(11).
1309 (c) The corporation and any authorized and approved
1310 subsidiary are subject to the public meetings and records
1311 requirements of s. 24, Art. I of the State Constitution, chapter
1312 119, and s. 286.011.
1313 (d) The corporation and any authorized and approved
1314 subsidiary are not subject to the provisions of chapter 287.
1315 (e) The corporation is a patient safety organization as
1316 defined in s. 766.1016.
1317 (3) PURPOSE.--
1318 (a) The purpose of the corporation is to serve as a
1319 learning organization dedicated to assisting health care
1320 providers in this state to improve the quality and safety of
1321 health care rendered and to reduce harm to patients. The
1322 corporation shall promote the development of a culture of
1323 patient safety in the health care system in this state. The
1324 corporation shall not regulate health care providers in this
1325 state.

1326 (b) In fulfilling its purpose, the corporation shall work
1327 with a consortium of patient safety centers and other patient
1328 safety programs.
1329 (4) BOARD OF DIRECTORS; MEMBERSHIP.--The corporation shall
1330 be governed by a board of directors. The board of directors
1331 shall consist of:
1332 (a) The chair of the Florida Council of Medical School
1333 Deans.
1334 (b) Two representatives with expertise in patient safety
1335 issues for the authorized health insurer and authorized health
1336 maintenance organization with the largest market shares,
1337 respectively, as measured by premiums written in the state for
1338 the most recent calendar year, appointed by such insurer.
1339 (c) A representative of an authorized medical malpractice
1340 insurer appointed by the Florida Insurance Council.
1341 (d) The president of the Central Florida Health Care
1342 Coalition.
1343 (e) Two representatives of a hospital in this state that
1344 is implementing innovative patient safety initiatives, appointed
1345 by the Florida Hospital Association.
1346 (f) A physician with expertise in patient safety,
1347 appointed by the Florida Medical Association.
1348 (g) A physician with expertise in patient safety,
1349 appointed by the Florida Osteopathic Medical Association.
1350 (h) A physician with expertise in patient safety,
1351 appointed by the Florida Podiatric Medical Association.
1352 (i) A physician with expertise in patient safety,
1353 appointed by the Florida Chiropractic Association.

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1354 (j) A dentist with expertise in patient safety, appointed
1355 by the Florida Dental Association.
1356 (k) A nurse with expertise in patient safety, appointed by
1357 the Florida Nurses Association.
1358 (l) An institutional pharmacist, appointed by the Florida
1359 Society of Health-System Pharmacists.
1360 (m) A representative of Florida AARP, appointed by the
1361 state director of Florida AARP.
1362 (5) ADVISORY COMMITTEES.--In addition to any committees
1363 that the corporation may establish, the corporation shall
1364 establish the following advisory committees:
1365 (a) A scientific research advisory committee that
1366 includes, at a minimum, a representative from each patient
1367 safety center or other patient safety program in the
1368 universities of the state who are physicians licensed pursuant
1369 to chapter 458 or chapter 459, with experience in patient safety
1370 and evidenced-based medicine. The duties of the advisory
1371 committee shall include, but not be limited to, the analysis of
1372 existing data and research to improve patient safety and
1373 encourage evidence-based medicine.
1374 (b) A technology advisory committee that includes, at a
1375 minimum, a representative of a hospital that has implemented a
1376 computerized physician order entry system and a health care
1377 provider that has implemented an electronic medical records
1378 system. The duties of the advisory committee shall include, but
1379 not be limited to, implementation of new technologies, including
1380 electronic medical records.

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1381 (c) A health care provider advisory committee that
1382 includes, at a minimum, representatives of hospitals, ambulatory
1383 surgical centers, physicians, nurses, and pharmacists licensed
1384 in this state and a representative of the Veterans Integrated
1385 Service Network 8, Virginia Patient Safety Center. The duties of
1386 the advisory committee shall include, but not be limited to,
1387 promotion of a culture of patient safety that reduces errors.
1388 (d) A health care consumer advisory committee that
1389 includes, at a minimum, representatives of businesses that
1390 provide health insurance coverage to their employees, consumer
1391 advocacy groups, and representatives of patient safety
1392 organizations. The duties of the advisory committee shall
1393 include, but not be limited to, incentives to encourage patient
1394 safety and the efficiency and quality of care.
1395 (e) A state agency advisory committee that includes, at a
1396 minimum, a representative from each state agency that has
1397 regulatory responsibilities related to patient safety. The
1398 duties of the advisory committee shall include, but not be
1399 limited to, interagency coordination of patient safety efforts.
1400 (f) A litigation alternatives advisory committee that
1401 includes, at a minimum, representatives of medical malpractice
1402 attorneys for plaintiffs and defendants and a representative of
1403 each law school in the state. The duties of the advisory
1404 committee shall include, but not be limited to, alternatives
1405 systems to compensate for injuries.
1406 (g) An education advisory committee that includes, at a
1407 minimum, the associate dean for education, or the equivalent
1408 position, as a representative from each medicine, nursing,

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1409 public health, or allied health service to provide advice on the
1410 development, implementation, and measurement of core
1411 competencies for patient safety to be considered for
1412 incorporation in the educational programs of the universities
1413 and colleges of this state.
1414 (6) ORGANIZATION; MEETINGS.--
1415 (a) The Agency for Health Care Administration shall assist
1416 the corporation in its organizational activities required under
1417 chapter 617, including, but not limited to:
1418 1. Eliciting appointments for the initial board of
1419 directors.
1420 2. Convening the first meeting of the board of directors
1421 and assisting with other meetings of the board of directors,
1422 upon request of the board of directors, during the first year of
1423 operation of the corporation.
1424 3. Drafting articles of incorporation for the board of
1425 directors and, upon request of the board of directors,
1426 delivering articles of incorporation to the Department of State
1427 for filing.
1428 4. Drafting proposed bylaws for the corporation.
1429 5. Paying fees related to incorporation.
1430 6. Providing office space and administrative support, at
1431 the request of the board of directors, but not beyond July 1,
1432 2005.
1433 (b) The board of directors must conduct its first meeting
1434 no later than August 1, 2004, and shall meet thereafter as
1435 frequently as necessary to carry out the duties of the
1436 corporation.

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1437 (7) POWERS AND DUTIES.--
1438 (a) In addition to the powers and duties prescribed in
1439 chapter 617, and the articles and bylaws adopted under that
1440 chapter, the corporation shall, directly or through contract:
1441 1. Secure staff necessary to properly administer the
1442 corporation.
1443 2. Collect, analyze, and evaluate patient safety data and
1444 quality and patient safety indicators, medical malpractice
1445 closed claims, and adverse incidents reported to the Agency for
1446 Health Care Administration and the Department of Health for the
1447 purpose of recommending changes in practices and procedures that
1448 may be implemented by health care practitioners and health care
1449 facilities to improve health care quality and to prevent future
1450 adverse incidents. Notwithstanding any other provision of law,
1451 the Agency for Health Care Administration and the Department of
1452 Health shall make available to the corporation any adverse
1453 incident report submitted under ss. 395.0197, 458.351, and
1454 459.026. To the extent that adverse incident reports submitted
1455 under s. 395.0197 are confidential and exempt, the confidential
1456 and exempt status of such reports shall be maintained by the
1457 corporation.
1458 3. Establish a "near-miss" patient safety reporting
1459 system. The purpose of the near-miss reporting system is to:
1460 identify potential systemic problems that could lead to adverse
1461 incidents; enable publication of systemwide alerts of potential
1462 harm; and facilitate development of both facility-specific and
1463 statewide options to avoid adverse incidents and improve patient
1464 safety. The reporting system shall record "near misses"

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1465 submitted by hospitals, birthing centers, and ambulatory
1466 surgical centers and other providers. For the purpose of the
1467 reporting system:
1468 a. The term "near miss" means any potentially harmful
1469 event that could have had an adverse result but, through chance
1470 or intervention in which, harm was prevented.
1471 b. The near-miss reporting system shall be voluntary and
1472 anonymous and independent of mandatory reporting systems used
1473 for regulatory purposes.
1474 c. Near-miss data submitted to the corporation is patient
1475 safety data as defined in s. 766.1016.
1476 d. Reports of near-miss data shall be published on a
1477 regular basis and special alerts shall be published as needed
1478 regarding newly identified, significant risks.
1479 e. Aggregated data shall be made available publicly.
1480 f. The corporation shall report the performance and
1481 results of the near-miss project in its annual report.
1482 4. Work collaboratively with the appropriate state
1483 agencies in the development of electronic health records.
1484 5. Provide for access to an active library of evidence-
1485 based medicine and patient safety practices, together with the
1486 emerging evidence supporting their retention or modification,
1487 and make this information available to health care
1488 practitioners, health care facilities, and the public. Support
1489 for implementation of evidence-based medicine shall include:
1490 a. A report to the Governor, the President of the Senate,
1491 the Speaker of the House of Representatives, and the Agency for
1492 Health Care Administration by January 1, 2005, on:

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1493 (I) The ability to join or support efforts for the use of
1494 evidence-based medicine already underway, such as those of the
1495 Leapfrog Group, the international group Bandolier, and the
1496 Healthy Florida Foundation.
1497 (II) The means by which to promote research using Medicaid
1498 and other data collected by the Agency for Health Care
1499 Administration to identify and quantify the most cost-effective
1500 treatment and interventions, including disease management and
1501 prevention programs.
1502 (III) The means by which to encourage development of
1503 systems to measure and reward providers who implement evidence-
1504 based medical practices.
1505 (IV) The review of other state and private initiatives and
1506 published literature for promising approaches and the
1507 dissemination of information about them to providers.
1508 (V) The encouragement of the Florida health care boards
1509 under the Department of Health to regularly publish findings
1510 related to the cost-effectiveness of disease-specific, evidence-
1511 based standards.
1512 (VI) Public and private sector initiatives related to
1513 evidence-based medicine and communication systems for the
1514 sharing of clinical information among caregivers.
1515 (VII) Regulatory barriers that interfere with the sharing
1516 of clinical information among caregivers.
1517 b. An implementation plan reported to the Governor, the
1518 President of the Senate, the Speaker of the House of
1519 Representatives, and the Agency for Health Care Administration
1520 by September 1, 2005, that must include, but need not be limited

1521 to: estimated costs and savings, capital investment
1522 requirements, recommended investment incentives, initial
1523 committed provider participation by region, standards of
1524 functionality and features, a marketing plan, and implementation
1525 schedules for key components.
1526 6. Develop and recommend core competencies in patient
1527 safety that can be incorporated into the undergraduate and
1528 graduate curricula in schools of medicine, nursing, and allied
1529 health in the state.
1530 7. Develop and recommend programs to educate the public
1531 about the role of health care consumers in promoting patient
1532 safety.
1533 8. Provide recommendations for interagency coordination of
1534 patient safety efforts in the state.
1535 (b) In carrying out its powers and duties, the corporation
1536 may also:
1537 1. Assess the patient safety culture at volunteering
1538 hospitals and recommend methods to improve the working
1539 environment related to patient safety at these hospitals.
1540 2. Inventory the information technology capabilities
1541 related to patient safety of health care facilities and health
1542 care practitioners and recommend a plan for expediting the
1543 implementation of patient safety technologies statewide.
1544 3. Recommend continuing medical education regarding
1545 patient safety to practicing health care practitioners.
1546 4. Study and facilitate the testing of alternative systems
1547 of compensating injured patients as a means of reducing and
1548 preventing medical errors and promoting patient safety.

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1549 5. Conduct other activities identified by the board of
1550 directors to promote patient safety in this state.
1551 (8) ANNUAL REPORT.--By December 1, 2004, the corporation
1552 shall prepare a report on the startup activities of the
1553 corporation and any proposals for legislative action that are
1554 needed for the corporation to fulfill its purposes under this
1555 section. By December 1 of each year thereafter, the corporation
1556 shall prepare a report for the preceding fiscal year. The
1557 report, at a minimum, must include:
1558 (a) A description of the activities of the corporation
1559 under this section.
1560 (b) Progress made in improving patient safety and reducing
1561 medical errors.
1562 (c) Policies and programs that have been implemented and
1563 their outcomes.
1564 (d) A compliance and financial audit of the accounts and
1565 records of the corporation at the end of the preceding fiscal
1566 year conducted by an independent certified public accountant.
1567 (e) Recommendations for legislative action needed to
1568 improve patient safety in the state.
1569 (f) An assessment of the ability of the corporation to
1570 fulfill the duties specified in this section and the
1571 appropriateness of those duties for the corporation.
1572
1573 The corporation shall submit the report to the Governor, the
1574 President of the Senate, and the Speaker of the House of
1575 Representatives.

