By the Committees on Banking and Insurance; Health, Aging, and Long-Term Care; and Senator Peaden

311-2442-04

A bill to be entitled

An act relating to affordable health care; providing a popular name; providing purpose; amending s. 381.026, F.S.; requiring certain licensed facilities to provide public Internet access to certain financial information; providing a penalty; amending s. 381.734, F.S.; including participation by health care providers, small businesses, and health insurers in the Healthy Communities, Healthy People Program; requiring the Department of Health to provide public Internet access to certain public health programs; requiring the department to monitor and assess the effectiveness of such programs; requiring a report; requiring the Office of Program Policy and Government Accountability to evaluate the effectiveness of such programs; requiring a report; amending s. 395.1041, F.S.; authorizing hospitals to develop certain emergency room diversion programs; amending s. 395.301, F.S.; requiring certain licensed facilities to provide public Internet access to certain financial information; requiring certain licensed facilities to provide prospective patients certain estimates of charges for services; amending s. 408.061, F.S.; requiring the Agency for Health Care Administration to require health care facilities, health care providers, and health insurers to submit certain information; requiring the agency to

adopt certain rules; amending s. 408.062, F.S.; requiring the agency to conduct certain health care costs and access research, analyses, and studies; expanding the scope of such studies to include collection of pharmacy retail price data, use of emergency departments, and Internet patient charge information availability; requiring a report; requiring the agency to conduct additional data-based studies and make recommendations to the Legislature; requiring the agency to implement a strategy for the use of electronic health records and make recommendations to the Legislature to protect the confidentiality of such records; amending s. 408.05, F.S.; requiring the agency to develop a plan to make performance outcome and financial data available to consumers for health care services comparison purposes; requiring submittal of the plan to the Governor and Legislature; requiring the agency to update the plan; requiring the agency to make the plan available electronically; providing plan requirements; amending s. 409.9066, F.S.; requiring the agency to provide certain information relating to the Medicare prescription discount program; amending s. 408.7056, F.S.; renaming the Statewide Provider and Subscriber Assistance Program as the Subscriber Assistance Program; revising provisions to conform; expanding certain records availability provisions; revising

membership provisions relating to a subscriber grievance hearing panel; providing hearing procedures; amending s. 641.3154, F.S., to conform to the renaming of the Subscriber Assistance Program; amending s. 641.511, F.S., to conform to the renaming of the Subscriber Assistance Program; adopting and incorporating by reference the Employee Retirement Income Security Act of 1974, as implemented by federal regulations; amending s. 641.58, F.S., to conform to the renaming of the Subscriber Assistance Program; amending s. 408.909, F.S.; expanding a definition of "health flex plan entity" to include public-private partnerships; making a pilot health flex plan program apply permanently statewide; providing additional program requirements; creating s. 381.0271, F.S.; providing definitions; creating the Florida Patient Safety Corporation, which shall be registered, incorporated, organized, and operated in compliance with ch. 617, F.S.; authorizing the corporation to create not-for-profit subsidiaries; specifying that the corporation is not an agency within the meaning of s. 20.03(11), F.S.; requiring the corporation to be subject to public meetings and records requirements; specifying that the corporation is not subject to the provisions of ch. 297, F.S., relating to procurement of personal property and services; providing a purpose for the corporation; establishing the

membership of the board of directors of the corporation; requiring the formation of certain advisory committees for the corporation; requiring the Agency for Health Care Administration to provide assistance in establishing the corporation; specifying the powers and duties of the corporation; requiring annual reports; requiring the Office of Program Policy Analysis and Government Accountability, in consultation with the Agency for Health Care Administration and the Department of Health, to develop performance measures for the corporation; requiring a performance audit; requiring a report to the Governor and the Legislature; requiring the Patient Safety Center at the Florida State University College of Medicine to study the return on investment by hospitals from implementing computerized physician order entry and other information technologies related to patient safety; providing requirements for the study; requiring a report to the Governor and the Legislature; amending s. 395.1012, F.S.; providing additional duties of the patient safety committee at hospitals and other licensed facilities; requiring such facilities to adopt a plan to reduce medication errors and adverse drug events, including the use of computerized physician order entry and other information technologies; repealing s. 766.1016(3), F.S., which requires a patient safety organization to

promptly remove patient-identifying information from patient safety data reported to the organization and requires such organization to maintain the confidentiality of patient-identifying information; amending s. 409.91255, F.S.; expanding assistance to certain health centers to include community emergency room diversion programs and urgent care services; amending s. 627.410, F.S.; requiring insurers to file certain rates with the Office of Insurance Regulation; exempting group health insurance policies insuring groups of a certain size from a requirement to file rates with the Office of Insurance Regulation; creating s. 624.6405, F.S.; making legislative findings related to inappropriate utilization of emergency room care; requiring health insurers to take certain actions and authorizing higher copayments for certain uses of emergency departments; amending s. 627.6487, F.S.; revising a definition; creating s. 627.64872, F.S.; providing legislative intent; creating the Florida Health Insurance Plan for certain purposes; providing definitions; providing requirements for operation of the plan; providing for a board of directors; providing for appointment of members; providing for terms; specifying service without compensation; providing for travel and per diem expenses; requiring a plan of operation; providing requirements; providing for powers of

the plan; requiring reports to the Governor and Legislature; providing certain immunity from liability for plan obligations; authorizing the board to provide for indemnification of certain costs; requiring an annually audited financial statement; providing for eligibility for coverage under the plan; providing criteria; requirements, and limitations; specifying certain activity as an unfair trade practice; providing for a plan administrator; providing criteria; providing requirements; providing term limits for the plan administrator; providing duties; providing for paying the administrator; providing for funding mechanisms of the plan; providing for premium rates for plan coverage; providing rate limitations; providing for assessing certain insurers providing coverage for persons under the Health Insurance Portability and Accountability Act; specifying benefits under the plan; providing criteria, requirements, and limitations; providing for nonduplication of benefits; providing for annual and maximum lifetime benefits; providing for tax exempt status; providing for abolition of the Florida Comprehensive Health Association upon implementation of the plan; providing for enrollment in the plan of persons enrolled in the association; requiring insurers to pay certain assessments to the board for certain purposes; providing criteria, requirements, and

