By Senator Peaden

2-1470-04

A bill to be entitled

An act relating to health care; creating the Florida Health Insurance Plan to provide health insurance for certain residents; providing for a board to supervise and control the plan; providing for a plan of operation to establish operating procedures; providing powers of the plan and of the board; providing for reports; providing liability of the plan; providing for audits; prescribing eligibility requirements; prohibiting unfair referrals to the plan; providing for a plan administrator and its term limits and duties; providing for funding the plan; prescribing benefits; providing annual and cumulative maximum benefits; providing for tax exemption; creating the Small Employers Access Program; prescribing eligibility requirements; providing for administration of the program; providing qualifications and duties of insurers; providing for reports; prescribing benefits; providing for an advisory council; creating a Statewide Electronic Medical Records Advisory Panel and providing its powers and duties; amending s. 381.026, F.S.; requiring disclosure of certain financial information to patients by health care facilities or providers; amending s. 395.301, F.S.; requiring disclosure of certain financial information to patients of licensed hospitals and similar facilities; amending s. 408.909, F.S.; redefining the term "health flex plan

entity"; revising guidelines for review of health flex plan applications; amending s. 627.610, F.S.; revising applicability of provisions relating to health insurance policy and annuity contract forms; creating s. 627.64101, F.S.; requiring certain insurers to make available coverage for disorders or conditions involving speech, language, swallowing, and hearing and hearing aid and earmold benefits; creating s. 627.6421, F.S.; requiring the offering of standardized policies; amending s. 627.6487, F.S.; redefining the term "eligible individual" for purposes of guaranteed availability of coverage; creating s. 627.66912, F.S.; requiring certain insurers to make available coverage for disorders or conditions involving speech, language, swallowing, and hearing and hearing aid and earmold benefits; amending s. 627.6699, F.S.; redefining the term "modified community rating" for purposes of the Employee Health Care Access Act; revising provisions relating to premium rates; amending s. 636.003, F.S.; redefining the term "prepaid limited health service organization"; amending s. 641.31, F.S.; requiring certain health maintenance organizations to make available coverage for disorders or conditions involving speech, language, swallowing, and hearing and hearing aid and earmold benefits; providing effective dates.

WHEREAS, the Legislature finds that 2.8 million Floridians do not have access to health insurance coverage, and

WHEREAS, often this lack of health insurance coverage is because premiums are not affordable, and

WHEREAS, the Legislature finds that many small employers are unable to provide health insurance to their employees because of rising health care premiums, and

WHEREAS, it is the intent of the Legislature to stabilize Florida's health insurance markets and make them more competitive, and

WHEREAS, it is the intent of the Legislature to provide access to health coverage for more of Florida's small employers, and

WHEREAS, it is the intent of the Legislature to provide access to health coverage to Florida's uninsurables, and

WHEREAS, it is the intent of the Legislature to make health insurance affordable by bringing about reductions in costs to all of Florida's insureds, NOW, THEREFORE,

Be It Enacted by the Legislature of the State of Florida:

Section 1. <u>There is created the Florida Health Insurance Plan.</u>

<u>(1) DEFINITIONS.--As used in this section, the term:</u>

<u>(a) "Board" means the board of directors of the plan.</u>

<u>(b) "Governor" means the Governor of the State of Florida.</u>

<u>(c) "Office" means the Office of Insurance Regulation of the Financial Services Commission.</u>

(d) "Dependent" means a resident spouse or resident unmarried child under the age of 19 years, a child who is a student under the age of 25 years and who is financially dependent upon the parent, or a child of any age who is disabled and dependent upon the parent.

(e) "Director" means the Director of the Office of Insurance Regulation.

(f) "Health insurance" means any hospital or medical expense incurred policy, health maintenance organization subscriber contract pursuant to chapter 641, Florida Statutes, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise. The term does not include short term, accident, dental-only, vision-only, fixed indemnity, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(g) "Insurer" means any entity that provides health insurance in this state. For purposes of this act, the term includes an insurance company with a valid certificate in accordance with chapter 624, Florida Statutes, or a health maintenance organization with a valid certificate of authority in accordance with parts I and III of chapter 641, Florida Statutes; prepaid health clinic authorized to transact business in this state pursuant to part II of chapter 641, Florida Statutes; multiple employer welfare arrangement authorized to transact business in this state pursuant to

sections 624.436-624.45, Florida Statutes; or fraternal benefit society providing health benefits to its members as authorized pursuant to chapter 632, Florida Statutes.

(h) "Medicare" means coverage under both Parts A and B of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq., as amended.

(i) "Medicaid" means coverage under Titles XIX and XXI of the Social Security Act.

(j) "Participating insurer" means any insurer providing health insurance to residents of this state.

(k) "Provider" means any physician, hospital, or other institution, organization, or person that furnishes health care services and is licensed or otherwise authorized to practice in this state.

(l) "Plan" means the Florida Health Insurance Plan as created in this section.

(m) "Plan of operation" means the articles, bylaws, and operating rules and procedures adopted by the board pursuant to this act.

(n) "Resident" means an individual who has been legally domiciled in this state for a period of at least 30 days.

(2) OPERATION OF THE PLAN.--

(a) The plan shall be managed during full implementation of this act by a three-member team appointed by the Governor. The director shall head the team.

