Bill No. CS for CS for CS for SB 2910

Amendment No. ___ Barcode 454326

CHAMBER ACTION

Senate		House
WD/2R 04/26/2004 08:29 AM	.	

Senator Saunders moved the following amendment:

Senate Amendment (with title amendment)

On page 31, line 24, through

page 27, line 23, delete those lines

and insert:

Section 13. Section 468.352, Florida Statutes, is amended to read:

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

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

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

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

1 individual judgment.

2 (3) "Critical care" means care given to a patient in

3 any setting involving a life-threatening emergency.

4 (4) "Department" means the Department of Health.

5 (5) "Direct supervision" means practicing under the

6 direction of a licensed, registered, or certified respiratory

7 therapist who is physically on the premises and readily

8 available, as defined by the board.

9 (6) "Physician supervision" means supervision and

10 control by a physician licensed under chapter 458 or chapter

11 459 who assumes the legal liability for the services rendered

12 by the personnel employed in his or her office. Except in the

13 case of an emergency, physician supervision requires the easy

14 availability of the physician within the office or the

15 physical presence of the physician for consultation and

16 direction of the actions of the persons who deliver

17 respiratory care services.

18 (7) "Practice of respiratory care" or "respiratory

19 therapy" means the allied health specialty associated with the

20 cardiopulmonary system that is practiced under the orders of a

21 physician licensed under chapter 458 or chapter 459 and in

22 accordance with protocols, policies, and procedures

23 established by a hospital or other health care provider or the

24 board, including the assessment, diagnostic evaluation,

25 treatment, management, control, rehabilitation, education, and

26 care of patients in all care settings.

27 (8) "Registered respiratory therapist" means any

28 person licensed under this part who is registered by the

29 National Board for Respiratory Care or its successor, and who

30 is employed to deliver respiratory care services under the

31 order of a physician licensed under chapter 458 or chapter

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

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

1 practitioner or respiratory therapist.
2 (4) An individual providing respiratory care services
3 in an emergency who does not represent himself or herself as a
4 respiratory care practitioner or respiratory therapist.
5 (5) Any individual employed to deliver, assemble, set
6 up, or test equipment for use in a home, upon the order of a
7 physician licensed pursuant to chapter 458 or chapter 459.
8 This subsection does not, however, authorize the practice of
9 respiratory care without a license.
10 (6) Any individual certified or registered as a
11 pulmonary function technologist who is credentialed by the
12 National Board for Respiratory Care for performing
13 cardiopulmonary diagnostic studies.
14 (7) Any student who is enrolled in an accredited
15 respiratory care program approved by the board, while
16 performing respiratory care as an integral part of a required
17 course.
18 (8) The delivery of incidental respiratory care to
19 noninstitutionalized persons by surrogate family members who
20 do not represent themselves as registered or certified
21 respiratory care therapists.
22 (9) Any individual credentialed by the Underseas
23 Hyperbaric Society in hyperbaric medicine or its equivalent as
24 determined by the board, while performing related duties. This
25 subsection does not, however, authorize the practice of
26 respiratory care without a license.
27 Section 16. Effective January 1, 2005, sections
28 468.356 and 468.357, Florida Statutes, are repealed.
29 Section 17. Section 627.6499, Florida Statutes, is
30 amended to read:
31 627.6499 Reporting by insurers and third-party

administrators.--

(1) The office may require any insurer, third-party administrator, or service company to report any information reasonably required to assist the board in assessing insurers as required by this act.

(2) Each health insurance issuer shall make available on its Internet website a link to the performance outcome and financial data that is published by the Agency for Health Care Administration pursuant to s. 408.05(3)(l) and shall include in every policy delivered or issued for delivery to any person in the state or any materials provided as required by s. 627.64725 notice that such information is available electronically and the address of its Internet website.

Section 18. Subsections (6) and (7) are added to section 641.54, Florida Statutes, to read:

641.54 Information disclosure.--

(6) Each health maintenance organization shall make available to its subscribers the estimated co-pay, coinsurance percentage, or deductible, whichever is applicable, for any covered services, the status of the subscriber's maximum annual out-of-pocket payments for a covered individual or family, and the status of the subscriber's maximum lifetime benefit. Such estimate shall not preclude the actual co-pay, coinsurance percentage, or deductible, whichever is applicable, from exceeding the estimate.

(7) Each health maintenance organization shall make available on its Internet website a link to the performance outcome and financial data that is published by the Agency for Health Care Administration pursuant to s. 408.05(3)(l) and shall include in every policy delivered or issued for delivery to any person in the state or any materials provided as

1 required by s. 627.64725 notice that such information is
2 available electronically and the address of its Internet
3 website.
4 Section 19. Section 408.7056, Florida Statutes, is
5 amended to read:
6 408.7056 ~~Statewide Provider and~~ Subscriber Assistance
7 Program.--
8 (1) As used in this section, the term:
9 (a) "Agency" means the Agency for Health Care
10 Administration.
11 (b) "Department" means the Department of Financial
12 Services.
13 (c) "Grievance procedure" means an established set of
14 rules that specify a process for appeal of an organizational
15 decision.
16 (d) "Health care provider" or "provider" means a
17 state-licensed or state-authorized facility, a facility
18 principally supported by a local government or by funds from a
19 charitable organization that holds a current exemption from
20 federal income tax under s. 501(c)(3) of the Internal Revenue
21 Code, a licensed practitioner, a county health department
22 established under part I of chapter 154, a prescribed
23 pediatric extended care center defined in s. 400.902, a
24 federally supported primary care program such as a migrant
25 health center or a community health center authorized under s.
26 329 or s. 330 of the United States Public Health Services Act
27 that delivers health care services to individuals, or a
28 community facility that receives funds from the state under
29 the Community Alcohol, Drug Abuse, and Mental Health Services
30 Act and provides mental health services to individuals.
31 (e) "Managed care entity" means a health maintenance

1 organization or a prepaid health clinic certified under
2 chapter 641, a prepaid health plan authorized under s.
3 409.912, or an exclusive provider organization certified under
4 s. 627.6472.
5 (f) "Office" means the Office of Insurance Regulation
6 of the Financial Services Commission.
7 (g) "Panel" means a ~~statewide provider and~~ subscriber
8 assistance panel selected as provided in subsection (11).
9 (2) The agency shall adopt and implement a program to
10 provide assistance to subscribers ~~and providers~~, including
11 those whose grievances are not resolved by the managed care
12 entity to the satisfaction of the subscriber ~~or provider~~. The
13 program shall consist of one or more panels that meet as often
14 as necessary to timely review, consider, and hear grievances
15 and recommend to the agency or the office any actions that
16 should be taken concerning individual cases heard by the
17 panel. The panel shall hear every grievance filed by
18 subscribers ~~and providers~~ on behalf of subscribers, unless the
19 grievance:
20 (a) Relates to a managed care entity's refusal to
21 accept a provider into its network of providers;
22 (b) Is part of an internal grievance in a Medicare
23 managed care entity or a reconsideration appeal through the
24 Medicare appeals process which does not involve a quality of
25 care issue;
26 (c) Is related to a health plan not regulated by the
27 state such as an administrative services organization,
28 third-party administrator, or federal employee health benefit
29 program;
30 (d) Is related to appeals by in-plan suppliers and
31 providers, unless related to quality of care provided by the

1 plan;
2 (e) Is part of a Medicaid fair hearing pursued under
3 42 C.F.R. ss. 431.220 et seq.;
4 (f) Is the basis for an action pending in state or
5 federal court;
6 (g) Is related to an appeal by nonparticipating
7 providers, unless related to the quality of care provided to a
8 subscriber by the managed care entity and the provider is
9 involved in the care provided to the subscriber;
10 (h) Was filed before the subscriber ~~or provider~~
11 completed the entire internal grievance procedure of the
12 managed care entity, the managed care entity has complied with
13 its timeframes for completing the internal grievance
14 procedure, and the circumstances described in subsection (6)
15 do not apply;
16 (i) Has been resolved to the satisfaction of the
17 subscriber ~~or provider~~ who filed the grievance, unless the
18 managed care entity's initial action is egregious or may be
19 indicative of a pattern of inappropriate behavior;
20 (j) Is limited to seeking damages for pain and
21 suffering, lost wages, or other incidental expenses, including
22 accrued interest on unpaid balances, court costs, and
23 transportation costs associated with a grievance procedure;
24 (k) Is limited to issues involving conduct of a health
25 care provider or facility, staff member, or employee of a
26 managed care entity which constitute grounds for disciplinary
27 action by the appropriate professional licensing board and is
28 not indicative of a pattern of inappropriate behavior, and the
29 agency, office, or department has reported these grievances to
30 the appropriate professional licensing board or to the health
31 facility regulation section of the agency for possible

investigation; or

(l) Is withdrawn by the subscriber ~~or provider~~. Failure of the subscriber ~~or the provider~~ to attend the hearing shall be considered a withdrawal of the grievance.

(3) The agency shall review all grievances within 60 days after receipt and make a determination whether the grievance shall be heard. Once the agency notifies the panel, the subscriber ~~or provider~~, and the managed care entity that a grievance will be heard by the panel, the panel shall hear the grievance either in the network area or by teleconference no later than 120 days after the date the grievance was filed. The agency shall notify the parties, in writing, by facsimile transmission, or by phone, of the time and place of the hearing. The panel may take testimony under oath, request certified copies of documents, and take similar actions to collect information and documentation that will assist the panel in making findings of fact and a recommendation. The panel shall issue a written recommendation, supported by findings of fact, to the ~~provider or~~ subscriber, to the managed care entity, and to the agency or the office no later than 15 working days after hearing the grievance. If at the hearing the panel requests additional documentation or additional records, the time for issuing a recommendation is tolled until the information or documentation requested has been provided to the panel. The proceedings of the panel are not subject to chapter 120.

(4) If, upon receiving a proper patient authorization along with a properly filed grievance, the agency requests ~~medical~~ records from a health care provider or managed care entity, the health care provider or managed care entity that has custody of the records has 10 days to provide the records

1 to the agency. Records include medical records, communication
2 logs associated with the grievance both to and from the
3 subscriber, contracts, and any other contents of the internal
4 grievance file associated with the complaint filed with the
5 Subscriber Assistance Program. Failure to provide requested
6 ~~medical~~ records may result in the imposition of a fine of up
7 to $500. Each day that records are not produced is considered
8 a separate violation.
9 (5) Grievances that the agency determines pose an
10 immediate and serious threat to a subscriber's health must be
11 given priority over other grievances. The panel may meet at
12 the call of the chair to hear the grievances as quickly as
13 possible but no later than 45 days after the date the
14 grievance is filed, unless the panel receives a waiver of the
15 time requirement from the subscriber. The panel shall issue a
16 written recommendation, supported by findings of fact, to the
17 office or the agency within 10 days after hearing the
18 expedited grievance.
19 (6) When the agency determines that the life of a
20 subscriber is in imminent and emergent jeopardy, the chair of
21 the panel may convene an emergency hearing, within 24 hours
22 after notification to the managed care entity and to the
23 subscriber, to hear the grievance. The grievance must be heard
24 notwithstanding that the subscriber has not completed the
25 internal grievance procedure of the managed care entity. The
26 panel shall, upon hearing the grievance, issue a written
27 emergency recommendation, supported by findings of fact, to
28 the managed care entity, to the subscriber, and to the agency
29 or the office for the purpose of deferring the imminent and
30 emergent jeopardy to the subscriber's life. Within 24 hours
31 after receipt of the panel's emergency recommendation, the

1 agency or office may issue an emergency order to the managed
2 care entity. An emergency order remains in force until:
3 (a) The grievance has been resolved by the managed
4 care entity;
5 (b) Medical intervention is no longer necessary; or
6 (c) The panel has conducted a full hearing under
7 subsection (3) and issued a recommendation to the agency or
8 the office, and the agency or office has issued a final order.
9 (7) After hearing a grievance, the panel shall make a
10 recommendation to the agency or the office which may include
11 specific actions the managed care entity must take to comply
12 with state laws or rules regulating managed care entities.
13 (8) A managed care entity, subscriber, or provider
14 that is affected by a panel recommendation may within 10 days
15 after receipt of the panel's recommendation, or 72 hours after
16 receipt of a recommendation in an expedited grievance, furnish
17 to the agency or office written evidence in opposition to the
18 recommendation or findings of fact of the panel.
19 (9) No later than 30 days after the issuance of the
20 panel's recommendation and, for an expedited grievance, no
21 later than 10 days after the issuance of the panel's
22 recommendation, the agency or the office may adopt the panel's
23 recommendation or findings of fact in a proposed order or an
24 emergency order, as provided in chapter 120, which it shall
25 issue to the managed care entity. The agency or office may
26 issue a proposed order or an emergency order, as provided in
27 chapter 120, imposing fines or sanctions, including those
28 contained in ss. 641.25 and 641.52. The agency or the office
29 may reject all or part of the panel's recommendation. All
30 fines collected under this subsection must be deposited into
31 the Health Care Trust Fund.

1 (10) In determining any fine or sanction to be
2 imposed, the agency and the office may consider the following
3 factors:
4 (a) The severity of the noncompliance, including the
5 probability that death or serious harm to the health or safety
6 of the subscriber will result or has resulted, the severity of
7 the actual or potential harm, and the extent to which
8 provisions of chapter 641 were violated.
9 (b) Actions taken by the managed care entity to
10 resolve or remedy any quality-of-care grievance.
11 (c) Any previous incidents of noncompliance by the
12 managed care entity.
13 (d) Any other relevant factors the agency or office
14 considers appropriate in a particular grievance.
15 (11)(a) The panel shall consist of the Insurance
16 Consumer Advocate, or designee thereof, established by s.
17 627.0613; at least two members employed by the agency and at
18 least two members employed by the department, chosen by their
19 respective agencies; a consumer appointed by the Governor; a
20 physician appointed by the Governor, as a standing member;
21 and, if necessary, physicians who have expertise relevant to
22 the case to be heard, on a rotating basis. The agency may
23 contract with a medical director, ~~and~~ a primary care
24 physician, or both, who shall provide additional technical
25 expertise to the panel but shall not be voting members of the
26 panel. The medical director shall be selected from a health
27 maintenance organization with a current certificate of
28 authority to operate in Florida.
29 (b) A majority of those panel members required under
30 paragraph (a) shall constitute a quorum for any meeting or
31 hearing of the panel. A grievance may not be heard or voted

1 upon at any panel meeting or hearing unless a quorum is
2 present, except that a minority of the panel may adjourn a
3 meeting or hearing until a quorum is present. A panel convened
4 for the purpose of hearing a subscriber's grievance in
5 accordance with subsections (2) and (3) shall not consist of
6 more than 11 members.
7 (12) Every managed care entity shall submit a
8 quarterly report to the agency, the office, and the department
9 listing the number and the nature of all subscribers' and
10 providers' grievances which have not been resolved to the
11 satisfaction of the subscriber or provider after the
12 subscriber or provider follows the entire internal grievance
13 procedure of the managed care entity. The agency shall notify
14 all subscribers and providers included in the quarterly
15 reports of their right to file an unresolved grievance with
16 the panel.
17 (13) A proposed order issued by the agency or office
18 which only requires the managed care entity to take a specific
19 action under subsection (7) is subject to a summary hearing in
20 accordance with s. 120.574, unless all of the parties agree
21 otherwise. If the managed care entity does not prevail at the
22 hearing, the managed care entity must pay reasonable costs and
23 attorney's fees of the agency or the office incurred in that
24 proceeding.
25 (14)(a) Any information that identifies a subscriber
26 which is held by the panel, agency, or department pursuant to
27 this section is confidential and exempt from the provisions of
28 s. 119.07(1) and s. 24(a), Art. I of the State Constitution.
29 However, at the request of a subscriber or managed care entity
30 involved in a grievance procedure, the panel, agency, or
31 department shall release information identifying the

1 subscriber involved in the grievance procedure to the
2 requesting subscriber or managed care entity.
3 (b) Meetings of the panel shall be open to the public
4 unless the provider or subscriber whose grievance will be
5 heard requests a closed meeting or the agency or the
6 department determines that information which discloses the
7 subscriber's medical treatment or history or information
8 relating to internal risk management programs as defined in s.
9 641.55(5)(c), (6), and (8) may be revealed at the panel
10 meeting, in which case that portion of the meeting during
11 which a subscriber's medical treatment or history or internal
12 risk management program information is discussed shall be
13 exempt from the provisions of s. 286.011 and s. 24(b), Art. I
14 of the State Constitution. All closed meetings shall be
15 recorded by a certified court reporter.
16 Section 20. Paragraph (c) of subsection (4) of section
17 641.3154, Florida Statutes, is amended to read:
18 641.3154 Organization liability; provider billing
19 prohibited.--
20 (4) A provider or any representative of a provider,
21 regardless of whether the provider is under contract with the
22 health maintenance organization, may not collect or attempt to
23 collect money from, maintain any action at law against, or
24 report to a credit agency a subscriber of an organization for
25 payment of services for which the organization is liable, if
26 the provider in good faith knows or should know that the
27 organization is liable. This prohibition applies during the
28 pendency of any claim for payment made by the provider to the
29 organization for payment of the services and any legal
30 proceedings or dispute resolution process to determine whether
31 the organization is liable for the services if the provider is

1 informed that such proceedings are taking place. It is
2 presumed that a provider does not know and should not know
3 that an organization is liable unless:
4 (c) The office or agency makes a final determination
5 that the organization is required to pay for such services
6 subsequent to a recommendation made by the ~~Statewide Provider~~
7 ~~and~~ Subscriber Assistance Panel pursuant to s. 408.7056; or
8 Section 21. Subsection (1), paragraphs (b) and (e) of
9 subsection (3), paragraph (d) of subsection (4), subsection
10 (5), paragraph (g) of subsection (6), and subsections (9),
11 (10), and (11) of section 641.511, Florida Statutes, are
12 amended to read:
13 641.511 Subscriber grievance reporting and resolution
14 requirements.--
15 (1) Every organization must have a grievance procedure
16 available to its subscribers for the purpose of addressing
17 complaints and grievances. Every organization must notify its
18 subscribers that a subscriber must submit a grievance within 1
19 year after the date of occurrence of the action that initiated
20 the grievance, and may submit the grievance for review to the
21 ~~Statewide Provider and~~ Subscriber Assistance Program panel as
22 provided in s. 408.7056 after receiving a final disposition of
23 the grievance through the organization's grievance process. An
24 organization shall maintain records of all grievances and
25 shall report annually to the agency the total number of
26 grievances handled, a categorization of the cases underlying
27 the grievances, and the final disposition of the grievances.
28 (3) Each organization's grievance procedure, as
29 required under subsection (1), must include, at a minimum:
30 (b) The names of the appropriate employees or a list
31 of grievance departments that are responsible for implementing

the organization's grievance procedure. The list must include the address and the toll-free telephone number of each grievance department, the address of the agency and its toll-free telephone hotline number, and the address of the ~~Statewide Provider and~~ Subscriber Assistance Program and its toll-free telephone number.