limitations for such assessments; providing for repeal of ss. 627.6488, 627.6489, 627.649, 627.6492, 627.6494, 627.6496, and 627.6498, F.S., relating to the Florida Comprehensive Health Association, upon implementation of the plan; amending s. 627.662, F.S.; providing for application of certain claim payment methodologies and actions related to inappropriate use of emergency care to certain types of insurance; amending s. 627.6699, F.S.; revising provisions requiring small employer carriers to offer certain health benefit plans; preserving a right to open enrollment for certain small groups; revising size limits on small employer groups to which premium rate guidelines are applicable for purposes of the Employee Health Care Access Act; requiring small employer carriers to file and provide coverage under certain high deductible plans; including high deductible plans under certain required plan provisions; creating the Small Employers Access Program; providing legislative intent; providing definitions; providing participation eligibility requirements and criteria; requiring the Office of Insurance Regulation to administer the program by selecting an insurer through competitive bidding; providing requirements; specifying insurer qualifications; providing duties of the insurer; providing a contract term; providing insurer reporting requirements; providing

application requirements; providing for benefits under the program; requiring the office to annually report to the Governor and Legislature; providing for decreases in inappropriate use of emergency care; providing legislative intent; requiring health insurers to provide certain information electronically and develop community emergency department diversion programs; amending s. 627.9175, F.S.; requiring certain health insurers to annually report certain coverage information to the office; providing requirements; deleting certain reporting requirements; creating part I of ch. 636, F.S., relating to prepaid limited health services organization; providing a short title; revising the definition of the term "prepaid limited health services organization"; creating part II of ch. 636, F.S., relating to discount medical plan organization; providing a short title; providing definitions; requiring that a person be licensed before conducting business in this state as a discount medical plan organizations; providing for an application to receive a license; providing for the contents of the application; requiring each discount medical plan organization to create an Internet website; authorizing the Office of Insurance Regulation to investigate or examine a discount medical plan organization under certain conditions; specifying the permitted and prohibited activities of a discount medical

plan organization; directing each discount medical plan organization to disclose certain specified information to members and prospective members; providing for contracts and agreements with providers and networks of providers; detailing the required contents of the contract or agreement; requiring each discount medical plan organization to file its proposed rates with the office; directing each discount medical plan organization to file an annual report with the office; specifying the contents of the report; providing for fines when a discount medical plan organization is delinquent in filing the annual report; requiring minimum capitalization; providing the circumstances and procedures when the office proposes to suspend or revoke the license of a discount medical plan organization; directing each discount medical plan organization to maintain an up-to-date list of the names and addresses of the providers with whom it has a contract to deliver medical services; directing that the list be posted on the organization's website; providing for marketing plans; authorizing the office to adopt rules; providing for service of process; providing for a security deposit by each discount medical plan organization; providing criminal penalties for violations of the act; authorizing the office to seek temporary and permanent injunctive relief against a discount medical

plan organization under certain conditions; providing civil remedies for any person injured by another acting in violation of the act; providing venue for a civil action; creating ss. 627.65626 and 627.6402, F.S.; providing for insurance rebates for healthy lifestyles; providing for rebate of certain premiums for participation in health wellness, maintenance, or improvement programs under certain circumstances; providing requirements; amending s. 641.31, F.S.; authorizing health maintenance organizations offering certain point-of-service riders to offer such riders to certain employers for certain employees; providing requirements and limitations; providing for application of certain claim payment methodologies to certain types of insurance; providing for rebate of certain premiums for participation in health wellness, maintenance, or improvement programs under certain circumstances; providing requirements; preserving certain rights to enrollment in certain health benefit coverage for certain groups under certain circumstances; creating s. 465.0244, F.S.; requiring each pharmacy to make available on its Internet website a link to certain performance outcome and financial data of the Agency for Health Care Administration and a notice of the availability of such information; amending s. 627.6499, F.S.; requiring each health insurer to make available

on its Internet website a link to certain performance outcome and financial data of the Agency for Health Care Administration and a notice in policies of the availability of such information; amending s. 641.54, F.S.; requiring health maintenance organizations to make certain insurance financial information available to subscribers; requiring health maintenance organizations to make available on its Internet website a link to certain performance outcome and financial data of the Agency for Health Care Administration and a notice in policies of the availability of such information; repealing s. 408.02, F.S., relating to the development, endorsement, implementation, and evaluation of patient management practice parameters by the Agency for Health Care Administration; repealing s. 766.1016(3), F.S., which requires a patient safety organization to promptly remove patient-identifying information from patient safety data reported to the organization and requires such organization to maintain the confidentiality of patient-identifying information; providing appropriations; providing an effective date.

WHEREAS, according to the Kaiser Family Foundation, eight out of ten uninsured Americans are workers or dependents of workers and nearly eight out of ten uninsured Americans have family incomes above the poverty level, and

WHEREAS, fifty-five percent of those who do not have insurance state the reason they don't have insurance is lack of affordability, and

WHEREAS, average health insurance premium increases for the last two years have been in the range of ten to twenty percent for Florida's employers, and

WHEREAS, an increasing number of employers are opting to cease providing insurance coverage to their employees due to the high cost, and

WHEREAS, an increasing number of employers who continue providing coverage are forced to shift more premium cost to their employees, thus diminishing the value of employee wage increases, and

WHEREAS, according to studies, the rate of avoidable hospitalization is fifty to seventy percent lower for the insured versus the uninsured, and

WHEREAS, according to Florida Cancer Registry data, the uninsured have a seventy percent greater chance of a late diagnosis, thus decreasing the chances of a positive health outcome, and

WHEREAS, according to the Agency for Health Care Administration's 2002 financial data, uncompensated care in Florida's hospitals is growing at the rate of twelve to thirteen percent per year, and, at $4.3 billion in 2001, this cost, when shifted to Floridians who remain insured, is not sustainable, and

WHEREAS, the Florida Legislature, through the creation of Health Flex, has already identified the need for lower cost alternatives, and

WHEREAS, it is of vital importance and in the best interests of the people of the State of Florida that the issue

of available, affordable health care insurance be addressed in a cohesive and meaningful manner, and

WHEREAS, there is general recognition that the issues surrounding the problem of access to affordable health insurance are complicated and multifaceted, NOW, THEREFORE,

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

Section 1. This act may be referred to by the popular name "The 2004 Affordable Health Care for Floridians Act."

Section 2. The purpose of this act is to address the underlying cause of the double-digit increases in health insurance premiums by mitigating the overall growth in health care costs.

Section 3. Paragraph (c) of subsection (4) of section 381.026, Florida Statutes, is 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 information regarding package price of service. The term "package pricing" means all facility-related charges for all services typically associated with a procedure or diagnosis-related group. The facility shall maintain on its website a description of and a link to the agency's website which provides an average cost of the top 50 inpatient and top 50 outpatient services provided. 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 pricing information 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 price of service is negotiable for eligible patients based upon the patient's ability to pay.