(b) Following full implementation, the plan shall operate subject to the supervision and control of the board. The board shall consist of the director or his or her designated representative, who shall serve as a member of the board and shall be its chairperson, and an additional eight

members appointed by the Governor. A majority of the board must be composed of individuals who are not representatives of insurers or health care providers.

(c) The initial board members shall be appointed as follows: one-third of the members to serve a term of 2 years each; one-third of the members to serve a term of 3 years each; and one-third of the members to serve a term of 4 years each. Subsequent board members shall serve for a term of 3 years. A board member's term shall continue until his or her successor is appointed.

(d) Vacancies in the board shall be filled by the Governor. Board members may be removed by the Governor for cause.

(e) Members shall not be compensated in their capacity as board members but shall be reimbursed for reasonable expenses incurred in the necessary performance of their duties in accordance with section 112.061, Florida Statutes.

(f) The board shall submit to the Governor a plan of operation for the plan and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the plan. The plan of operation shall ensure that the plan qualifies to apply for any available funding from the Federal Government which adds to the financial viability of the plan. The plan of operation shall become effective upon approval in writing by the Governor consistent with the date on which the coverage under this act must be made available. If the board fails to submit a suitable plan of operation within 180 days after the appointment of the board of directors, or at any time thereafter fails to submit suitable amendments to the plan of operation, the office shall adopt and promulgate such rules as are necessary or advisable

to effectuate this section. Such rules shall continue in force until modified by the office or superseded by a plan of operation submitted by the board and approved by the Governor.

(3) PLAN OF OPERATION.--The plan of operation shall:

(a) Establish procedures for operation of the plan.

(b) Establish procedures for selecting an administrator in accordance with subsection (13).

(c) Establish procedures to create a fund, under management of the board, for administrative expenses.

(d) Establish procedures for the handling, accounting, and auditing of assets, moneys, and claims of the plan and the plan administrator.

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

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

(g) Provide for other matters as are necessary and proper for the execution of the board's powers, duties, and obligations under this act.

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

(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this act, including the authority, with the approval of the Governor, to enter into contracts with similar plans of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

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

(c) Take such legal action as is necessary:

1. To avoid payment of improper claims against the plan or the coverage provided by or through the plan;

2. To recover any amounts erroneously or improperly paid by the plan;

3. To recover any amounts paid by the plan as a result of mistake of fact or law; or

4. To recover other amounts due the plan.

(d) Establish and modify as appropriate, rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas, and any other actuarial functions appropriate to the operation of the plan. Rates and rate schedules may be adjusted for appropriate factors such as age, sex, and geographic variation in claim cost and shall take into consideration appropriate factors in accordance with established actuarial and underwriting practices;

(e) Issue policies of insurance in accordance with the requirements of this act;

(f) Appoint appropriate legal, actuarial, investment, and other committees as necessary to provide technical assistance in the operation of the plan, develop and educate its policyholders regarding health savings accounts (HSAs),

policy and contract design, and any other function within the authority of the plan;

(g) Borrow money to effect the purposes of the plan. Any notes or other evidence of indebtedness of the plan not in default shall be legal investments for insurers and may be carried as admitted assets;

(h) Employ and fix the compensation of employees;

(i) Prepare and distribute certificate of eligibility forms and enrollment instruction forms to insurance producers and to the general public;

(j) Provide for reinsurance of risks incurred by the plan;

(k) Provide for and employ cost containment measures and requirements, including, but not limited to, preadmission screening, second surgical opinion, concurrent utilization review, and individual case management for the purpose of making the plan more cost effective;

(l) Design, use, contract, or otherwise arrange for the delivery of cost effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations, and other limited network provider arrangements; and

(m) Adopt such bylaws, policies, and procedures as are necessary or convenient for the implementation of this act and the operation of the plan.

(5) INTERIM REPORT.--No later than December 1, 2004, the Transition Team shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives, which includes an independent actuarial study to determine, including, but not be limited to, the following issues:

1. The impact the creation of this plan will have on the small group insurance market on premiums paid by insureds. This shall include an estimate of the total anticipated aggregate savings for all small employers in the state.

2. How many people the pool could reasonably cover at various funding levels and specifically how many people the pool could cover at each of those funding levels.

3. A recommendation as to the best source of funding for the anticipated deficits of the pool.

(6) ANNUAL REPORT.--The board shall make an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The report shall summarize the activities of the plan in the preceding calendar year, including the net written and earned premiums, plan enrollment, the expense of administration, and the paid and incurred losses.

(7) EVALUATION REPORT.--The board shall report to the Governor, the President of the Senate, and the Speaker of the House of Representatives 3 years after commencement of operations of the plan whether or nor the plan has met the intent of this act.

(8) LIABILITY OF THE PLAN.--Neither the board nor its employees shall be liable for any obligations of the plan. No member or employee of the board is liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under this act, unless such act or omission constitutes willful or wanton misconduct. The board may provide in its bylaws or rules for indemnification of, and legal representation for, its members and employees.

(9) AUDITED FINANCIAL STATEMENT.--No later than June 1 following the close of each calendar year the plan shall submit to the Governor an audited financial statement, prepared in accordance with Statutory Accounting Principles as adopted by the National Association of Insurance Commissioners.

(10) ADDITIONAL POWERS OF THE BOARD.--The board is authorized to open up the plan to all eligible individual persons as defined in subsection (11) for whom the estimated loss ratio is 100 percent or less. The Governor may establish additional powers and duties of the board to implement this act.