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1576 (9) FUNDING.--The corporation is required to seek private
1577 sector funding and apply for grants to accomplish its goals and
1578 duties.
1579 (10) PERFORMANCE EXPECTATIONS.--The Office of Program
1580 Policy Analysis and Government Accountability, the Agency for
1581 Health Care Administration, and the Department of Health shall
1582 develop performance standards by which to measure the success of
1583 the corporation in fulfilling the purposes established in this
1584 section. Using the performance standards, the Office of Program
1585 Policy Analysis and Government Accountability shall conduct a
1586 performance audit of the corporation during 2006 and shall
1587 submit a report to the Governor, the President of the Senate,
1588 and the Speaker of the House of Representatives by January 1,
1589 2007.
1590 Section 19. Subsection (3) of section 409.91255, Florida
1591 Statutes, is amended to read:
1592 409.91255 Federally qualified health center access
1593 program.--
1594 (3) ASSISTANCE TO FEDERALLY QUALIFIED HEALTH CENTERS.--The
1595 Department of Health shall develop a program for the expansion
1596 of federally qualified health centers for the purpose of
1597 providing comprehensive primary and preventive health care and
1598 urgent care services, including services that may reduce the
1599 morbidity, mortality, and cost of care among the uninsured
1600 population of the state. The program shall provide for
1601 distribution of financial assistance to federally qualified
1602 health centers that apply and demonstrate a need for such
1603 assistance in order to sustain or expand the delivery of primary

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1604 and preventive health care services. In selecting centers to
1605 receive this financial assistance, the program:
1606 (a) Shall give preference to communities that have few or
1607 no community-based primary care services or in which the current
1608 services are unable to meet the community's needs.
1609 (b) Shall require that primary care services be provided
1610 to the medically indigent using a sliding fee schedule based on
1611 income.
1612 (c) Shall allow innovative and creative uses of federal,
1613 state, and local health care resources.
1614 (d) Shall require that the funds provided be used to pay
1615 for operating costs of a projected expansion in patient
1616 caseloads or services or for capital improvement projects.
1617 Capital improvement projects may include renovations to existing
1618 facilities or construction of new facilities, provided that an
1619 expansion in patient caseloads or services to a new patient
1620 population will occur as a result of the capital expenditures.
1621 The department shall include in its standard contract document a
1622 requirement that any state funds provided for the purchase of or
1623 improvements to real property are contingent upon the contractor
1624 granting to the state a security interest in the property at
1625 least to the amount of the state funds provided for at least 5
1626 years from the date of purchase or the completion of the
1627 improvements or as further required by law. The contract must
1628 include a provision that, as a condition of receipt of state
1629 funding for this purpose, the contractor agrees that, if it
1630 disposes of the property before the department's interest is

1631 vacated, the contractor will refund the proportionate share of
1632 the state's initial investment, as adjusted by depreciation.
1633 (e) May require in-kind support from other sources.
1634 (f) May encourage coordination among federally qualified
1635 health centers, other private-sector providers, and publicly
1636 supported programs.
1637 (g) Shall allow the development of community emergency
1638 room diversion programs in conjunction with local resources,
1639 providing extended hours of operation to urgent care patients.
1640 Diversion programs shall include case management for emergency
1641 room followup care.
1642 Section 20. Paragraph (a) of subsection (6) of section
1643 627.410, Florida Statutes, is amended to read:
1644 627.410 Filing, approval of forms.--
1645 (6)(a) An insurer shall not deliver or issue for delivery
1646 or renew in this state any health insurance policy form until it
1647 has filed with the office a copy of every applicable rating
1648 manual, rating schedule, change in rating manual, and change in
1649 rating schedule; if rating manuals and rating schedules are not
1650 applicable, the insurer must file with the office ~~order~~
1651 applicable premium rates and any change in applicable premium
1652 rates. This paragraph does not apply to group health insurance
1653 policies, effectuated and delivered in this state, insuring
1654 groups of 51 or more persons, except for Medicare supplement
1655 insurance, long-term care insurance, and any coverage under
1656 which the increase in claim costs over the lifetime of the
1657 contract due to advancing age or duration is prefunded in the
1658 premium.

1659 Section 21. Section 627.64872, Florida Statutes, is
1660 created to read:
1661 627.64872 Florida Health Insurance Plan.--
1662 (1) LEGISLATIVE INTENT.--
1663 (a) The Legislature recognizes that to secure a more
1664 stable and orderly health insurance market, the establishment of
1665 a plan to assume risks deemed uninsurable by the private
1666 marketplace is required.
1667 (b) The Florida Health Insurance Plan is to make coverage
1668 available to individuals who have no other option for similar
1669 coverage, at a premium that is commensurate with the risk and
1670 benefits provided, and with benefit designs that are reasonable
1671 in relation to the general market. While plan operations may
1672 include supplementary funding, the plan shall fundamentally
1673 operate on sound actuarial principles, using basic insurance
1674 management techniques to ensure that the plan is run in an
1675 economical, cost-efficient, and sound manner, conserving plan
1676 resources to serve the maximum number of people possible in a
1677 sustainable fashion.
1678 (2) DEFINITIONS.--As used in this section:
1679 (a) "Board" means the board of directors of the plan.
1680 (b) "Dependent" means a resident spouse or resident
1681 unmarried child under the age of 19 years, a child who is a
1682 student under the age of 25 years and who is financially
1683 dependent upon the parent, or a child of any age who is disabled
1684 and dependent upon the parent.
1685 (c) "Director" means the director of the Office of
1686 Insurance Regulation.

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1687 (d) "Health insurance" means any hospital or medical
1688 expense incurred policy or health maintenance organization
1689 subscriber contract pursuant to chapter 641. The term does not
1690 include short-term, accident, dental-only, vision-only, fixed-
1691 indemnity, limited-benefit, or credit insurance; disability
1692 income insurance; coverage for onsite medical clinics; insurance
1693 coverage specified in federal regulations issued pursuant to
1694 Pub. L. No. 104-191, under which benefits for medical care are
1695 secondary or incidental to other insurance benefits; benefits
1696 for long-term care, nursing home care, home health care,
1697 community-based care, or any combination thereof, or other
1698 similar, limited benefits specified in federal regulations
1699 issued pursuant to Pub. L. No. 104-191; benefits provided under
1700 a separate policy, certificate, or contract of insurance, under
1701 which there is no coordination between the provision of the
1702 benefits and any exclusion of benefits under any group health
1703 plan maintained by the same plan sponsor and the benefits are
1704 paid with respect to an event without regard to whether benefits
1705 are provided with respect to such an event under any group
1706 health plan maintained by the same plan sponsor, such as for
1707 coverage only for a specified disease or illness; hospital
1708 indemnity or other fixed indemnity insurance; coverage offered
1709 as a separate policy, certificate, or contract of insurance,
1710 such as Medicare supplemental health insurance as defined under
1711 s. 1882(g)(1) of the Social Security Act; coverage supplemental
1712 to the coverage provided under chapter 55 of Title 10, United
1713 States Code, the Civilian Health and Medical Program of the
1714 Uniformed Services (CHAMPUS); similar supplemental coverage

1715 provided to coverage under a group health plan; coverage issued
1716 as a supplement to liability insurance; insurance arising out of
1717 a workers' compensation or similar law; automobile medical
1718 payment insurance; or insurance under which benefits are payable
1719 with or without regard to fault and which is statutorily
1720 required to be contained in any liability insurance policy or
1721 equivalent selfinsurance.
1722 (e) "Implementation" means the effective date after the
1723 first meeting of the board when legal authority and
1724 administrative ability exists for the board to subsume the
1725 transfer of all statutory powers, duties, functions, assets,
1726 records, personnel, and property of the Florida Comprehensive
1727 Health Association as specified in s. 627.6488.
1728 (f) "Insurer" means any entity that provides health
1729 insurance in this state. For purposes of this section, insurer
1730 includes an insurance company with a valid certificate in
1731 accordance with chapter 624, a health maintenance organization
1732 with a valid certificate of authority in accordance with part I
1733 or part III of chapter 641, a prepaid health clinic authorized
1734 to transact business in this state pursuant to part II of
1735 chapter 641, multiple employer welfare arrangements authorized
1736 to transact business in this state pursuant to ss. 624.436-
1737 624.45, or a fraternal benefit society providing health benefits
1738 to its members as authorized pursuant to chapter 632.
1739 (g) "Medicare" means coverage under both Parts A and B of
1740 Title XVIII of the Social Security Act, 42 USC 1395 et seq., as
1741 amended.

1742 (h) "Medicaid" means coverage under Title XIX of the
1743 Social Security Act.
1744 (i) "Office" means the Office of Insurance Regulation of
1745 the Financial Services Commission.
1746 (j) "Participating insurer" means any insurer providing
1747 health insurance to citizens of this state.
1748 (k) "Provider" means any physician, hospital, or other
1749 institution, organization, or person that furnishes health care
1750 services and is licensed or otherwise authorized to practice in
1751 the state.
1752 (l) "Plan" means the Florida Health Insurance Plan created
1753 in subsection (1).
1754 (m) "Plan of operation" means the articles, bylaws, and
1755 operating rules and procedures adopted by the board pursuant to
1756 this section.
1757 (n) "Resident" means an individual who has been legally
1758 domiciled in this state for a period of at least 6 months.
1759 (3) BOARD OF DIRECTORS.--
1760 (a) The plan shall operate subject to the supervision and
1761 control of the board. The board shall consist of the director or
1762 his or her designated representative, who shall serve as a
1763 member of the board and shall be its chair, and an additional
1764 eight members, five of whom shall be appointed by the Governor,
1765 at least two of whom shall be individuals not representative of
1766 insurers or health care providers, one of whom shall be
1767 appointed by the President of the Senate, one of whom shall be
1768 appointed by the Speaker of the House of Representatives, and
1769 one of whom shall be appointed by the Chief Financial Officer.

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1770 (b) The term to be served on the board by the director of
1771 the Office of Insurance Regulation shall be determined by
1772 continued employment in such position. The remaining initial
1773 board members shall serve for a period of time as follows: two
1774 members appointed by the Governor and the members appointed by
1775 the President of the Senate and the Speaker of the House of
1776 Representatives shall serve a term of 2 years; and three members
1777 appointed by the Governor and the Chief Financial Officer shall
1778 serve a term of 4 years. Subsequent board members shall serve
1779 for a term of 3 years. A board member's term shall continue
1780 until his or her successor is appointed.
1781 (c) Vacancies on the board shall be filled by the
1782 appointing authority, such authority being the Governor, the
1783 President of the Senate, the Speaker of the House of
1784 Representatives, or the Chief Financial Officer. The appointing
1785 authority may remove board members for cause.
1786 (d) The director, or his or her recognized representative,
1787 shall be responsible for any organizational requirements
1788 necessary for the initial meeting of the board which shall take
1789 place no later than September 1, 2004.
1790 (e) Members shall not be compensated in their capacity as
1791 board members but shall be reimbursed for reasonable expenses
1792 incurred in the necessary performance of their duties in
1793 accordance with s. 112.061.
1794 (f) The board shall submit to the Financial Services
1795 Commission a plan of operation for the plan and any amendments
1796 thereto necessary or suitable to ensure the fair, reasonable,
1797 and equitable administration of the plan. The plan of operation

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1798 shall ensure that the plan qualifies to apply for any available
1799 funding from the Federal Government that adds to the financial
1800 viability of the plan. The plan of operation shall become
1801 effective upon approval in writing by the Financial Services
1802 Commission consistent with the date on which the coverage under
1803 this section must be made available. If the board fails to
1804 submit a suitable plan of operation within 1 year after the
1805 appointment of the board of directors, or at any time thereafter
1806 fails to submit suitable amendments to the plan of operation,
1807 the Financial Services Commission shall adopt such rules as are
1808 necessary or advisable to effectuate the provisions of this
1809 section. Such rules shall continue in force until modified by
1810 the office or superseded by a plan of operation submitted by the
1811 board and approved by the Financial Services Commission.
1812 (4) PLAN OF OPERATION.--The plan of operation shall:
1813 (a) Establish procedures for operation of the plan.
1814 (b) Establish procedures for selecting an administrator in
1815 accordance with subsection (11).
1816 (c) Establish procedures to create a fund, under
1817 management of the board, for administrative expenses.
1818 (d) Establish procedures for the handling, accounting, and
1819 auditing of assets, moneys, and claims of the plan and the plan
1820 administrator.
1821 (e) Develop and implement a program to publicize the
1822 existence of the plan, plan eligibility requirements, and
1823 procedures for enrollment and maintain public awareness of the
1824 plan.

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1825 (f) Establish procedures under which applicants and
1826 participants may have grievances reviewed by a grievance
1827 committee appointed by the board. The grievances shall be
1828 reported to the board after completion of the review, with the
1829 committee's recommendation for grievance resolution. The board
1830 shall retain all written grievances regarding the plan for at
1831 least 3 years.
1832 (g) Provide for other matters as may be necessary and
1833 proper for the execution of the board's powers, duties, and
1834 obligations under this section.
1835 (5) POWERS OF THE PLAN.--The plan shall have the general
1836 powers and authority granted under the laws of this state to
1837 health insurers and, in addition thereto, the specific authority
1838 to:
1839 (a) Enter into such contracts as are necessary or proper
1840 to carry out the provisions and purposes of this section,
1841 including the authority, with the approval of the Chief
1842 Financial Officer, to enter into contracts with similar plans of
1843 other states for the joint performance of common administrative
1844 functions, or with persons or other organizations for the
1845 performance of administrative functions.
1846 (b) Take any legal actions necessary or proper to recover
1847 or collect assessments due the plan.
1848 (c) Take such legal action as is necessary to:
1849 1. Avoid payment of improper claims against the plan or
1850 the coverage provided by or through the plan;
1851 2. Recover any amounts erroneously or improperly paid by
1852 the plan;

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1853 3. Recover any amounts paid by the plan as a result of
1854 mistake of fact or law; or
1855 4. Recover other amounts due the plan.
1856 (d) Establish, and modify as appropriate, rates, rate
1857 schedules, rate adjustments, expense allowances, agents'
1858 commissions, claims reserve formulas, and any other actuarial
1859 functions appropriate to the operation of the plan. Rates and
1860 rate schedules may be adjusted for appropriate factors such as
1861 age, sex, and geographic variation in claim cost and shall take
1862 into consideration appropriate factors in accordance with
1863 established actuarial and underwriting practices. For purposes
1864 of this paragraph, usual and customary agent's commissions shall
1865 be paid for the initial placement of coverage with the plan and
1866 for one renewal only.
1867 (e) Issue policies of insurance in accordance with the
1868 requirements of this section.
1869 (f) Appoint appropriate legal, actuarial, investment, and
1870 other committees as necessary to provide technical assistance in
1871 the operation of the plan and develop and educate its
1872 policyholders regarding health savings accounts, policy and
1873 contract design, and any other function within the authority of
1874 the plan.
1875 (g) Borrow money to effectuate the purposes of the plan.
1876 Any notes or other evidence of indebtedness of the plan not in
1877 default shall be legal investments for insurers and may be
1878 carried as admitted assets.
1879 (h) Employ and fix the compensation of employees.