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

(4)

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

(5) Except as provided in subsection (6), the organization shall resolve a grievance within 60 days after receipt of the grievance, or within a maximum of 90 days if the grievance involves the collection of information outside the service area. These time limitations are tolled if the organization has notified the subscriber, in writing, that additional information is required for proper review of the grievance and that such time limitations are tolled until such information is provided. After the organization receives the

1 requested information, the time allowed for completion of the
2 grievance process resumes. The Employee Retirement Income
3 Security Act of 1974, as implemented by 29 C.F.R. 2560.503-1,
4 is adopted and incorporated by reference as applicable to all
5 organizations that administer small and large group health
6 plans that are subject to 29 C.F.R. 2560.503-1. The claims
7 procedures of the regulations of the Employee Retirement
8 Income Security Act of 1974 as implemented by 29 C.F.R.
9 2560.503-1 shall be the minimum standards for grievance
10 processes for claims for benefits for small and large group
11 health plans that are subject to 29 C.F.R. 2560.503-1.
12 (6)
13 (g) In any case when the expedited review process does
14 not resolve a difference of opinion between the organization
15 and the subscriber or the provider acting on behalf of the
16 subscriber, the subscriber or the provider acting on behalf of
17 the subscriber may submit a written grievance to the ~~Statewide~~
18 ~~Provider and~~ Subscriber Assistance Program.
19 (9)(a) The agency shall advise subscribers with
20 grievances to follow their organization's formal grievance
21 process for resolution prior to review by the ~~Statewide~~
22 ~~Provider and~~ Subscriber Assistance Program. The subscriber
23 may, however, submit a copy of the grievance to the agency at
24 any time during the process.
25 (b) Requiring completion of the organization's
26 grievance process before the ~~Statewide Provider and~~ Subscriber
27 Assistance Program panel's review does not preclude the agency
28 from investigating any complaint or grievance before the
29 organization makes its final determination.
30 (10) Each organization must notify the subscriber in a
31 final decision letter that the subscriber may request review

1 of the organization's decision concerning the grievance by the
2 ~~Statewide Provider and~~ Subscriber Assistance Program, as
3 provided in s. 408.7056, if the grievance is not resolved to
4 the satisfaction of the subscriber. The final decision letter
5 must inform the subscriber that the request for review must be
6 made within 365 days after receipt of the final decision
7 letter, must explain how to initiate such a review, and must
8 include the addresses and toll-free telephone numbers of the
9 agency and the ~~Statewide Provider and~~ Subscriber Assistance
10 Program.
11 (11) Each organization, as part of its contract with
12 any provider, must require the provider to post a consumer
13 assistance notice prominently displayed in the reception area
14 of the provider and clearly noticeable by all patients. The
15 consumer assistance notice must state the addresses and
16 toll-free telephone numbers of the Agency for Health Care
17 Administration, the ~~Statewide Provider and~~ Subscriber
18 Assistance Program, and the Department of Financial Services.
19 The consumer assistance notice must also clearly state that
20 the address and toll-free telephone number of the
21 organization's grievance department shall be provided upon
22 request. The agency may adopt rules to implement this section.
23 Section 22. Subsection (4) of section 641.58, Florida
24 Statutes, is amended to read:
25 641.58 Regulatory assessment; levy and amount; use of
26 funds; tax returns; penalty for failure to pay.--
27 (4) The moneys received and deposited into the Health
28 Care Trust Fund shall be used to defray the expenses of the
29 agency in the discharge of its administrative and regulatory
30 powers and duties under this part, including conducting an
31 annual survey of the satisfaction of members of health

maintenance organizations; contracting with physician consultants for the ~~Statewide Provider and~~ Subscriber Assistance Panel; maintaining offices and necessary supplies, essential equipment, and other materials, salaries and expenses of required personnel; and discharging the administrative and regulatory powers and duties imposed under this part.

Section 23. Paragraph (f) of subsection (2) and subsections (3) and (9) of section 408.909, Florida Statutes, are amended to read:

408.909 Health flex plans.--

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

(f) "Health flex plan entity" means a health insurer, health maintenance organization, health-care-provider-sponsored organization, local government, health care district, ~~or~~ other public or private community-based organization, or public-private partnership that develops and implements an approved health flex plan and is responsible for administering the health flex plan and paying all claims for health flex plan coverage by enrollees of the health flex plan.

(3) ~~PILOT~~ PROGRAM.--The agency and the office shall each approve or disapprove health flex plans that provide health care coverage for eligible participants ~~who reside in the three areas of the state that have the highest number of uninsured persons, as identified in the Florida Health Insurance Study conducted by the agency and in Indian River County~~ . A health flex plan may limit or exclude benefits otherwise required by law for insurers offering coverage in this state, may cap the total amount of claims paid per year per enrollee, may limit the number of enrollees, or may take

1 any combination of those actions. A health flex plan offering
2 may include the option of a catastrophic plan supplementing
3 the health flex plan.
4 (a) The agency shall develop guidelines for the review
5 of applications for health flex plans and shall disapprove or
6 withdraw approval of plans that do not meet or no longer meet
7 minimum standards for quality of care and access to care. The
8 agency shall ensure that the health flex plans follow
9 standardized grievance procedures similar to those required of
10 health maintenance organizations.
11 (b) The office shall develop guidelines for the review
12 of health flex plan applications and provide regulatory
13 oversight of health flex plan advertisement and marketing
14 procedures. The office shall disapprove or shall withdraw
15 approval of plans that:
16 1. Contain any ambiguous, inconsistent, or misleading
17 provisions or any exceptions or conditions that deceptively
18 affect or limit the benefits purported to be assumed in the
19 general coverage provided by the health flex plan;
20 2. Provide benefits that are unreasonable in relation
21 to the premium charged or contain provisions that are unfair
22 or inequitable or contrary to the public policy of this state,
23 that encourage misrepresentation, or that result in unfair
24 discrimination in sales practices; or
25 3. Cannot demonstrate that the health flex plan is
26 financially sound and that the applicant is able to underwrite
27 or finance the health care coverage provided.
28 (c) The agency and the Financial Services Commission
29 may adopt rules as needed to administer this section.
30 (9) PROGRAM EVALUATION.--The agency and the office
31 shall evaluate the pilot program and its effect on the

entities that seek approval as health flex plans, on the number of enrollees, and on the scope of the health care coverage offered under a health flex plan; shall provide an assessment of the health flex plans and their potential applicability in other settings; shall use health flex plans to gather more information to evaluate low-income consumer driven benefit packages; and shall, by January 1, 2005 ~~2004~~, jointly submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Section 24. Effective upon this act becoming a law, section 381.0271, Florida Statutes, is created to read:

381.0271 Florida Patient Safety Corporation.--

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

(a) "Adverse incident" has the same meanings as provided in ss. 395.0197, 458.351, and 459.026.

(b) "Corporation" means the Florida Patient Safety Corporation created in this section.

(c) "Patient safety data" has the same meaning as provided in s. 766.1016.

(2) CREATION.--

(a) There is created a not-for-profit corporation to be known as the Florida Patient Safety Corporation, which shall be registered, incorporated, organized, and operated in compliance with chapter 617. Upon the prior approval of the board of directors, the corporation may create not-for-profit corporate subsidiaries, organized under the provisions of chapter 617, as necessary to fulfill the mission of the corporation.

(b) The corporation or any authorized and approved subsidiary is not an agency within the meaning of s. 20.03(11).

1 (c) The corporation and its authorized and approved
2 subsidiaries are subject to the public meetings and records
3 requirements of s. 24, Art I of the State Constitution,
4 chapter 119, and s. 286.011.
5 (d) The corporation and its authorized and approved
6 subsidiaries are not subject to the provisions of chapter 287.
7 (e) The corporation is a patient safety organization
8 for purposes of s. 766.1016.
9 (3) PURPOSE.--
10 (a) The purpose of the Florida Patient Safety
11 Corporation is to serve as a learning organization dedicated
12 to assisting health care providers in the state to improve the
13 quality and safety of health care rendered and to reduce harm
14 to patients. The corporation shall promote the development of
15 a culture of patient safety in the health care system in the
16 state. The corporation may not regulate health care providers
17 in this state.
18 (b) In the fulfillment of its purpose, the corporation
19 shall work with a consortium of patient safety centers and
20 other patient safety programs within the universities in this
21 state.
22 (4) BOARD OF DIRECTORS; MEMBERSHIP.--The corporation
23 shall be governed by a board of directors. The board of
24 directors shall consist of:
25 (a) The chairperson of the Council of Medical School
26 Deans.
27 (b) The person responsible for patient safety issues
28 for the authorized health insurer with the largest market
29 share as measured by premiums written in the state for the
30 most recent calendar year, appointed by such insurer.
31 (c) A representative of the authorized medical

1 malpractice insurer with the largest market share as measured
2 by premiums written in the state for the most recent calendar
3 year, appointed by such insurer.
4 (d) The president of the Florida Health Care
5 Coalition.
6 (e) A representative of a hospital in the state that
7 is implementing innovative patient safety initiatives,
8 appointed by the Florida Hospital Association.
9 (f) A physician with expertise in patient safety,
10 appointed by the Florida Medical Association.
11 (g) A physician with expertise in patient safety,
12 appointed by the Florida Osteopathic Medical Association.
13 (h) A nurse with expertise in patient safety,
14 appointed by the Florida Nurses Association.
15 (i) An institutional pharmacist, appointed by the
16 Florida Society of Health System Pharmacists, Inc.
17 (j) A representative of Florida AARP, appointed by the
18 state director of the Florida AARP.
19 (k) An independent consultant on health care
20 information systems, appointed jointly by the Central Florida
21 Chapter and the South Florida Chapter of the Healthcare
22 Information and Management Systems Society.
23 (l) A physician with expertise in patient safety,
24 appointed by the Florida Podiatric Medical Association.
25 (m) A physician with expertise in patient safety,
26 appointed by the Florida Chiropractic Association.
27 (n) A dentist with expertise in patient safety,
28 appointed bt the Florida Dental Association.
29 (5) ADVISORY COMMITTEES.--In addition to any
30 committees that the corporation may establish, the corporation
31 shall establish the following advisory committees:

1 (a) A scientific research advisory committee that
2 includes, at a minimum, a representative from each patient
3 safety center or other patient safety program in the
4 universities of this state who is a physician licensed under
5 chapter 458 or chapter 459, with experience in patient safety
6 and evidence-based medicine. The duties of the scientific
7 research advisory committee shall include, but not be limited
8 to, the analysis of existing data and research to improve
9 patient safety and encourage evidence-based medicine.
10 (b) A technology advisory committee that includes, at
11 a minimum, a representative of a hospital that has implemented
12 a computerized physician order entry system and a health care
13 provider that has implemented an electronic medical records
14 system. The duties of the technology advisory committee shall
15 include, but not be limited to, fostering development and use
16 of new patient safety technologies, including electronic
17 medical records.
18 (c) A health care provider advisory committee that
19 includes, at a minimum, representatives of hospitals,
20 ambulatory surgical centers, physicians, nurses, and
21 pharmacists licensed in this state and a representative of the
22 Veterans Integrated Service Network 8 VA Patient Safety
23 Center. The duties of the health care provider advisory
24 committee shall include, but not be limited to, promotion of a
25 culture of patient safety that reduces errors.
26 (d) A health care consumer advisory committee that
27 includes, at a minimum, representatives of businesses that
28 provide health insurance coverage to their employees, consumer
29 advocacy groups, and representatives of patient organizations.
30 The duties of the health care consumer advisory committee
31 shall include, but not be limited to, identification of

1 incentives to encourage patient safety and the efficiency and
2 quality of care.
3 (e) A state agency advisory committee that includes,
4 at a minimum, a representative from each state agency that has
5 regulatory responsibilities related to patient safety. The
6 duties of the state agency advisory committee shall include,
7 but not be limited to, fostering coordination of patient
8 safety activities among state agencies.
9 (f) A litigation alternatives advisory committee that
10 includes, at a minimum, representatives of attorneys who
11 represent plaintiffs and defendants in medical malpractice
12 cases, a representative of each law school in the state,
13 physicians, and health care facilities. The duties of the
14 litigation alternatives advisory committee shall include, but
15 not be limited to, identification of alternative systems to
16 compensate for injuries.
17 (g) An education advisory committee that includes, at
18 a minimum, the associate dean for education, or the equivalent
19 position, as a representative from each school of medicine,
20 nursing, public health, or allied health to provide advice on
21 the development, implementation, and measurement of core
22 competencies for patient safety to be considered for
23 incorporation in the educational programs of the universities
24 and colleges of this state.
25 (6) ORGANIZATION; MEETINGS.--
26 (a) The Agency for Health Care Administration shall
27 assist the corporation in its organizational activities
28 required under chapter 617, including, but not limited to:
29 1. Eliciting appointments for the initial board of
30 directors.
31 2. Convening the first meeting of the board of

1 directors and assisting with other meetings of the board of
2 directors, upon the request of the board of directors, during
3 the first year of operation of the corporation.
4 3. Drafting articles of incorporation for the board of
5 directors and, upon the request of the board of directors,
6 delivering articles of incorporation to the Department of
7 State for filing.
8 4. Drafting proposed bylaws for the corporation.
9 5. Paying fees related to incorporation.
10 6. Providing office space and administrative support,
11 at the request of the board of directors, but not beyond July
12 1, 2005.
13 (b) The board of directors must conduct its first
14 meeting no later than August 1, 2004, and shall meet
15 thereafter as frequently as necessary to carry out the duties
16 of the corporation.
17 (7) POWERS AND DUTIES.--In addition to the powers and
18 duties prescribed in chapter 617 and the articles and bylaws
19 adopted under that chapter, the corporation shall directly or
20 through contract:
21 (a) Secure staff necessary to properly administer the
22 corporation.
23 (b) Collect, analyze, and evaluate patient safety
24 data, quality and patient safety indicators, medical
25 malpractice closed claims, and adverse incidents reported to
26 the Agency for Health Care Administration and the Department
27 of Health for the purpose of recommending changes in practices
28 and procedures which may be implemented by health care
29 practitioners and health care facilities to improve the
30 quality of health care and to prevent future adverse
31 incidents. Notwithstanding any other law, the Agency for

1 Health Care Administration and the Department of Health shall
2 make available to the corporation any adverse incident report
3 submitted under s. 395.0197, s. 458.351, or s. 459.026. To the
4 extent that adverse incident reports submitted under s.
5 395.0197 are confidential and exempt from disclosure, the
6 confidential and exempt status of such reports must be
7 maintained by the corporation.
8 (c) Maintain an active library of best practices
9 relating to patient safety and patient safety literature,
10 along with the emerging evidence supporting the retention or
11 modification of such practices, and make this information
12 available to health care practitioners, health care
13 facilities, and the public.
14 (d) Assess the patient safety culture at volunteering
15 hospitals and recommend methods to improve the working
16 environment related to patient safety at these hospitals.
17 (e) Inventory the information technology capabilities
18 related to patient safety of health care facilities and health
19 care practitioners and recommend a plan for expediting
20 implementation of safety technologies statewide.
21 (f) Facilitate the development of core competencies
22 relevant to patient safety which can be made available to be
23 considered for incorporation into the undergraduate and
24 graduate curriculums in schools of medicine, nursing, and
25 allied health in this state.
26 (g) Facilitate continuing professional education
27 regarding patient safety for practicing health care
28 practitioners.
29 (h) Study and facilitate the testing of alternative
30 systems of encouraging the implementation of effective risk
31 management strategies and clinical best practices, and of