(11) ELIGIBILITY.--

(a) Any individual person who is and continues to be a resident of this state is eligible for plan coverage if evidence is provided of:

1. A notice of rejection or refusal to issue substantially similar insurance for health reasons by one insurer;

2. A refusal by an insurer to issue insurance except at a rate exceeding the plan rate. A rejection or refusal by an insurer offering only stoploss, excess of loss, or reinsurance coverage with respect to the applicant is not sufficient evidence under this paragraph; or

3. That person's eligibility for individual coverage in accordance with the Health Insurance Accountability and Portability Act (HIPAA).

(b) The board may promulgate a list of medical or health conditions for which a person shall be eligible for plan coverage without applying for health insurance pursuant to paragraph (a). Persons who can demonstrate the existence or

history of any medical or health conditions on the list promulgated by the board shall not be required to provide the evidence specified in paragraph (a). The list shall be effective on the first day of the operation of the plan and may be amended as appropriate.

(c) Each resident dependent of a person who is eligible for plan coverage is also eligible for plan coverage.

(d) A person is not eligible for coverage under the plan if:

1. The person has or obtains health insurance coverage substantially similar to or more comprehensive than a plan policy, or would be eligible to obtain coverage, unless a person may maintain other coverage for the period of time the person is satisfying any preexisting condition waiting period under a plan policy, and may maintain plan coverage for the period of time the person is satisfying a preexisting condition waiting period under another health insurance policy intended to replace the plan policy;

2. The person is determined to be eligible for health care benefits under Medicaid or any other federal, state, or local government program that provides health benefits;

3. The person has previously terminated plan coverage unless 12 months have lapsed since such termination;

4. The plan has paid out $1 million in benefits on behalf of the person;

5. The person is an inmate or resident of a public institution; or

6. The person's premiums are paid for or reimbursed under any government-sponsored program or by any government agency or health care provider, except as an otherwise

qualifying full-time employee, or dependent thereof, of a government agency or health care provider.

(e) Coverage shall cease:

1. On the date a person is no longer a resident of this state;

2. On the date a person requests coverage to end;

3. Upon the death of the covered person;

4. On the date state law requires cancellation of the policy; or

5. At the option of the plan, 30 days after the plan makes any inquiry concerning the person's eligibility or place of residence to which the person does not reply.

(f) Except under the circumstances described in this subsection, a person who ceases to meet the eligibility requirements of this section may be terminated at the end of the policy period for which the necessary premiums have been paid.

(12) UNFAIR REFERRAL TO PLAN.--It shall constitute an unfair trade practice for the purposes of part IX of chapter 626, Florida Statutes, or section 641.3901, Florida Statutes, for an insurer, health maintenance organization, insurance agent, insurance broker, or third-party administrator to refer an individual employee to the plan, or arrange for an individual employee to apply to the plan, for the purpose of separating that employee from group health insurance coverage provided in connection with the employee's employment.

(13) PLAN ADMINISTRATOR.--The board shall select through a competitive bidding process a plan administrator to administer the plan. The board shall evaluate bids submitted based on criteria established by the board, which shall include:

(a) The plan administrator's proven ability to handle health insurance coverage to individuals;

(b) The efficiency and timeliness of the plan administrator's claim-processing procedures;

(c) An estimate of total charges for administering the plan;

(d) The plan administrator's ability to apply effective cost containment programs and procedures and to administer the plan in a cost efficient manner; and

(e) The financial condition and stability of the plan administrator.

The administrator shall be either an insurer, a health maintenance organization or a third-party administrator, or another organization duly authorized pursuant to the Florida Insurance Code.

(14) ADMINISTRATOR TERM LIMITS.--The plan administrator shall serve for a period specified in the contract between the plan and the plan administrator, subject to removal for cause and subject to any terms, conditions, and limitations of the contract between the plan and the plan administrator. At least 1 year before the expiration of each period of service by a plan administrator, the board shall invite eligible entities, including the current plan administrator, to submit bids to serve as the plan administrator. Selection of the plan administrator for each succeeding period shall be made at least 6 months before the end of the current period.

(15) DUTIES OF THE PLAN ADMINISTRATOR.--The plan administrator shall perform such functions relating to the plan as are assigned to it, including, but not limited to:

(a) Determination of eligibility;

(b) Payment of claims;

(c) Establishment of a premium billing procedure for collection of premiums from persons covered under the plan; and

(d) Other necessary functions to assure timely payment of benefits to covered persons under the plan.

The plan administer shall submit regular reports to the board regarding the operation of the plan. The frequency, content, and form of the reports shall be specified in the contract between the board and the plan administrator. On March 1 following the close of each calendar year, the plan administrator shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the board and the Governor on a form prescribed by the Governor.

(16) PAYMENT OF THE PLAN ADMINISTRATOR.--The plan administrator shall be paid as provided in the contract between the plan and the plan administrator.

(17) FUNDING OF THE PLAN.--

(a) Premiums.--

1. The plan shall establish premium rates for plan coverage as provided in subparagraph 2. Separate schedules of premium rates based on age, sex, and geographical location may apply for individual risks. Premium rates and schedules shall be submitted to the office for approval before use.