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1880 (i) Prepare and distribute certificate of eligibility
1881 forms and enrollment instruction forms to insurance producers
1882 and to the general public.
1883 (j) Provide for reinsurance of risks incurred by the plan.
1884 (k) Provide for and employ cost-containment measures and
1885 requirements, including, but not limited to, preadmission
1886 screening, second surgical opinion, concurrent utilization
1887 review, and individual case management for the purpose of making
1888 the plan more cost-effective.
1889 (l) Design, use, contract, or otherwise arrange for the
1890 delivery of cost-effective health care services, including, but
1891 not limited to, establishing or contracting with preferred
1892 provider organizations, health maintenance organizations, and
1893 other limited network provider arrangements.
1894 (m) Adopt such bylaws, policies, and procedures as may be
1895 necessary or convenient for the implementation of this section
1896 and the operation of the plan.
1897 (n) Subsume the transfer of statutory powers, duties,
1898 functions, assets, records, personnel, and property of the
1899 Florida Comprehensive Health Association as specified in ss.
1900 627.6488, 627.6489, 627.649, 627.6492, 627.6496, 627.6498, and
1901 627.6499, unless otherwise specified by law.
1902 (6) INTERIM REPORT; ANNUAL REPORT.--
1903 (a) By no later than December 1, 2004, the board shall
1904 report to the Governor, the President of the Senate, and the
1905 Speaker of the House of Representatives the results of an
1906 actuarial study conducted by the board to determine, including,
1907 but not limited to:

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1908 1. The impact the creation of the plan will have on the
1909 small group insurance market and the individual market on
1910 premiums paid by insureds. This shall include an estimate of the
1911 total anticipated aggregate savings for all small employers in
1912 the state.
1913 2. The number of individuals the pool could reasonably
1914 cover at various funding levels, specifically, the number of
1915 people the pool may cover at each of those funding levels.
1916 3. A recommendation as to the best source of funding for
1917 the anticipated deficits of the pool.
1918 4. The effect on the individual and small group market by
1919 including in the Florida Health Insurance Plan persons eligible
1920 for coverage under s. 627.6487, as well as the cost of including
1921 these individuals.
1922
1923 The board shall take no action to implement the Florida Health
1924 Insurance Plan, other than the completion of the actuarial study
1925 authorized in this paragraph, until funds are appropriated for
1926 startup cost and any projected deficits.
1927 (b) No later than December 1, 2005, and annually
1928 thereafter, the board shall submit to the Governor, the
1929 President of the Senate, the Speaker of the House of
1930 Representatives, and the substantive legislative committees of
1931 the Legislature a report which includes an independent actuarial
1932 study to determine, including, but not be limited to:
1933 1. The impact the creation of the plan has on the small
1934 group and individual insurance market, specifically on the
1935 premiums paid by insureds. This shall include an estimate of the

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1936 total anticipated aggregate savings for all small employers in
1937 the state.
1938 2. The actual number of individuals covered at the current
1939 funding and benefit level, the projected number of individuals
1940 that may seek coverage in the forthcoming fiscal year, and the
1941 projected funding needed to cover anticipated increase or
1942 decrease in plan participation.
1943 3. A recommendation as to the best source of funding for
1944 the anticipated deficits of the pool.
1945 4. A summarization of the activities of the plan in the
1946 preceding calendar year, including the net written and earned
1947 premiums, plan enrollment, the expense of administration, and
1948 the paid and incurred losses.
1949 5. A review of the operation of the plan as to whether the
1950 plan has met the intent of this section.
1951 (7) LIABILITY OF THE PLAN.--Neither the board nor its
1952 employees shall be liable for any obligations of the plan. No
1953 member or employee of the board shall be liable, and no cause of
1954 action of any nature may arise against a member or employee of
1955 the board, for any act or omission related to the performance of
1956 any powers and duties under this section, unless such act or
1957 omission constitutes willful or wanton misconduct. The board may
1958 provide in its bylaws or rules for indemnification of, and legal
1959 representation for, its members and employees.
1960 (8) AUDITED FINANCIAL STATEMENT.--No later than June 1
1961 following the close of each calendar year, the plan shall submit
1962 to the Financial Services Commission an audited financial
1963 statement prepared in accordance with statutory accounting

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1964 principles as adopted by the National Association of Insurance
1965 Commissioners.
1966 (9) ELIGIBILITY.--
1967 (a) Any individual person who is and continues to be a
1968 resident of this state shall be eligible for coverage under the
1969 plan if:
1970 1. Evidence is provided that the person received notices
1971 of rejection or refusal to issue substantially similar coverage
1972 for health reasons from at least two health insurers or health
1973 maintenance organizations. A rejection or refusal by an insurer
1974 offering only stoploss, excess of loss, or reinsurance coverage
1975 with respect to the applicant shall not be sufficient evidence
1976 under this paragraph.
1977 2. The person is enrolled in the Florida Comprehensive
1978 Health Association as of the date the plan is implemented.
1979 (b) Each resident dependent of a person who is eligible
1980 for coverage under the plan shall also be eligible for such
1981 coverage.
1982 (c) A person shall not be eligible for coverage under the
1983 plan if:
1984 1. The person has or obtains health insurance coverage
1985 substantially similar to or more comprehensive than a plan
1986 policy, or would be eligible to obtain such coverage, unless a
1987 person may maintain other coverage for the period of time the
1988 person is satisfying any preexisting condition waiting period
1989 under a plan policy or may maintain plan coverage for the period
1990 of time the person is satisfying a preexisting condition waiting

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1991 period under another health insurance policy intended to replace
1992 the plan policy.
1993 2. The person is determined to be eligible for health care
1994 benefits under Medicaid, Medicare, the state's children's health
1995 insurance program, or any other federal, state, or local
1996 government program that provides health benefits;
1997 3. The person voluntarily terminated plan coverage unless
1998 12 months have elapsed since such termination;
1999 4. The person is an inmate or resident of a public
2000 institution; or
2001 5. The person's premiums are paid for or reimbursed under
2002 any government-sponsored program or by any government agency or
2003 health care provider.
2004 (d) Coverage shall cease:
2005 1. On the date a person is no longer a resident of this
2006 state;
2007 2. On the date a person requests coverage to end;
2008 3. Upon the death of the covered person;
2009 4. On the date state law requires cancellation or
2010 nonrenewal of the policy; or
2011 5. At the option of the plan, 30 days after the plan makes
2012 any inquiry concerning the person's eligibility or place of
2013 residence to which the person does not reply.
2014 6. Upon failure of the insured to pay for continued
2015 coverage.
2016 (e) Except under the circumstances described in this
2017 subsection, coverage of a person who ceases to meet the
2018 eligibility requirements of this subsection shall be terminated

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2019 at the end of the policy period for which the necessary premiums
2020 have been paid.
2021 (10) UNFAIR REFERRAL TO PLAN.--It is an unfair trade
2022 practice for the purposes of part IX of chapter 626 or s.
2023 641.3901 for an insurer, health maintenance organization
2024 insurance agent, insurance broker, or third-party administrator
2025 to refer an individual employee to the plan, or arrange for an
2026 individual employee to apply to the plan, for the purpose of
2027 separating that employee from group health insurance coverage
2028 provided in connection with the employee's employment.
2029 (11) PLAN ADMINISTRATOR.--The board shall select through a
2030 competitive bidding process a plan administrator to administer
2031 the plan. The board shall evaluate bids submitted based on
2032 criteria established by the board, which shall include:
2033 (a) The plan administrator's proven ability to handle
2034 health insurance coverage to individuals.
2035 (b) The efficiency and timeliness of the plan
2036 administrator's claim processing procedures.
2037 (c) An estimate of total charges for administering the
2038 plan.
2039 (d) The plan administrator's ability to apply effective
2040 cost-containment programs and procedures and to administer the
2041 plan in a cost-efficient manner.
2042 (e) The financial condition and stability of the plan
2043 administrator.
2044
2045 The administrator shall be an insurer, a health maintenance
2046 organization, or a third-party administrator, or another

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2047 organization duly authorized to provide insurance pursuant to
2048 the Florida Insurance Code.
2049 (12) ADMINISTRATOR TERM LIMITS.--The plan administrator
2050 shall serve for a period specified in the contract between the
2051 plan and the plan administrator subject to removal for cause and
2052 subject to any terms, conditions, and limitations of the
2053 contract between the plan and the plan administrator. At least 1
2054 year prior to the expiration of each period of service by a plan
2055 administrator, the board shall invite eligible entities,
2056 including the current plan administrator, to submit bids to
2057 serve as the plan administrator. Selection of the plan
2058 administrator for each succeeding period shall be made at least
2059 6 months prior to the end of the current period.
2060 (13) DUTIES OF THE PLAN ADMINISTRATOR.--
2061 (a) The plan administrator shall perform such functions
2062 relating to the plan as may be assigned to it, including, but
2063 not limited to:
2064 1. Determination of eligibility.
2065 2. Payment of claims.
2066 3. Establishment of a premium billing procedure for
2067 collection of premiums from persons covered under the plan.
2068 4. Other necessary functions to ensure timely payment of
2069 benefits to covered persons under the plan.
2070 (b) The plan administrator shall submit regular reports to
2071 the board regarding the operation of the plan. The frequency,
2072 content, and form of the reports shall be specified in the
2073 contract between the board and the plan administrator.

2074 (c) On March 1 following the close of each calendar year,
2075 the plan administrator shall determine net written and earned
2076 premiums, the expense of administration, and the paid and
2077 incurred losses for the year and report this information to the
2078 board and the Governor on a form prescribed by the Governor.
2079 (14) PAYMENT OF THE PLAN ADMINISTRATOR.--The plan
2080 administrator shall be paid as provided in the contract between
2081 the plan and the plan administrator.
2082 (15) FUNDING OF THE PLAN.--
2083 (a) Premiums.--
2084 1. The plan shall establish premium rates for plan
2085 coverage as provided in this section. Separate schedules of
2086 premium rates based on age, sex, and geographical location may
2087 apply for individual risks. Premium rates and schedules shall be
2088 submitted to the office for approval prior to use.
2089 2. Initial rates for plan coverage shall be limited to no
2090 more than 300 percent of rates established for individual
2091 standard risks as specified in s. 627.6675(3)(c). Subject to the
2092 limits provided in this paragraph, subsequent rates shall be
2093 established to provide fully for the expected costs of claims,
2094 including recovery of prior losses, expenses of operation,
2095 investment income of claim reserves, and any other cost factors
2096 subject to the limitations described herein, but in no event
2097 shall premiums exceed the 300-percent rate limitation provided
2098 in this section. Notwithstanding the 300-percent rate
2099 limitation, sliding scale premium surcharges based upon the
2100 insured's income may apply to all enrollees.

2101 (b) Sources of additional revenue.--Any deficit incurred
2102 by the plan shall be primarily funded through amounts
2103 appropriated by the Legislature from general revenue sources,
2104 including, but not limited to, a portion of the annual growth in
2105 existing net insurance premium taxes. The board shall operate
2106 the plan in such a manner that the estimated cost of providing
2107 health insurance during any fiscal year will not exceed total
2108 income the plan expects to receive from policy premiums and
2109 funds appropriated by the Legislature, including any interest on
2110 investments. After determining the amount of funds appropriated
2111 to the board for a fiscal year, the board shall estimate the
2112 number of new policies it believes the plan has the financial
2113 capacity to insure during that year so that costs do not exceed
2114 income. The board shall take steps necessary to ensure that plan
2115 enrollment does not exceed the number of residents it has
2116 estimated it has the financial capacity to insure.
2117 (16) BENEFITS.--
2118 (a) The benefits provided shall be the same as the
2119 standard and basic plans for small employers as outlined in s.
2120 627.6699. The board shall also establish an option of
2121 alternative coverage such as catastrophic coverage that includes
2122 a minimum level of primary care coverage and a high deductible
2123 plan that meets the federal requirements of a health savings
2124 account.
2125 (b) In establishing the plan coverage, the board shall
2126 take into consideration the levels of health insurance provided
2127 in the state and such medical economic factors as may be deemed
2128 appropriate and adopt benefit levels, deductibles, copayments,

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2129 coinsurance factors, exclusions, and limitations determined to
2130 be generally reflective of and commensurate with health
2131 insurance provided through a representative number of large
2132 employers in the state.
2133 (c) The board may adjust any deductibles and coinsurance
2134 factors annually according to the medical component of the
2135 Consumer Price Index.
2136 (d)1. Plan coverage shall exclude charges or expenses
2137 incurred during the first 6 months following the effective date
2138 of coverage for any condition for which medical advice, care, or
2139 treatment was recommended or received for such condition during
2140 the 6-month period immediately preceding the effective date of
2141 coverage.
2142 2. Such preexisting condition exclusions shall be waived
2143 to the extent that similar exclusions, if any, have been
2144 satisfied under any prior health insurance coverage which was
2145 involuntarily terminated, provided application for pool coverage
2146 is made not later than 63 days following such involuntary
2147 termination. In such case, coverage under the plan shall be
2148 effective from the date on which such prior coverage was
2149 terminated and the applicant is not eligible for continuation or
2150 conversion rights that would provide coverage substantially
2151 similar to plan coverage.
2152 (17) NONDUPLICATION OF BENEFITS.--
2153 (a) The plan shall be payor of last resort of benefits
2154 whenever any other benefit or source of third-party payment is
2155 available. Benefits otherwise payable under plan coverage shall
2156 be reduced by all amounts paid or payable through any other

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2157 health insurance, by all hospital and medical expense benefits
2158 paid or payable under any workers' compensation coverage,
2159 automobile medical payment, or liability insurance, whether
2160 provided on the basis of fault or nonfault, and by any hospital
2161 or medical benefits paid or payable under or provided pursuant
2162 to any state or federal law or program.
2163 (b) The plan shall have a cause of action against an
2164 eligible person for the recovery of the amount of benefits paid
2165 that are not for covered expenses. Benefits due from the plan
2166 may be reduced or refused as a setoff against any amount
2167 recoverable under this paragraph.
2168 (18) ANNUAL AND MAXIMUM BENEFITS.--Maximum benefits under
2169 the plan shall be determined by the board.
2170 (19) TAXATION.--The plan is exempt from any tax imposed by
2171 this state. The plan shall apply for federal tax exemption
2172 status.
2173 (20) COMBINING MEMBERSHIP OF THE FLORIDA COMPREHENSIVE
2174 HEALTH ASSOCIATION; ASSESSMENT.--
2175 (a)1. Upon implementation of the Florida Health Insurance
2176 Plan, the Florida Comprehensive Health Association, as specified
2177 in s. 627.6488, is abolished as a separate nonprofit entity and
2178 shall be subsumed under the board of directors of the Florida
2179 Health Insurance Plan. All individuals actively enrolled in the
2180 Florida Comprehensive Health Association shall be enrolled in
2181 the plan subject to its rules and requirements, except as
2182 otherwise specified in this section. Maximum lifetime benefits
2183 paid to an individual in the plan shall not exceed the amount
2184 established under subsection (16), and benefits previously paid