1 compensating injured patients as a means of reducing and
2 preventing medical errors and promoting patient safety.
3 (i) Develop programs to educate the public about the
4 role of health care consumers in promoting patient safety.
5 (j) Provide interagency coordination of patient safety
6 efforts in this state.
7 (k) Conduct other activities identified by the board
8 of directors to promote patient safety in this state.
9 (8) ANNUAL REPORT.--By December 1, 2004, the
10 corporation shall prepare a report on the start-up activities
11 of the corporation and any proposals for legislative action
12 needed to enable the corporation to fulfill its purposes under
13 this section. By December 1 of each year thereafter, the
14 corporation shall prepare a report for the preceding fiscal
15 year. The report, at a minimum, must include:
16 (a) A description of the activities of the corporation
17 under this section.
18 (b) Progress made in improving patient safety and
19 reducing medical errors.
20 (c) A compliance and financial audit of the accounts
21 and records of the corporation at the end of the preceding
22 fiscal year conducted by an independent certified public
23 accountant.
24 (d) An assessment of the ability of the corporation to
25 fulfill the duties specified in subsection (7) and the
26 appropriateness of those duties for the corporation.
27 (e) Recommendations for legislative action needed to
28 improve patient safety in this state.
29
30 The corporation shall submit the report to the Governor, the
31 President of the Senate, and the Speaker of the House of

1 Representatives.
2 (9) PERFORMANCE EXPECTATIONS.--The Office of Program
3 Policy Analysis and Government Accountability, in consultation
4 with the Agency for Health Care Administration, the Department
5 of Health, and the corporation, shall develop performance
6 standards by which to measure the success of the corporation
7 in organizing to fulfill and beginning to implement the
8 purposes and duties established in this section. The Office of
9 Program Policy Analysis and Government Accountability shall
10 conduct a performance audit of the corporation during 2006,
11 using the performance standards, and shall submit a report to
12 the Governor, the President of the Senate, and the Speaker of
13 the House of Representatives by January 1, 2007.
14 Section 25. The Patient Safety Center at the Florida
15 State University College of Medicine, in collaboration with
16 researchers at other state universities, shall conduct a study
17 to analyze the return on investment that hospitals in this
18 state could realize from implementing computerized physician
19 order entry and other information technologies related to
20 patient safety. For the purposes of this analysis, the return
21 on investment shall include both financial results and
22 benefits relating to quality of care and patient safety. The
23 study must include a representative sample of large and small
24 hospitals, located in urban and rural areas, in the north,
25 central, and southern regions of the state. By February 1,
26 2005, the Patient Safety Center at the Florida State
27 University College of Medicine must submit a report to the
28 Governor, the President of the Senate, and the Speaker of the
29 House of Representatives concerning the results of the study.
30 Section 26. Section 395.1012, Florida Statutes, is
31 amended to read:

1 395.1012 Patient safety.--
2 (1) Each licensed facility must adopt a patient safety
3 plan. A plan adopted to implement the requirements of 42
4 C.F.R. part 482.21 shall be deemed to comply with this
5 requirement.
6 (2) Each licensed facility shall appoint a patient
7 safety officer and a patient safety committee, which shall
8 include at least one person who is neither employed by nor
9 practicing in the facility, for the purpose of promoting the
10 health and safety of patients, reviewing and evaluating the
11 quality of patient safety measures used by the facility,
12 recommending improvements in the patient safety measures used
13 by the facility, and assisting in the implementation of the
14 facility patient safety plan.
15 (3) Each licensed facility shall adopt a plan to
16 reduce medication errors and adverse drug events, which must
17 consider the use of computerized physician order entry and
18 other information technologies related to patient safety.
19 Section 27. Subsection (3) of section 409.91255,
20 Florida Statutes, is amended to read:
21 409.91255 Federally qualified health center access
22 program.--
23 (3) ASSISTANCE TO FEDERALLY QUALIFIED HEALTH
24 CENTERS.--The Department of Health shall develop a program for
25 the expansion of federally qualified health centers for the
26 purpose of providing comprehensive primary and preventive
27 health care and urgent care services~~, including services~~ that
28 may reduce the morbidity, mortality, and cost of care among
29 the uninsured population of the state. The program shall
30 provide for distribution of financial assistance to federally
31 qualified health centers that apply and demonstrate a need for

1 such assistance in order to sustain or expand the delivery of
2 primary and preventive health care services. In selecting
3 centers to receive this financial assistance, the program:
4 (a) Shall give preference to communities that have few
5 or no community-based primary care services or in which the
6 current services are unable to meet the community's needs.
7 (b) Shall require that primary care services be
8 provided to the medically indigent using a sliding fee
9 schedule based on income.
10 (c) Shall allow innovative and creative uses of
11 federal, state, and local health care resources.
12 (d) Shall require that the funds provided be used to
13 pay for operating costs of a projected expansion in patient
14 caseloads or services or for capital improvement projects.
15 Capital improvement projects may include renovations to
16 existing facilities or construction of new facilities,
17 provided that an expansion in patient caseloads or services to
18 a new patient population will occur as a result of the capital
19 expenditures. The department shall include in its standard
20 contract document a requirement that any state funds provided
21 for the purchase of or improvements to real property are
22 contingent upon the contractor granting to the state a
23 security interest in the property at least to the amount of
24 the state funds provided for at least 5 years from the date of
25 purchase or the completion of the improvements or as further
26 required by law. The contract must include a provision that,
27 as a condition of receipt of state funding for this purpose,
28 the contractor agrees that, if it disposes of the property
29 before the department's interest is vacated, the contractor
30 will refund the proportionate share of the state's initial
31 investment, as adjusted by depreciation.

1 (e) May require in-kind support from other sources.
2 (f) May encourage coordination among federally
3 qualified health centers, other private-sector providers, and
4 publicly supported programs.
5 (g) Shall allow the development of community emergency
6 room diversion programs in conjunction with local resources,
7 providing extended hours of operation to urgent care patients.
8 Diversion programs shall include case management for emergency
9 room followup care.
10 Section 28. Paragraph (a) of subsection (6) of section
11 627.410, Florida Statutes, is amended to read:
12 627.410 Filing, approval of forms.--
13 (6)(a) An insurer shall not deliver or issue for
14 delivery or renew in this state any health insurance policy
15 form until it has filed with the office a copy of every
16 applicable rating manual, rating schedule, change in rating
17 manual, and change in rating schedule; if rating manuals and
18 rating schedules are not applicable, the insurer must file
19 with the office ~~order~~ applicable premium rates and any change
20 in applicable premium rates. This paragraph does not apply to
21 group health insurance policies, effectuated and delivered in
22 this state, insuring groups of 51 or more persons, except for
23 Medicare supplement insurance, long-term care insurance, and
24 any coverage under which the increase in claim costs over the
25 lifetime of the contract due to advancing age or duration is
26 prefunded in the premium.
27 Section 29. Section 627.6405, Florida Statutes, is
28 created to read:
29 627.6405 Decrease in inappropriate utilization of
30 emergency care.--
31 (1) The Legislature finds and declares it to be of

1 vital importance that emergency services and care be provided
2 by hospitals and physicians to every person in need of such
3 care, but with the double-digit increases in health insurance
4 premiums, health care providers and insurers should encourage
5 patients and the insured to assume responsibility for their
6 treatment, including emergency care. The Legislature finds
7 that inappropriate utilization of emergency department
8 services increases the overall cost of providing health care
9 and these costs are ultimately borne by the hospital, the
10 insured patients, and, many times, by the taxpayers of this
11 state. Finally, the Legislature declares that the providers
12 and insurers must share the responsibility of providing
13 alternative treatment options to urgent care patients outside
14 of the emergency department. Therefore, it is the intent of
15 the Legislature to place the obligation for educating
16 consumers and creating mechanisms for delivery of care that
17 will decrease the overutilization of emergency service on
18 health insurers and providers.
19 (2) Health insurers shall provide on their websites
20 information regarding appropriate utilization of emergency
21 care services which shall include, but not be limited to, a
22 list of alternative urgent care contracted providers, the
23 types of services offered by these providers, and what to do
24 in the event of a true emergency.
25 (3) Health insurers shall develop community emergency
26 department diversion programs. Such programs may include, at
27 the discretion of the insurer, but are not limited to,
28 enlisting providers to be on call to insurers after hours,
29 coordinating care through local community resources, and
30 incentives to providers for case management.
31 (4) As a disincentive for insureds to inappropriately

1 use emergency department services, health insurers may require
2 higher copayments for nonemergency use of emergency
3 departments and higher copayments for use of out-of-network
4 emergency departments. For the purposes of this section, the
5 term "emergency care" has the same meaning as provided in s.
6 395.002, and shall include services provided to rule out an
7 emergency medical condition.
8 Section 30. Effective upon this act becoming a law,
9 section 627.64872, Florida Statutes, is created to read:
10 627.64872 Florida Health Insurance Plan.--
11 (1) LEGISLATIVE INTENT; FLORIDA HEALTH INSURANCE
12 PLAN.--
13 (a) The Legislature recognizes that to secure a more
14 stable and orderly health insurance market, the establishment
15 of a plan to assume risks deemed uninsurable by the private
16 marketplace is required.
17 (b) The Florida Health Insurance Plan is created to
18 make coverage available to individuals who have no other
19 option for similar coverage, at a premium that is commensurate
20 with the risk and benefits provided, and with benefit designs
21 that are reasonable in relation to the general market. While
22 plan operations may include supplementary funding, the plan
23 shall fundamentally operate on sound actuarial principles,
24 using basic insurance management techniques to ensure that the
25 plan is run in an economical, cost-efficient, and sound
26 manner, conserving plan resources to serve the maximum number
27 of people possible in a sustainable fashion.
28 (2) DEFINITIONS.--As used in this section:
29 (a) "Board" means the board of directors of the plan.
30 (b) "Commission" means the Financial Services
31 Commission.

1 (c) "Dependent" means a resident spouse or resident
2 unmarried child under the age of 19 years, a child who is a
3 student under the age of 25 years and who is financially
4 dependent upon the parent, or a child of any age who is
5 disabled and dependent upon the parent.
6 (d) "Director" means the director of the Office of
7 Insurance Regulation.
8 (e) "Health insurance" means any hospital or medical
9 expense incurred policy pursuant to this chapter or health
10 maintenance organization subscriber contract pursuant to
11 chapter 641. The term does not include short term, accident,
12 dental-only, vision-only, fixed indemnity, limited benefit,
13 credit, or disability income insurance; coverage for onsite
14 medical clinics; insurance coverage specified in federal
15 regulations issued pursuant to Pub. L. No. 104-191, under
16 which benefits for medical care are secondary or incidental to
17 other insurance benefits; benefits for long-term care, nursing
18 home care, home health care, community-based care, or any
19 combination thereof, or other similar, limited benefits
20 specified in federal regulations issued pursuant to Pub. L.
21 No. 104-191; benefits provided under a separate policy,
22 certificate, or contract of insurance where there is no
23 coordination between the provision of the benefits and any
24 exclusion of benefits under any group health plan maintained
25 by the same plan sponsor, and the benefits are paid with
26 respect to an event without regard to whether benefits are
27 provided with respect to such an event under any group health
28 plan maintained by the same plan sponsor, such as for coverage
29 only for a specified disease or illness; hospital indemnity or
30 other fixed indemnity insurance; coverage offered as a
31 separate policy, certificate, or contract of insurance, such

1 as Medicare supplemental health insurance as defined under s.
2 1882(g)(1) of the Social Security Act; coverage supplemental
3 to the coverage provided under Chapter 55 of Title 10, United
4 States Code (Civilian Health and Medical Program of the
5 Uniformed Services (CHAMPUS)); similar supplemental coverage
6 provided to coverage under a group health plan; coverage
7 issued as a supplement to liability insurance; insurance
8 arising out of a workers' compensation or similar law;
9 automobile medical-payment insurance; or insurance under which
10 benefits are payable with or without regard to fault and which
11 is statutorily required to be contained in any liability
12 insurance policy or equivalent self-insurance.
13 (f) "Implementation" means the effective date after
14 the first meeting of the board when legal authority and
15 administrative ability exist for the board to subsume the
16 transfer of all statutory powers, duties, functions, assets,
17 records, personnel, and property of the Florida Comprehensive
18 Health Association as specified in s. 627.6488.
19 (g) "Insurer" means any entity that provides health
20 insurance in this state. For purposes of this section, insurer
21 includes an insurance company with a valid certificate in
22 accordance with chapter 624, a health maintenance organization
23 with a valid certificate of authority in accordance with part
24 I or part III of chapter 641, a prepaid health clinic
25 authorized to transact business in this state pursuant to part
26 II of chapter 641, multiple employer welfare arrangements
27 authorized to transact business in this state pursuant to ss.
28 624.436-624.45, or a fraternal benefit society providing
29 health benefits to its members as authorized pursuant to
30 chapter 632.
31 (h) "Medicare" means coverage under both Parts A and B

1 of Title XVIII of the Social Security Act, 42 USC 1395 et
2 seq., as amended.
3 (i) "Medicaid" means coverage under Title XIX of the
4 Social Security Act.
5 (j) "Office" means the Office of Insurance Regulation
6 of the Financial Services Commission.
7 (k) "Participating insurer" means any insurer
8 providing health insurance to citizens of this state.
9 (l) "Provider" means any physician, hospital, or other
10 institution, organization, or person that furnishes health
11 care services and is licensed or otherwise authorized to
12 practice in the state.
13 (m) "Plan" means the Florida Health Insurance Plan
14 created in subsection (1).
15 (n) "Plan of operation" means the articles, bylaws,
16 and operating rules and procedures adopted by the board
17 pursuant to this section.
18 (o) "Resident" means an individual who has been
19 legally domiciled in this state for a period of at least 6
20 months.
21 (3) BOARD OF DIRECTORS.--
22 (a) The plan shall operate subject to the supervision
23 and control of the board. The board shall consist of the
24 director or his or her designated representative, who shall
25 serve as a member of the board and shall be its chair, and an
26 additional eight members, five of whom shall be appointed by
27 the Governor, at least three of whom shall be individuals not
28 representative of insurers or health care providers, one of
29 whom shall be appointed by the Chief Financial Officer, one of
30 whom shall be appointed by the President of the Senate, and
31 one of whom shall be appointed by the Speaker of the House of

1 Representatives.
2 (b) The Director of the Office of Insurance
3 Regulation's term on the board shall be determined by
4 continued employment in the position. The remaining initial
5 board members shall serve for a period of time as follows: two
6 members appointed by the Governor and the members appointed by
7 the President of the Senate and the Speaker of the House of
8 Representatives shall serve 2-year terms; and three members
9 appointed by the Governor and the state's Chief Financial
10 Officer shall serve 4-year terms. Subsequent board members
11 shall serve for 3-year terms. A board member's term shall
12 continue until his or her successor is appointed.
13 (c) Vacancies on the board shall be filled by the
14 appointing authority, the authority being the Governor, the
15 President of the Senate, the Speaker of the House of
16 Representatives, or the Chief Financial Officer. Board members
17 may be removed by the appointing authority for cause.
18 (d) The director, or his or her representative, is
19 responsible for any organizational requirements necessary for
20 the initial meeting of the board which shall take place no
21 later than September 1, 2004.
22 (e) Members shall not be compensated in their capacity
23 as board members but shall be reimbursed for reasonable
24 expenses incurred in the necessary performance of their duties
25 in accordance with s. 112.061.
26 (f) The board shall submit to the commission a plan of
27 operation for the plan and any amendments thereto necessary or
28 suitable to ensure the fair, reasonable, and equitable
29 administration of the plan. The plan of operation shall ensure
30 that the plan qualifies to apply for any available funding
31 from the Federal Government that adds to the financial

1 viability of the plan. The plan of operation shall become
2 effective upon approval in writing by the commission
3 consistent with the date on which the coverage under this
4 section must be made available. If the board fails to submit a
5 suitable plan of operation within 1 year after the appointment
6 of the board of directors, or at any time thereafter fails to
7 submit suitable amendments to the plan of operation, the
8 commission shall adopt such rules as are necessary or
9 advisable to effectuate the provisions of this section. Such
10 rules shall continue in force until modified by the office or
11 superseded by a plan of operation submitted by the board and
12 approved by the commission.
13 (g) The board shall take no action to implement the
14 plan, other than the administration of coverage of individuals
15 enrolled in the Florida Comprehensive Health Association, as
16 specified in subsection (20) and the completion of the
17 actuarial study authorized in subsection (6), until funds are
18 appropriated for start-up costs and any projected deficits.
19 (4) PLAN OF OPERATION.--The plan of operation shall:
20 (a) Establish procedures for operation of the plan.
21 (b) Establish procedures for selecting an
22 administrator in accordance with subsection (11).
23 (c) Establish procedures to create a fund, under
24 management of the board, for administrative expenses.
25 (d) Establish procedures for the handling, accounting,
26 and auditing of assets, moneys, and claims of the plan and the
27 plan administrator.
28 (e) Develop and implement a program to publicize the
29 existence of the plan, plan eligibility requirements, and
30 procedures for enrollment and maintain public awareness of the
31 plan.