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. Failure to provide data upon request as required by this paragraph shall result in a fine of $500 for each instance of the facility's failure to provide the requested information.

Section 4. Subsection (1) and paragraph (g) of subsection (3) of section 381.734, Florida Statutes, are amended, and subsections (4), (5), and (6) are added to that section, to read:

381.734 Healthy Communities, Healthy People Program.--

(1) The department shall develop and implement the Healthy Communities, Healthy People Program, a comprehensive and community-based health promotion and wellness program. The program shall be designed to reduce major behavioral risk factors associated with chronic diseases, including those chronic diseases identified in chapter 385, by enhancing the knowledge, skills, motivation, and opportunities for individuals, organizations, health care providers, small businesses, health insurers,and communities to develop and maintain healthy lifestyles.

(3) The program shall include:

(g) The establishment of a comprehensive program to inform the public, health care professionals, health insurers, and communities about the prevalence of chronic diseases in the state; known and potential risks, including social and behavioral risks; and behavior changes that would reduce risks.

(4) The department shall make available on its Internet website, no later than October 1, 2004, and in a hard-copy format upon request, a listing of age-specific, disease-specific, and community-specific health promotion, preventive care, and wellness programs offered and established

under the Healthy Communities, Healthy People Program. The website shall also provide residents with information to identify behavior risk factors that lead to diseases that are preventable by maintaining a healthy lifestyle. The website shall allow consumers to select by county or region disease-specific statistical information.

(5) The department shall monitor and assess the effectiveness of such programs. The department shall submit a status report based on this monitoring and assessment to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the substantive committees of each house of the Legislature, with the first annual report due January 31, 2005.

(6) The Office of Program Policy and Government Accountability shall evaluate and report to the Governor, the President of the Senate, and the Speaker of the House of Representatives, by March 1, 2005, on the effectiveness of the department's monitoring and assessment of the program's effectiveness.

Section 5. Subsection (7) is added to section 395.1041, Florida Statutes, to read:

395.1041 Access to emergency services and care.--

(7) EMERGENCY ROOM DIVERSION PROGRAMS.--Hospitals may develop emergency room diversion programs, including, but not limited to, an "Emergency Hotline" which allows patients to help determine if emergency department services are appropriate or if other health care settings may be more appropriate for care, and a "Fast Track" program allowing nonemergency patients to be treated at an alternative site. Alternative sites may include health care programs funded with local tax revenue and federally funded community health

centers, county health departments, or other nonhospital providers of health care services. The program may include provisions for followup care and case management.

Section 6. 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 provide, prior to provision of any medical services, an estimate of charges for the proposed service upon request of a prospective patient who does not have insurance coverage or whose insurer or health maintenance organization does not have a contract with the hospital and an emergency medical condition does not exist or the service is not a covered service. The estimate may be the average charges for that diagnosis-related group or the average charges for that procedure. Such estimate shall not preclude the actual charges from exceeding the estimate. The facility shall place a notice in reception areas that such information is available electronically and the website address.

(8) Each licensed facility 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).

Section 7. Subsection (1) of section 408.061, Florida Statutes, is amended to read:

408.061 Data collection; uniform systems of financial reporting; information relating to physician charges; confidential information; immunity.--

(1) The agency shall ~~may~~ require the submission by health care facilities, health care providers, and health

insurers of data necessary to carry out the agency's duties. Specifications for data to be collected under this section shall be developed by the agency with the assistance of technical advisory panels including representatives of affected entities, consumers, purchasers, and such other interested parties as may be determined by the agency.

(a) Data ~~to be~~ submitted by health care facilities, including the facilities as defined in chapter 395, shall ~~may~~ include, but are not limited to: case-mix data, patient admission and ~~or~~ discharge data, outpatient data which shall include the number of patients treated in the emergency department of a licensed hospital reported by patient acuity level, data on hospital-acquired infections as specified by rule, data on complications including date of diagnosis as specified by rule, data on readmissions as specified by rule, with patient and provider-specific identifiers included, actual charge data by diagnostic groups, financial data, accounting data, operating expenses, expenses incurred for rendering services to patients who cannot or do not pay, interest charges, depreciation expenses based on the expected useful life of the property and equipment involved, and demographic data. The agency shall adopt the 3M All Patient Refined DRG software risk and severity adjustment methodology for all data submitted as required by this section.Data may be obtained from documents such as, but not limited to: leases, contracts, debt instruments, itemized patient bills, medical record abstracts, and related diagnostic information. Reported data elements shall be reported electronically in accordance with Rule 59E-7.012, Florida Administrative Code. Data submitted shall be certified by the Chief Executive Officer or an appropriate and duly authorized representative

or employee of the licensed facility that the information submitted is true and accurate.

(b) Data to be submitted by health care providers may include, but are not limited to: Medicare and Medicaid participation, types of services offered to patients, amount of revenue and expenses of the health care provider, and such other data which are reasonably necessary to study utilization patterns.

(c) Data to be submitted by health insurers may include percentage of claims denied, percentage of claims meeting prompt pay requirements, and medical and administrative loss ratios, but are not limited to: claims, premium, administration, and financial information. Data submitted shall be certified by the appropriate and duly authorized representative or employee of the insurer that the information submitted is true and accurate.

(d) Data required to be submitted by health care facilities, health care providers, or health insurers shall not include specific provider contract reimbursement information. However, such specific provider reimbursement data shall be reasonably available for onsite inspection by the agency as is necessary to carry out the agency's regulatory duties. Any such data obtained by the agency as a result of onsite inspections may not be used by the state for purposes of direct provider contracting and are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(e) A requirement to submit data shall be adopted by rule if the submission of data is being required of all members of any type of health care facility, health care provider, or health insurer. Rules are not required, however,

for the submission of data for a special study mandated by the Legislature or when information is being requested for a single health care facility, health care provider, or health insurer.

Section 8. Subsections (1) and (4) of section 408.062, Florida Statutes, are amended to read:

408.062 Research, analyses, studies, and reports.--

(1) The agency shall ~~have the authority to~~ conduct research, analyses, and studies relating to health care costs and access to and quality of health care services as access and quality are affected by changes in health care costs. Such research, analyses, and studies shall include, but not be limited to~~, research and analysis relating to~~:

(a) The financial status of any health care facility or facilities subject to the provisions of this chapter.

(b) The impact of uncompensated charity care on health care facilities and health care providers.

(c) The state's role in assisting to fund indigent care.

(d) In conjunction with the Office of Insurance Regulation, the availability and affordability of health insurance for small businesses.