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2185 for any individual by the Florida Comprehensive Health
2186 Association shall be used in the determination of total lifetime
2187 benefits paid under the plan.
2188 2. All persons enrolled in the Florida Comprehensive
2189 Health Association upon implementation of the Florida Health
2190 Insurance Plan are only eligible for the benefits authorized
2191 under subsection (16). Persons identified by this section shall
2192 convert to the benefits authorized under subsection (16) no
2193 later than January 1, 2005.
2194 3. Except as otherwise provided in this section, the
2195 administration of the coverage of persons actively enrolled in
2196 the Florida Comprehensive Health Association shall operate under
2197 the existing plan of operation without modification until the
2198 adoption of the new plan of operation for the Florida Health
2199 Insurance Plan.
2200 (b)1. As a condition of doing business in this state, an
2201 insurer shall pay an assessment to the board in the amount
2202 prescribed by this section. For operating losses incurred on or
2203 after July 1, 2004, by persons enrolled in the Florida
2204 Comprehensive Health Association, each insurer shall annually be
2205 assessed by the board in the following calendar year a portion
2206 of such incurred operating losses of the plan. Such portion
2207 shall be determined by multiplying such operating losses by a
2208 fraction, the numerator of which equals the insurer's earned
2209 premium pertaining to direct writings of health insurance in the
2210 state during the calendar year preceding that for which the
2211 assessment is levied, and the denominator of which equals the

2212 total of all such premiums earned by insurers in the state
2213 during such calendar year.
2214 2. The total of all assessments under this paragraph upon
2215 an insurer shall not exceed 1 percent of such insurer's health
2216 insurance premium earned in this state during the calendar year
2217 preceding the year for which the assessments were levied.
2218 3. All rights, title, and interest in the assessment funds
2219 collected under this paragraph shall vest in this state.
2220 However, all of such funds and interest earned shall be used by
2221 the plan to pay claims and administrative expenses.
2222 (c) If assessments and other receipts by the plan, board,
2223 or plan administrator exceed the actual losses and
2224 administrative expenses of the plan, the excess shall be held in
2225 interest and used by the board to offset future losses. As used
2226 in this subsection, the term "future losses" includes reserves
2227 for claims incurred but not reported.
2228 (d) Each insurer's assessment shall be determined annually
2229 by the board or plan administrator based on annual statements
2230 and other reports deemed necessary by the board or plan
2231 administrator and filed with the board or plan administrator by
2232 the insurer. Any deficit incurred under the plan by persons
2233 previously enrolled in the Florida Comprehensive Health
2234 Association shall be recouped by the assessments against
2235 insurers by the board or plan administrator in the manner
2236 provided in paragraph (b), and the insurers may recover the
2237 assessment in the normal course of their respective businesses
2238 without time limitation.

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2239 (e) If a person actively enrolled in the Florida
2240 Comprehensive Health Association after implementation of the
2241 plan loses eligibility for participation in the Florida
2242 Comprehensive Health Association, such person shall not be
2243 included in the calculation of the assessment if the person
2244 later regains eligibility for participation in the plan.
2245 (f) When all persons actively enrolled in the Florida
2246 Comprehensive Health Association as of the date of
2247 implementation of the plan are no longer eligible for
2248 participation in the Florida Comprehensive Health Association,
2249 the board of directors and plan administrator shall no longer be
2250 allowed to assess insurers in this state for incurred losses in
2251 the Florida Comprehensive Health Association.
2252 Section 22. Upon implementation, as defined in s.
2253 627.64872(2), Florida Statutes, and as provided in s.
2254 627.64872(20), Florida Statutes, of the Florida Health Insurance
2255 Plan created under s. 627.64872, Florida Statutes, sections
2256 627.6488, 627.6489, 627.649, 627.6492, 627.6494, 627.6496, and
2257 627.6498, Florida Statutes, are repealed.
2258 Section 23. Subsections (12) and (13) are added to section
2259 627.662, Florida Statutes, to read:
2260 627.662 Other provisions applicable.--The following
2261 provisions apply to group health insurance, blanket health
2262 insurance, and franchise health insurance:
2263 (12) Section 627.6044, relating to the use of specific
2264 methodology for payment of claims.
2265 (13) Section 627.6405, relating to the inappropriate
2266 utilization of emergency care.

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2267 Section 24. Paragraphs (c) and (d) of subsection (5),
2268 paragraph (b) of subsection (6), and subsection (12) of section
2269 627.6699, Florida Statutes, are amended, subsections (15) and
2270 (16) of said section are renumbered as subsections (16) and
2271 (17), respectively, present subsection (15) of said section is
2272 amended, and new subsections (15) and (18) are added to said
2273 section, to read:
2274 627.6699 Employee Health Care Access Act.--
2275 (5) AVAILABILITY OF COVERAGE.--
2276 (c) Every small employer carrier must, as a condition of
2277 transacting business in this state:
2278 1. Offer and issue all small employer health benefit plans
2279 on a guaranteed-issue basis to every eligible small employer,
2280 with 2 to 50 eligible employees, that elects to be covered under
2281 such plan, agrees to make the required premium payments, and
2282 satisfies the other provisions of the plan. A rider for
2283 additional or increased benefits may be medically underwritten
2284 and may only be added to the standard health benefit plan. The
2285 increased rate charged for the additional or increased benefit
2286 must be rated in accordance with this section.
2287 2. In the absence of enrollment availability in the
2288 Florida Health Insurance Plan, offer and issue basic and
2289 standard small employer health benefit plans on a guaranteed-
2290 issue basis, during a 31-day open enrollment period of August 1
2291 through August 31 of each year, to every eligible small
2292 employer, with fewer than two eligible employees, which small
2293 employer is not formed primarily for the purpose of buying
2294 health insurance and which elects to be covered under such plan,

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2295 agrees to make the required premium payments, and satisfies the
2296 other provisions of the plan. Coverage provided under this
2297 subparagraph shall begin on October 1 of the same year as the
2298 date of enrollment, unless the small employer carrier and the
2299 small employer agree to a different date. A rider for additional
2300 or increased benefits may be medically underwritten and may only
2301 be added to the standard health benefit plan. The increased rate
2302 charged for the additional or increased benefit must be rated in
2303 accordance with this section. For purposes of this subparagraph,
2304 a person, his or her spouse, and his or her dependent children
2305 constitute a single eligible employee if that person and spouse
2306 are employed by the same small employer and either that person
2307 or his or her spouse has a normal work week of less than 25
2308 hours. Any right to an open enrollment of health benefit
2309 coverage for groups of fewer than two employees, pursuant to
2310 this section, shall remain in full force and effect in the
2311 absence of the availability of new enrollment into the Florida
2312 Health Insurance Plan.
2313 3. This paragraph does not limit a carrier's ability to
2314 offer other health benefit plans to small employers if the
2315 standard and basic health benefit plans are offered and
2316 rejected.
2317 (d) A small employer carrier must file with the office, in
2318 a format and manner prescribed by the committee, a standard
2319 health care plan, a high deductible plan that meets the federal
2320 requirements of a health savings account plan or a health
2321 reimbursement arrangement, and a basic health care plan to be
2322 used by the carrier. The provisions of this section requiring

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2323 the filing of a high deductible plan are effective September 1,
2324 2004.
2325 (6) RESTRICTIONS RELATING TO PREMIUM RATES.--
2326 (b) For all small employer health benefit plans that are
2327 subject to this section and are issued by small employer
2328 carriers on or after January 1, 1994, premium rates for health
2329 benefit plans subject to this section are subject to the
2330 following:
2331 1. Small employer carriers must use a modified community
2332 rating methodology in which the premium for each small employer
2333 must be determined solely on the basis of the eligible
2334 employee's and eligible dependent's gender, age, family
2335 composition, tobacco use, or geographic area as determined under
2336 paragraph (5)(j) and in which the premium may be adjusted as
2337 permitted by this paragraph.
2338 2. Rating factors related to age, gender, family
2339 composition, tobacco use, or geographic location may be
2340 developed by each carrier to reflect the carrier's experience.
2341 The factors used by carriers are subject to office review and
2342 approval.
2343 3. Small employer carriers may not modify the rate for a
2344 small employer for 12 months from the initial issue date or
2345 renewal date, unless the composition of the group changes or
2346 benefits are changed. However, a small employer carrier may
2347 modify the rate one time prior to 12 months after the initial
2348 issue date for a small employer who enrolls under a previously
2349 issued group policy that has a common anniversary date for all
2350 employers covered under the policy if:

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2351 a. The carrier discloses to the employer in a clear and
2352 conspicuous manner the date of the first renewal and the fact
2353 that the premium may increase on or after that date.
2354 b. The insurer demonstrates to the office that
2355 efficiencies in administration are achieved and reflected in the
2356 rates charged to small employers covered under the policy.
2357 4. A carrier may issue a group health insurance policy to
2358 a small employer health alliance or other group association with
2359 rates that reflect a premium credit for expense savings
2360 attributable to administrative activities being performed by the
2361 alliance or group association if such expense savings are
2362 specifically documented in the insurer's rate filing and are
2363 approved by the office. Any such credit may not be based on
2364 different morbidity assumptions or on any other factor related
2365 to the health status or claims experience of any person covered
2366 under the policy. Nothing in this subparagraph exempts an
2367 alliance or group association from licensure for any activities
2368 that require licensure under the insurance code. A carrier
2369 issuing a group health insurance policy to a small employer
2370 health alliance or other group association shall allow any
2371 properly licensed and appointed agent of that carrier to market
2372 and sell the small employer health alliance or other group
2373 association policy. Such agent shall be paid the usual and
2374 customary commission paid to any agent selling the policy.
2375 5. Any adjustments in rates for claims experience, health
2376 status, or duration of coverage may not be charged to individual
2377 employees or dependents. For a small employer's policy, such
2378 adjustments may not result in a rate for the small employer

2379 which deviates more than 15 percent from the carrier's approved
2380 rate. Any such adjustment must be applied uniformly to the rates
2381 charged for all employees and dependents of the small employer.
2382 A small employer carrier may make an adjustment to a small
2383 employer's renewal premium, not to exceed 10 percent annually,
2384 due to the claims experience, health status, or duration of
2385 coverage of the employees or dependents of the small employer.
2386 Semiannually, small group carriers shall report information on
2387 forms adopted by rule by the commission, to enable the office to
2388 monitor the relationship of aggregate adjusted premiums actually
2389 charged policyholders by each carrier to the premiums that would
2390 have been charged by application of the carrier's approved
2391 modified community rates. If the aggregate resulting from the
2392 application of such adjustment exceeds the premium that would
2393 have been charged by application of the approved modified
2394 community rate by 4 ~~5~~ percent for the current reporting period,
2395 the carrier shall limit the application of such adjustments only
2396 to minus adjustments beginning not more than 60 days after the
2397 report is sent to the office. For any subsequent reporting
2398 period, if the total aggregate adjusted premium actually charged
2399 does not exceed the premium that would have been charged by
2400 application of the approved modified community rate by 4 ~~5~~
2401 percent, the carrier may apply both plus and minus adjustments.
2402 A small employer carrier may provide a credit to a small
2403 employer's premium based on administrative and acquisition
2404 expense differences resulting from the size of the group. Group
2405 size administrative and acquisition expense factors may be

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2406 developed by each carrier to reflect the carrier's experience
2407 and are subject to office review and approval.
2408 6. A small employer carrier rating methodology may include
2409 separate rating categories for one dependent child, for two
2410 dependent children, and for three or more dependent children for
2411 family coverage of employees having a spouse and dependent
2412 children or employees having dependent children only. A small
2413 employer carrier may have fewer, but not greater, numbers of
2414 categories for dependent children than those specified in this
2415 subparagraph.
2416 7. Small employer carriers may not use a composite rating
2417 methodology to rate a small employer with fewer than 10
2418 employees. For the purposes of this subparagraph, a "composite
2419 rating methodology" means a rating methodology that averages the
2420 impact of the rating factors for age and gender in the premiums
2421 charged to all of the employees of a small employer.
2422 8.a. A carrier may separate the experience of small
2423 employer groups with less than 2 eligible employees from the
2424 experience of small employer groups with 2-50 eligible employees
2425 for purposes of determining an alternative modified community
2426 rating.
2427 b. If a carrier separates the experience of small employer
2428 groups as provided in sub-subparagraph a., the rate to be
2429 charged to small employer groups of less than 2 eligible
2430 employees may not exceed 150 percent of the rate determined for
2431 small employer groups of 2-50 eligible employees. However, the
2432 carrier may charge excess losses of the experience pool
2433 consisting of small employer groups with less than 2 eligible

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2434 employees to the experience pool consisting of small employer
2435 groups with 2-50 eligible employees so that all losses are
2436 allocated and the 150-percent rate limit on the experience pool
2437 consisting of small employer groups with less than 2 eligible
2438 employees is maintained. Notwithstanding s. 627.411(1), the rate
2439 to be charged to a small employer group of fewer than 2 eligible
2440 employees, insured as of July 1, 2002, may be up to 125 percent
2441 of the rate determined for small employer groups of 2-50
2442 eligible employees for the first annual renewal and 150 percent
2443 for subsequent annual renewals.
2444 (12) STANDARD, BASIC, HIGH DEDUCTIBLE, AND LIMITED HEALTH
2445 BENEFIT PLANS.--
2446 (a)1. The Chief Financial Officer shall appoint a health
2447 benefit plan committee composed of four representatives of
2448 carriers which shall include at least two representatives of
2449 HMOs, at least one of which is a staff model HMO, two
2450 representatives of agents, four representatives of small
2451 employers, and one employee of a small employer. The carrier
2452 members shall be selected from a list of individuals recommended
2453 by the board. The Chief Financial Officer may require the board
2454 to submit additional recommendations of individuals for
2455 appointment.
2456 2. The plans shall comply with all of the requirements of
2457 this subsection.
2458 3. The plans must be filed with and approved by the office
2459 prior to issuance or delivery by any small employer carrier.
2460 4. After approval of the revised health benefit plans, if
2461 the office determines that modifications to a plan might be