2. The plan, in conjunction with the office, shall determine a standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be

established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Initial rates for plan coverage shall not be less than 200 percent of rates established as applicable for individual standard risks. The plan shall also develop a sliding scale premium surcharge based upon the insured's income. Subject to the limits provided in this paragraph, subsequent rates shall be established to provide fully for the expected costs of claims, including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein.

(b) Sources of additional revenue.--Any deficit incurred by the plan shall be funded through amounts appropriated by the Legislature from general revenue sources, including, but not limited to, a portion of the annual growth in existing net insurance premium taxes. The board shall operate the plan in such a manner that the estimated cost of providing health insurance during any fiscal year will not exceed total income the plan expects to receive from policy premiums and funds appropriated by the Legislature, including any interest on investments. After determining the amount of funds appropriated to it for a fiscal year, the board shall estimate the number of new policies it believes the plan has the financial capacity to insure during that year so that costs do not exceed income. The board shall take steps necessary to assure that plan enrollment does not exceed the number of residents it has estimated it has the financial capacity to insure.

(18) BENEFITS.--

(a) The benefits provided shall be the same as the standard and basic plans for small employers as outlined in

section 627.6699, Florida Statutes. The board may also establish an option of alternative coverage such as catastrophic coverage that includes a minimum level of primary care coverage.

(b) In establishing the plan coverage, the board shall take into consideration the levels of health insurance provided in the state and such medical economic factors as are deemed appropriate and adopt benefit levels, deductibles, co-payments, coinsurance factors, exclusions and limitations determined to be generally reflective of and commensurate with health insurance provided through a representative number of large employers in the state.

(c) The board may adjust any deductibles and coinsurance factors annually according to the Medical Component of the Consumer Price Index.

(d)1. Plan coverage shall exclude charges or expenses incurred during the first 6 months following the effective date of coverage for any condition for which medical advice, care, or treatment was recommended or received during the 6-month period immediately preceding the effective date of coverage.

2. Such preexisting condition exclusions shall be waived to the extent that similar exclusions, if any, have been satisfied under any prior health insurance coverage that was involuntarily terminated, provided that application for pool coverage is made not later than 63 days following such involuntary termination; and, in such case, coverage in the plan shall be effective from the date on which such prior coverage was terminated and the applicant is not eligible for continuation or conversion rights that would provide coverage substantially similar to plan coverage.

(19) NONDUPLICATION OF BENEFITS.--

(a) The plan shall be payer of last resort of benefits whenever any other benefit or source of third-party payment is available. Benefits otherwise payable under plan coverage shall be reduced by all amounts paid or payable through any other health insurance and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

(b) The plan shall have a cause of action against an eligible person for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due from the plan may be reduced or refused as a set-off against any amount recoverable under this paragraph.

(20) ANNUAL AND MAXIMUM BENEFITS.--Maximum benefits shall be limited to $75,000 annually and $1 million per lifetime.

(21) TAXATION.--The plan established pursuant to this act shall be exempt from any and all taxes. The plan shall apply for federal tax exemption.

Section 2. There is created The Small Employers Access Program.

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

(a) "Office" means the Office of Insurance Regulation of the Department of Financial Services.

(b) "Insurer" means any entity that provides health insurance in this state. For purposes of this section, the term includes an insurance company holding a certificate of authority pursuant to chapter 624, Florida Statutes, or a

health maintenance organization holding a certificate of authority pursuant to chapter 641, Florida Statutes, which qualifies to provide coverage to small employer groups pursuant to section 627.6699, Florida Statutes.

(c) "Participating insurer" means any insurer providing health insurance to small employers which has been selected by the office in accordance with this section for its designated region.

(d) "Program" means the Small Employer Access Program created by this section.

(e) "Fair Commission" means a commission structure determined by the office and the insurers, which will carry out the intent of this section.

(2) ELIGIBILITY.--

(a) Any small employer group up to 25 employees may participate.

(b) Each dependent of a person eligible for coverage is also eligible.

(c) Any municipality, county, school district, or hospital located in a rural community as defined in section 288.0656(2)(b), Florida Statutes.

(d) A small employer group that ceases to meet the eligibility requirements of this section may be terminated at the end of the policy period for which the necessary premiums have been paid.

(3) ADMINISTRATION.--The office shall by competitive bid, in accordance with current state law, select an insurer to provide coverage to small employers within established geographical areas of this state. The office may develop exclusive regions for the program similar to those used by the Healthy Kids Corporation. However, the office is not precluded

from developing, in conjunction with insurers, regions different from those used by the Healthy Kids Corporation if the office deems that such a region will carry out the intentions of this act. The office shall evaluate bids submitted based upon criteria established by the office, which shall include, but are not limited to:

(a) The insurer's proven ability to provide health insurance coverage to small employer groups;

(b) The efficiency and timeliness of the insurer's claim-processing procedures;

(c) The insurer's ability to apply effective cost containment programs and procedures and to administer the program in a cost-efficient manner; and

(d) The financial condition and stability of the insurer. The office may use any financial information available to it through its regulatory duties to make this evaluation.

(4) INSURER QUALIFICATIONS.--The insurer shall be a duly authorized insurer or health maintenance organization.

(5) DUTIES OF THE INSURER.--The insurer shall develop and implement a program to publicize the existence of the program, the eligibility requirements, procedures for enrollment, and

(a) Maintain employer awareness of the program.

(b) Demonstrate the ability to use delivery of cost effective health care services.

(c) Encourage, educate, advise, and administer the effective use of health savings accounts (HSAs) by covered employees and dependents.