1 (f) Establish procedures under which applicants and
2 participants may have grievances reviewed by a grievance
3 committee appointed by the board. The grievances shall be
4 reported to the board after completion of the review, with the
5 committee's recommendation for grievance resolution. The board
6 shall retain all written grievances regarding the plan for at
7 least 3 years.
8 (g) Provide for other matters as may be necessary and
9 proper for the execution of the board's powers, duties, and
10 obligations under this section.
11 (5) POWERS OF THE PLAN.--The plan shall have the
12 general powers and authority granted under the laws of this
13 state to health insurers and, in addition thereto, the
14 specific authority to:
15 (a) Enter into such contracts as are necessary or
16 proper to carry out the provisions and purposes of this
17 section, including the authority, with the approval of the
18 commission, to enter into contracts with similar plans of
19 other states for the joint performance of common
20 administrative functions, or with persons or other
21 organizations for the performance of administrative functions.
22 (b) Take any legal actions necessary or proper to
23 recover or collect assessments due the plan.
24 (c) Take such legal action as is necessary to:
25 1. Avoid payment of improper claims against the plan
26 or the coverage provided by or through the plan;
27 2. Recover any amounts erroneously or improperly paid
28 by the plan;
29 3. Recover any amounts paid by the plan as a result of
30 mistake of fact or law; or
31 4. Recover other amounts due the plan.

1 (d) Establish, and modify as appropriate, rates, rate
2 schedules, rate adjustments, expense allowances, agents'
3 commissions, claims reserve formulas, and any other actuarial
4 functions appropriate to the operation of the plan. Rates and
5 rate schedules may be adjusted for appropriate factors such as
6 age, sex, and geographic variation in claim cost and shall
7 take into consideration appropriate factors in accordance with
8 established actuarial and underwriting practices. For purposes
9 of this paragraph, usual and customary agent's commissions
10 shall be paid for the initial placement of coverage with the
11 plan and for one renewal only.
12 (e) Issue policies of insurance in accordance with the
13 requirements of this section.
14 (f) Appoint appropriate legal, actuarial, investment,
15 and other committees as necessary to provide technical
16 assistance in the operation of the plan and develop and
17 educate its policyholders regarding health savings accounts,
18 policy and contract design, and any other function within the
19 authority of the plan.
20 (g) Borrow money to effectuate the purposes of the
21 plan. Any notes or other evidence of indebtedness of the plan
22 not in default shall be legal investments for insurers and may
23 be carried as admitted assets.
24 (h) Employ and fix the compensation of employees.
25 (i) Prepare and distribute certificate of eligibility
26 forms and enrollment instruction forms to insurance producers
27 and to the general public.
28 (j) Provide for reinsurance of risks incurred by the
29 plan.
30 (k) Provide for and employ cost-containment measures
31 and requirements, including, but not limited to, preadmission

1 screening, second surgical opinion, concurrent utilization
2 review, and individual case management for the purpose of
3 making the plan more cost-effective.
4 (l) Design, use, contract, or otherwise arrange for
5 the delivery of cost-effective health care services,
6 including, but not limited to, establishing or contracting
7 with preferred provider organizations, health maintenance
8 organizations, and other limited network provider
9 arrangements.
10 (m) Adopt such bylaws, policies, and procedures as may
11 be necessary or convenient for the implementation of this
12 section and the operation of the plan.
13 (n) Subsume the transfer of statutory powers, duties,
14 functions, assets, records, personnel, and property of the
15 Florida Comprehensive Health Association as specified in ss.
16 627.6488, 627.6489, 627.649, 627.6492, 627.6496, 627.6498, and
17 627.6499, unless otherwise specified by law.
18 (6)(a) Interim report.--No later than December 1,
19 2004, the board shall submit to the Governor, the President of
20 the Senate, and the Speaker of the House of Representatives an
21 actuarial study to determine, including, but not limited to:
22 1. The impact the creation of this plan will have on
23 the small group insurance market, specifically on the premiums
24 paid by insureds. This shall include an estimate of the total
25 anticipated aggregate savings for all small employers in the
26 state.
27 2. The number of individuals the pool could reasonably
28 cover at various funding levels.
29 3. A recommendation as to the best source of funding
30 for the anticipated deficits of the pool.
31 4. The effect on the individual and small group market

1 by including in the Florida Health Insurance Plan persons
2 eligible for coverage under s. 627.6487, as well as the cost
3 of including these individuals.
4 (b) Annual report.--No later than December 1, 2005,
5 and annually thereafter, the board shall submit to the
6 Governor, the President of the Senate, the Speaker of the
7 House of Representatives, and the substantive legislative
8 committees of the Legislature a report which includes an
9 independent actuarial study to determine, including, but not
10 be limited to:
11 1. The impact the creation of the plan has on the
12 small group and individual insurance market, specifically on
13 the premiums paid by insureds. This shall include an estimate
14 of the total anticipated aggregate savings for all small
15 employers in the state.
16 2. The actual number of individuals covered at the
17 current funding and benefit level, the projected number of
18 individuals that may seek coverage in the forthcoming fiscal
19 year, and the projected funding needed to cover anticipated
20 increase or decrease in plan participation.
21 3. A recommendation as to the best source of funding
22 for the anticipated deficits of the pool.
23 4. A summarization of the activities of the plan in
24 the preceding calendar year, including the net written and
25 earned premiums, plan enrollment, the expense of
26 administration, and the paid and incurred losses.
27 5. A review of the operation of the plan as to whether
28 the plan has met the intent of this section.
29 (7) LIABILITY OF THE PLAN.--Neither the board nor its
30 employees shall be liable for any obligations of the plan. No
31 member or employee of the board shall be liable, and no cause

1 of action of any nature may arise against a member or employee
2 of the board, for any act or omission related to the
3 performance of any powers and duties under this section,
4 unless such act or omission constitutes willful or wanton
5 misconduct. The board may provide in its bylaws or rules for
6 indemnification of, and legal representation for, its members
7 and employees.
8 (8) AUDITED FINANCIAL STATEMENT.--No later than June 1
9 following the close of each calendar year, the plan shall
10 submit to the Governor an audited financial statement prepared
11 in accordance with statutory accounting principles as adopted
12 by the National Association of Insurance Commissioners.
13 (9) ELIGIBILITY.--
14 (a) Any individual person who is and continues to be a
15 resident of this state shall be eligible for coverage under
16 the plan if:
17 1. Evidence is provided that the person received
18 notices of rejection or refusal to issue substantially similar
19 insurance for health reasons from two or more health insurers.
20 A rejection or refusal by an insurer offering only stoploss,
21 excess of loss, or reinsurance coverage with respect to the
22 applicant shall not be sufficient evidence under this
23 paragraph; or
24 2. The person is enrolled in the Florida Comprehensive
25 Health Association as of the date the plan is implemented.
26 (b) Each resident dependent of a person who is
27 eligible for coverage under the plan shall also be eligible
28 for such coverage.
29 (c) A person shall not be eligible for coverage under
30 the plan if:
31 1. The person has or obtains health insurance coverage

1 substantially similar to or more comprehensive than a plan
2 policy, or would be eligible to obtain such coverage, unless a
3 person may maintain other coverage for the period of time the
4 person is satisfying any preexisting condition waiting period
5 under a plan policy or may main tain plan coverage for the
6 period of time the person is satisfying a preexisting
7 condition waiting period under another health insurance policy
8 intended to replace the plan policy;
9 2. The person is determined to be eligible for health
10 care benefits under Medicaid, Medicare, the state's children's
11 health insurance program, or any other federal, state, or
12 local government program that provides health benefits;
13 3. The person voluntarily terminated plan coverage
14 unless 12 months have elapsed since such termination;
15 4. The person is an inmate or resident of a public
16 institution; or
17 5. The person's premiums are paid for or reimbursed
18 under any government-sponsored program or by any government
19 agency or health care provider.
20 (d) Coverage shall cease:
21 1. On the date a person is no longer a resident of
22 this state;
23 2. On the date a person requests coverage to end;
24 3. Upon the death of the covered person;
25 4. On the date state law requires cancellation or
26 nonrenewal of the policy;
27 5. At the option of the plan, 30 days after the plan
28 makes any inquiry concerning the person's eligibility or place
29 of residence to which the person does not reply; or
30 6. Upon failure of the insured to pay for continued
31 coverage.

1 (e) Except under the circumstances described in this
2 subsection, coverage of a person who ceased to meet the
3 eligibility requirements of this subsection shall be
4 terminated at the end of the policy period for which the
5 necessary premiums have been paid.
6 (10) UNFAIR REFERRAL TO PLAN.--It is an unfair trade
7 practice for the purposes of part IX of chapter 626 or s.
8 641.3901 for an insurer, health maintenance organization
9 insurance agent, insurance broker, or third-party
10 administrator to refer an individual employee to the plan, or
11 arrange for an individual employee to apply to the plan, for
12 the purpose of separating that employee from group health
13 insurance coverage provided in connection with the employee's
14 employment.
15 (11) PLAN ADMINISTRATOR.--The board shall select
16 through a competitive bidding process a plan administrator to
17 administer the plan. The board shall evaluate bids submitted
18 based on criteria established by the board, which shall
19 include:
20 (a) The plan administrator's proven ability to handle
21 health insurance coverage to individuals.
22 (b) The efficiency and timeliness of the plan
23 administrator's claim processing procedures.
24 (c) An estimate of total charges for administering the
25 plan.
26 (d) The plan administrator's ability to apply
27 effective cost-containment programs and procedures and to
28 administer the plan in a cost-efficient manner.
29 (e) The financial condition and stability of the plan
30 administrator.
31

1 The administrator shall be an insurer, a health maintenance
2 organization, or a third-party administrator, or another
3 organization duly authorized to provide insurance pursuant to
4 the Florida Insurance Code.
5 (12) ADMINISTRATOR TERM LIMITS.--The plan
6 administrator shall serve for a period specified in the
7 contract between the plan and the plan administrator subject
8 to removal for cause and subject to any terms, conditions, and
9 limitations of the contract between the plan and the plan
10 administrator. At least 1 year prior to the expiration of each
11 period of service by a plan administrator, the board shall
12 invite eligible entities, including the current plan
13 administrator, to submit bids to serve as the plan
14 administrator. Selection of the plan administrator for each
15 succeeding period shall be made at least 6 months prior to the
16 end of the current period.
17 (13) DUTIES OF THE PLAN ADMINISTRATOR.--
18 (a) The plan administrator shall perform such
19 functions relating to the plan as may be assigned to it,
20 including, but not limited to:
21 1. Determination of eligibility.
22 2. Payment of claims.
23 3. Establishment of a premium billing procedure for
24 collection of premiums from persons covered under the plan.
25 4. Other necessary functions to ensure timely payment
26 of benefits to covered persons under the plan.
27 (b) The plan administrator shall submit regular
28 reports to the board regarding the operation of the plan. The
29 frequency, content, and form of the reports shall be specified
30 in the contract between the board and the plan administrator.
31 (c) On March 1 following the close of each calendar

1 year, the plan administrator shall determine net written and
2 earned premiums, the expense of administration, and the paid
3 and incurred losses for the year and report this information
4 to the board and the Governor on a form prescribed by the
5 Governor.
6 (14) PAYMENT OF THE PLAN ADMINISTRATOR.--The plan
7 administrator shall be paid as provided in the contract
8 between the plan and the plan administrator.
9 (15) FUNDING OF THE PLAN.--
10 (a) Premiums.--
11 1. The plan shall establish premium rates for plan
12 coverage as provided in this section. Separate schedules of
13 premium rates based on age, sex, and geographical location may
14 apply for individual risks. Premium rates and schedules shall
15 be submitted to the office for approval prior to use.
16 2. Initial rates for plan coverage shall be limited to
17 200 percent of rates established as applicable for individual
18 standard risks as specified in s. 627.6675(3)(c). Subject to
19 the limits provided in this paragraph, subsequent rates shall
20 be established to provide fully for the expected costs of
21 claims, including recovery of prior losses, expenses of
22 operation, investment income of claim reserves, and any other
23 cost factors subject to the limitations described herein, but
24 in no event shall premiums exceed the 200-percent rate
25 limitation provided in this section. Notwithstanding the
26 200-percent rate limitation, sliding scale premium surcharges
27 based upon the insured's income may apply to all enrollees,
28 provided that such premiums do not exceed 300 percent of the
29 standard risk rate.
30 (b) Sources of additional revenue.--Any deficit
31 incurred by the plan shall be primarily funded through amounts

1 appropriated by the Legislature from general revenue sources,
2 including, but not limited to, a portion of the annual growth
3 in existing net insurance premium taxes. The board shall
4 operate the plan in such a manner that the estimated cost of
5 providing health insurance during any fiscal year will not
6 exceed total income the plan expects to receive from policy
7 premiums and funds appropriated by the Legislature, including
8 any interest on investments. After determining the amount of
9 funds appropriated to the board for a fiscal year, the board
10 shall estimate the number of new policies it believes the plan
11 has the financial capacity to insure during that year so that
12 costs do not exceed income. The board shall take steps
13 necessary to ensure that plan enrollment does not exceed the
14 number of residents it has estimated it has the financial
15 capacity to insure.
16 (16) BENEFITS.--
17 (a) The benefits provided shall be the same as the
18 standard and basic plans for small employers as outlined in s.
19 627.6699. The board shall also establish an option of
20 alternative coverage such as catastrophic coverage that
21 includes a minimum level of primary care coverage and a high
22 deductible plan that meets the federal requirements of a
23 health savings account.
24 (b) In establishing the plan coverage, the board shall
25 take into consideration the levels of health insurance
26 provided in the state and such medical economic factors as may
27 be deemed appropriate and adopt benefit levels, deductibles,
28 copayments, coinsurance factors, exclusions, and limitations
29 determined to be generally reflective of and commensurate with
30 health insurance provided through a representative number of
31 large employers in the state.

1 (c) The board may adjust any deductibles and
2 coinsurance factors annually according to the medical
3 component of the Consumer Price Index.
4 (d)1. Plan coverage shall exclude charges or expenses
5 incurred during the first 6 months following the effective
6 date of coverage for any condition for which medical advice,
7 care, or treatment was recommended or received for such
8 condition during the 6-month period immediately preceding the
9 effective date of coverage.
10 2. Such preexisting condition exclusions shall be
11 waived to the extent that similar exclusions, if any, have
12 been satisfied under any prior health insurance coverage which
13 was involuntarily terminated, provided application for pool
14 coverage is made not later than 63 days following such
15 involuntary termination. In such case, coverage under the plan
16 shall be effective from the date on which such prior coverage
17 was terminated and the applicant is not eligible for
18 continuation or conversion rights that would provide coverage
19 substantially similar to plan coverage.
20 (17) NONDUPLICATION OF BENEFITS.--
21 (a) The plan shall be payor of last resort of benefits
22 whenever any other benefit or source of third-party payment is
23 available. Benefits otherwise payable under plan coverage
24 shall be reduced by all amounts paid or payable through any
25 other health insurance, by all hospital and medical expense
26 benefits paid or payable under any workers' compensation
27 coverage, automobile medical payment, or liability insurance,
28 whether provided on the basis of fault or nonfault, and by any
29 hospital or medical benefits paid or payable under or provided
30 pursuant to any state or federal law or program.
31 (b) The plan shall have a cause of action against an

1 eligible person for the recovery of the amount of benefits
2 paid that are not for covered expenses. Benefits due from the
3 plan may be reduced or refused as a setoff against any amount
4 recoverable under this paragraph.
5 (18) ANNUAL AND MAXIMUM BENEFITS.--Maximum benefits
6 under the plan shall be determined by the board.
7 (19) TAXATION.--The plan is exempt from any tax
8 imposed by this state. The plan shall apply for federal tax
9 exemption status.
10 (20) COMBINING MEMBERSHIP OF THE FLORIDA COMPREHENSIVE
11 HEALTH ASSOCIATION.--
12 (a)1. Upon implementation of the Florida Health
13 Insurance Plan, the Florida Comprehensive Health Association,
14 as specified in s. 627.6488 is abolished as a separate
15 nonprofit entity and shall be subsumed under the Board of
16 Directors of the Florida Health Insurance Plan. All
17 individuals actively enrolled in the Florida Comprehensive
18 Health Association shall be enrolled in th plan subject to its
19 rules and requirements, except as otherwise specified in this
20 section. Maximum lifetime benefits paid to an individual in
21 the plan may not exceed the amount established under
22 subsection (16), and benefits previously paid for any
23 individual by the Florida Comprehensive Health Association
24 shall be used in the determination of the total lifetime
25 benefits paid under the plan.
26 2. All persons enrolled in the Florida Comprehensive
27 Health Association upon implementation of the Florida Health
28 Insurance Plan are eligible only for the benefits authorized
29 under subsection (16). Persons identified by this section
30 shall convert to the benefits authorized under subsection (16)
31 no later than January 1, 2005.