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2462 appropriate, the Chief Financial Officer shall appoint a new
2463 health benefit plan committee in the manner provided in
2464 subparagraph 1. to submit recommended modifications to the
2465 office for approval.
2466 (b)1. Each small employer carrier issuing new health
2467 benefit plans shall offer to any small employer, upon request, a
2468 standard health benefit plan, and a basic health benefit plan,
2469 and a high deductible plan that meets the requirements of a
2470 health savings account plan as defined by federal law or a
2471 health reimbursement arrangement as authorized by the Internal
2472 Revenue Service, that meet meets the criteria set forth in this
2473 section.
2474 2. For purposes of this subsection, the terms "standard
2475 health benefit plan," and "basic health benefit plan," and "high
2476 deductible plan" mean policies or contracts that a small
2477 employer carrier offers to eligible small employers that
2478 contain:
2479 a. An exclusion for services that are not medically
2480 necessary or that are not covered preventive health services;
2481 and
2482 b. A procedure for preauthorization by the small employer
2483 carrier, or its designees.
2484 3. A small employer carrier may include the following
2485 managed care provisions in the policy or contract to control
2486 costs:
2487 a. A preferred provider arrangement or exclusive provider
2488 organization or any combination thereof, in which a small
2489 employer carrier enters into a written agreement with the

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2490 provider to provide services at specified levels of
2491 reimbursement or to provide reimbursement to specified
2492 providers. Any such written agreement between a provider and a
2493 small employer carrier must contain a provision under which the
2494 parties agree that the insured individual or covered member has
2495 no obligation to make payment for any medical service rendered
2496 by the provider which is determined not to be medically
2497 necessary. A carrier may use preferred provider arrangements or
2498 exclusive provider arrangements to the same extent as allowed in
2499 group products that are not issued to small employers.
2500 b. A procedure for utilization review by the small
2501 employer carrier or its designees.
2502
2503 This subparagraph does not prohibit a small employer carrier
2504 from including in its policy or contract additional managed care
2505 and cost containment provisions, subject to the approval of the
2506 office, which have potential for controlling costs in a manner
2507 that does not result in inequitable treatment of insureds or
2508 subscribers. The carrier may use such provisions to the same
2509 extent as authorized for group products that are not issued to
2510 small employers.
2511 4. The standard health benefit plan shall include:
2512 a. Coverage for inpatient hospitalization;
2513 b. Coverage for outpatient services;
2514 c. Coverage for newborn children pursuant to s. 627.6575;
2515 d. Coverage for child care supervision services pursuant
2516 to s. 627.6579;

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2517 e. Coverage for adopted children upon placement in the
2518 residence pursuant to s. 627.6578;
2519 f. Coverage for mammograms pursuant to s. 627.6613;
2520 g. Coverage for handicapped children pursuant to s.
2521 627.6615;
2522 h. Emergency or urgent care out of the geographic service
2523 area; and
2524 i. Coverage for services provided by a hospice licensed
2525 under s. 400.602 in cases where such coverage would be the most
2526 appropriate and the most cost-effective method for treating a
2527 covered illness.
2528 5. The standard health benefit plan and the basic health
2529 benefit plan may include a schedule of benefit limitations for
2530 specified services and procedures. If the committee develops
2531 such a schedule of benefits limitation for the standard health
2532 benefit plan or the basic health benefit plan, a small employer
2533 carrier offering the plan must offer the employer an option for
2534 increasing the benefit schedule amounts by 4 percent annually.
2535 6. The basic health benefit plan shall include all of the
2536 benefits specified in subparagraph 4.; however, the basic health
2537 benefit plan shall place additional restrictions on the benefits
2538 and utilization and may also impose additional cost containment
2539 measures.
2540 7. Sections 627.419(2), (3), and (4), 627.6574, 627.6612,
2541 627.66121, 627.66122, 627.6616, 627.6618, 627.668, and 627.66911
2542 apply to the standard health benefit plan and to the basic
2543 health benefit plan. However, notwithstanding said provisions,
2544 the plans may specify limits on the number of authorized

2545 treatments, if such limits are reasonable and do not
2546 discriminate against any type of provider.
2547 8. The high deductible plan associated with a health
2548 savings account or a health reimbursement arrangement shall
2549 include all the benefits specified in subparagraph 4.
2550 9.8. Each small employer carrier that provides for
2551 inpatient and outpatient services by allopathic hospitals may
2552 provide as an option of the insured similar inpatient and
2553 outpatient services by hospitals accredited by the American
2554 Osteopathic Association when such services are available and the
2555 osteopathic hospital agrees to provide the service.
2556 (c) If a small employer rejects, in writing, the standard
2557 health benefit plan, and the basic health benefit plan, and the
2558 high deductible health savings account plan or a health
2559 reimbursement arrangement, the small employer carrier may offer
2560 the small employer a limited benefit policy or contract.
2561 (d)1. Upon offering coverage under a standard health
2562 benefit plan, a basic health benefit plan, or a limited benefit
2563 policy or contract for any small employer, the small employer
2564 carrier shall provide such employer group with a written
2565 statement that contains, at a minimum:
2566 a. An explanation of those mandated benefits and providers
2567 that are not covered by the policy or contract;
2568 b. An explanation of the managed care and cost control
2569 features of the policy or contract, along with all appropriate
2570 mailing addresses and telephone numbers to be used by insureds
2571 in seeking information or authorization; and

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2572 c. An explanation of the primary and preventive care
2573 features of the policy or contract.
2574
2575 Such disclosure statement must be presented in a clear and
2576 understandable form and format and must be separate from the
2577 policy or certificate or evidence of coverage provided to the
2578 employer group.
2579 2. Before a small employer carrier issues a standard
2580 health benefit plan, a basic health benefit plan, or a limited
2581 benefit policy or contract, it must obtain from the prospective
2582 policyholder a signed written statement in which the prospective
2583 policyholder:
2584 a. Certifies as to eligibility for coverage under the
2585 standard health benefit plan, basic health benefit plan, or
2586 limited benefit policy or contract;
2587 b. Acknowledges the limited nature of the coverage and an
2588 understanding of the managed care and cost control features of
2589 the policy or contract;
2590 c. Acknowledges that if misrepresentations are made
2591 regarding eligibility for coverage under a standard health
2592 benefit plan, a basic health benefit plan, or a limited benefit
2593 policy or contract, the person making such misrepresentations
2594 forfeits coverage provided by the policy or contract; and
2595 d. If a limited plan is requested, acknowledges that the
2596 prospective policyholder had been offered, at the time of
2597 application for the insurance policy or contract, the
2598 opportunity to purchase any health benefit plan offered by the

2599 carrier and that the prospective policyholder had rejected that
2600 coverage.
2601
2602 A copy of such written statement shall be provided to the
2603 prospective policyholder no later than at the time of delivery
2604 of the policy or contract, and the original of such written
2605 statement shall be retained in the files of the small employer
2606 carrier for the period of time that the policy or contract
2607 remains in effect or for 5 years, whichever period is longer.
2608 3. Any material statement made by an applicant for
2609 coverage under a health benefit plan which falsely certifies as
2610 to the applicant's eligibility for coverage serves as the basis
2611 for terminating coverage under the policy or contract.
2612 4. Each marketing communication that is intended to be
2613 used in the marketing of a health benefit plan in this state
2614 must be submitted for review by the office prior to use and must
2615 contain the disclosures stated in this subsection.
2616 (e) A small employer carrier may not use any policy,
2617 contract, form, or rate under this section, including
2618 applications, enrollment forms, policies, contracts,
2619 certificates, evidences of coverage, riders, amendments,
2620 endorsements, and disclosure forms, until the insurer has filed
2621 it with the office and the office has approved it under ss.
2622 627.410 and 627.411 and this section.
2623 (15) SMALL EMPLOYERS ACCESS PROGRAM.--
2624 (a) Popular name.--This subsection may be referred to by
2625 the popular name "The Small Employers Access Program."

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2626 (b) Intent.--The Legislature finds that increased access
2627 to health care coverage for small employers with up to 25
2628 employees could improve employees' health and reduce the
2629 incidence and costs of illness and disabilities among residents
2630 in this state. Many employers do not offer health care benefits
2631 to their employees citing the increased cost of this benefit. It
2632 is the intent of the Legislature to create the Small Business
2633 Health Plan to provide small employers the option and ability to
2634 provide health care benefits to their employees at an affordable
2635 cost through the creation of purchasing pools for employers with
2636 up to 25 employees, and rural hospital employers and nursing
2637 home employers regardless of the number of employees.
2638 (c) Definitions.--For purposes of this subsection:
2639 1. "Fair commission" means a commission structure
2640 determined by the insurers and reflected in the insurers' rate
2641 filings made pursuant to this subsection.
2642 2. "Insurer" means any entity that provides health
2643 insurance in this state. For purposes of this subsection,
2644 insurer includes an insurance company holding a certificate of
2645 authority pursuant to chapter 624 or a health maintenance
2646 organization holding a certificate of authority pursuant to
2647 chapter 641, which qualifies to provide coverage to small
2648 employer groups pursuant to this section.
2649 3. "Mutually supported benefit plan" means an optional
2650 alternative coverage plan developed within a defined geographic
2651 region which may include, but is not limited to, a minimum level
2652 of primary care coverage in which the percentage of the premium
2653 is distributed among the employer, the employee, and community-

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2654 generated revenue either alone or in conjunction with federal
2655 matching funds.
2656 4. "Office" means the Office of Insurance Regulation of
2657 the Department of Financial Services.
2658 5. "Participating insurer" means any insurer providing
2659 health insurance to small employers that has been selected by
2660 the office in accordance with this subsection for its designated
2661 region.
2662 6. "Program" means the Small Employer Access Program as
2663 created by this subsection.
2664 (d) Eligibility.--
2665 1. Any small employer that is actively engaged in
2666 business, has its principal place of business in this state,
2667 employs up to 25 eligible employees on business days during the
2668 preceding calendar year, employs at least 2 employees on the
2669 first day of the plan year, and has had no prior coverage for
2670 the last 6 months may participate.
2671 2. Any municipality, county, school district, or hospital
2672 employer located in a rural community as defined in s.
2673 288.0656(2)(b), may participate.
2674 3. Nursing home employers may participate.
2675 4. Each dependent of a person eligible for coverage is
2676 also eligible to participate.
2677
2678 Any employer participating in the program must do so until the
2679 end of the term for which the carrier providing the coverage is
2680 obligated to provide such coverage to the program. Coverage for
2681 a small employer group that ceases to meet the eligibility

2682 requirements of this section may be terminated at the end of the
2683 policy period for which the necessary premiums have been paid.
2684 (e) Administration.--
2685 1. The office shall by competitive bid, in accordance with
2686 current state law, select an insurer to provide coverage through
2687 the program to eligible small employers within an established
2688 geographical area of this state. The office may develop
2689 exclusive regions for the program similar to those used by the
2690 Healthy Kids Corporation. However the office is not precluded
2691 from developing, in conjunction with insurers, regions different
2692 from those used by the Healthy Kids Corporation if the office
2693 deems that such a region will carry out the intentions of this
2694 subsection.
2695 2. The office shall evaluate bids submitted based upon
2696 criteria established by the office, which shall include, but not
2697 be limited to:
2698 a. The insurer's proven ability to handle health insurance
2699 coverage to small employer groups.
2700 b. The efficiency and timeliness of the insurer's claim
2701 processing procedures.
2702 c. The insurer's ability to apply effective cost-
2703 containment programs and procedures and to administer the
2704 program in a cost-efficient manner.
2705 d. The financial condition and stability of the insurer.
2706 e. The insurer's ability to develop an optional mutually
2707 supported benefit plan.
2708

2709 The office may use any financial information available to it
2710 through its regulatory duties to make this evaluation.
2711 (f) Insurer qualifications.--The insurer shall be a duly
2712 authorized insurer or health maintenance organization.
2713 (g) Duties of the insurer.--The insurer shall:
2714 1. Develop and implement a program to publicize the
2715 existence of the program, program eligibility requirements, and
2716 procedures for enrollment and maintain public awareness of the
2717 program.
2718 2. Maintain employer awareness of the program.
2719 3. Demonstrate the ability to use delivery of cost-
2720 effective health care services.
2721 4. Encourage, educate, advise, and administer the
2722 effective use of health savings accounts by covered employees
2723 and dependents.
2724 5. Serve for a period specified in the contract between
2725 the office and the insurer, subject to removal for cause and
2726 subject to any terms, conditions, and limitations of the
2727 contract between the office and the insurer as may be specified
2728 in the request for proposal.
2729 (h) Contract term.--The contract term shall not exceed 3
2730 years. At least 6 months prior to the expiration of each
2731 contract period, the office shall invite eligible entities,
2732 including the current insurer, to submit bids to serve as the
2733 insurer for a designated geographic area. Selection of the
2734 insurer for the succeeding period shall be made at least 3
2735 months prior to the end of the current period. If a protest is
2736 filed and not resolved by the end of the contract period, the

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2737 contract with the existing administrator may be extended for a
2738 period not to exceed 6 months. During the contract extension
2739 period, the administrator shall be paid at a rate to be
2740 negotiated by the office.
2741 (i) Insurer reporting requirements.--On March 1 following
2742 the close of each calendar year, the insurer shall determine net
2743 written and earned premiums, the expense of administration, and
2744 the paid and incurred losses for the year and report this
2745 information to the office on a form prescribed by the office.
2746 (j) Application requirements.--The insurer shall permit or
2747 allow any licensed and duly appointed health insurance agent
2748 residing in the designated region to submit applications for
2749 coverage, and such agent shall be paid a fair commission if
2750 coverage is written. The agent must be appointed to at least one
2751 insurer.
2752 (k) Benefits.--The benefits provided by the plan shall be
2753 the same as the coverage required for small employers under
2754 subsection (12). Upon the approval of the office, the insurer
2755 may also establish an optional mutually supported benefit plan
2756 which is an alternative plan developed within a defined
2757 geographic region of this state or any other such alternative
2758 plan which will carry out the intent of this subsection. Any
2759 small employer carrier issuing new health benefit plans may
2760 offer a benefit plan with coverages similar to, but not less
2761 than, any alternative coverage plan developed pursuant to this
2762 subsection.
2763 (l) Annual reporting.--The office shall make an annual
2764 report to the Governor, the President of the Senate, and the