(e) Total health care expenditures in the state according to the sources of payment and the type of expenditure.

(f) The quality of health services, using techniques such as small area analysis, severity adjustments, and risk-adjusted mortality rates.

(g) The development of physician information ~~payment~~ systems which are capable of providing data for health care consumers taking into account the amount of resources consumed

at licensed facilities as defined in chapter 395 and the outcomes produced in the delivery of care.

(h) The collection of a statistically valid sample of data on the retail prices charged by pharmacies for the 50 most frequently prescribed medicines from any pharmacy licensed by this state as a special study authorized by the Legislature to be performed by the agency quarterly. If the drug is available generically, price data shall be reported for the generic drug and price data of a brand-named drug for which the generic drug is the equivalent shall be reported. The agency shall make drug prices for a 30-day supply at a standard dose available on its Internet website for each pharmacy no later than October 1, 2005. The data collected shall be reported for each drug by pharmacy and by metropolitan statistical area or region and updated quarterly ~~The impact of subacute admissions on hospital revenues and expenses for purposes of calculating adjusted admissions as defined in s. 408.07~~.

(i) The use of emergency department services by patient acuity level and the implication of increasing hospital cost by providing nonurgent care in emergency departments. The agency shall submit an annual report based on this monitoring and assessment to the Governor, the Speaker of the House of Representatives, the President of the Senate, and the substantive legislative committees with the first report due January 1, 2006.

(j) The making available on its Internet website no later than October 1, 2004, and in a hard-copy format upon request, of patient charge, volumes, length of stay, and performance outcome indicators collected from health care facilities pursuant to s. 408.061(1)(a) for specific medical

conditions, surgeries, and procedures provided in inpatient and outpatient facilities as determined by the agency. In making the determination of specific medical conditions, surgeries, and procedures to include, the agency shall consider such factors as volume, severity of the illness, urgency of admission, individual and societal costs, and whether the condition is acute or chronic. Performance outcome indicators shall be risk adjusted or severity adjusted as applicable using 3M All Patient Refined DRG's. The website shall also provide an interactive search that allows consumers to view and compare the information for specific facilities, a map that allows consumers to select a county or region, definitions of all of the data, descriptions of each procedure, and an explanation about why the data may differ from facility to facility. Such public data shall be updated quarterly. The agency shall submit an annual status report on the collection of data and publication of performance outcome indicators to the Governor, the Speaker of the House of Representatives, the President of the Senate, and the substantive legislative committees with the first status report due January 1, 2005.

(4)(a) The agency shall ~~may~~ conduct data-based studies and evaluations and make recommendations to the Legislature and the Governor concerning exemptions, the effectiveness of limitations of referrals, restrictions on investment interests and compensation arrangements, and the effectiveness of public disclosure. Such analysis shall ~~may~~ include, but need not be limited to, utilization of services, cost of care, quality of care, and access to care. The agency may require the submission of data necessary to carry out this duty, which may include, but need not be limited to, data concerning

ownership, Medicare and Medicaid, charity care, types of services offered to patients, revenues and expenses, patient-encounter data, and other data reasonably necessary to study utilization patterns and the impact of health care provider ownership interests in health-care-related entities on the cost, quality, and accessibility of health care.

(b) The agency may collect such data from any health facility or licensed health care provider as a special study.

(5) The agency shall develop and implement a strategy for the adoption and use of electronic health records. The agency may develop rules to facilitate the functionality and protect the confidentiality of electronic health records. The agency shall report to the Governor, the Speaker of the House, and the President of the Senate on legislative recommendations to protect the confidentiality of electronic health records.

Section 9. Paragraph (l) is added to subsection (3) of section 408.05, Florida Statutes, to read:

408.05 State Center for Health Statistics.--

(3) COMPREHENSIVE HEALTH INFORMATION SYSTEM.--In order to produce comparable and uniform health information and statistics, the agency shall perform the following functions:

(l) Develop, in conjunction with the State Comprehensive Health Information System Advisory Council, and implement a long-range plan for making available performance outcome and financial data that will allow consumers to compare health care services. The performance outcomes and financial data the agency must make available shall include, but is not limited to, pharmaceuticals, physicians, health care facilities, and health plans and managed care entities. The agency shall submit the initial plan to the Governor, the President of the Senate, and the Speaker of the House of

Representatives by March 1, 2005, and shall update the plan and report on the status of its implementation annually thereafter. The agency shall also make the plan and status report available to the public on its Internet website. As part of the plan, the agency shall identify the process and timeframes for implementation, any barriers to implementation, and recommendations of changes in the law that may be enacted by the Legislature to eliminate the barriers. As preliminary elements of the plan, the agency shall:

1. Make available performance outcome and patient charge data collected from health care facilities pursuant to s. 408.061(1)(a) and (2). The agency shall determine which conditions and procedures, performance outcomes, and patient charge data to disclose based upon input from the council. When determining which conditions and procedures are to be disclosed, the council and the agency shall consider variation in costs, variation in outcomes, and magnitude of variations and other relevant information. When determining which performance outcomes to disclose, the agency:

a. Shall consider such factors as volume of cases; average patient charges; average length of stay; complication rates; mortality rates; and infection rates, among others, which shall be adjusted for case mix and severity, if applicable.

b. May consider such additional measures that are adopted by the Centers for Medicare and Medicaid Studies, National Quality Forum, the Joint Commission on Accreditation of Healthcare Organizations, the Agency for Healthcare Research and Quality, or a similar national entity that establishes standards to measure the performance of health care providers, or by other states.

When determining which patient charge data to disclose, the agency shall consider such measures as average charge, average net revenue per adjusted patient day, average cost per adjusted patient day, and average cost per admission, among others.

2. Make available performance measures, benefit design, and premium cost data from health plans licensed pursuant to chapter 627 or chapter 641. The agency shall determine which performance outcome and member and subscriber cost data to disclose, based upon input from the council. When determining which data to disclose, the agency shall consider information that may be required by either individual or group purchasers to assess the value of the product, which may include membership satisfaction, quality of care, current enrollment or membership, coverage areas, accreditation status, premium costs, plan costs, premium increases, range of benefits, copayments and deductibles, accuracy and speed of claims payment, credentials of physicians, number of providers, names of network providers, and hospitals in the network.

3. Determine the method and format for public disclosure of data reported pursuant to this paragraph. The agency shall make its determination based upon input from the Comprehensive Health Information System Advisory Council. At a minimum, the data shall be made available on the agency's Internet website in a manner that allows consumers to conduct an interactive search that allows them to view and compare the information for specific providers. The website must include such additional information as is determined necessary to ensure that the website enhances informed decision making

among consumers and health care purchasers, which shall include, at a minimum, appropriate guidance on how to use the data and an explanation of why the data may vary from provider to provider. The data specified in subparagraph 1. shall be released no later than March 1, 2005. The data specified in subparagraph 2. shall be released no later than March 1, 2006.