(d) Serve for a period specified in the contract between the office and the insurer subject to removal for

cause and subject to any terms, conditions, and limitations of the contract between the office and the insurer as are specified in the request for proposal.

(6) CONTRACT TERM.--The contract term shall not exceed 3 years. At least 6 months before the expiration of each contract period, the office shall invite eligible entities, including the current insurer, to submit bids to serve as the insurer for a designated geographic area. Selection of the insurer for the succeeding period must be made at least 3 months before the end of the current period.

(7) INSURER REPORTING REQUIREMENTS.--On March 1, following the close of each calendar year, the insurer shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the office on a form prescribed by the office.

(8) APPLICATION REQUIREMENTS.--The insurer shall permit or allow any licensed and duly appointed health insurance agent residing in the designated region to submit applications for coverage, and such agent shall be paid a fair commission if coverage is written. The agency must be appointed to at least one insurer.

(9) BENEFITS.--The benefits provided shall be the same as the standard and basic plans for small employers as outlined in section 627.6699, Florida Statutes, except that the insurer, with the approval of the office, may also establish an option of alternative coverage such as catastrophic coverage that includes a minimum level of primary care coverage or other such benefit plan, which will carry out the intent of this act.

(10) ANNUAL REPORTING.--The office shall make an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The report shall summarize the activities of the program in the preceding calendar year, including the net written and earned premiums, program enrollment, the expense of administration, and the paid and incurred losses. The report shall be submitted no later than March 15 following the close of the prior calendar year.

(11) ADVISORY COUNCIL.--The office, in conjunction with representatives of each of the regional insurers, provider groups, and small employer representatives, and a person designated by the Governor shall meet at least annually to review the operations of the program, suggest improvements, and recommend incentives to the Governor and the Legislature which will encourage employer participation in the program.

Section 3. There is created a Statewide Electronic Medical Records Advisory Panel to serve as a body of experts to guide the Agency for Health Care Administration in the development of policy related to electronic medical records and the technology required for sharing clinical information among caregivers.

(1) The agency shall provide staff support to the panel and may enter into contracts as are necessary or proper to carry out the provisions and purposes of this act, assisting the advisory panel in the creation of the Electronic Medical Records System.

(2) The advisory panel shall be appointed by the Governor.

(3) The panel shall meet at least quarterly and advise the Governor, the Legislature, and the agency regarding:

(a) Public and private sector initiatives related to electronic medical records and communication systems for the sharing of clinical information among caregivers;

(b) Regulatory barriers that interfere with the sharing of clinical information among caregivers;

(c) Investment incentives to promote the use of recommended technologies by health care providers;

(d) Educational strategies to promote the use of recommended technologies by health care providers; and

(e) Standards for public access to facilitate transparency in pricing, costs, and quality.

(4) By November 30, 2004, and annually thereafter, the advisory panel shall provide to the Office of the Governor, the President of the Senate, and the Speaker of the House of Representatives, a status report to include any recommendations and an implementation plan to include, but not limited to, estimated costs, capital investment requirements, recommended investment incentives, initial committed provider participation by region, standards of functionality and features, marketing plan, and implementation schedules for key components.

(5) Members of the advisory panel shall serve without compensation but shall be entitled to receive reimbursement for per diem and travel expenses as provided in section 112.061, Florida Statutes.

(6) The sum of $2 million is appropriated from the General Revenue Fund to the Agency for Health Care Administration for funding activities relative to the Statewide Electronic Advisory Panel.

(7) Unless otherwise reenacted by the Legislature, the advisory panel is abolished effective July 1, 2007.

Section 4. Paragraph (c) of subsection (4) and subsection (6) of section 381.026, Florida Statutes, are amended to read:

381.026 Florida Patient's Bill of Rights and Responsibilities.--

(4) RIGHTS OF PATIENTS.--Each health care facility or provider shall observe the following standards:

(c) Financial information and disclosure.--

1. A patient has the right to be given, upon request, by the responsible provider, his or her designee, or a representative of the health care facility full information and necessary counseling on the availability of known financial resources for the patient's health care.

2. A health care provider or a health care facility shall, upon request, disclose to each patient who is eligible for Medicare, in advance of treatment, whether the health care provider or the health care facility in which the patient is receiving medical services accepts assignment under Medicare reimbursement as payment in full for medical services and treatment rendered in the health care provider's office or health care facility.

3. A health care provider or a health care facility shall, upon request, furnish a patient, prior to provision of medical services, a reasonable estimate of charges for such services. Such reasonable estimate shall not preclude the health care provider or health care facility from exceeding the estimate or making additional charges based on changes in the patient's condition or treatment needs.

4. Each licensed facility not operated by the state shall make available to the public on its Internet website or by other electronic means package prices for each of the top

50 most used elective inpatient and outpatient procedures. The package pricing shall include all hospital-related services and shall include separate estimates of costs for professional fees charged by independent contractor physicians or physician groups. The licensed facility shall also make available to the public on its Internet website or by other electronic means each of the top 50 most used inpatient and outpatient procedures. Such list shall be updated quarterly. The facility shall place a notice in the reception areas that such information is available electronically and the website address. The licensed facility may indicate that the package pricing is based on a compilation of charges for the average patient and that each patient's bill may vary from the average depending upon the severity of illness and individual resources consumed. The licensed facility may also indicate that the package pricing is negotiable based upon the patient's health plan and the ability to pay. The agency shall develop rules for implementation of a uniform mechanism for reporting this information on the facility's website.