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2765 Speaker of the House of Representatives. The report shall
2766 summarize the activities of the program in the preceding
2767 calendar year, including the net written and earned premiums,
2768 program enrollment, the expense of administration, and the paid
2769 and incurred losses. The report shall be submitted no later than
2770 March 15 following the close of the prior calendar year.
2771 (16)~~(15)~~ APPLICABILITY OF OTHER STATE LAWS.--
2772 (a) Except as expressly provided in this section, a law
2773 requiring coverage for a specific health care service or
2774 benefit, or a law requiring reimbursement, utilization, or
2775 consideration of a specific category of licensed health care
2776 practitioner, does not apply to a standard or basic health
2777 benefit plan policy or contract or a limited benefit policy or
2778 contract offered or delivered to a small employer unless that
2779 law is made expressly applicable to such policies or contracts.
2780 A law restricting or limiting deductibles, coinsurance,
2781 copayments, or annual or lifetime maximum payments does not
2782 apply to any health plan policy, including a standard or basic
2783 health benefit plan policy or contract, offered or delivered to
2784 a small employer unless such law is made expressly applicable to
2785 such policy or contract. However, every small employer carrier
2786 must offer to eligible small employers the standard benefit plan
2787 and the basic benefit plan, as required by subsection (5), as
2788 such plans have been approved by the office pursuant to
2789 subsection (12).
2790 (b) Except as provided in this section, a standard or
2791 basic health benefit plan policy or contract or limited benefit

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2792 policy or contract offered to a small employer is not subject to
2793 any provision of this code which:
2794 1. Inhibits a small employer carrier from contracting with
2795 providers or groups of providers with respect to health care
2796 services or benefits;
2797 2. Imposes any restriction on a small employer carrier's
2798 ability to negotiate with providers regarding the level or
2799 method of reimbursing care or services provided under a health
2800 benefit plan; or
2801 3. Requires a small employer carrier to either include a
2802 specific provider or class of providers when contracting for
2803 health care services or benefits or to exclude any class of
2804 providers that is generally authorized by statute to provide
2805 such care.
2806 (c) Any second tier assessment paid by a carrier pursuant
2807 to paragraph (11)(j) may be credited against assessments levied
2808 against the carrier pursuant to s. 627.6494.
2809 (d) Notwithstanding chapter 641, a health maintenance
2810 organization is authorized to issue contracts providing benefits
2811 equal to the standard health benefit plan, the basic health
2812 benefit plan, and the limited benefit policy authorized by this
2813 section.
2814 (17) ~~(16)~~ RULEMAKING AUTHORITY.--The commission may adopt
2815 rules to administer this section, including rules governing
2816 compliance by small employer carriers and small employers.
2817 Section 25. Section 627.6405, Florida Statutes, is created
2818 to read:

2819 627.6405 Decreasing inappropriate utilization of emergency
2820 care.--
2821 (1) The Legislature finds and declares it to be of vital
2822 importance that emergency services and care be provided by
2823 hospitals and physicians to every person in need of such care,
2824 but with the double-digit increases in health insurance
2825 premiums, health care providers and insurers should encourage
2826 patients and the insured to assume responsibility for their
2827 treatment, including emergency care. The Legislature finds that
2828 inappropriate utilization of emergency department services
2829 increases the overall cost of providing health care and these
2830 costs are ultimately borne by the hospital, the insured
2831 patients, and, many times, by the taxpayers of this state.
2832 Finally, the Legislature declares that the providers and
2833 insurers must share the responsibility of providing alternative
2834 treatment options to urgent care patients outside of the
2835 emergency department. Therefore, it is the intent of the
2836 Legislature to place the obligation for educating consumers and
2837 creating mechanisms for delivery of care that will decrease the
2838 overutilization of emergency service on health insurers and
2839 providers.
2840 (2) Health insurers shall provide on their websites
2841 information regarding appropriate utilization of emergency care
2842 services which shall include, but not be limited to, a list of
2843 alternative urgent care contracted providers, the types of
2844 services offered by these providers, and what to do in the event
2845 of a true emergency.

2846 (3) Health insurers shall develop community emergency
2847 department diversion programs. Such programs may include, at the
2848 discretion of the insurer, but not be limited to, enlisting
2849 providers to be on call to insurers after hours, coordinating
2850 care through local community resources, and providing incentives
2851 to providers for case management.
2852 (4) As a disincentive for insureds to inappropriately use
2853 emergency department services for nonemergency care, health
2854 insurers may require higher copayments for urgent care or
2855 primary care provided in an emergency department and higher
2856 copayments for use of out-of-network emergency departments.
2857 Higher copayments may not be charged for the utilization of the
2858 emergency department for emergency care. For the purposes of
2859 this section, the term "emergency care" has the same meaning as
2860 provided in s. 395.002, and shall include services provided to
2861 rule out an emergency medical condition.
2862 Section 26. Section 641.31097, Florida Statutes, is
2863 created to read:
2864 641.31097 Decreasing inappropriate utilization of
2865 emergency care.--
2866 (1) The Legislature finds and declares it to be of vital
2867 importance that emergency services and care be provided by
2868 hospitals and physicians to every person in need of such care,
2869 but with the double-digit increases in health insurance
2870 premiums, health care providers and insurers should encourage
2871 patients and the insured to assume responsibility for their
2872 treatment, including emergency care. The Legislature finds that
2873 inappropriate utilization of emergency department services

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2874 increases the overall cost of providing health care and these
2875 costs are ultimately borne by the hospital, by the insured
2876 patients, and, many times, by the taxpayers of this state.
2877 Finally, the Legislature declares that the providers and
2878 insurers must share the responsibility of providing alternative
2879 treatment options to urgent care patients outside of the
2880 emergency department. Therefore, it is the intent of the
2881 Legislature to place the obligation for educating consumers and
2882 creating mechanisms for delivery of care that will decrease the
2883 overutilization of emergency service on health maintenance
2884 organizations and providers.
2885 (2) Health maintenance organizations shall provide on
2886 their Internet websites information regarding appropriate
2887 utilization of emergency care services, which shall include, but
2888 not be limited to, a list of alternative urgent care contracted
2889 providers, the types of services offered by these providers, and
2890 what to do in the event of a true emergency.
2891 (3) Health maintenance organizations shall develop
2892 community emergency department diversion programs. Such programs
2893 may include at the discretion of the health maintenance
2894 organization, but not be limited to, enlisting providers to be
2895 on call to subscribers after hours, coordinating care through
2896 local community resources, and providing incentives to providers
2897 for case management.
2898 (4) As a disincentive for subscribers to inappropriately
2899 use emergency department services for nonemergency care, health
2900 maintenance organizations may require higher copayments for
2901 urgent care or primary care provided in an emergency department

2902 and higher copayments for use of out-of-network emergency
2903 departments. Higher copayments may not be charged for the
2904 utilization of the emergency department for emergency care. For
2905 the purposes of this section, the term "emergency care" has the
2906 same meaning as provided in s. 395.002 and shall include
2907 services provided to rule out an emergency medical condition.
2908 Section 27. Subsection (1) of section 627.9175, Florida
2909 Statutes, is amended to read:
2910 627.9175 Reports of information on health and accident
2911 insurance.--
2912 (1) Each health insurer, prepaid limited health services
2913 organization, and health maintenance organization shall submit,
2914 no later than April 1 of each year, ~~annually~~ to the office
2915 information concerning health and accident insurance coverage
2916 and medical plans being marketed and currently in force in this
2917 state. The required information shall be described by market
2918 segment, to include, but not be limited to:
2919 (a) Issuing, servicing company, and entity contact
2920 information.
2921 (b) Information on all health and accident insurance
2922 policies and prepaid limited health service organizations and
2923 health maintenance organization contracts in force and issued in
2924 the previous year. Such information shall include, but not be
2925 limited to, direct premiums earned, direct losses incurred,
2926 number of policies, number of certificates, number of covered
2927 lives, and the average number of days taken to pay claims. ~~as to~~
2928 ~~policies of individual health insurance:~~

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2929 ~~(a) A summary of typical benefits, exclusions, and~~
2930 ~~limitations for each type of individual policy form currently~~
2931 ~~being issued in the state. The summary shall include, as~~
2932 ~~appropriate:~~
2933 ~~1. The deductible amount;~~
2934 ~~2. The coinsurance percentage;~~
2935 ~~3. The out-of-pocket maximum;~~
2936 ~~4. Outpatient benefits;~~
2937 ~~5. Inpatient benefits; and~~
2938 ~~6. Any exclusions for preexisting conditions.~~
2939
2940 ~~The commission shall determine other appropriate benefits,~~
2941 ~~exclusions, and limitations to be reported for inclusion in the~~
2942 ~~consumer's guide published pursuant to this section.~~
2943 ~~(b) A schedule of rates for each type of individual policy~~
2944 ~~form reflecting typical variations by age, sex, region of the~~
2945 ~~state, or any other applicable factor which is in use and is~~
2946 ~~determined to be appropriate for inclusion by the commission.~~
2947
2948 The commission may establish rules governing ~~shall provide by~~
2949 ~~rule a uniform format for~~ the submission of ~~this~~ information
2950 described in this section, including the use of uniform formats
2951 and electronic data transmission ~~order to allow for meaningful~~
2952 ~~comparisons of premiums charged for comparable benefits. The~~
2953 ~~office shall provide this information to the department, which~~
2954 ~~shall publish annually a consumer's guide which summarizes and~~
2955 ~~compares the information required to be reported under this~~
2956 ~~subsection~~.

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2957 Section 28. Chapter 636, Florida Statutes, entitled
2958 "Prepaid Limited Health Service Organizations," is retitled as
2959 "Prepaid Limited Health Service Organizations and Discount
2960 Medical Plan Organizations."
2961 Section 29. Sections 636.002 through 636.067, Florida
2962 Statutes, are designated as part I of chapter 636, Florida
2963 Statutes, and entitled "Prepaid Limited Health Service
2964 Organizations."
2965 Section 30. Paragraph (c) of subsection (7) of section
2966 636.003, Florida Statutes, is amended to read:
2967 636.003 Definitions.--As used in this act, the term:
2968 (7) "Prepaid limited health service organization" means
2969 any person, corporation, partnership, or any other entity which,
2970 in return for a prepayment, undertakes to provide or arrange
2971 for, or provide access to, the provision of a limited health
2972 service to enrollees through an exclusive panel of providers.
2973 Prepaid limited health service organization does not include:
2974 (c) Any person who is licensed pursuant to part II as a
2975 discount medical plan organization~~, in exchange for fees, dues,~~
2976 ~~charges or other consideration, provides access to a limited~~
2977 ~~health service provider without assuming any responsibility for~~
2978 ~~payment for the limited health service or any portion thereof~~.
2979 Section 31. Effective January 1, 2005, part II of chapter
2980 636, Florida Statutes, consisting of sections 636.202, 636.204,
2981 636.206, 636.208, 636.210, 636.212, 636.214, 636.216, 636.218,
2982 636.220, 636.222, 636.224, 636.226, 636.228, 636.230, 636.232,
2983 636.234, 636.236, 636.238, 636.240, 636.242, and 636.244, is
2984 created to read:

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2985 PART II

2986 DISCOUNT MEDICAL PLAN ORGANIZATIONS

2987 636.202 Definitions.--As used in this part, the term:

2988 (1) "Discount medical plan" means a business arrangement
2989 or contract in which a person, in exchange for fees, dues,
2990 charges, or other consideration, provides access for plan
2991 members to providers of medical services and the right to
2992 receive medical services from those providers at a discount. The
2993 term "discount medical plan" does not include any product
2994 regulated under chapter 627, chapter 641, or part I of chapter
2995 636.

2996 (2) "Discount medical plan organization" means an entity
2997 which, in exchange for fees, dues, charges, or other
2998 consideration, provides access for plan members to providers of
2999 medical services and the right to receive medical services from
3000 those providers at a discount. The term "discount medical plan"
3001 does not include any product regulated under chapter 627,
3002 chapter 641, or part I of chapter 636.

3003 (3) "Marketer" means a person or entity which markets,
3004 promotes, sells, or distributes a discount medical plan,
3005 including a private label entity which places its name on and
3006 markets or distributes a discount medical plan but does not
3007 operate a discount medical plan.

3008 (4) "Medical services" means any care, service, or
3009 treatment of illness or dysfunction of, or injury to, the human
3010 body, including, but not limited to, physician care, inpatient
3011 care, hospital surgical services, emergency services, ambulance
3012 services, dental care services, vision care services, mental

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3013 health services, substance abuse services, chiropractic
3014 services, podiatric care services, laboratory services, and
3015 medical equipment and supplies. The term does not include
3016 pharmaceutical supplies or prescriptions.
3017 (5) "Member" means any person who pays fees, dues,
3018 charges, or other consideration for the right to receive the
3019 purported benefits of a discount medical plan.
3020 (6) "Provider" means any person or institution which is
3021 contracted, directly or indirectly, with a discount medical plan
3022 organization to provide medical services to members.
3023 (7) "Provider network" means an entity which negotiates on
3024 behalf of more than one provider with a discount medical plan
3025 organization to provide medical services to members.
3026 636.204 License required.--
3027 (1) Before doing business in this state as a discount
3028 medical plan organization, an entity must be a corporation,
3029 incorporated under the laws of this state or, if a foreign
3030 corporation, authorized to transact business in this state, and
3031 must possess a license as a discount medical plan organization
3032 from the office.
3033 (2) An application for a license to operate as a discount
3034 medical plan organization must be filed with the office on a
3035 form prescribed by the commission. Such application must be
3036 sworn to by an officer or authorized representative of the
3037 applicant and be accompanied by the following:
3038 (a) A copy of the applicant's articles of incorporation,
3039 including all amendments.
3040 (b) A copy of the corporation's bylaws.