1 3. Except as otherwise provided in this section, the
2 Florida Comprehensive Health Association shall operate under
3 the existing plan of operation without modification until the
4 adoption of the new plan of operation for the Florida Health
5 Insurance Plan.
6 (b)1. As a condition of doing business in this state,
7 an insurer shall pay an assessment to the board in the amount
8 prescribed by this paragraph. For operating losses incurred on
9 or after July 1, 2004, by persons previously enrolled in the
10 Florida Comprehensive Health Association, each insurer shall
11 annually be assessed by the board in the following calendar
12 year a portion of such incurred operating losses of the plan.
13 Such portion shall be determined by multiplying such operating
14 losses by a fraction, the numerator of which equals the
15 insurer's earned premium pertaining to direct writings of
16 health insurance in the state during the calendar year
17 proceeding that for which the assessment is levied, and the
18 denominator of which equals the total of all such premiums
19 earned by participating insurers in the state during such
20 calendar year.
21 2. The total of all assessments under this paragraph
22 upon a participating insurer shall not exceed 1 percent of
23 such insurer's health insurance premium earned in this state
24 during the calendar year preceding the year for which the
25 assessments were levied.
26 3. All rights, title, and interest in the assessment
27 funds collected under this paragraph shall vest in this state.
28 However, all of such funds and interest earned shall be used
29 by the plan to pay claims and administrative expenses.
30 (c) If assessments and other receipts by the plan,
31 board, or plan administrator exceed the actual losses and

1 administrative expenses of the plan, the excess shall be held
2 in interest and used by the board to offset future losses. As
3 used in this subsection, the term "future losses" includes
4 reserves for claims incurred but not reported.
5 (d) Each insurer's assessment shall be determined
6 annually by the board or plan administrator based on annual
7 statements and other reports deemed necessary by the board or
8 plan administrator and filed with the board or plan
9 administrator by the insurer. Any deficit incurred under the
10 plan by persons previously enrolled in the Florida
11 Comprehensive Health Association shall be recouped by the
12 assessments against participating insurers by the board or
13 plan administrator in the manner provided in paragraph (b),
14 and the insurers may recover the assessment in the normal
15 course of their respective businesses without time limitation.
16 (e) If a person enrolled in the Florida Comprehensive
17 Health Association as of July 1, 2004, loses eligibility for
18 participation in the plan, such person shall not be included
19 in the calculation of incurred operational losses as described
20 in paragraph (b) if the person later regains eligibility for
21 participation in the plan.
22 (f) After all persons enrolled in the Florida
23 Comprehensive Health Association as of July 1, 2004, are no
24 longer eligible for participation in the plan, the plan,
25 board, or plan administrator shall no longer be allowed to
26 assess insurers in this state for incurred losses as described
27 in paragraph (b).
28 Section 31. Upon implementation, as defined in section
29 627.64872(2), Florida Statutes, and provided in section
30 627.64872(20), Florida Statutes, of the Florida Health Benefit
31 Plan created under section 627.64872, Florida Statutes,

1 sections 627.6488, 627.6489, 627.649, 627.6492, 627.6494,
2 627.6496, and 627.6498, Florida Statutes, are repealed.
3 Section 32. Subsections (12) and (13) are added to
4 section 627.662, Florida Statutes, to read:
5 627.662 Other provisions applicable.--The following
6 provisions apply to group health insurance, blanket health
7 insurance, and franchise health insurance:
8 (12) Section 627.6044, relating to the use of specific
9 methodology for payment of claims.
10 (13) Section 627.6405, relating to inappropriate
11 utilization of emergency care.
12 Section 33. Paragraphs (c) and (d) of subsection (5),
13 subsection (6), and subsection (12) of section 627.6699,
14 Florida Statutes, are amended, subsections (15) and (16) of
15 that section are renumbered as subsections (16) and (17),
16 respectively, present subsection (15) of that section is
17 amended, and new subsections (15) and (18) are added to that
18 section, to read:
19 627.6699 Employee Health Care Access Act.--
20 (5) AVAILABILITY OF COVERAGE.--
21 (c) Every small employer carrier must, as a condition
22 of transacting business in this state:
23 1. Offer and issue all small employer health benefit
24 plans on a guaranteed-issue basis to every eligible small
25 employer, with 2 to 50 eligible employees, that elects to be
26 covered under such plan, agrees to make the required premium
27 payments, and satisfies the other provisions of the plan. A
28 rider for additional or increased benefits may be medically
29 underwritten and may only be added to the standard health
30 benefit plan. The increased rate charged for the additional or
31 increased benefit must be rated in accordance with this

1 section.

2 2. In the absence of enrollment availability in the
3 Florida Health Insurance Plan, offer and issue basic and
4 standard small employer health benefit plans on a
5 guaranteed-issue basis, during a 31-day open enrollment period
6 of August 1 through August 31 of each year, to every eligible
7 small employer, with fewer than two eligible employees, which
8 small employer is not formed primarily for the purpose of
9 buying health insurance and which elects to be covered under
10 such plan, agrees to make the required premium payments, and
11 satisfies the other provisions of the plan. Coverage provided
12 under this subparagraph shall begin on October 1 of the same
13 year as the date of enrollment, unless the small employer
14 carrier and the small employer agree to a different date. A
15 rider for additional or increased benefits may be medically
16 underwritten and may only be added to the standard health
17 benefit plan. The increased rate charged for the additional or
18 increased benefit must be rated in accordance with this
19 section. For purposes of this subparagraph, a person, his or
20 her spouse, and his or her dependent children constitute a
21 single eligible employee if that person and spouse are
22 employed by the same small employer and either that person or
23 his or her spouse has a normal work week of less than 25
24 hours. Any right to an open enrollment of health benefit
25 coverage for groups of fewer than two employees, pursuant to
26 this section, shall remain in full force and effect in the
27 absence of the availability of new enrollment into the Florida
28 Health Insurance Plan.

29 3. This paragraph does not limit a carrier's ability
30 to offer other health benefit plans to small employers if the
31 standard and basic health benefit plans are offered and

1 rejected.
2 (d) A small employer carrier must file with the
3 office, in a format and manner prescribed by the committee, a
4 standard health care plan, a high deductible plan that meets
5 the federal requirements of a health savings account plan or a
6 health reimbursement arrangement, and a basic health care plan
7 to be used by the carrier. The provisions of this section
8 which require the filing of a high deductible plan shall take
9 effect September 1, 2004.
10 (6) RESTRICTIONS RELATING TO PREMIUM RATES.--
11 (a) The commission may, by rule, establish regulations
12 to administer this section and to assure that rating practices
13 used by small employer carriers are consistent with the
14 purpose of this section, including assuring that differences
15 in rates charged for health benefit plans by small employer
16 carriers are reasonable and reflect objective differences in
17 plan design, not including differences due to the nature of
18 the groups assumed to select particular health benefit plans.
19 (b) For all small employer health benefit plans that
20 are subject to this section and are issued by small employer
21 carriers on or after January 1, 1994, premium rates for health
22 benefit plans subject to this section are subject to the
23 following:
24 1. Small employer carriers must use a modified
25 community rating methodology in which the premium for each
26 small employer must be determined solely on the basis of the
27 eligible employee's and eligible dependent's gender, age,
28 family composition, tobacco use, or geographic area as
29 determined under paragraph (5)(j) and in which the premium may
30 be adjusted as permitted by this paragraph.
31 2. Rating factors related to age, gender, family

1 composition, tobacco use, or geographic location may be
2 developed by each carrier to reflect the carrier's experience.
3 The factors used by carriers are subject to office review and
4 approval.
5 3. Small employer carriers may not modify the rate for
6 a small employer for 12 months from the initial issue date or
7 renewal date, unless the composition of the group changes or
8 benefits are changed. However, a small employer carrier may
9 modify the rate one time prior to 12 months after the initial
10 issue date for a small employer who enrolls under a previously
11 issued group policy that has a common anniversary date for all
12 employers covered under the policy if:
13 a. The carrier discloses to the employer in a clear
14 and conspicuous manner the date of the first renewal and the
15 fact that the premium may increase on or after that date.
16 b. The insurer demonstrates to the office that
17 efficiencies in administration are achieved and reflected in
18 the rates charged to small employers covered under the policy.
19 4. A carrier may issue a group health insurance policy
20 to a small employer health alliance or other group association
21 with rates that reflect a premium credit for expense savings
22 attributable to administrative activities being performed by
23 the alliance or group association if such expense savings are
24 specifically documented in the insurer's rate filing and are
25 approved by the office. Any such credit may not be based on
26 different morbidity assumptions or on any other factor related
27 to the health status or claims experience of any person
28 covered under the policy. Nothing in this subparagraph exempts
29 an alliance or group association from licensure for any
30 activities that require licensure under the insurance code. A
31 carrier issuing a group health insurance policy to a small

1 employer health alliance or other group association shall
2 allow any properly licensed and appointed agent of that
3 carrier to market and sell the small employer health alliance
4 or other group association policy. Such agent shall be paid
5 the usual and customary commission paid to any agent selling
6 the policy.
7 5. Any adjustments in rates for claims experience,
8 health status, or duration of coverage may not be charged to
9 individual employees or dependents. For a small employer's
10 policy, such adjustments may not result in a rate for the
11 small employer which deviates more than 15 percent from the
12 carrier's approved rate. Any such adjustment must be applied
13 uniformly to the rates charged for all employees and
14 dependents of the small employer. A small employer carrier may
15 make an adjustment to a small employer's renewal premium, not
16 to exceed 10 percent annually, due to the claims experience,
17 health status, or duration of coverage of the employees or
18 dependents of the small employer. Semiannually, small group
19 carriers shall report information on forms adopted by rule by
20 the commission, to enable the office to monitor the
21 relationship of aggregate adjusted premiums actually charged
22 policyholders by each carrier to the premiums that would have
23 been charged by application of the carrier's approved modified
24 community rates. If the aggregate resulting from the
25 application of such adjustment exceeds the premium that would
26 have been charged by application of the approved modified
27 community rate by 4 ~~5~~ percent for the current reporting
28 period, the carrier shall limit the application of such
29 adjustments only to minus adjustments beginning not more than
30 60 days after the report is sent to the office. For any
31 subsequent reporting period, if the total aggregate adjusted

premium actually charged does not exceed the premium that would have been charged by application of the approved modified community rate by 4 ~~5~~ percent, the carrier may apply both plus and minus adjustments. A small employer carrier may provide a credit to a small employer's premium based on administrative and acquisition expense differences resulting from the size of the group. Group size administrative and acquisition expense factors may be developed by each carrier to reflect the carrier's experience and are subject to office review and approval.

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

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

8.a. A carrier may separate the experience of small employer groups with fewer ~~less~~ than 2 eligible employees from the experience of small employer groups with 2-50 eligible employees for purposes of determining an alternative modified community rating.

b. If a carrier separates the experience of small employer groups as provided in sub-subparagraph a., the rate

1 to be charged to small employer groups of fewer ~~less~~ than 2
2 eligible employees may not exceed 150 percent of the rate
3 determined for small employer groups of 2-50 eligible
4 employees. However, the carrier may charge excess losses of
5 the experience pool consisting of small employer groups with
6 fewer ~~less~~ than 2 eligible employees to the experience pool
7 consisting of small employer groups with 2-50 eligible
8 employees so that all losses are allocated and the 150-percent
9 rate limit on the experience pool consisting of small employer
10 groups with fewer ~~less~~ than 2 eligible employees is
11 maintained. Notwithstanding s. 627.411(1), the rate to be
12 charged to a small employer group of fewer than 2 eligible
13 employees, insured as of July 1, 2002, may be up to 125
14 percent of the rate determined for small employer groups of
15 2-50 eligible employees for the first annual renewal and 150
16 percent for subsequent annual renewals.
17 (c) For all small employer health benefit plans that
18 are subject to this section, that are issued by small employer
19 carriers before January 1, 1994, and that are renewed on or
20 after January 1, 1995, renewal rates must be based on the same
21 modified community rating standard applied to new business.
22 (d) Notwithstanding s. 627.401(2), this section and
23 ss. 627.410 and 627.411 apply to any health benefit plan
24 provided by a small employer carrier that is an insurer, and
25 this section and s. 641.31 apply to any health benefit
26 provided by a small employer carrier that is a health
27 maintenance organization, that provides coverage to one or
28 more employees of a small employer regardless of where the
29 policy, certificate, or contract is issued or delivered, if
30 the health benefit plan covers employees or their covered
31 dependents who are residents of this state.

1 (12) STANDARD, BASIC, HIGH DEDUCTIBLE, AND LIMITED
2 HEALTH BENEFIT PLANS.--
3 (a)1. The Chief Financial Officer shall appoint a
4 health benefit plan committee composed of four representatives
5 of carriers which shall include at least two representatives
6 of HMOs, at least one of which is a staff model HMO, two
7 representatives of agents, four representatives of small
8 employers, and one employee of a small employer. The carrier
9 members shall be selected from a list of individuals
10 recommended by the board. The Chief Financial Officer may
11 require the board to submit additional recommendations of
12 individuals for appointment.
13 2. The plans shall comply with all of the requirements
14 of this subsection.
15 3. The plans must be filed with and approved by the
16 office prior to issuance or delivery by any small employer
17 carrier.
18 4. After approval of the revised health benefit plans,
19 if the office determines that modifications to a plan might be
20 appropriate, the Chief Financial Officer shall appoint a new
21 health benefit plan committee in the manner provided in
22 subparagraph 1. to submit recommended modifications to the
23 office for approval.
24 (b)1. Each small employer carrier issuing new health
25 benefit plans shall offer to any small employer, upon request,
26 a standard health benefit plan, ~~and~~ a basic health benefit
27 plan, and a high deductible plan that meets the requirements
28 of a health savings account plan or health reimbursement
29 account as defined by federal law, that meet ~~meets~~ the
30 criteria set forth in this section.
31 2. For purposes of this subsection, the terms

1 "standard health benefit plan," ~~and~~ "basic health benefit
2 plan," and "high deductible plan" mean policies or contracts
3 that a small employer carrier offers to eligible small
4 employers that contain:
5 a. An exclusion for services that are not medically
6 necessary or that are not covered preventive health services;
7 and
8 b. A procedure for preauthorization by the small
9 employer carrier, or its designees.
10 3. A small employer carrier may include the following
11 managed care provisions in the policy or contract to control
12 costs:
13 a. A preferred provider arrangement or exclusive
14 provider organization or any combination thereof, in which a
15 small employer carrier enters into a written agreement with
16 the provider to provide services at specified levels of
17 reimbursement or to provide reimbursement to specified
18 providers. Any such written agreement between a provider and a
19 small employer carrier must contain a provision under which
20 the parties agree that the insured individual or covered
21 member has no obligation to make payment for any medical
22 service rendered by the provider which is determined not to be
23 medically necessary. A carrier may use preferred provider
24 arrangements or exclusive provider arrangements to the same
25 extent as allowed in group products that are not issued to
26 small employers.
27 b. A procedure for utilization review by the small
28 employer carrier or its designees.
29
30 This subparagraph does not prohibit a small employer carrier
31 from including in its policy or contract additional managed

1 care and cost containment provisions, subject to the approval
2 of the office, which have potential for controlling costs in a
3 manner that does not result in inequitable treatment of
4 insureds or subscribers. The carrier may use such provisions
5 to the same extent as authorized for group products that are
6 not issued to small employers.
7 4. The standard health benefit plan shall include:
8 a. Coverage for inpatient hospitalization;
9 b. Coverage for outpatient services;
10 c. Coverage for newborn children pursuant to s.
11 627.6575;
12 d. Coverage for child care supervision services
13 pursuant to s. 627.6579;
14 e. Coverage for adopted children upon placement in the
15 residence pursuant to s. 627.6578;
16 f. Coverage for mammograms pursuant to s. 627.6613;
17 g. Coverage for handicapped children pursuant to s.
18 627.6615;
19 h. Emergency or urgent care out of the geographic
20 service area; and
21 i. Coverage for services provided by a hospice
22 licensed under s. 400.602 in cases where such coverage would
23 be the most appropriate and the most cost-effective method for
24 treating a covered illness.
25 5. The standard health benefit plan and the basic
26 health benefit plan may include a schedule of benefit
27 limitations for specified services and procedures. If the
28 committee develops such a schedule of benefits limitation for
29 the standard health benefit plan or the basic health benefit
30 plan, a small employer carrier offering the plan must offer
31 the employer an option for increasing the benefit schedule

amounts by 4 percent annually.

6. The basic health benefit plan shall include all of the benefits specified in subparagraph 4.; however, the basic health benefit plan shall place additional restrictions on the benefits and utilization and may also impose additional cost containment measures.

7. Sections 627.419(2), (3), and (4), 627.6574, 627.6612, 627.66121, 627.66122, 627.6616, 627.6618, 627.668, and 627.66911 apply to the standard health benefit plan and to the basic health benefit plan. However, notwithstanding said provisions, the plans may specify limits on the number of authorized treatments, if such limits are reasonable and do not discriminate against any type of provider.

8. The high deductible plan associated with a health savings account or a health reimbursement arrangement shall include all the benefits specified in subparagraph 4.

9.~~8.~~ Each small employer carrier that provides for inpatient and outpatient services by allopathic hospitals may provide as an option of the insured similar inpatient and outpatient services by hospitals accredited by the American Osteopathic Association when such services are available and the osteopathic hospital agrees to provide the service.

(c) If a small employer rejects, in writing, the standard health benefit plan, ~~and~~ the basic health benefit plan, and the high deductible health savings account plan or a health reimbursement arrangement, the small employer carrier may offer the small employer a limited benefit policy or contract.