5.~~4.~~ A patient has the right to receive a copy of an itemized bill upon request. A patient has a right to be given an explanation of charges upon request.

(6) SUMMARY OF RIGHTS AND RESPONSIBILITIES.--Any health care provider who treats a patient in an office or any health care facility licensed under chapter 395 that provides emergency services and care or outpatient services and care to a patient, or admits and treats a patient, shall adopt and make available to the patient, in writing, a statement of the rights and responsibilities of patients, including the following:

SUMMARY OF THE FLORIDA PATIENT'S BILL
OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

A patient has the right to a prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his or her care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

A patient has the right to know what rules and regulations apply to his or her conduct.

A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for the proposed service.

A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past

illnesses, hospitalizations, medications, and other matters relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care provider.

A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

Section 5. Subsections (7) and (8) are added to section 395.301, Florida Statutes, to read:

395.301 Itemized patient bill; form and content prescribed by the agency.--

(7) Each licensed facility not operated by the state shall make available to the public on its Internet website or by other electronic means package prices for each of the top 50 most used elective inpatient and outpatient procedures. The package pricing shall include all hospital-related services and shall include separate estimates of costs for professional

fees charged by independent contractor physicians or physician groups. The licensed facility shall also make available to the public on its Internet website or by other electronic means the top 50 most used procedures in both the inpatient and outpatient settings. The list shall be updated quarterly. The facility shall place a notice in the reception areas that such information is available electronically and the website address. The licensed facility may indicate that the package pricing is based on a compilation of charges for the average patient and that each patient's bill may vary from the average depending upon the severity of illness and individual resources consumed. The licensed facility may also indicate that the package pricing is negotiable based upon the patient's health plan and the ability to pay. The agency shall develop rules for implementation of a uniform mechanism for reporting this information on the facility's website.

(8) Each licensed facility not operated by the state shall, upon request of a prospective patient prior to the provision of medical services, provide a reasonable estimate of charges for the proposed service. Such estimate shall not preclude the actual charges from exceeding the estimate based on changes in the patient's medical condition or the treatment needs of the patient as determined by the attending and consulting physicians.

Section 6. 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 any combination of those actions.

(a) The agency shall develop guidelines for the review of applications for health flex plans and shall disapprove or withdraw approval of plans that do not meet or no longer meet minimum standards for quality of care and access to care. The agency shall ensure that the health flex plans follow standardized grievance procedures similar to those required of health maintenance organizations.

(b) The office shall develop guidelines for the review of health flex plan applications and provide regulatory oversight of health flex plan advertisement and marketing procedures. The office shall disapprove or shall withdraw approval of plans that:

1. Contain any ambiguous, inconsistent, or misleading provisions or any exceptions or conditions that deceptively affect or limit the benefits purported to be assumed in the general coverage provided by the health flex plan;

2. Provide benefits that are unreasonable in relation to the premium charged or contain provisions that are unfair or inequitable or contrary to the public policy of this state, that encourage misrepresentation, or that result in unfair discrimination in sales practices; or

3. Cannot demonstrate that the health flex plan is financially sound and that the applicant is able to underwrite or finance the health care coverage provided.

(c) The agency and the Financial Services Commission may adopt rules as needed to administer this section.

(9) PROGRAM EVALUATION.--The agency and the office 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; <u>shall use health flex plans to gather more information to evaluate low-income consumer driven benefit packages;</u>and shall, by January 1, 2004, jointly submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Section 7. Paragraph (a) of subsection (6) of section 627.610, Florida Statutes, is amended to read:

627.410 Filing, approval of forms.--

(6)(a) An insurer shall not deliver or issue for delivery or renew in this state any health insurance policy form until it has filed with the office a copy of every

applicable rating manual, rating schedule, change in rating manual, and change in rating schedule; if rating manuals and rating schedules are not applicable, the insurer must file with the order applicable premium rates and any change in applicable premium rates. This paragraph does not apply to group health insurance policies, effectuated and delivered in this state, insuring groups of 26 ~~51~~ or more persons, except for Medicare supplement insurance, long-term care insurance, and any coverage under which the increase in claim costs over the lifetime of the contract due to advancing age or duration is prefunded in the premium.

Section 8. Section 627.64101, Florida Statutes, is created to read:

627.64101 Optional coverage for speech, language, swallowing, and hearing disorders.--

(1) Insurers issuing individual health insurance policies in this state shall make available to the policyholder as part of the application for any such policy of insurance, for an appropriate additional premium, the benefits or levels of benefits specified in the December 1999 Florida Medicaid Therapy Services Handbook for genetic or congenital disorders or conditions involving speech, language, swallowing, and hearing and a hearing aid and earmolds benefit at the level of benefits specified in the January 2001 Florida Medicaid Hearing Services Handbook.

(2) This section does not apply to specified-accident, specified-disease, hospital indemnity, limited benefit, disability income, or long-term care insurance policies.

(3) Such optional coverage is not required to be offered when substantially similar benefits are included in the policy of insurance issued to the policyholder.

(4) This section does not require or prohibit the use of a provider network.

(5) This section does no prohibit an insurer from requiring prior authorization for the benefits under this section.