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3041 (c) A list of the names, addresses, official positions,
3042 and biographical information of the individuals who are
3043 responsible for conducting the applicant's affairs, including,
3044 but not limited to, all members of the board of directors, board
3045 of trustees, executive committee, or other governing board or
3046 committee, the officers, contracted management company
3047 personnel, and any person or entity owning or having the right
3048 to acquire 10 percent or more of the voting securities of the
3049 applicant. Such listing must fully disclose the extent and
3050 nature of any contracts or arrangements between any individual
3051 who is responsible for conducting the applicant's affairs and
3052 the discount medical plan organization, including any possible
3053 conflicts of interest.
3054 (d) A complete biographical statement, on forms prescribed
3055 by the commission, an independent investigation report, and a
3056 set of fingerprints, as provided in chapter 624, with respect to
3057 each individual identified under paragraph (c).
3058 (e) A statement generally describing the applicant, its
3059 facilities and personnel, and the medical services to be
3060 offered.
3061 (f) A copy of the form of all contracts made or to be made
3062 between the applicant and any providers or provider networks
3063 regarding the provision of medical services to members.
3064 (g) A copy of the form of any contract made or arrangement
3065 to be made between the applicant and any person listed in
3066 paragraph (c).
3067 (h) A copy of the form of any contract made or to be made
3068 between the applicant and any person, corporation, partnership,

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3069 or other entity for the performance on the applicant's behalf of
3070 any function, including, but not limited to, marketing,
3071 administration, enrollment, investment management, and
3072 subcontracting for the provision of health services to members.
3073 (i) A copy of the applicant's most recent financial
3074 statements audited by an independent certified public
3075 accountant.
3076 (j) A description of the proposed method of marketing.
3077 (k) A description of the subscriber complaint procedures
3078 to be established and maintained.
3079 (l) The fee for issuance of a license.
3080 (m) Such other information as the commission or office may
3081 reasonably require to make the determinations required by this
3082 part.
3083 (3) The office shall issue a license which shall expire 1
3084 year later, and each year on that date thereafter, and which the
3085 office shall renew if the licensee pays the annual license fee
3086 of $50 and if the office is satisfied that the licensee is in
3087 compliance with this part.
3088 (4) Prior to licensure by the office, each discount
3089 medical plan organization must establish an Internet website so
3090 as to conform to the requirements of s. 636.226.
3091 (5) The license fee under subsection (2) is $50 per year
3092 per licensee. All amounts collected shall be deposited into the
3093 General Revenue Fund.
3094 (6) Nothing in this part requires a provider who provides
3095 discounts to his or her own patients to obtain and maintain a
3096 license as a discount medical plan organization.

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3097 636.206 Examinations and investigations.--
3098 (1) The office may examine or investigate the business and
3099 affairs of any discount medical plan organization. The office
3100 may order any discount medical plan organization or applicant to
3101 produce any records, books, files, advertising and solicitation
3102 materials, or other information and may take statements under
3103 oath to determine whether the discount medical plan organization
3104 or applicant is in violation of the law or is acting contrary to
3105 the public interest. The expenses incurred in conducting any
3106 examination or investigation must be paid by the discount
3107 medical plan organization or applicant. Examinations and
3108 investigations must be conducted as provided in chapter 624, and
3109 discount medical plan organizations are subject to all
3110 applicable provisions of the insurance code.
3111 (2) Failure by the discount medical plan organization to
3112 pay the expenses incurred under subsection (1) is grounds for
3113 denial or revocation.
3114 636.208 Fees.--A discount medical plan organization may
3115 charge a reasonable one-time processing fee and a periodic
3116 charge. If a discount medical plan charges for a time period in
3117 excess of one month, the plan must, in the event of cancellation
3118 of the membership by either party, make a pro rata reimbursement
3119 of the fees to the member.
3120 636.210 Prohibited activities of a discount medical plan
3121 organization.--
3122 (1) A discount medical plan organization may not:

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3123 (a) Use in its advertisements, marketing material,
3124 brochures, and discount cards the term "insurance" except as
3125 otherwise provided in this part;
3126 (b) Use in its advertisements, marketing material,
3127 brochures, and discount cards the terms "health plan,"
3128 "coverage," "copay," "copayments," "preexisting conditions,"
3129 "guaranteed issue," "premium," "enrollment," "PPO," "preferred
3130 provider organization," or other terms that could reasonably
3131 mislead a person into believing the discount medical plan was
3132 health insurance;
3133 (c) Have restrictions on free access to plan providers,
3134 including, but not limited to, waiting periods and notification
3135 periods; or
3136 (d) Pay providers any fees for medical services.
3137 (2) A discount medical plan organization may not collect
3138 or accept money from a member for payment to a provider for
3139 specific medical services furnished or to be furnished to the
3140 member unless the organization has an active certificate of
3141 authority from the office to act as an administrator.
3142 636.212 Disclosures.--The following disclosures must be
3143 made in writing to any prospective member and must be on the
3144 first page of any advertisements, marketing materials, or
3145 brochures relating to a discount medical plan. The disclosures
3146 must be printed in not less than 12-point type or no smaller
3147 than the largest type on the page if larger than 12-point type:
3148 (1) That the plan is not a health insurance policy.
3149 (2) That the plan provides discounts at certain health
3150 care providers for medical services.

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3151 (3) That the plan does not make payments directly to the
3152 providers of medical services.
3153 (4) That the plan member is obligated to pay for all
3154 health care services but will receive a discount from those
3155 health care providers who have contracted with the discount plan
3156 organization.
3157 (5) The corporate name and the locations of the licensed
3158 discount medical plan organization.
3159 636.214 Provider agreements.--
3160 (1) All providers offering medical services to members
3161 under a discount medical plan must provide such services
3162 pursuant to a written agreement. The agreement may be entered
3163 into directly by the provider or by a provider network to which
3164 the provider belongs.
3165 (2) A provider agreement must provide the following:
3166 (a) A list of the services and products to be provided at
3167 a discount.
3168 (b) The amount or amounts of the discounts or,
3169 alternatively, a fee schedule which reflects the provider's
3170 discounted rates.
3171 (c) That the provider will not charge members more than
3172 the discounted rates.
3173 (3) A provider agreement between a discount medical plan
3174 organization and a provider network shall require that the
3175 provider network have written agreements with its providers
3176 which:
3177 (a) Contain the terms described in subsection (2).

3178 (b) Authorize the provider network to contract with the
3179 discount medical plan organization on behalf of the provider.
3180 (c) Require the network to maintain an up-to-date list of
3181 its contracted providers and to provide that list on a monthly
3182 basis to the discount medical plan organization.
3183 (4) The discount medical plan organization shall maintain
3184 a copy of each active provider agreement.
3185 636.216 Form filings.--
3186 (1) All charges to members must be filed with the office
3187 and any charge to members greater than $30 per month or $360 per
3188 year must be approved by the office before the charges can be
3189 used. The discount medical plan organization has the burden of
3190 proof that the charges bear a reasonable relation to the
3191 benefits received by the member.
3192 (2) There must be a written agreement between the discount
3193 medical plan organization and the member specifying the benefits
3194 under the discount medical plan and complying with the
3195 disclosure requirements of this part.
3196 (3) All forms used, including the written agreement
3197 pursuant to subsection (2), must first be filed with and
3198 approved by the office. Every form filed shall be identified by
3199 a unique form number placed in the lower left corner of each
3200 form.
3201 (4) If such filings are disapproved, the office shall
3202 notify the discount medical plan organization and shall specify
3203 in the notice the reasons for disapproval. The discount medical
3204 plan organization has 21 days from the date of receipt of notice
3205 to request a hearing before the office pursuant to chapter 120.

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3206 636.218 Annual reports.--
3207 (1) Each discount medical plan organization must file with
3208 the office, within 3 months after the end of each fiscal year,
3209 an annual report.
3210 (2) Such reports must be on forms prescribed by the
3211 commission and must include:
3212 (a) Audited financial statements prepared in accordance
3213 with generally accepted accounting principles certified by an
3214 independent certified public accountant, including the
3215 organization's balance sheet, income statement, and statement of
3216 changes in cash flow for the preceding year.
3217 (b) A list of the names and residence addresses of all
3218 persons responsible for the conduct of the organization's
3219 affairs, together with a disclosure of the extent and nature of
3220 any contracts or arrangements between such persons and the
3221 discount medical plan organization, including any possible
3222 conflicts of interest.
3223 (c) The number of discount medical plan members.
3224 (d) Such other information relating to the performance of
3225 the discount medical plan organization as is reasonably required
3226 by the commission or office.
3227 (3) Every discount medical plan organization which fails
3228 to file an annual report in the form and within the time
3229 required by this section shall forfeit up to $500 for each day
3230 for the first 10 days during which the neglect continues and
3231 shall forfeit up to $1,000 for each day after the first 10 days
3232 during which the neglect continues; and, upon notice by the
3233 office to that effect, the organization's authority to enroll

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3234 new members or to do business in this state ceases while such
3235 default continues. The office shall deposit all sums collected
3236 by the office under this section to the credit of the Insurance
3237 Regulatory Trust Fund. The office may not collect more than
3238 $50,000 for each report.
3239 636.220 Minimum capital requirements.--
3240 (1) Each discount medical plan organization must at all
3241 times maintain a net worth of at least $150,000.
3242 (2) The office may not issue a license unless the discount
3243 medical plan organization has a net worth of at least $150,000.
3244 636.222 Suspension or revocation of license; suspension of
3245 enrollment of new members; terms of suspension.--
3246 (1) The office may suspend the authority of a discount
3247 medical plan organization to enroll new members, revoke any
3248 license issued to a discount medical plan organization, or order
3249 compliance if the office finds that any of the following
3250 conditions exist:
3251 (a) The organization is not operating in compliance with
3252 this part.
3253 (b) The organization does not have the minimum net worth
3254 as required by this part.
3255 (c) The organization has advertised, merchandised, or
3256 attempted to merchandise its services in such a manner as to
3257 misrepresent its services or capacity for service or has engaged
3258 in deceptive, misleading, or unfair practices with respect to
3259 advertising or merchandising.
3260 (d) The organization is not fulfilling its obligations as
3261 a medical discount medical plan organization.

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3262 (e) The continued operation of the organization would be
3263 hazardous to its members.
3264 (2) If the office has cause to believe that grounds for
3265 the suspension or revocation of a license exist, the office
3266 shall notify the discount medical plan organization in writing
3267 specifically stating the grounds for suspension or revocation
3268 and shall pursue a hearing on the matter in accordance with the
3269 provisions of chapter 120.
3270 (3) When the license of a discount medical plan
3271 organization is surrendered or revoked, such organization must
3272 proceed, immediately following the effective date of the order
3273 of revocation, to wind up its affairs transacted under the
3274 license. The organization may not engage in any further
3275 advertising, solicitation, collecting of fees, or renewal of
3276 contracts.
3277 (4) The office shall, in its order suspending the
3278 authority of a discount medical plan organization to enroll new
3279 members, specify the period during which the suspension is to be
3280 in effect and the conditions, if any, which must be met by the
3281 discount medical plan organization prior to reinstatement of its
3282 license to enroll new members. The order of suspension is
3283 subject to rescission or modification by further order of the
3284 office prior to the expiration of the suspension period.
3285 Reinstatement may not be made unless requested by the discount
3286 medical plan organization; however, the office may not grant
3287 reinstatement if it finds that the circumstances for which the
3288 suspension occurred still exist or are likely to recur.

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3289 636.224 Notice of change of name or address of discount
3290 medical plan organization.--Each discount medical plan
3291 organization must provide the office at least 30 days' advance
3292 notice of any change in the discount medical plan organization's
3293 name, address, principal business address, or mailing address.
3294 636.226 Provider name listing.--Each discount medical plan
3295 organization must maintain an up-to-date list of the names and
3296 addresses of the providers with which it has contracted, on an
3297 Internet website page, the address of which shall be prominently
3298 displayed on all its advertisements, marketing materials,
3299 brochures, and discount cards. This section applies to those
3300 providers with whom the discount medical plan organization has
3301 contracted directly, as well as those who are members of a
3302 provider network with which the discount medical plan
3303 organization has contracted.
3304 636.228 Marketing of discount medical plans.--
3305 (1) All advertisements, marketing materials, brochures,
3306 and discount cards used by marketers must be approved in writing
3307 for such use by the discount medical plan organization.
3308 (2) The discount medical plan organization shall have an
3309 executed written agreement with a marketer prior to the
3310 marketer's marketing, promoting, selling, or distributing the
3311 discount medical plan and shall be responsible and financially
3312 liable for any acts of its marketers that do not comply with the
3313 provisions of this part.
3314 636.230 Bundling discount medical plans with other
3315 insurance products.--When a marketer or discount medical plan
3316 organization sells a discount medical plan together with any

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3317 other product, the fees for each individual product must be
3318 provided in writing to the member and itemized.
3319 636.232 Rules.--The commission may adopt rules to
3320 administer this part, including rules for the licensing of
3321 discount medical plan organizations; establishing standards for
3322 evaluating forms, advertisements, marketing materials,
3323 brochures, and discount cards; providing for the collection of
3324 data; relating to disclosures to plan members; and defining
3325 terms used in this part.
3326 636.234 Service of process on a discount medical plan
3327 organization.--Sections 624.422 and 624.423 apply to a discount
3328 medical plan organization as if the discount medical plan
3329 organization were an insurer.
3330 636.236 Security deposit.--
3331 (1) A licensed discount medical plan organization must
3332 deposit and maintain deposited in trust with the department
3333 securities eligible for deposit under s. 625.52, having at all
3334 times a value of not less than $35,000, for use by the office in
3335 protecting plan members.
3336 (2) No judgment creditor or other claimant of a discount
3337 medical plan organization, other than the office or department,
3338 shall have the right to levy upon any of the assets or
3339 securities held in this state as a deposit under subsection (1).
3340 636.238 Penalties for violation of this part.--
3341 (1) Except as provided in subsection (2), a person who
3342 violates any provision of this part commits a misdemeanor of the
3343 second degree, punishable as provided in s. 775.082 or s.
3344 775.083.