(d)1. Upon offering coverage under a standard health benefit plan, a basic health benefit plan, or a limited benefit policy or contract for any small employer, the small

1 employer carrier shall provide such employer group with a
2 written statement that contains, at a minimum:
3 a. An explanation of those mandated benefits and
4 providers that are not covered by the policy or contract;
5 b. An explanation of the managed care and cost control
6 features of the policy or contract, along with all appropriate
7 mailing addresses and telephone numbers to be used by insureds
8 in seeking information or authorization; and
9 c. An explanation of the primary and preventive care
10 features of the policy or contract.
11
12 Such disclosure statement must be presented in a clear and
13 understandable form and format and must be separate from the
14 policy or certificate or evidence of coverage provided to the
15 employer group.
16 2. Before a small employer carrier issues a standard
17 health benefit plan, a basic health benefit plan, or a limited
18 benefit policy or contract, it must obtain from the
19 prospective policyholder a signed written statement in which
20 the prospective policyholder:
21 a. Certifies as to eligibility for coverage under the
22 standard health benefit plan, basic health benefit plan, or
23 limited benefit policy or contract;
24 b. Acknowledges the limited nature of the coverage and
25 an understanding of the managed care and cost control features
26 of the policy or contract;
27 c. Acknowledges that if misrepresentations are made
28 regarding eligibility for coverage under a standard health
29 benefit plan, a basic health benefit plan, or a limited
30 benefit policy or contract, the person making such
31 misrepresentations forfeits coverage provided by the policy or

1 contract; and
2 d. If a limited plan is requested, acknowledges that
3 the prospective policyholder had been offered, at the time of
4 application for the insurance policy or contract, the
5 opportunity to purchase any health benefit plan offered by the
6 carrier and that the prospective policyholder had rejected
7 that coverage.
8
9 A copy of such written statement shall be provided to the
10 prospective policyholder no later than at the time of delivery
11 of the policy or contract, and the original of such written
12 statement shall be retained in the files of the small employer
13 carrier for the period of time that the policy or contract
14 remains in effect or for 5 years, whichever period is longer.
15 3. Any material statement made by an applicant for
16 coverage under a health benefit plan which falsely certifies
17 as to the applicant's eligibility for coverage serves as the
18 basis for terminating coverage under the policy or contract.
19 4. Each marketing communication that is intended to be
20 used in the marketing of a health benefit plan in this state
21 must be submitted for review by the office prior to use and
22 must contain the disclosures stated in this subsection.
23 (e) A small employer carrier may not use any policy,
24 contract, form, or rate under this section, including
25 applications, enrollment forms, policies, contracts,
26 certificates, evidences of coverage, riders, amendments,
27 endorsements, and disclosure forms, until the insurer has
28 filed it with the office and the office has approved it under
29 ss. 627.410 and 627.411 and this section.
30 (15) SMALL EMPLOYERS ACCESS PROGRAM.--
31 (a) Popular name.--This subsection may be referred to

1 by the popular name "The Small Employers Access Program."
2 (b) Intent.--The Legislature finds that increased
3 access to health care coverage for small employers with up to
4 25 employees could improve employees' health and reduce the
5 incidence and costs of illness and disabilities among
6 residents in this state. Many employers do not offer health
7 care benefits to their employees citing the increased cost of
8 this benefit. It is the intent of the Legislature to create
9 the Small Business Health Plan to provide small employers the
10 option and ability to provide health care benefits to their
11 employees at an affordable cost through the creation of
12 purchasing pools for employers with up to 25 employees, and
13 rural hospital employers and nursing home employers regardless
14 of the number of employees.
15 (c) Definitions.--For purposes of this subsection, the
16 term:
17 1. "Fair commission" means a commission structure
18 determined by the insurers and reflected in the insurers' rate
19 filings made pursuant to this subsection.
20 2. "Insurer" means any entity that provides health
21 insurance in this state. For purposes of this subsection,
22 insurer includes an insurance company holding a certificate of
23 authority pursuant to chapter 624 or a health maintenance
24 organization holding a certificate of authority pursuant to
25 chapter 641, which qualifies to provide coverage to small
26 employer groups pursuant to this section.
27 3. "Mutually supported benefit plan" means an optional
28 alternative coverage plan developed within a defined
29 geographic region which may include, but is not limited to, a
30 minimum level of primary care coverage in which the percentage
31 of the premium is distributed among the employer, the

1 employee, and community-generated revenue either alone or in
2 conjunction with federal matching funds.
3 4. "Office" means the Office of Insurance Regulation
4 of the Department of Financial Services.
5 5. "Participating insurer" means any insurer providing
6 health insurance to small employers that has been selected by
7 the office in accordance with this subsection for its
8 designated region.
9 6. "Program" means the Small Employer Access Program
10 as created by this subsection.
11 (d) Eligibility.--
12 1. Any small employer group of up to 25 employees.
13 2. Any municipality, county, school district, or
14 hospital located in a rural community as defined in s.
15 288.0636(2)(b).
16 3. Nursing home employers may participate.
17 4. Each dependent of a person eligible for coverage is
18 also eligible to participate.
19 5. Any small employer that is actively engaged in
20 business, has its principal place of business in this state,
21 employed up to 25 eligible employees on business days during
22 the preceding calendar year, and employs at least 2 employees
23 on the first day of the plan year may participate.
24
25 Coverage for a small employer group that ceases to meet the
26 eligibility requirements of this section may be terminated at
27 the end of the policy period for which the necessary premiums
28 have been paid.
29 (e) Administration.--
30 1. The office shall by competitive bid, in accordance
31 with current state law, select an insurer to provide coverage

1 through the program to eligible small employers within an
2 established geographical area of this state. The office may
3 develop exclusive regions for the program similar to those
4 used by the Healthy Kids Corporation. However the office is
5 not precluded from developing, in conjunction with insurers,
6 regions different from those used by the Healthy Kids
7 Corporation if the office deems that such a region will carry
8 out the intentions of this subsection.
9 2. The office shall evaluate bids submitted based upon
10 criteria established by the office, which shall include, but
11 not be limited to:
12 a. The insurer's proven ability to handle health
13 insurance coverage to small employer groups.
14 b. The efficiency and timeliness of the insurer's
15 claim processing procedures.
16 c. The insurer's ability to apply effective
17 cost-containment programs and procedures and to administer the
18 program in a cost-efficient manner.
19 d. The financial condition and stability of the
20 insurer.
21 e. The insurer's ability to develop an optional
22 mutually supported benefit plan.
23
24 The office may use any financial information available to it
25 through its regulatory duties to make this evaluation.
26 (f) Insurer qualifications.--The insurer shall be a
27 duly authorized insurer or health maintenance organization.
28 (g) Duties of the insurer.--The insurer shall:
29 1. Develop and implement a program to publicize the
30 existence of the program, program eligibility requirements,
31 and procedures for enrollment and maintain public awareness of

1 the program.
2 2. Maintain employer awareness of the program.
3 3. Demonstrate the ability to use delivery of
4 cost-effective health care services.
5 4. Encourage, educate, advise, and administer the
6 effective use of health savings accounts by covered employees
7 and dependents.
8 5. Serve for a period specified in the contract
9 between the office and the insurer, subject to removal for
10 cause and subject to any terms, conditions, and limitations of
11 the contract between the office and the insurer as may be
12 specified in the request for proposal.
13 (h) Contract term.--The contract term shall not exceed
14 3 years. At least 6 months prior to the expiration of each
15 contract period, the office shall invite eligible entities,
16 including the current insurer, to submit bids to serve as the
17 insurer for a designated geographic area. Selection of the
18 insurer for the succeeding period shall be made at least 3
19 months prior to the end of the current period. If a protest is
20 filed and not resolved by the end of the contract period, the
21 contract with the existing administrator may be extended for a
22 period not to exceed 6 months. During the contract extension
23 period, the administrator shall be paid at a rate to be
24 negotiated by the office.
25 (i) Insurer reporting requirements.--On March 1
26 following the close of each calendar year, the insurer shall
27 determine net written and earned premiums, the expense of
28 administration, and the paid and incurred losses for the year
29 and report this information to the office on a form prescribed
30 by the office.
31 (j) Application requirements.--The insurer shall

1 permit or allow any licensed and duly appointed health
2 insurance agent residing in the designated region to submit
3 applications for coverage, and such agent shall be paid a fair
4 commission if coverage is written. The agent must be appointed
5 to at least one insurer.
6 (k) Benefits.--The benefits provided by the plan shall
7 be the same as the coverage required for small employers under
8 subsection (12). Upon the approval of the office, the insurer
9 may also establish an optional mutually supported benefit plan
10 which is an alternative plan developed within a defined
11 geographic region of this state or any other such alternative
12 plan which will carry out the intent of this subsection. Any
13 small employer carrier issuing new health benefit plans may
14 offer a benefit plan with coverages similar to, but not less
15 than, any alternative coverage plan developed pursuant to this
16 subsection.
17 (l) Annual reporting.--The office shall make an annual
18 report to the Governor, the President of the Senate, and the
19 Speaker of the House of Representatives. The report shall
20 summarize the activities of the program in the preceding
21 calendar year, including the net written and earned premiums,
22 program enrollment, the expense of administration, and the
23 paid and incurred losses. The report shall be submitted no
24 later than March 15 following the close of the prior calendar
25 year.
26 (16)~~(15)~~ APPLICABILITY OF OTHER STATE LAWS.--
27 (a) Except as expressly provided in this section, a
28 law requiring coverage for a specific health care service or
29 benefit, or a law requiring reimbursement, utilization, or
30 consideration of a specific category of licensed health care
31 practitioner, does not apply to a standard or basic health

1 benefit plan policy or contract or a limited benefit policy or
2 contract offered or delivered to a small employer unless that
3 law is made expressly applicable to such policies or
4 contracts. A law restricting or limiting deductibles,
5 coinsurance, copayments, or annual or lifetime maximum
6 payments does not apply to any health plan policy, including a
7 standard or basic health benefit plan policy or contract,
8 offered or delivered to a small employer unless such law is
9 made expressly applicable to such policy or contract. However,
10 every small employer carrier must offer to eligible small
11 employers the standard benefit plan and the basic benefit
12 plan, as required by subsection (5), as such plans have been
13 approved by the office pursuant to subsection (12).
14 (b) Except as provided in this section, a standard or
15 basic health benefit plan policy or contract or limited
16 benefit policy or contract offered to a small employer is not
17 subject to any provision of this code which:
18 1. Inhibits a small employer carrier from contracting
19 with providers or groups of providers with respect to health
20 care services or benefits;
21 2. Imposes any restriction on a small employer
22 carrier's ability to negotiate with providers regarding the
23 level or method of reimbursing care or services provided under
24 a health benefit plan; or
25 3. Requires a small employer carrier to either include
26 a specific provider or class of providers when contracting for
27 health care services or benefits or to exclude any class of
28 providers that is generally authorized by statute to provide
29 such care.
30 (c) Any second tier assessment paid by a carrier
31 pursuant to paragraph (11)(j) may be credited against

1 assessments levied against the carrier pursuant to s.
2 627.6494.
3 (d) Notwithstanding chapter 641, a health maintenance
4 organization is authorized to issue contracts providing
5 benefits equal to the standard health benefit plan, the basic
6 health benefit plan, and the limited benefit policy authorized
7 by this section.
8 (17)~~(16)~~ RULEMAKING AUTHORITY.--The commission may
9 adopt rules to administer this section, including rules
10 governing compliance by small employer carriers and small
11 employers.
12 Section 34. Section 627.9175, Florida Statutes, is
13 amended to read:
14 627.9175 Reports of information on health and accident
15 insurance.--
16 (1) Each health insurer, prepaid limited health
17 services organization, and health maintenance organization
18 shall submit, no later than April 1 of each year, ~~annually~~ to
19 the office information concerning health and accident
20 insurance coverage and medical plans being marketed and
21 currently in force in this state. The required information
22 shall be described by market segment, including, but not
23 limited to:
24 (a) Issuing, servicing company, and entity contact
25 information.
26 (b) Information on all health and accident insurance
27 policies and prepaid limited health service organizations and
28 health maintenance organization contracts in force and issued
29 in the previous year. Such information shall include, but not
30 be limited to, direct premiums earned, direct losses incurred,
31 number of policies, number of certificates, number of covered

1 lives, and the average number of days taken to pay claims. ~~as~~
2 ~~to policies of individual health insurance:~~
3 ~~(a) A summary of typical benefits, exclusions, and~~
4 ~~limitations for each type of individual policy form currently~~
5 ~~being issued in the state. The summary shall include, as~~
6 ~~appropriate:~~
7 ~~1. The deductible amount;~~
8 ~~2. The coinsurance percentage;~~
9 ~~3. The out-of-pocket maximum;~~
10 ~~4. Outpatient~~ benefits;
11 ~~5. Inpatient benefits; and~~
12 ~~6. Any exclusions for preexisting conditions.~~
13
14 ~~The commission shall determine other appropriate benefits,~~
15 ~~exclusions, and limitations to be reported for inclusion in~~
16 ~~the consumer's guide published pursuant to this section.~~
17 ~~(b) A schedule of rates for each type of individual~~
18 ~~policy form reflecting typical variations by age, sex, region~~
19 ~~of the state, or any other applicable factor which is in use~~
20 ~~and is determined to be appropriate for inclusion by the~~
21 ~~commission.~~
22
23 The commission may establish rules governing ~~shall provide by~~
24 ~~rule a uniform format for~~ the submission of ~~this~~ information
25 described in this section, including the use of uniform
26 formats and electronic data transmission ~~order to allow for~~
27 ~~meaningful comparisons of premiums charged for comparable~~
28 ~~benefits. The office shall provide this information to the~~
29 ~~department, which shall publish annually a consumer's guide~~
30 ~~which summarizes and compares the information required to be~~
31 ~~reported under this subsection~~.

1 (2)(a) Every insurer transacting health insurance in
2 this state shall report annually to the office, not later than
3 April 1, information relating to any measure the insurer has
4 implemented or proposes to implement during the next calendar
5 year for the purpose of containing health insurance costs or
6 cost increases. The reports shall identify each measure and
7 the forms to which the measure is applied, shall provide an
8 explanation as to how the measure is used, and shall provide
9 an estimate of the cost effect of the measure.
10 (b) The commission shall promulgate forms to be used
11 by insurers in reporting information pursuant to this
12 subsection and shall utilize such forms to analyze the effects
13 of health care cost containment programs used by health
14 insurers in this state.
15 (c) The office shall analyze the data reported under
16 this subsection and shall annually make available to the
17 department which shall provide to the public a summary of its
18 findings as to the types of cost containment measures reported
19 and the estimated effect of these measures.
20 Section 35. (1) Effective January 1, 2005, chapter
21 636, Florida Statutes, is redesignated as "Prepaid Limited
22 Health Service Organizations and Discount Medical Plan
23 Organizations."
24 (2) Effective January 1, 2005, sections
25 636.002-636.067, Florida Statutes, are designated as part I of
26 chapter 636, Florida Statutes, entitled "Prepaid Limited
27 Health Service Organizations."
28 Section 36. Effective January 1, 2005, section
29 636.002, Florida Statutes, is amended to read:
30 636.002 Short title.--This part ~~Sections 1-57, chapter~~
31 ~~93-148, Laws of Florida,~~ may be cited as the "Prepaid Limited

1 Health Service Organization Act of Florida."
2 Section 37. Effective January 1, 2005, subsection (7)
3 of section 636.003, Florida Statutes, is amended to read:
4 636.003 Definitions.--As used in this act, the term:
5 (7) "Prepaid limited health service organization"
6 means any person, corporation, partnership, or any other
7 entity which, in return for a prepayment, undertakes to
8 provide or arrange for, or provide access to, the provision of
9 a limited health service to enrollees through an exclusive
10 panel of providers. Prepaid limited health service
11 organization does not include:
12 (a) An entity otherwise authorized pursuant to the
13 laws of this state to indemnify for any limited health
14 service;
15 (b) A provider or entity when providing limited health
16 services pursuant to a contract with a prepaid limited health
17 service organization, a health maintenance organization, a
18 health insurer, or a self-insurance plan; or
19 (c) Any person who is licensed pursuant to part II of
20 this chapter as a discount medical plan organization~~, in~~
21 ~~exchange for fees, dues, charges or other consideration,~~
22 ~~provides access to a limited health service provider without~~
23 ~~assuming any responsibility for payment for the limited health~~
24 ~~service or any portion thereof~~.
25 Section 38. Effective January 1, 2005, part II of
26 chapter 636, Florida Statutes, consisting of sections 636.202,
27 636.204, 636.206, 636.208, 636.210, 636.212, 636.214, 636.216,
28 636.218, 636.220, 636.222, 636.224, 636.226, 636.228, 636.230,
29 636.232, 636.234, 636.236, 636.238, 636.240, 636.242, and
30 636.244, is created to read:
31 Part II