Section 10. Subsection (3) of section 409.9066, Florida Statutes, is amended to read:

409.9066 Medicare prescription discount program.--

(3) The Agency for Health Care Administration shall publish, on a free website available to the public, the most recent average wholesale prices for the 200 drugs most frequently dispensed ~~to the elderly~~ and~~, to the extent possible,~~ shall provide a mechanism that consumers may use to calculate the retail price and the price that should be paid after the discount required in subsection (1) is applied. The agency shall provide retail information by geographic area and retail information by provider within geographical areas.

Section 11. Section 408.7056, Florida Statutes, is amended to read:

408.7056 ~~Statewide Provider and~~ Subscriber Assistance Program.--

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

(a) "Agency" means the Agency for Health Care Administration.

(b) "Department" means the Department of Financial Services.

(c) "Grievance procedure" means an established set of rules that specify a process for appeal of an organizational decision.

(d) "Health care provider" or "provider" means a state-licensed or state-authorized facility, a facility principally supported by a local government or by funds from a charitable organization that holds a current exemption from federal income tax under s. 501(c)(3) of the Internal Revenue Code, a licensed practitioner, a county health department established under part I of chapter 154, a prescribed pediatric extended care center defined in s. 400.902, a federally supported primary care program such as a migrant health center or a community health center authorized under s. 329 or s. 330 of the United States Public Health Services Act that delivers health care services to individuals, or a community facility that receives funds from the state under the Community Alcohol, Drug Abuse, and Mental Health Services Act and provides mental health services to individuals.

(e) "Managed care entity" means a health maintenance organization or a prepaid health clinic certified under chapter 641, a prepaid health plan authorized under s. 409.912, or an exclusive provider organization certified under s. 627.6472.

(f) "Office" means the Office of Insurance Regulation of the Financial Services Commission.

(g) "Panel" means a ~~statewide provider and~~ subscriber assistance panel selected as provided in subsection (11).

(2) The agency shall adopt and implement a program to provide assistance to subscribers ~~and providers~~, including those whose grievances are not resolved by the managed care entity to the satisfaction of the subscriber ~~or provider~~. The program shall consist of one or more panels that meet as often as necessary to timely review, consider, and hear grievances and recommend to the agency or the office any actions that

should be taken concerning individual cases heard by the panel. The panel shall hear every grievance filed by subscribers ~~and providers~~ on behalf of subscribers, unless the grievance:

(a) Relates to a managed care entity's refusal to accept a provider into its network of providers;

(b) Is part of an internal grievance in a Medicare managed care entity or a reconsideration appeal through the Medicare appeals process which does not involve a quality of care issue;

(c) Is related to a health plan not regulated by the state such as an administrative services organization, third-party administrator, or federal employee health benefit program;

(d) Is related to appeals by in-plan suppliers and providers, unless related to quality of care provided by the plan;

(e) Is part of a Medicaid fair hearing pursued under 42 C.F.R. ss. 431.220 et seq.;

(f) Is the basis for an action pending in state or federal court;

(g) Is related to an appeal by nonparticipating providers, unless related to the quality of care provided to a subscriber by the managed care entity and the provider is involved in the care provided to the subscriber;

(h) Was filed before the subscriber ~~or provider~~ completed the entire internal grievance procedure of the managed care entity, the managed care entity has complied with its timeframes for completing the internal grievance procedure, and the circumstances described in subsection (6) do not apply;

(i) Has been resolved to the satisfaction of the subscriber ~~or provider~~ who filed the grievance, unless the managed care entity's initial action is egregious or may be indicative of a pattern of inappropriate behavior;

(j) Is limited to seeking damages for pain and suffering, lost wages, or other incidental expenses, including accrued interest on unpaid balances, court costs, and transportation costs associated with a grievance procedure;

(k) Is limited to issues involving conduct of a health care provider or facility, staff member, or employee of a managed care entity which constitute grounds for disciplinary action by the appropriate professional licensing board and is not indicative of a pattern of inappropriate behavior, and the agency, office, or department has reported these grievances to the appropriate professional licensing board or to the health 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 to the agency. Records include medical records, communication logs associated with the grievance both to and from the subscriber, contracts, and any other contents of the internal grievance file associated with the complaint filed with the Subscriber Assistance Program.Failure to provide requested ~~medical~~ records may result in the imposition of a fine of up to $500. Each day that records are not produced is considered a separate violation.

(5) Grievances that the agency determines pose an immediate and serious threat to a subscriber's health must be given priority over other grievances. The panel may meet at the call of the chair to hear the grievances as quickly as possible but no later than 45 days after the date the grievance is filed, unless the panel receives a waiver of the time requirement from the subscriber. The panel shall issue a

written recommendation, supported by findings of fact, to the office or the agency within 10 days after hearing the expedited grievance.

(6) When the agency determines that the life of a subscriber is in imminent and emergent jeopardy, the chair of the panel may convene an emergency hearing, within 24 hours after notification to the managed care entity and to the subscriber, to hear the grievance. The grievance must be heard notwithstanding that the subscriber has not completed the internal grievance procedure of the managed care entity. The panel shall, upon hearing the grievance, issue a written emergency recommendation, supported by findings of fact, to the managed care entity, to the subscriber, and to the agency or the office for the purpose of deferring the imminent and emergent jeopardy to the subscriber's life. Within 24 hours after receipt of the panel's emergency recommendation, the agency or office may issue an emergency order to the managed care entity. An emergency order remains in force until:

(a) The grievance has been resolved by the managed care entity;

(b) Medical intervention is no longer necessary; or

(c) The panel has conducted a full hearing under subsection (3) and issued a recommendation to the agency or the office, and the agency or office has issued a final order.

(7) After hearing a grievance, the panel shall make a recommendation to the agency or the office which may include specific actions the managed care entity must take to comply with state laws or rules regulating managed care entities.

(8) A managed care entity, subscriber, or provider that is affected by a panel recommendation may within 10 days after receipt of the panel's recommendation, or 72 hours after

receipt of a recommendation in an expedited grievance, furnish to the agency or office written evidence in opposition to the recommendation or findings of fact of the panel.