3345 (2) A person who operates as or aids and abets another
3346 operating as a discount medical plan organization in violation
3347 of s. 636.204(1) commits a felony punishable as provided for in
3348 s. 624.401(4)(b), as if the unlicensed discount medical plan
3349 organization were an unauthorized insurer, and the fees, dues,
3350 charges, or other consideration collected from the members by
3351 the unlicensed discount medical plan organization or marketer
3352 were insurance premium.
3353 (3) A person who collects fees for purported membership in
3354 a discount medical plan but fails to provide the promised
3355 benefits commits a theft, punishable as provided in s. 812.014.
3356 636.240 Injunctions.--
3357 (1) In addition to the penalties and other enforcement
3358 provisions of this part, the office may seek both temporary and
3359 permanent injunctive relief when:
3360 (a) A discount medical plan is being operated by any
3361 person or entity that is not licensed pursuant to this part.
3362 (b) Any person, entity, or discount medical plan
3363 organization has engaged in any activity prohibited by this part
3364 or any rule adopted pursuant to this part.
3365 (2) The venue for any proceeding bought pursuant to this
3366 section shall be in the Circuit Court of Leon County.
3367 (3) The office's authority to seek injunctive relief is
3368 not conditioned on having conducted any proceeding pursuant to
3369 chapter 120.
3370 636.242 Civil remedies.--Any person damaged by the acts of
3371 a person in violation of this part may bring a civil action
3372 against the person committing the violation in the circuit court

3373 of the county in which the alleged violator resides or has a
3374 principal place of business or in the county in which the
3375 alleged violation occurred. Upon an adverse adjudication, the
3376 defendant is liable for damages, together with court costs and
3377 reasonable attorney's fees incurred by the plaintiff. When so
3378 awarded, court costs and attorney's fees must be included in the
3379 judgment or decree rendered in the case. If it appears to the
3380 court that the suit brought by the plaintiff is frivolous or
3381 brought for purposes of harassment, the court may apply
3382 sanctions in accordance with chapter 57.
3383 636.244 Unlicensed discount medical plan
3384 organizations.--The provisions of ss. 626.901-626.912 apply to
3385 the activities of an unlicensed discount medical plan
3386 organization as if the unlicensed discount medical plan
3387 organization were an unauthorized insurer.
3388 Section 32. Section 627.65626, Florida Statutes, is
3389 created to read:
3390 627.65626 Insurance rebates for healthy lifestyles.--
3391 (1) Any rate, rating schedule, or rating manual for a
3392 health insurance policy filed with the office shall provide for
3393 an appropriate rebate of premiums paid in the last calendar year
3394 when the majority of members of a health plan have enrolled and
3395 maintained participation in any health wellness, maintenance, or
3396 improvement program offered by the employer. The employer must
3397 provide evidence of demonstrative maintenance or improvement of
3398 the enrollees' health status as determined by assessments of
3399 agreed-upon health status indicators between the employer and
3400 the health insurer, including, but not limited to, reduction in

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3401 weight, body mass index, and smoking cessation. Any rebate
3402 provided by the health insurer is presumed to be appropriate
3403 unless credible data demonstrates otherwise, but shall not
3404 exceed 10 percent of paid premiums.
3405 (2) The premium rebate authorized by this section shall be
3406 effective for an insured on an annual basis, unless the number
3407 of participating employees becomes less than the majority of the
3408 employees eligible for participation in the wellness program.
3409 Section 33. Section 627.6402, Florida Statutes, is created
3410 to read:
3411 627.6402 Insurance rebates for healthy lifestyles.--
3412 (1) Any rate, rating schedule, or rating manual for an
3413 individual health insurance policy filed with the office shall
3414 provide for an appropriate rebate of premiums paid in the last
3415 calendar year when the individual covered by such plan is
3416 enrolled in and maintains participation in any health wellness,
3417 maintenance, or improvement program approved by the health plan.
3418 The individual must provide evidence of demonstrative
3419 maintenance or improvement of the individual's health status as
3420 determined by assessments of agreed-upon health status
3421 indicators between the individual and the health insurer,
3422 including, but not limited to, reduction in weight, body mass
3423 index, and smoking cessation. Any rebate provided by the health
3424 insurer is presumed to be appropriate unless credible data
3425 demonstrates otherwise, but shall not exceed 10 percent of paid
3426 premiums.
3427 (2) The premium rebate authorized by this section shall be
3428 effective for an insured on an annual basis, unless the

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3429 individual fails to maintain or improve his or her health status
3430 while participating in an approved wellness program, or credible
3431 evidence demonstrates that the individual is not participating
3432 in the approved wellness program.
3433 Section 34. Subsection (38) of section 641.31, Florida
3434 Statutes, is amended, and subsection (40) is added to said
3435 section, to read:
3436 641.31 Health maintenance contracts.--
3437 (38)(a) Notwithstanding any other provision of this part,
3438 a health maintenance organization that meets the requirements of
3439 paragraph (b) may, through a point-of-service rider to its
3440 contract providing comprehensive health care services, include a
3441 point-of-service benefit. Under such a rider, a subscriber or
3442 other covered person of the health maintenance organization may
3443 choose, at the time of covered service, a provider with whom the
3444 health maintenance organization does not have a health
3445 maintenance organization provider contract. The rider may not
3446 require a referral from the health maintenance organization for
3447 the point-of-service benefits.
3448 (b) A health maintenance organization offering a point-of-
3449 service rider under this subsection must have a valid
3450 certificate of authority issued under the provisions of the
3451 chapter, must have been licensed under this chapter for a
3452 minimum of 3 years, and must at all times that it has riders in
3453 effect maintain a minimum surplus of $5 million. A health
3454 maintenance organization offering a point-of-service rider to
3455 its contract providing comprehensive health care services may
3456 offer the rider to employers who have employees living and

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3457 working outside the health maintenance organization's approved
3458 geographic service area without having to obtain a health care
3459 provider certificate, as long as the master group contract is
3460 issued to an employer that maintains its primary place of
3461 business within the health maintenance organization's approved
3462 service area. Any member or subscriber that lives and works
3463 outside the health maintenance organization's service area and
3464 elects coverage under the health maintenance organization's
3465 point-of-service rider must provide a statement to the health
3466 maintenance organization that indicates the member or subscriber
3467 understands the limitations of his or her policy and that only
3468 those benefits under the point-of-service rider will be covered
3469 when services are provided outside the service area.
3470 (c) Premiums paid in for the point-of-service riders may
3471 not exceed 15 percent of total premiums for all health plan
3472 products sold by the health maintenance organization offering
3473 the rider. If the premiums paid for point-of-service riders
3474 exceed 15 percent, the health maintenance organization must
3475 notify the office and, once this fact is known, must immediately
3476 cease offering such a rider until it is in compliance with the
3477 rider premium cap.
3478 (d) Notwithstanding the limitations of deductibles and
3479 copayment provisions in this part, a point-of-service rider may
3480 require the subscriber to pay a reasonable copayment for each
3481 visit for services provided by a noncontracted provider chosen
3482 at the time of the service. The copayment by the subscriber may
3483 either be a specific dollar amount or a percentage of the
3484 reimbursable provider charges covered by the contract and must

3485 be paid by the subscriber to the noncontracted provider upon
3486 receipt of covered services. The point-of-service rider may
3487 require that a reasonable annual deductible for the expenses
3488 associated with the point-of-service rider be met and may
3489 include a lifetime maximum benefit amount. The rider must
3490 include the language required by s. 627.6044 and must comply
3491 with copayment limits described in s. 627.6471. Section 641.3154
3492 does not apply to a point-of-service rider authorized under this
3493 subsection.
3494 (e) The point-of-service rider must contain provisions
3495 that comply with s. 627.6044.
3496 (f)~~(e)~~ The term "point of service" may not be used by a
3497 health maintenance organization except with riders permitted
3498 under this section or with forms approved by the office in which
3499 a point-of-service product is offered with an indemnity carrier.
3500 (g)~~(f)~~ A point-of-service rider must be filed and approved
3501 under ss. 627.410 and 627.411.
3502 (40)(a) Any rate, rating schedule, or rating manual for a
3503 health maintenance organization policy filed with the office
3504 shall provide for an appropriate rebate of premiums paid in the
3505 last calendar year when the individual covered by such plan is
3506 enrolled in and maintains participation in any health wellness,
3507 maintenance, or improvement program approved by the health plan.
3508 The individual must provide evidence of demonstrative
3509 maintenance or improvement of his or her health status as
3510 determined by assessments of agreed-upon health status
3511 indicators between the individual and the health insurer,
3512 including, but not limited to, reduction in weight, body mass

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3513 index, and smoking cessation. Any rebate provided by the health
3514 insurer is presumed to be appropriate unless credible data
3515 demonstrates otherwise, but shall not exceed 10 percent of paid
3516 premiums.
3517 (b) The premium rebate authorized by this section shall be
3518 effective for an insured on an annual basis, unless the
3519 individual fails to maintain or improve his or her health status
3520 while participating in an approved wellness program, or credible
3521 evidence demonstrates that the individual is not participating
3522 in the approved wellness program.
3523 Section 35. Section 626.191, Florida Statutes, is amended
3524 to read:
3525 626.191 Repeated applications.--The failure of an
3526 applicant to secure a license upon an application shall not
3527 preclude the applicant him or her from applying again as many
3528 times as desired, but the department or office shall not give
3529 consideration to or accept any further application by the same
3530 individual for a similar license dated or filed within 30 days
3531 subsequent to the date the department or office denied the last
3532 application, except as provided in s. 626.281.
3533 Section 36. Subsection (1) of section 626.201, Florida
3534 Statutes, is amended to read:
3535 626.201 Investigation.--
3536 (1) The department or office may propound any reasonable
3537 interrogatories in addition to those contained in the
3538 application, to any applicant for license or appointment, or on
3539 any renewal, reinstatement, or continuation thereof, relating to
3540 the applicant's his or her qualifications, residence,

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3541 prospective place of business, and any other matter which, in
3542 the opinion of the department or office, is deemed necessary or
3543 advisable for the protection of the public and to ascertain the
3544 applicant's qualifications.
3545 Section 37. Section 626.593, Florida Statutes, is created
3546 to read:
3547 626.593 Insurance agent; written contract for
3548 compensation.--
3549 (1) No person licensed as an insurance agent may receive
3550 any fee or commission or any other thing of value in addition to
3551 the rates filed pursuant to chapter 627 for examining any group
3552 health insurance or any group health benefit plan for the
3553 purpose of giving or offering advice, counsel, recommendation,
3554 or information in respect to terms, conditions, benefits,
3555 coverage, or premium of any such policy or contract unless such
3556 compensation is based upon a written contract signed by the
3557 party to be charged and specifying or clearly defining the
3558 amount or extent of such compensation and informing the party to
3559 be charged that any commission received from an insurer will be
3560 rebated to the party in accordance with subsection (3). In
3561 addition, all compensation to be paid to the insurance agent
3562 must be disclosed in the contract.
3563 (2) A copy of every such contract shall be retained by the
3564 licensee for not less than 3 years after such services have been
3565 fully performed.
3566 (3) Notwithstanding the provisions of s. 626.572, all
3567 commissions received by an insurance agent from an insurer in
3568 connection with the issuance of a policy, when a separate fee or

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3569 other consideration has been paid to the insurance agent by an
3570 insured, shall be rebated to the insured or other party being
3571 charged within 30 days after receipt of such commission by the
3572 insurance agent.
3573 (4) This section is subject to the unfair insurance trade
3574 practices provisions of s. 626.9541(1)(g).
3575 Section 38. Notwithstanding the amendment to s.
3576 627.6699(5)(c), Florida Statutes, by this act, any right to an
3577 open enrollment offer of health benefit coverage for groups of
3578 fewer than two employees, pursuant to s. 627.6699(5)(c), Florida
3579 Statutes, as it existed immediately before the effective date of
3580 this act, shall remain in full force and effect until the
3581 enactment of s. 627.64872, Florida Statutes, and the subsequent
3582 date upon which such plan begins to accept new risks or members.
3583 Section 39. Section 465.0244, Florida Statutes, is created
3584 to read:
3585 465.0244 Information disclosure.--Every pharmacy shall
3586 make available on its Internet website a link to the performance
3587 outcome and financial data that is published by the Agency for
3588 Health Care Administration pursuant to s. 408.05(3)(l) and shall
3589 place in the area where customers receive filled prescriptions
3590 notice that such information is available electronically and the
3591 address of its Internet website.
3592 Section 40. Section 627.6499, Florida Statutes, is amended
3593 to read:
3594 627.6499 Reporting by insurers and third-party
3595 administrators.--

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3596 (1) The office may require any insurer, third-party
3597 administrator, or service company to report any information
3598 reasonably required to assist the board in assessing insurers as
3599 required by this act.
3600 (2) Each health insurance issuer shall make available on
3601 its Internet website a link to the performance outcome and
3602 financial data that is published by the Agency for Health Care
3603 Administration pursuant to s. 408.05(3)(l) and shall include in
3604 every policy delivered or issued for delivery to any person in
3605 the state or any materials provided as required by s. 627.64725
3606 notice that such information is available electronically and the
3607 address of its Internet website.
3608 Section 41. Subsections (6) and (7) are added to section
3609 641.54, Florida Statutes, to read:
3610 641.54 Information disclosure.--
3611 (6) Each health maintenance organization shall make
3612 available to its subscribers the estimated copay, coinsurance
3613 percentage, or deductible, whichever is applicable, for any
3614 covered services, the status of the subscriber's maximum annual
3615 out-of-pocket payments for a covered individual or family, and
3616 the status of the subscriber's maximum lifetime benefit. Such
3617 estimate shall not preclude the actual copay, coinsurance
3618 percentage, or deductible, whichever is applicable, from
3619 exceeding the estimate.
3620 (7) Each health maintenance organization shall make
3621 available on its Internet website a link to the performance
3622 outcome and financial data that is published by the Agency for
3623 Health Care Administration pursuant to s. 408.05(3)(l) and shall

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3624 include in every policy delivered or issued for delivery to any
3625 person in the state or any materials provided as required by s.
3626 627.64725 notice that such information is available
3627 electronically and the address of its Internet website.
3628 Section 42. Section 408.02, Florida Statutes, is repealed.
3629 Section 43. The sum of $250,000 is appropriated from the
3630 Insurance Regulatory Trust Fund in the Department of Financial
3631 Services to the Office of Insurance Regulation for the purpose
3632 of implementing the provisions in this act relating to the Small
3633 Employers Access Program.
3634 Section 44. The sum of $250,000 is appropriated from the
3635 Insurance Regulatory Trust Fund to enable the board of the
3636 Florida Health Insurance Plan to conduct an actuarial study
3637 required under s. 627.64872, Florida Statutes.
3638 Section 45. The sum of $169,069 is appropriated from the
3639 Insurance Regulatory Trust Fund in the Department of Financial
3640 Services to the Office of Insurance Regulation, and three full-
3641 time equivalent positions are authorized, for the purpose of
3642 implementing the provisions in this act relating to the
3643 regulation of Discount Medical Plan Organizations.
3644 Section 46. The sum of $650,000 is appropriated from the
3645 General Revenue Fund to the Agency for Health Care
3646 Administration for the purposes of implementing the Florida
3647 Patient Safety Corporation. The sum of $350,000 shall be used as
3648 startup funds for the Florida Patient Safety Corporation and
3649 $300,000 shall be used for the "near miss" project within the
3650 Florida Patient Safety Corporation.

3651 Section 47. The sum of $1,136,171 is appropriated from the
3652 General Revenue Fund to the Agency for Health Care
3653 Administration, and 11 full-time equivalent positions are
3654 authorized, for the purposes of implementing the provisions of
3655 this act relating to the reporting of performance and cost data
3656 for hospitals, physicians, and pharmacies.
3657 Section 48. Except as otherwise provided herein, this act
3658 shall take effect July 1, 2004.