Section 9. Section 627.6421, Florida Statutes, is created to read:

627.6421 Required standardized policy offering.--

(1) Beginning January 1, 2005, every authorized insurer or health maintenance organization issuing a health benefit plan as defined in s. 627.6699(3)(k) to individuals in this state, including certificates of coverage offered to individuals in this state as part of a group policy issued to an association outside this state, must, as a condition of transacting business in this state, offer to the prospective individual insured or prospective subscriber a standard health benefit plan and a basic health benefit plan as created pursuant to s. 627.6699(12). Such health issuer shall offer a standard health benefit plan or a basic health benefit plan to every individual who meets the issuer's underwriting criteria, agrees to make the required premium payments under such plan, and agrees to satisfy the other provisions of the plan.

(2) If an individual rejects, in writing, the standard health benefit plan and the basic health benefit plan, the insurer or health maintenance organization may offer the individual any other policy or contract filed and approved by the state for issuance to individuals.

Section 10. Subsection (3) of section 627.6487, Florida Statutes, is amended to read:

627.6487 Guaranteed availability of individual health insurance coverage to eligible individuals.--

(3) For the purposes of this section, the term "eligible individual" means an individual:

(a)1. For whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage, as defined in s. 627.6561(5) and (6), is 18 or more months; and

2.a. Whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan, or health insurance coverage offered in connection with any such plan; or

b. Whose most recent prior creditable coverage was under an individual plan issued in this state by a health insurer or health maintenance organization, which coverage is terminated due to the insurer or health maintenance organization becoming insolvent or discontinuing the offering of all individual coverage in the State of Florida, or due to the insured no longer living in the service area in the State of Florida of the insurer or health maintenance organization that provides coverage through a network plan in the State of Florida;

(b) Who is not eligible for coverage under:

1. A group health plan, as defined in s. 2791 of the Public Health Service Act;

2. A conversion policy or contract issued by an authorized insurer or health maintenance organization under s. 627.6675 or s. 641.3921, respectively, offered to an individual who is no longer eligible for coverage under either an insured or self-insured employer plan;

3. Part A or part B of Title XVIII of the Social Security Act; ~~or~~

4. A state plan under Title XIX of such act, or any successor program, and does not have other health insurance coverage; or

5. The Florida Health Insurance Plan as specified in s. 627.64872 and such plan is accepting new enrollment;

(c) With respect to whom the most recent coverage within the coverage period described in paragraph (a) was not terminated based on a factor described in s. 627.6571(2)(a) or (b), relating to nonpayment of premiums or fraud, unless such nonpayment of premiums or fraud was due to acts of an employer or person other than the individual;

(d) Who, having been offered the option of continuation coverage under a COBRA continuation provision or under s. 627.6692, elected such coverage; and

(e) Who, if the individual elected such continuation provision, has exhausted such continuation coverage under such provision or program.

Section 11. Section 627.66912, Florida Statutes, is created to read:

627.66912 Optional coverage for speech, language, swallowing, and hearing disorders.--

(1) Insures issuing group health insurance policies in this stage shall make available to the policyholder as part of the application for any such policy of insurance, for an appropriate additional premium, the benefits or levels of benefits specified in the December 1999 Florida Medicaid Therapy Services Handbook for genetic or congenital disorders or conditions involving speech, language, swallowing, and hearing and a hearing aid and earmolds benefits at the level of benefit specified in the January 2001 Florida Medicaid Hearing Services Handbook.

(2) This ection does not apply to specified-accident, specified-disease, hospital indemnity, limited benefit, disability income, or long-term care insurance policies.

(3) Such optional coverage is not required to be offered when substantially similar benefits are included in the policy of insurance issued to the policyholder.

(4) This section does not require or prohibit the use of a provider network.

(5) This section does not prohibit an insurer from requiring prior authorization for the benefits under this section.

Section 12. Paragraph (n) of subsection (3) and paragraph (b) of subsection (6) of section 627.6699, Florida Statutes, are amended to read:

627.6699 Employee Health Care Access Act.--

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

(n) "Modified community rating" means a method used to develop carrier premiums which spreads financial risk across a large population; allows the use of separate rating factors for age, gender, family composition, tobacco usage, and geographic area as determined under paragraph (5)(j); and allows adjustments for~~: claims experience, health status, or duration of coverage as permitted under subparagraph (6)(b)5.; and~~ administrative and acquisition expenses as permitted under subparagraph (6)(b)5.

(6) RESTRICTIONS RELATING TO PREMIUM RATES.--

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

1. Small employer carriers must use a modified community rating methodology in which the premium for each small employer must be determined solely on the basis of the eligible employee's and eligible dependent's gender, age, family composition, tobacco use, or geographic area as determined under paragraph (5)(j) and in which the premium may be adjusted as permitted by this paragraph.

2. Rating factors related to age, gender, family composition, tobacco use, or geographic location may be developed by each carrier to reflect the carrier's experience. The factors used by carriers are subject to office review and approval.

3. Small employer carriers may not modify the rate for a small employer for 12 months from the initial issue date or renewal date, unless the composition of the group changes or benefits are changed. However, a small employer carrier may modify the rate one time prior to 12 months after the initial issue date for a small employer who enrolls under a previously issued group policy that has a common anniversary date for all employers covered under the policy if:

a. The carrier discloses to the employer in a clear and conspicuous manner the date of the first renewal and the fact that the premium may increase on or after that date.

b. The insurer demonstrates to the office that efficiencies in administration are achieved and reflected in the rates charged to small employers covered under the policy.