1 Discount Medical Plan Organizations
2 636.202 Definitions.--As used in this part, the term:
3 (1) "Commission" means the Financial Services
4 Commission.
5 (2) "Discount medical plan" means a business
6 arrangement or contract in which a person, in exchange for
7 fees, dues, charges, or other consideration, provides access
8 for plan members to providers of medical services and the
9 right to receive medical services from those providers at a
10 discount. However, the term does not include any product
11 regulated under chapter 627, chapter 641, or part I of this
12 chapter.
13 (3) "Discount medical plan organization" means a
14 person who, in exchange for fees, dues, charges, or other
15 consideration, provides members a discount medical plan.
16 Discount medical plan organization does not include an entity
17 licensed under chapter 624, chapter 641, or part I of chapter
18 636.
19 (4) "Marketer" means a person that markets, promotes,
20 sells, or distributes a discount medical plan, including a
21 private label entity which places its name on and markets or
22 distributes a discount medical plan, but does not operate a
23 discount medical plan.
24 (5) "Medical services" means any care, service, or
25 treatment of an illness or a dysfunction of, or injury to, the
26 human body, including, but not limited to, physician care,
27 inpatient care, hospital surgical services, emergency
28 services, ambulance services, dental care services, vision
29 care services, mental health services, substance abuse
30 services, chiropractic services, podiatric care services,
31 laboratory services, medical equipment and supplies. The term

1 does not include pharmaceutical supplies or prescriptions.
2 (6) "Member" means any person who pays fees, dues,
3 charges, or other consideration for the right to receive the
4 benefits of a discount medical plan.
5 (7) "Office" means the Office of Insurance Regulation
6 of the Financial Services Commission.
7 (8) "Provider" means any person that contracts,
8 directly or indirectly, with a discount medical plan
9 organization to provide medical services to members.
10 (9) "Provider network" means an entity that negotiates
11 on behalf of more than one provider with a discount medical
12 plan organization to provide medical services to members.
13 636.204 License.--
14 (1) A person may not conduct business in this state as
15 a discount medical plan organization unless the person:
16 (a) Is a corporation, either incorporated under the
17 laws of this state, or, if a foreign corporation, is
18 authorized to transact business in this state; and
19 (b) Is licensed as a discount medical plan
20 organization by the office.
21 (2) An application for a license to operate as a
22 discount medical plan organization must be filed with the
23 office on a form prescribed by the commission. The application
24 must be sworn to by an officer or authorized representative of
25 the applicant and must be accompanied by the following:
26 (a) A copy of the applicant's articles of
27 incorporation, including all amendments.
28 (b) A copy of the corporate bylaws.
29 (c) A list of the names, addresses, official
30 positions, and biographical information of the individuals
31 responsible for conducting the applicant's affairs, including,

1 but not limited to, all members of the board of directors,
2 board of trustees, executive committee, or other governing
3 board or committee, the officers, contracted management
4 company personnel, and any person or entity owning or having
5 the right to acquire 10 percent or more of the voting
6 securities of the applicant. The list must fully disclose the
7 extent and nature of any contract or arrangement between any
8 individual who is responsible for conducting the applicant's
9 affairs and the discount medical plan organization, including
10 any possible conflicts of interest.
11 (d) A complete biographical statement, on forms
12 prescribed by the commission, an independent investigation
13 report, and a set of fingerprints, as provided in chapter 624,
14 from each individual identified in subsection (c).
15 (e) A statement describing the applicant, its
16 facilities, and personnel and the medical services it proposes
17 to offer.
18 (f) A copy of any form contract used by the applicant
19 with any provider or provider network regarding the provision
20 of medical services to members.
21 (g) A copy of any form contract used by the applicant
22 with any person listed in subsection (c).
23 (h) A copy of any form contract used by the applicant
24 with any person, corporation, partnership, or other entity for
25 the performance on the applicant's behalf of any function,
26 including, but not limited to, marketing, administration,
27 enrollment, investment management, and subcontracting for the
28 provision of health services to members.
29 (i) A copy of the applicant's most recent financial
30 statements that have been audited by an independent certified
31 public accountant.

1 (j) A description of the applicant's proposed method
2 of marketing.
3 (k) A description of the member's complaint procedures
4 to be established and maintained by the applicant.
5 (l) The fee for issuance of a license.
6 (m) Such other information as the commission or office
7 may request from the applicant.
8 (3) The office shall issue a license that expires 1
9 year after the date of issuance, and each year on that date
10 thereafter. The office shall renew the license if the licensee
11 pays the annual license fee of $50 and if the licensee is in
12 compliance with this part.
13 (4) Before the office issues a license, each medical
14 discount plan organization must establish a website in order
15 to conform with the requirements of s. 636.226.
16 (5) The license fee under this section is $50 per
17 year, per licensee. All amounts collected shall be deposited
18 in the General Revenue Fund.
19 (6) This part does not require a provider who provides
20 discounts to his or her own patients to obtain and maintain a
21 license as a discount medical plan organization.
22 636.206 Examinations and investigations.--
23 (1) The office may examine or investigate any discount
24 medical plan organization. The office may order any discount
25 medical plan organization or applicant to produce any records,
26 books, files, advertising and solicitation materials, or other
27 information and may take statements under oath to determine
28 whether the discount medical plan organization or applicant is
29 in violation of the law or is acting contrary to the public
30 interest. The expenses incurred in conducting an examination
31 or investigation must be paid by the discount medical plan

1 organization or applicant. Examinations and investigations
2 must be conducted as provided in chapter 624 and a discount
3 medical plan organization is subject to all applicable
4 provisions of the Florida Insurance Code.
5 (2) Failure by a discount medical plan organization to
6 pay the costs incurred under this section is grounds for
7 denial or revocation of a license.
8 636.208 Fees.--A discount medical plan organization
9 may charge a reasonable one-time processing fee and a periodic
10 charge. If a discount medical plan charges a fee for a time
11 period exceeding 1 month, it must, in the event of
12 cancellation of the membership by either party, make a pro
13 rata reimbursement of the fee to the member.
14 636.210 Prohibited activities of a discount medical
15 plan.--
16 (1) A discount medical plan organization may not:
17 (a) Use in its advertisements, marketing material,
18 brochures, or discount cards the term "insurance" except as
19 otherwise authorized in this part;
20 (b) Use in its advertisements, marketing material,
21 brochures, or discount cards the terms "health plan,"
22 "coverage," "co-pay," "co-payments," "pre-existing
23 conditions," "guaranteed issue," "premium," "enrollment,"
24 "PPO," "preferred provider organization," or other terms that
25 could reasonably mislead a person into believing the discount
26 medical plan was health insurance;
27 (c) Have restrictions on free access to plan
28 providers, including, but not limited to, waiting periods and
29 notification periods; or
30 (d) Pay providers any fees for medical services.
31 (2) A discount medical plan organization is prohibited

1 from collecting or accepting money from a member for payment
2 to a provider for specific medical services furnished or to be
3 furnished to the member unless it has an active certificate of
4 authority from the office to act as an administrator.
5 636.212 Disclosures.--The following disclosures must
6 be made in writing to any prospective member, and must be on
7 the first page of any advertisements, marketing material, or
8 brochures relating to a discount medical plan. The disclosures
9 must be printed in not less than 12-point type or no smaller
10 than the largest type on the page if larger than 12-point
11 type, and must state:
12 (1) That the plan is not a health insurance policy;
13 (2) That the plan provides discounts at certain
14 healthcare providers for medical services;
15 (3) That the plan does not make payments directly to
16 providers of medical services;
17 (4) That the plan member is obligated to pay for all
18 health care services but will receive a discount from those
19 health care providers who have contracted with the discount
20 plan organization; and
21 (5) The corporate name and the locations of the
22 licensed discount medical plan organization.
23 636.214 Provider agreements.--
24 (1) A provider offering medical services to a member
25 under a discount medical plan must provide the service under a
26 written agreement with the organization. The agreement may be
27 entered into directly by the provider or by a provider network
28 to which the provider belongs.
29 (2) A provider agreement must contain the following:
30 (a) A list of the services and products to be
31 delivered at a discount;

1 (b) A statement specifying the amount of the discounts
2 offered or, alternatively, a fee schedule that reflects the
3 provider's discounted rates; and
4 (c) A statement that the provider will not charge
5 members more than the discounted rates.
6 (3) A provider agreement between a discount medical
7 plan organization and a provider network shall require the
8 provider network to have written agreements with each
9 provider. An agreement must:
10 (a) Contain the elements described in subsection (2);
11 (b) Authorize the provider network to contract with
12 the medical discount medical plan organization on behalf of
13 the provider; and
14 (c) Require the provider network to maintain an
15 up-to-date list of the providers with whom it has a contract
16 and to deliver that list to the discount medical plan
17 organization each month.
18 (4) The discount medical plan organization shall
19 maintain a copy of each active provider agreement.
20 636.216 Form and fees filings.--
21 (1) All fees charged to members must be filed with the
22 office and any fee or charge to members greater than $30 per
23 month or $360 per year must be approved by the office before
24 they can be imposed on a member. The discount medical plan
25 organization has the burden of proof that the fees charged
26 bear a reasonable relation to the benefits received by the
27 member.
28 (2) There must be a written agreement between the
29 discount medical plan organization and the member specifying
30 the benefits under the discount medical plan and complying
31 with the disclosure requirements of this part.

1 (3) Any form used by the discount medical plan
2 organization, including the written agreement between the
3 organization and the member, must first be filed with and
4 approved by the office. Every form filed shall be identified
5 by a unique form number placed in the lower left corner of
6 each form.
7 (4) If the office disapproves any filing, the office
8 shall notify the discount medical plan organization in writing
9 and must specify the reasons why the office disapproved the
10 filing. The discount medical plan organization has 21 days
11 from the date it receives the disapproval notice to request a
12 hearing before the office under chapter 120.
13 636.218 Annual reports.--
14 (1) Each discount medical plan organization must file
15 with the office an annual report no later than 3 months after
16 the end of the organization's fiscal year.
17 (2) The report must be on a form and in a format
18 prescribed by the commission and must include:
19 (a) Audited financial statements prepared in
20 accordance with generally accepted accounting principles and
21 certified by an independent certified public accountant. The
22 financial statements shall include the organization's balance
23 sheet, income statement, and statement of changes in cash flow
24 for the preceding year.
25 (b) A list of the names and residence addresses of all
26 persons responsible for the conduct of its affairs, together
27 with a disclosure of the extent and nature of any contracts or
28 arrangements between these persons and the discount medical
29 plan organization, including any possible conflicts of
30 interest.
31 (c) The number of discount medical plan members.

1 (d) Such other information relating to the performance
2 of the discount medical plan organization that is required by
3 the commission or office.
4 (3) A discount medical plan organization that fails to
5 file an annual report in the form and within the time required
6 by this section shall forfeit up to $500 for each day for the
7 first 10 days during which the report is delinquent and shall
8 forfeit up to $1,000 for each day after the first 10 days
9 during which the report is delinquent. Upon notice by the
10 office, the organization may no longer enroll new members or
11 do business in this state until the organization complies with
12 this section. The office shall deposit all sums collected by
13 it under this section to the credit of the Insurance
14 Regulatory Trust Fund. The office may not collect more than
15 $50,000 for each delinquent report.
16 636.220 Minimum capital requirements.--
17 (1) Each discount medical plan organization must at
18 all times maintain a net worth of at least $150,000.
19 (2) The office may not issue a license unless the
20 medical discount medical plan organization has a net worth of
21 at least $150,000.
22 636.222 Suspension or revocation of license;
23 suspension of enrollment of new members; terms of
24 suspension.--
25 (1) The office may suspend the authority of a discount
26 medical plan organization to enroll new members, may revoke a
27 license issued to a discount medical plan organization, or may
28 order compliance if it finds that any of the following
29 conditions exist:
30 (a) The organization is not operating in compliance
31 with this part.

1 (b) The discount medical plan organization does not
2 have the minimum net worth as required by this part.
3 (c) The organization has advertised, merchandised, or
4 attempted to merchandise its services in a manner as to
5 misrepresent its services or capacity for service or has
6 engaged in deceptive, misleading, or unfair practices with
7 respect to advertising or merchandising.
8 (d) The discount medical plan organization is not
9 fulfilling its obligations as a discount medical plan
10 organization.
11 (e) The continued operation of the discount medical
12 plan organization would be hazardous to its members.
13 (2) If the office has cause to believe that grounds
14 for the suspension or revocation of a license exist, it shall
15 notify the discount medical plan organization in writing
16 specifically stating the grounds for suspension or revocation
17 and shall pursue a hearing on the matter in accordance with
18 chapter 120.
19 (3) If the license of a discount medical plan
20 organization is surrendered or revoked, the organization must
21 proceed, immediately following the effective date of the order
22 of revocation, to wind up its affairs transacted under the
23 license. It may not engage in any further advertising,
24 solicitation, collecting of fees, or renewal of contracts.
25 (4) The office shall, in its order suspending the
26 authority of a discount medical plan organization to enroll
27 new members, specify the period during which the suspension is
28 to be in effect and the conditions, if any, which must be met
29 by the discount medical plan organization before reinstatement
30 of its license to enroll new members. The order of suspension
31 is subject to rescission or modification by further order of

1 the office before expiration of the suspension period.
2 Reinstatement may not be made unless requested by the discount
3 medical plan organization. However, the office may not grant
4 reinstatement if it finds that the circumstances for which the
5 suspension occurred still exist or are likely to recur.
6 636.224 Notice of change of name or address of
7 discount medical plan organization.--Each discount medical
8 plan organization must notify the office at least 30 days in
9 advance of any change in the discount medical plan
10 organization's name, address, principal business address, or
11 mailing address.
12 636.226 Provider name listing.--
13 (1) Each discount medical plan organization must
14 maintain an up-to-date list of the names and addresses of the
15 providers with whom it has a contract to deliver medical
16 services. The list must be stored on its website, the Internet
17 address of which must be prominently displayed on all its
18 advertisements, marketing material, brochures, and discount
19 cards.
20 (2) This section applies to providers with whom the
21 discount medical plan organization has contracted directly and
22 to those who are members of a provider network with which the
23 discount medical plan organization has a contract to deliver
24 medical services.
25 636.228 Marketing of discount medical plans.--
26 (1) All advertisements, marketing material, brochures,
27 and discount cards used by marketers must be approved in
28 writing for use by the discount medical plan organization.
29 (2) The discount medical plan organization shall have
30 an executed written agreement with a marketer before the
31 marketer marketing, promoting, selling, or distributing the

1 discount medical plan and shall be responsible and financially
2 liable for any acts of its marketers which do not comply with
3 the provisions of this part.
4 636.230 Bundling discount medical plans with other
5 insurance products.--When a marketer or discount medical plan
6 organization sells a discount medical plan along with any
7 other product, the fees for each product must be itemized
8 separately and provided to the members in writing.
9 636.232 Rules.--The commission may adopt rules to
10 administer this part, including rules for the licensing of
11 discount medical plan organizations; establishing standards
12 for evaluating forms, advertisements, marketing material,
13 brochures, and discount cards; the collection of data;
14 disclosures to plan members; and rules defining terms used in
15 this act.
16 636.234 Service of process on a discount medical plan
17 organization.--Sections 624.422 and 624.423 apply to a
18 discount medical plan organization as if a discount medical
19 plan organization were an insurer.
20 636.236 Security deposit.--
21 (1) A licensed discount medical plan organization must
22 deposit, and maintain deposited in trust with the department,
23 securities eligible for deposit under s. 625.52, in order that
24 the office might protect plan members. The securities must, at
25 all times, have a value of not less than $35,000.
26 (2) A judgment creditor or other claimant of a
27 discount medical plan organization, other than the office or
28 the Department of Financial Services, does not have the right
29 to levy upon any of the assets or securities held in this
30 state as a deposit under this section.
31 636.238 Penalties for violation of this part.--

1 (1) Except as provided in subsection (2), a person who
2 violates this part commits a misdemeanor of the second degree,
3 punishable as provided in s. 775.082 or s. 775.083.
4 (2) A person who operates as or aids and abets another
5 operating as a discount medical plan organization in violation
6 of s. 636.204(1) commits a felony punishable as provided for
7 in s. 624.401(4)(b), as if the unlicensed discount medical
8 plan organization were an unauthorized insurer, and the fees,
9 dues, charges, or other consideration collected from the
10 members by the unlicensed discount medical plan organization
11 or marketer were insurance premium.
12 (3) A person who collects fees for purported
13 membership in a discount medical plan but fails to provide the
14 promised benefits commits a theft punishable as provided in s.
15 812.014.
16 636.240 Injunction.--
17 (1) In addition to the penalties and other enforcement
18 provisions of this act, the office may commence an action for
19 temporary and permanent injunctive relief if:
20 (a) A discount medical plan is operated by a person
21 that is not licensed under this part.
22 (b) A person, entity, or discount medical plan
23 organization has engaged in any activity prohibited by this
24 act or any rule adopted under this act.
25 (2) Venue for any proceeding bought under this section
26 shall be in the Circuit Court for Leon County.
27 (3) The office's authority to seek injunctive relief
28 is not conditioned on having conducted any proceeding under
29 chapter 120.
30 636.242 Civil remedies.--Any person injured by a
31 person acting in violation of this part may bring a civil