(9) No later than 30 days after the issuance of the panel's recommendation and, for an expedited grievance, no later than 10 days after the issuance of the panel's recommendation, the agency or the office may adopt the panel's recommendation or findings of fact in a proposed order or an emergency order, as provided in chapter 120, which it shall issue to the managed care entity. The agency or office may issue a proposed order or an emergency order, as provided in chapter 120, imposing fines or sanctions, including those contained in ss. 641.25 and 641.52. The agency or the office may reject all or part of the panel's recommendation. All fines collected under this subsection must be deposited into the Health Care Trust Fund.

(10) In determining any fine or sanction to be imposed, the agency and the office may consider the following factors:

(a) The severity of the noncompliance, including the probability that death or serious harm to the health or safety of the subscriber will result or has resulted, the severity of the actual or potential harm, and the extent to which provisions of chapter 641 were violated.

(b) Actions taken by the managed care entity to resolve or remedy any quality-of-care grievance.

(c) Any previous incidents of noncompliance by the managed care entity.

(d) Any other relevant factors the agency or office considers appropriate in a particular grievance.

(11)(a) The panel shall consist of the Insurance Consumer Advocate, or designee thereof, established by s. 627.0613; at least two members employed by the agency and at least two members employed by the department, chosen by their respective agencies; a consumer appointed by the Governor; a physician appointed by the Governor, as a standing member; and, if necessary, physicians who have expertise relevant to the case to be heard, on a rotating basis. The agency may contract with a medical director, ~~and~~ a primary care physician, or both, who shall provide additional technical expertise to the panel but shall not be voting members of the panel. The medical director shall be selected from a health maintenance organization with a current certificate of authority to operate in Florida.

(b) A majority of those panel members required under paragraph (a) shall constitute a quorum for any meeting or hearing of the panel. A grievance may not be heard or voted upon at any panel meeting or hearing unless a quorum is present, except that a minority of the panel may adjourn a meeting or hearing until a quorum is present. A panel convened for the purpose of hearing a subscriber's grievance in accordance with subsections (2) and (3) shall not consist of more than 11 members.

(12) Every managed care entity shall submit a quarterly report to the agency, the office, and the department listing the number and the nature of all subscribers' and providers' grievances which have not been resolved to the satisfaction of the subscriber or provider after the subscriber or provider follows the entire internal grievance procedure of the managed care entity. The agency shall notify all subscribers and providers included in the quarterly

reports of their right to file an unresolved grievance with the panel.

(13) A proposed order issued by the agency or office which only requires the managed care entity to take a specific action under subsection (7) is subject to a summary hearing in accordance with s. 120.574, unless all of the parties agree otherwise. If the managed care entity does not prevail at the hearing, the managed care entity must pay reasonable costs and attorney's fees of the agency or the office incurred in that proceeding.

(14)(a) Any information that identifies a subscriber which is held by the panel, agency, or department pursuant to this section is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution. However, at the request of a subscriber or managed care entity involved in a grievance procedure, the panel, agency, or department shall release information identifying the subscriber involved in the grievance procedure to the requesting subscriber or managed care entity.

(b) Meetings of the panel shall be open to the public unless the provider or subscriber whose grievance will be heard requests a closed meeting or the agency or the department determines that information which discloses the subscriber's medical treatment or history or information relating to internal risk management programs as defined in s. 641.55(5)(c), (6), and (8) may be revealed at the panel meeting, in which case that portion of the meeting during which a subscriber's medical treatment or history or internal risk management program information is discussed shall be exempt from the provisions of s. 286.011 and s. 24(b), Art. I

of the State Constitution. All closed meetings shall be recorded by a certified court reporter.

Section 12. Paragraph (c) of subsection (4) of section 641.3154, Florida Statutes, is amended to read:

641.3154 Organization liability; provider billing prohibited.--

(4) A provider or any representative of a provider, regardless of whether the provider is under contract with the health maintenance organization, may not collect or attempt to collect money from, maintain any action at law against, or report to a credit agency a subscriber of an organization for payment of services for which the organization is liable, if the provider in good faith knows or should know that the organization is liable. This prohibition applies during the pendency of any claim for payment made by the provider to the organization for payment of the services and any legal proceedings or dispute resolution process to determine whether the organization is liable for the services if the provider is informed that such proceedings are taking place. It is presumed that a provider does not know and should not know that an organization is liable unless:

(c) The office or agency makes a final determination that the organization is required to pay for such services subsequent to a recommendation made by the ~~Statewide Provider and~~ Subscriber Assistance Panel pursuant to s. 408.7056; or

Section 13. Subsection (1), paragraphs (b) and (e) of subsection (3), paragraph (d) of subsection (4), subsection (5), paragraph (g) of subsection (6), and subsections (9), (10), and (11) of section 641.511, Florida Statutes, are amended to read:

641.511 Subscriber grievance reporting and resolution requirements.--

(1) Every organization must have a grievance procedure available to its subscribers for the purpose of addressing complaints and grievances. Every organization must notify its subscribers that a subscriber must submit a grievance within 1 year after the date of occurrence of the action that initiated the grievance, and may submit the grievance for review to the ~~Statewide Provider and~~ Subscriber Assistance Program panel as provided in s. 408.7056 after receiving a final disposition of the grievance through the organization's grievance process. An organization shall maintain records of all grievances and shall report annually to the agency the total number of grievances handled, a categorization of the cases underlying the grievances, and the final disposition of the grievances.

(3) Each organization's grievance procedure, as required under subsection (1), must include, at a minimum:

(b) The names of the appropriate employees or a list 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 requested information, the time allowed for completion of the grievance process resumes. The Employee Retirement Income Security Act of 1974, as implemented by 29 C.F.R. 2560.503-1, is adopted and incorporated by reference as applicable to all organizations that administer small and large group health plans that are subject to 29 C.F.R. 2560.503-1. The claims procedures of the regulations of the Employee Retirement Income Security Act of 1974 as implemented by 29 C.F.R. 2560.503-1 shall be the minimum standards for grievance processes for claims for benefits for small and large group health plans that are subject to 29 C.F.R. 2560.503-1.

(6)

(g) In any case when the expedited 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.

(9)(a) The agency shall advise subscribers with grievances to follow their organization's formal grievance process for resolution prior to review by the ~~Statewide Provider and~~ Subscriber Assistance Program. The subscriber may, however, submit a copy of the grievance to the agency at any time during the process.

(b) Requiring completion of the organization's grievance process before the ~~Statewide Provider and~~ Subscriber Assistance Program panel's review does not preclude the agency from investigating any complaint or grievance before the organization makes its final determination.