4. A carrier may issue a group health insurance policy to a small employer health alliance or other group association with rates that reflect a premium credit for expense savings attributable to administrative activities being performed by the alliance or group association if such expense savings are

specifically documented in the insurer's rate filing and are approved by the office. Any such credit may not be based on different morbidity assumptions or on any other factor related to the health status or claims experience of any person covered under the policy. Nothing in this subparagraph exempts an alliance or group association from licensure for any activities that require licensure under the insurance code. A carrier issuing a group health insurance policy to a small employer health alliance or other group association shall allow any properly licensed and appointed agent of that carrier to market and sell the small employer health alliance or other group association policy. Such agent shall be paid the usual and customary commission paid to any agent selling the policy.

5. ~~Any adjustments in rates for claims experience, health status, or duration of coverage may not be charged to individual employees or dependents. For a small employer's policy, such adjustments may not result in a rate for the small employer which deviates more than 15 percent from the carrier's approved rate. Any such adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer. A small employer carrier may make an adjustment to a small employer's renewal premium, not to exceed 10 percent annually, due to the claims experience, health status, or duration of coverage of the employees or dependents of the small employer. Semiannually, small group carriers shall report information on forms adopted by rule by the commission, to enable the office to monitor the relationship of aggregate adjusted premiums actually charged policyholders by each carrier to the premiums that would have been charged by application of the carrier's approved modified~~

~~community rates. If the aggregate resulting from the application of such adjustment exceeds the premium that would have been charged by application of the approved modified community rate by 5 percent for the current reporting period, the carrier shall limit the application of such adjustments only to minus adjustments beginning not more than 60 days after the report is sent to the office. For any 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 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 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 to be charged to small employer groups of less than 2 eligible employees may not exceed 150 percent of the rate determined for small employer groups of 2-50 eligible employees. However, the carrier may charge excess losses of the experience pool consisting of small employer groups with less than 2 eligible employees to the experience pool consisting of small employer groups with 2-50 eligible employees so that all losses are allocated and the 150-percent rate limit on the experience pool consisting of small employer groups with less than 2 eligible employees is maintained. Notwithstanding s. 627.411(1), the rate to be charged to a small employer group of fewer than 2 eligible employees, insured as of July 1, 2002, may be up to 125 percent of the rate determined for small employer groups of 2-50 eligible employees for the first annual renewal and 150 percent for subsequent annual renewals.

Section 13. Subsection (7) of section 636.003, Florida Statutes, is amended to read:

636.003 Definitions.--As used in this act, the term:

(7) "Prepaid limited health service organization" means any person, corporation, partnership, or any other entity which, in return for a prepayment, undertakes to provide or arrange for, or provide access to, the provision of

a limited health service to enrollees through an exclusive panel of providers or undertakes to provide access to any discounted medical services. Prepaid limited health service organization does not include:

(a) An entity otherwise authorized pursuant to the laws of this state to indemnify for any limited health service;

(b) A provider or entity when providing limited health services pursuant to a contract with a prepaid limited health service organization, a health maintenance organization, a health insurer, or a self-insurance plan; ~~or~~

(c) Any person who, in exchange for fees, dues, charges or other consideration, provides access to a limited health service provider without assuming any responsibility for payment for the limited health service or any portion thereof; or~~.~~

(d) Any plan or program of discounted medical services for which fees, dues, charges, or other consideration paid to the plan by consumers does not exceed $15 per month or $180 per year and which in its advertising and contracts:

1. Clearly indicates that the plan is not insurance, that the plan is not obligated to pay any portion of the discounted medical fees, and that the consumer is responsible for paying the full amount of the discounted fees;

2. Does not use the term "affordable health care" or "coverage," or any other term that misrepresents the nature of the program; and

3. Requires a statement beside the provider network on the discount card alerting the network providers and facilities that the cardholder does not have insurance and is

merely entitled to the network discount rate for services provided.

Section 14. Subsection (40) is added to section 641.31, Florida Statutes, to read:

641.31 Health maintenance contracts.--

(40) Health maintenance organizations shall make available to the contract holder as part of the application for any such contract, for an appropriate additional premium, the benefits or levels of benefits specified in the December 1999 Florida Medicaid Therapy Services Handbook for genetic or congenital disorders or conditions involving speech, language, swallowing, and hearing and a hearing aid and earmolds benefit at the level of benefits specified in the January 2001 Florida Medicaid Hearing Services Handbook.

(a) Such optional coverage is not required to be offered when substantially similar benefits are included in the contract issued to the subscriber.

(b) This section does not require or prohibit the use of a provider network.

(c) This section does not prohibit an organization from requiring prior authorization for the benefits under this subsection.

(d) This subsection does not apply to health maintenance organizations issuing individual coverage to fewer than 50,000 members.

Section 15. Except for this section and sections 5, 8, 11, and 14, which shall take effect July 1, 2004, and paragraph (17)(b) of section 1, which shall take effect July 1, 2005, this act shall take effect October 1, 2004.

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SENATE SUMMARY

Creates or revises a variety of provisions relating to health care, including creating a Florida Health Insurance Plan, a Small Employers Access Program, and a Statewide Electronic Medical Records Advisory Panel. Revises coverages that insurers must make available. (See bill for details.)