1 action against the person committing the violation in the
2 circuit court of the county in which the alleged violator
3 resides or has a principal place of business or in the county
4 where the alleged violation occurred. If the defendant is
5 found to have injured the plaintiff, the defendant is liable
6 for damages and the court may also award the prevailing
7 plaintiff court costs and reasonable attorney's fees. If so
8 awarded, the court costs and attorney's fees must be included
9 in the judgment or decree rendered in the case. If it appears
10 to the court that the suit brought by the plaintiff is
11 frivolous or brought for purposes of harassment, the court may
12 award the defendant court costs and reasonable attorney's fees
13 and may apply sanctions against the plaintiff in accordance
14 with chapter 57.
15 636.244 Unlicensed discount medical plan
16 organizations.--Sections 626.901 through 626.912 apply to the
17 activities of an unlicensed discount medical plan organization
18 as if an unlicensed discount medical plan organization were an
19 unauthorized insurer.
20 Section 39. Section 627.65626, Florida Statutes, is
21 created to read:
22 627.65626 Insurance rebates for healthy lifestyles.--
23 (1) Any rate, rating schedule, or rating manual for a
24 health insurance policy filed with the office shall provide
25 for an appropriate rebate of premiums paid in the last
26 calendar year when the majority of members of a health plan
27 have enrolled and maintained participation in any health
28 wellness, maintenance, or improvement program offered by the
29 employer. The employer must provide evidence of demonstrative
30 maintenance or improvement of the enrollees' health status as
31 determined by assessments of agreed-upon health status

1 indicators between the employer and the health insurer,
2 including, but not limited to, reduction in weight, body mass
3 index, and smoking cessation. Any rebate provided by the
4 health insurer is presumed to be appropriate unless credible
5 data demonstrates otherwise, but shall not exceed 10 percent
6 of paid premiums.
7 (2) The premium rebate authorized by this section
8 shall be effective for an insured on an annual basis, unless
9 the number of participating employees becomes less than the
10 majority of the employees eligible for participation in the
11 wellness program.
12 Section 40. Section 627.6402, Florida Statutes, is
13 created to read:
14 627.6402 Insurance rebates for healthy lifestyles.--
15 (1) Any rate, rating schedule, or rating manual for an
16 individual health insurance policy filed with the office shall
17 provide for an appropriate rebate of premiums paid in the last
18 calendar year when the individual covered by such plan is
19 enrolled in and maintains participation in any health
20 wellness, maintenance, or improvement program approved by the
21 health plan. The individual must provide evidence of
22 demonstrative maintenance or improvement of the individual's
23 health status as determined by assessments of agreed-upon
24 health status indicators between the individual and the health
25 insurer, including, but not limited to, reduction in weight,
26 body mass index, and smoking cessation. Any rebate provided by
27 the health insurer is presumed to be appropriate unless
28 credible data demonstrates otherwise, but shall not exceed 10
29 percent of paid premiums.
30 (2) The premium rebate authorized by this section
31 shall be effective for an insured on an annual basis, unless

1 the individual fails to maintain or improve his or her health
2 status while participating in an approved wellness program, or
3 credible evidence demonstrates that the individual is not
4 participating in the approved wellness program.
5 Section 41. Subsection (38) of section 641.31, Florida
6 Statutes, is amended, and subsection (40) is added to that
7 section, to read:
8 641.31 Health maintenance contracts.--
9 (38)(a) Notwithstanding any other provision of this
10 part, a health maintenance organization that meets the
11 requirements of paragraph (b) may, through a point-of-service
12 rider to its contract providing comprehensive health care
13 services, include a point-of-service benefit. Under such a
14 rider, a subscriber or other covered person of the health
15 maintenance organization may choose, at the time of covered
16 service, a provider with whom the health maintenance
17 organization does not have a health maintenance organization
18 provider contract. The rider may not require a referral from
19 the health maintenance organization for the point-of-service
20 benefits.
21 (b) A health maintenance organization offering a
22 point-of-service rider under this subsection must have a valid
23 certificate of authority issued under the provisions of the
24 chapter, must have been licensed under this chapter for a
25 minimum of 3 years, and must at all times that it has riders
26 in effect maintain a minimum surplus of $5 million. A health
27 maintenance organization offering a point-of-service rider to
28 its contract providing comprehensive health care services may
29 offer the rider to employers who have employees living and
30 working outside the health maintenance organization's approved
31 geographic service area without having to obtain a health care

1 provider certificate, as long as the master group contract is
2 issued to an employer that maintains its primary place of
3 business within the health maintenance organization's approved
4 service area. Any member or subscriber that lives and works
5 outside the health maintenance organization's service area and
6 elects coverage under the health maintenance organization's
7 point-of-service rider must provide a statement to the health
8 maintenance organization which indicates that the member or
9 subscriber understands the limitations of his or her policy
10 and that only those benefits under the point-of-service rider
11 will be covered when services are provided outside the service
12 area.
13 (c) Premiums paid in for the point-of-service riders
14 may not exceed 15 percent of total premiums for all health
15 plan products sold by the health maintenance organization
16 offering the rider. If the premiums paid for point-of-service
17 riders exceed 15 percent, the health maintenance organization
18 must notify the office and, once this fact is known, must
19 immediately cease offering such a rider until it is in
20 compliance with the rider premium cap.
21 (d) Notwithstanding the limitations of deductibles and
22 copayment provisions in this part, a point-of-service rider
23 may require the subscriber to pay a reasonable copayment for
24 each visit for services provided by a noncontracted provider
25 chosen at the time of the service. The copayment by the
26 subscriber may either be a specific dollar amount or a
27 percentage of the reimbursable provider charges covered by the
28 contract and must be paid by the subscriber to the
29 noncontracted provider upon receipt of covered services. The
30 point-of-service rider may require that a reasonable annual
31 deductible for the expenses associated with the

1 point-of-service rider be met and may include a lifetime
2 maximum benefit amount. The rider must include the language
3 required by s. 627.6044 and must comply with copayment limits
4 described in s. 627.6471. Section 641.3154 does not apply to a
5 point-of-service rider authorized under this subsection.
6 (e) The point-of-service rider must contain provisions
7 that comply with s. 627.6044.
8 (f)~~(e)~~ The term "point of service" may not be used by
9 a health maintenance organization except with riders permitted
10 under this section or with forms approved by the office in
11 which a point-of-service product is offered with an indemnity
12 carrier.
13 (g)~~(f)~~ A point-of-service rider must be filed and
14 approved under ss. 627.410 and 627.411.
15 (40)(a) Any rate, rating schedule, or rating manual
16 for a health maintenance organization policy filed with the
17 office shall provide for an appropriate rebate of premiums
18 paid in the last calendar year when the individual covered by
19 such plan is enrolled in and maintains participation in any
20 health wellness, maintenance, or improvement program approved
21 by the health plan. The individual must provide evidence of
22 demonstrative maintenance or improvement of his or her health
23 status as determined by assessments of agreed-upon health
24 status indicators between the individual and the health
25 insurer, including, but not limited to, reduction in weight,
26 body mass index, and smoking cessation. Any rebate provided by
27 the health insurer is presumed to be appropriate unless
28 credible data demonstrates otherwise, but shall not exceed 10
29 percent of paid premiums.
30 (b) The premium rebate authorized by this section
31 shall be effective for an insured on an annual basis, unless

1 the individual fails to maintain or improve his or her health
2 status while participating in an approved wellness program, or
3 credible evidence demonstrates that the individual is not
4 participating in the approved wellness program.
5 Section 42. Notwithstanding the amendment to section
6 627.6699(5)(c), Florida Statutes, by this act, any right to an
7 open enrollment offer of health benefit coverage for groups of
8 fewer than two employees, pursuant to section 627.6699(5)(c),
9 Florida Statutes, as it existed immediately before the
10 effective date of this act, shall remain in full force and
11 effect until the enactment of section 627.64872, Florida
12 Statutes, and the subsequent date upon which such plan begins
13 to accept new risks or members.
14 Section 43. Section 408.02, Florida Statutes, is
15 repealed.
16 Section 44. Subsection (1) of section 766.309, Florida
17 Statutes, is amended to read:
18 766.309 Determination of claims; presumption; findings
19 of administrative law judge binding on participants.--
20 (1) The administrative law judge shall make the
21 following determinations based upon all available evidence:
22 (a) Whether the injury claimed is a birth-related
23 neurological injury. If the claimant has demonstrated, to the
24 satisfaction of the administrative law judge, that the infant
25 has sustained a brain or spinal cord injury caused by oxygen
26 deprivation or mechanical injury and that the infant was
27 thereby rendered permanently and substantially mentally and
28 physically impaired, a rebuttable presumption shall arise that
29 the injury is a birth-related neurological injury as defined
30 in s. 766.302(2).
31 (b) Whether obstetrical services were delivered by a

1 participating physician in the course of labor, delivery, or
2 resuscitation in the immediate postdelivery period in a
3 hospital; or by a certified nurse midwife in a teaching
4 hospital supervised by a participating physician in the course
5 of labor, delivery, or resuscitation in the immediate
6 postdelivery period in a hospital.

7 (c) How much compensation, if any, is awardable
8 pursuant to s. 766.31.

9 (d) Whether, if raised by the claimant or other party,
10 the factual determinations regarding the notice requirements
11 in s. 766.316 are satisfied. The administrative law judge has
12 the exclusive jurisdiction to make these factual
13 determinations.

14 Section 45. The Agency for Health Care Administration
15 shall adopt all rules necessary to implement this act no later
16 than January 1, 2005.

17 Section 46. The amendment to section 766.309, Florida
18 Statutes, contained in this act, is intended to clarify that
19 the administrative law judge has always had the exclusive
20 jurisdiction to make factual determinations as to whether the
21 notice requirements in section 766.316, Florida Statutes, are
22 satisfied.

23 Section 47. The Auditor General shall conduct a study
24 of nursing home finances which shall examine the following:

25 (1) Profits of nursing home licensees, nursing home
26 management companies, related-party businesses, and owners of
27 real estate that is leased to nursing home operators in this
28 state;

29 (2) Salaries of nonfacility-based nursing home
30 executives, nursing home operators, management companies, and
31 real estate entities; and

1 (3) Home office costs and related party costs that are
2 reported to the Agency for Health Care Administration by a
3 nursing home.
4
5 The Auditor General shall report the overall profits of all
6 nursing home licensees and associated business entities,
7 including home office operators, management companies, real
8 estate entities, and related party organizations. The Auditor
9 General shall report on the retained earnings for nonprofit
10 facilities and any home office, management, real estate
11 entities, and related party organizations. The Auditor General
12 shall report the total amount of executive salaries, home
13 office costs, and related party costs for the most recently
14 completed cost-reporting period. The Auditor General shall
15 report its findings to the Governor, the President of the
16 Senate, and the Speaker of the House of Representatives by
17 December 15, 2004.
18 Section 48. The Agency for Health Care Administration
19 shall conduct a survey of all nursing home operators to
20 determine:
21 (1) The number of nursing home operators offering
22 health insurance to their employees, and the requirements for
23 this coverage;
24 (2) The number of nursing home employees not meeting
25 the employer's requirements for health insurance coverage;
26 (3) The number of nursing home employees enrolled in
27 employer-sponsored health insurance plans and the actual
28 number of employees not enrolled in an employer-sponsored
29 health insurance plan;
30 (4) The number of nursing home employees who have
31 employee-only coverage and the actual number of employees who

1 have dependent coverage; and
2 (5) The number of nursing home employees whose
3 dependents are enrollees in KidCare, Healthy Kids, and
4 Medicaid.
5
6 The agency shall report its findings to the Governor, the
7 President of the Senate, and the Speaker of the House of
8 Representatives by December 15, 2004.
9 Section 49. The sum of $250,000 is appropriated from
10 the Insurance Regulatory Trust Fund in the Department of
11 Financial Services to the Office of Insurance Regulation for
12 the purpose of implementing the provisions in this act
13 relating to the Small Employers Access Program.
14 Section 50. The sum of $350,000 in nonrecurring
15 general revenue funds is appropriated to the Agency for Health
16 Care Administration to support the establishment of and to
17 contract with the Florida Patient Safety Corporation to
18 implement the provisions of section 16 of this act during the
19 2004-2005 fiscal year.
20 Section 51. The sum of $113,500 in nonrecurring
21 general revenue funds is appropriated to the Florida State
22 University College of Medicine for the purpose of conducting
23 the study required in section 17 of this act during the
24 2004-2005 fiscal year.
25 Section 52. The sum of $250,000 is appropriated from
26 the Insurance Regulatory Trust Fund in the Department of
27 Financial Services to the Office of Insurance Regulation for
28 the board of the Florida Health Insurance Plan to contract for
29 an independent actuarial study for the interim report that the
30 board is required to submit pursuant to section 627.64872,
31 Florida Statutes, as created by this act. In addition, the

1 board shall include in that study an analysis of exempting
2 health insurance rates for employers with 26 to 50 employees
3 from the requirements of modified community rating, as
4 provided in section 672.6699, Florida Statutes, and the
5 potential impact that such an exemption would have on the
6 accessibility and affordability of health insurance coverage
7 in the small employer market.
8 Section 53. The sum of $169,069 is appropriated from
9 the Insurance Regulatory Trust Fund in the Department of
10 Financial Services to the Office of Insurance Regulation for
11 the purpose of implementing the provisions in this act
12 relating to the regulation of discount medical plan
13 organizations.
14 Section 54. The sum of $2 million in nonrecurring
15 general revenue funds is appropriated to the Agency for Health
16 Care Administration for its activities during the 2004-2005
17 fiscal year which relate to developing and implementing a
18 strategy for the adoption and use of electronic health
19 records.
20 Section 55. Except as otherwise expressly provided in
21 this act, and except for sections 13-15 and this section,
22 which shall take effect
23
24
25 ================ T I T L E A M E N D M E N T ===============
26 And the title is amended as follows:
27 On page 1, line 2, through
28 page 3, line 21, delete those lines
29
30 and insert:
31 An act relating to affordable and safe health

1 care; providing a popular name; providing
2 purpose; amending s. 381.026, F.S.; requiring
3 certain licensed facilities to provide public
4 Internet access to certain financial
5 information; amending s. 381.734, F.S.;
6 including participation by health care
7 providers, small businesses, and health
8 insurers in the Healthy Communities, Healthy
9 People Program; requiring the Department of
10 Health to provide public Internet access to
11 certain public health programs; requiring the
12 department to monitor and assess the
13 effectiveness of such programs; requiring a
14 report; requiring the Office of Program Policy
15 and Government Accountability to evaluate the
16 effectiveness of such programs; requiring a
17 report; amending s. 395.003, F.S.; prohibiting
18 the Agency for Health Care Administration from
19 issuing licenses for certain emergency
20 departments located off the primary premises of
21 a hospital before July 1, 2005; requiring a
22 study and report to the Legislature; amending
23 s. 395.1041, F.S.; authorizing hospitals to
24 develop certain emergency room diversion
25 programs; amending s. 395.301, F.S.; requiring
26 certain licensed facilities to provide
27 prospective patients certain estimates of
28 charges for services; requiring such facilities
29 to provide patients with certain bill
30 verification information; providing for a fine
31 for failure to provide such information;

1 providing charge limitations; requiring such
2 facilities to establish a patient question
3 review and response methodology; providing
4 requirements; requiring certain licensed
5 facilities to provide public Internet access to
6 certain financial information; providing an
7 exception for specified rural hospitals;
8 amending s. 408.061, F.S.; requiring the Agency
9 for Health Care Administration to require
10 health care facilities, health care providers,
11 and health insurers to submit certain
12 information; providing requirements; requiring
13 the agency to adopt certain risk and severity
14 adjustment methodologies; requiring the agency
15 to adopt certain rules; requiring certain
16 information to be certified; amending s.
17 408.062, F.S.; requiring the agency to conduct
18 certain health care costs and access research,
19 analyses, and studies; expanding the scope of
20 such studies to include collection of pharmacy
21 retail price data, use of emergency
22 departments, physician information, and
23 Internet patient charge information
24 availability; requiring publication of
25 information collected on the Internet;
26 requiring a report; requiring the agency to
27 conduct additional data-based studies and make
28 recommendations to the Legislature; requiring
29 the agency to develop and implement a strategy
30 to adopt and use electronic health records;
31 authorizing the agency to develop rules to

1 protect electronic records confidentiality;
2 requiring a report to the Governor and
3 Legislature; amending s. 408.05, F.S.;
4 requiring the agency to develop a plan to make
5 performance outcome and financial data
6 available to consumers for health care services
7 comparison purposes; requiring submittal of the
8 plan to the Governor and Legislature; requiring
9 the agency to update the plan; requiring the
10 agency to make the plan available
11 electronically; providing plan requirements;
12 amending s. 409.9066, F.S.; requiring the
13 agency to provide certain information relating
14 to the Medicare prescription discount program;
15 creating s. 465.0244, F.S.; requiring each
16 pharmacy to make available on its Internet
17 website a link to certain performance outcome
18 and financial data of the Agency for Health
19 Care Administration and a notice of the
20 availability of such information; amending s.
21 468.352, F.S.; revising and providing
22 definitions applicable to the regulation of
23 respiratory therapy; amending s. 468.355, F.S.;
24 revising provisions relating to respiratory
25 therapy licensure and testing requirements;
26 amending s. 468.368, F.S.; revising exemptions
27 from respiratory therapy licensure
28 requirements; repealing s. 468.356, F.S.,
29 relating to the approval of educational
30 programs; repealing s. 468.357, F.S., relating
31 to licensure by examination; amending s.