(10) Each organization must notify the subscriber in a final decision letter that the subscriber may request review of the organization's decision concerning the grievance by the ~~Statewide Provider and~~ Subscriber Assistance Program, as provided in s. 408.7056, if the grievance is not resolved to the satisfaction of the subscriber. The final decision letter must inform the subscriber that the request for review must be made within 365 days after receipt of the final decision letter, must explain how to initiate such a review, and must include the addresses and toll-free telephone numbers of the agency and the ~~Statewide Provider and~~ Subscriber Assistance Program.

(11) Each organization, as part of its contract with any provider, must require the provider to post a consumer

assistance notice prominently displayed in the reception area of the provider and clearly noticeable by all patients. The consumer assistance notice must state the addresses and toll-free telephone numbers of the Agency for Health Care Administration, the ~~Statewide Provider and~~ Subscriber Assistance Program, and the Department of Financial Services. The consumer assistance notice must also clearly state that the address and toll-free telephone number of the organization's grievance department shall be provided upon request. The agency may adopt rules to implement this section.

Section 14. Subsection (4) of section 641.58, Florida Statutes, is amended to read:

641.58 Regulatory assessment; levy and amount; use of funds; tax returns; penalty for failure to pay.--

(4) The moneys received and deposited into the Health Care Trust Fund shall be used to defray the expenses of the agency in the discharge of its administrative and regulatory powers and duties under this part, including conducting an 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 15. 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 health flex plan offering may include the option of a catastrophic plan supplementing the health flex plan.

(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; 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 16. 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).

(c) The corporation and its authorized and approved subsidiaries are subject to the public meetings and records requirements of s. 24, Art I of the State Constitution, chapter 119, and s. 286.011.

(d) The corporation and its authorized and approved subsidiaries are not subject to the provisions of chapter 287.

(e) The corporation is a patient safety organization for purposes of s. 766.1016.

(3) PURPOSE.--

(a) The purpose of the Florida Patient Safety Corporation is to serve as a learning organization dedicated to assisting health care providers in the state to improve the

quality and safety of health care rendered and to reduce harm to patients. The corporation shall promote the development of a culture of patient safety in the health care system in the state. The corporation may not regulate health care providers in this state.

(b) In the fulfillment of its purpose, the corporation shall work with a consortium of patient safety centers and other patient safety programs within the universities in this state.

(4) BOARD OF DIRECTORS; MEMBERSHIP.--The corporation shall be governed by a board of directors. The board of directors shall consist of:

(a) The chairperson of the Council of Medical School Deans.

(b) The person responsible for patient safety issues for the authorized health insurer with the largest market share as measured by premiums written in the state for the most recent calendar year, appointed by such insurer.

(c) A representative of the authorized medical malpractice insurer with the largest market share as measured by premiums written in the state for the most recent calendar year, appointed by such insurer.

(d) The president of the Florida Health Care Coalition.

(e) A representative of a hospital in the state that is implementing innovative patient safety initiatives, appointed by the Florida Hospital Association.

(f) A physician with expertise in patient safety, appointed by the Florida Medical Association.

(g) A physician with expertise in patient safety, appointed by the Florida Osteopathic Medical Association.

(h) A nurse with expertise in patient safety, appointed by the Florida Nurses Association.

(i) An institutional pharmacist, appointed by the Florida Society of Health System Pharmacists, Inc.

(j) A representative of Florida AARP, appointed by the state director of the Florida AARP.

(k) An independent consultant on health care information systems, appointed jointly by the Central Florida Chapter and the South Florida Chapter of the Healthcare Information and Management Systems Society.

(5) ADVISORY COMMITTEES.--In addition to any committees that the corporation may establish, the corporation shall establish the following advisory committees:

(a) A scientific research advisory committee that includes, at a minimum, a representative from each patient safety center or other patient safety program in the universities of this state, who are licensed physicians under ch. 458 or 459, F.S., with experience in patient safety and evidence based medicine.

(b) A technology advisory committee that includes, at a minimum, a representative of a hospital that has implemented a computerized physician order entry system and a health care provider that has implemented an electronic medical records system.

(c) A health care provider advisory committee that includes, at a minimum, representatives of hospitals, ambulatory surgical centers, physicians, nurses, and pharmacists licensed in this state and a representative of the Veterans Integrated Service Network 8 VA Patient Safety Center.

(d) A health care consumer advisory committee that includes, at a minimum, representatives of businesses that provide health insurance coverage to their employees, consumer advocacy groups, and representatives of patient organizations.

(e) A state agency advisory committee that includes, at a minimum, a representative from each state agency that has regulatory responsibilities related to patient safety.

(f) A litigation alternatives advisory committee that includes, at a minimum, representatives of attorneys who represent plaintiffs and defendants in medical malpractice cases and a representative of each law school in the state.

(g) An education advisory committee that includes, at a minimum, the associate dean for education, or the equivalent position, as a representative from each school of medicine, nursing, public health, or allied health to provide advice on the development, implementation, and measurement of core competencies for patient safety to be considered for incorporation in the educational programs of the universities of this state.

(6) ORGANIZATION; MEETINGS.--

(a) The Agency for Health Care Administration shall assist the corporation in its organizational activities required under chapter 617, including, but not limited to:

1. Eliciting appointments for the initial board of directors.

2. Convening the first meeting of the board of directors and assisting with other meetings of the board of directors, upon the request of the board of directors, during the first year of operation of the corporation.

3. Drafting articles of incorporation for the board of directors and, upon the request of the board of directors,

delivering articles of incorporation to the Department of State for filing.

4. Drafting proposed bylaws for the corporation.

5. Paying fees related to incorporation.

6. Providing office space and administrative support, at the request of the board of directors, but not beyond July 1, 2005.

(b) The board of directors must conduct its first meeting no later than August 1, 2004, and shall meet thereafter as frequently as necessary to carry out the duties of the corporation.

(7) POWERS AND DUTIES.--In addition to the powers and duties prescribed in chapter 617 and the articles and bylaws adopted under that chapter, the corporation shall directly or through contract:

(a) Secure staff necessary to properly administer the corporation.

(b) Collect, analyze, and evaluate patient safety data, quality and patient safety indicators, medical malpractice closed claims, and adverse incidents reported to the Agency for Health Care Administration and the Department of Health for the purpose of recommending changes in practices and procedures which may be implemented by health care practitioners and health care facilities to improve the quality of health care and to prevent future adverse incidents. Notwithstanding any other law, the Agency for Health Care Administration and the Department of Health shall make available to the corporation any adverse incident report submitted under s. 395.0197, s. 458.351, or s. 459.026. To the extent that adverse incident reports submitted under s. 395.0197 are confidential and exempt from disclosure, the

confidential and exempt status of such reports must be maintained by the corporation.

(c) Maintain an active library of best practices relating to patient safety and patient safety literature, along with the emerging evidence supporting the retention or modification of such practices, and make this information available to health care practitioners, health care facilities, and the public.

(d) Assess the patient safety culture at volunteering hospitals and recommend methods to improve the working environment related to patient safety at these hospitals.

(e) Inventory the information technology capabilities related to patient safety of health care facilities and health care practitioners and recommend a plan for expediting implementation of safety technologies statewide.

(f) Facilitate the development of core competencies relevant to patient safety which can be made available to be considered for incorporation into the undergraduate and graduate curriculums in schools of medicine, nursing, and allied health in this state.

(g) Facilitate continuing professional education regarding patient safety for practicing health care practitioners.

(h) Study and facilitate the testing of alternative systems of encouraging the implementation of effective risk management strategies and clinical best practices, and of compensating injured patients as a means of reducing and preventing medical errors and promoting patient safety.

(i) Develop programs to educate the public about the role of health care consumers in promoting patient safety.

(j) Provide interagency coordination of patient safety efforts in this state.

(k) Conduct other activities identified by the board of directors to promote patient safety in this state.

(8) ANNUAL REPORT.--By December 1, 2004, the corporation shall prepare a report on the start-up activities of the corporation and any proposals for legislative action needed to enable the corporation to fulfill its purposes under this section. By December 1 of each year thereafter, the corporation shall prepare a report for the preceding fiscal year. The report, at a minimum, must include:

(a) A description of the activities of the corporation under this section.

(b) Progress made in improving patient safety and reducing medical errors.

(c) A compliance and financial audit of the accounts and records of the corporation at the end of the preceding fiscal year conducted by an independent certified public accountant.

(d) An assessment of the ability of the corporation to fulfill the duties specified in subsection (7) and the appropriateness of those duties for the corporation.

(e) Recommendations for legislative action needed to improve patient safety in this state.

The corporation shall submit the report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

(9) PERFORMANCE EXPECTATIONS.--The Office of Program Policy Analysis and Government Accountability, in consultation with the Agency for Health Care Administration, the Department

of Health, and the corporation, shall develop performance standards by which to measure the success of the corporation in organizing to fulfill and beginning to implement the purposes and duties established in this section. The Office of Program Policy Analysis and Government Accountability shall conduct a performance audit of the corporation during 2006, using the performance standards, and shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2007.

Section 17. The Patient Safety Center at the Florida State University College of Medicine, in collaboration with researchers at other state universities, shall conduct a study to analyze the return on investment that hospitals in this state could realize from implementing computerized physician order entry and other information technologies related to patient safety. For the purposes of this analysis, the return on investment shall include both financial results and benefits relating to quality of care and patient safety. The study must include a representative sample of large and small hospitals, located in urban and rural areas, in the north, central, and southern regions of the state. By February 1, 2005, the Patient Safety Center at the Florida State University College of Medicine must submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives concerning the results of the study.

Section 18. Section 395.1012, Florida Statutes, is amended to read:

395.1012 Patient safety.--

(1) Each licensed facility must adopt a patient safety plan. A plan adopted to implement the requirements of 42

C.F.R. part 482.21 shall be deemed to comply with this requirement.

(2) Each licensed facility shall appoint a patient safety officer and a patient safety committee, which shall include at least one person who is neither employed by nor practicing in the facility, for the purpose of promoting the health and safety of patients, reviewing and evaluating the quality of patient safety measures used by the facility, recommending improvements in the patient safety measures used by the facility, and assisting in the implementation of the facility patient safety plan.

(3) Each licensed facility shall adopt a plan to reduce medication errors and adverse drug events, which must consider the use of computerized physician order entry and other information technologies related to patient safety.

Section 19. Subsection (3) of section 409.91255, Florida Statutes, is amended to read:

409.91255 Federally qualified health center access program.--

(3) ASSISTANCE TO FEDERALLY QUALIFIED HEALTH CENTERS.--The Department of Health shall develop a program for the expansion of federally qualified health centers for the purpose of providing comprehensive primary and preventive health care and urgent care services~~, including services~~ that may reduce the morbidity, mortality, and cost of care among the uninsured population of the state. The program shall provide for distribution of financial assistance to federally qualified health centers that apply and demonstrate a need for such assistance in order to sustain or expand the delivery of primary and preventive health care services. In selecting centers to receive this financial assistance, the program:

(a) Shall give preference to communities that have few or no community-based primary care services or in which the current services are unable to meet the community's needs.

(b) Shall require that primary care services be provided to the medically indigent using a sliding fee schedule based on income.

(c) Shall allow innovative and creative uses of federal, state, and local health care resources.

(d) Shall require that the funds provided be used to pay for operating costs of a projected expansion in patient caseloads or services or for capital improvement projects. Capital improvement projects may include renovations to existing facilities or construction of new facilities, provided that an expansion in patient caseloads or services to a new patient population will occur as a result of the capital expenditures. The department shall include in its standard contract document a requirement that any state funds provided for the purchase of or improvements to real property are contingent upon the contractor granting to the state a security interest in the property at least to the amount of the state funds provided for at least 5 years from the date of purchase or the completion of the improvements or as further required by law. The contract must include a provision that, as a condition of receipt of state funding for this purpose, the contractor agrees that, if it disposes of the property before the department's interest is vacated, the contractor will refund the proportionate share of the state's initial investment, as adjusted by depreciation.

(e) May require in-kind support from other sources.

(f) May encourage coordination among federally qualified health centers, other private-sector providers, and publicly supported programs.

(g) Shall allow the development of community emergency room diversion programs in conjunction with local resources, providing extended hours of operation to urgent care patients. Diversion programs shall include case management for emergency room followup care.

Section 20. Paragraph (a) of subsection (6) of section 627.410, 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 office ~~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 21. Section 624.6405, Florida Statutes, is created to read:

624.6405 Decrease in inappropriate utilization of emergency care.--

(1) The Legislature finds and declares it to be of vital importance that emergency services and care be provided

by hospitals and physicians to every person in need of such care, but with the double-digit increases in health insurance premiums, health care providers and insurers should encourage patients and the insured to assume responsibility for their treatment, including emergency care. The Legislature finds that inappropriate utilization of emergency department services increases the overall cost of providing health care and these costs are ultimately borne by the hospital, the insured patients, and, many times, by the taxpayers of this state. Finally, the Legislature declares that the providers and insurers must share the responsibility of providing alternative treatment options to urgent care patients outside of the emergency department. Therefore, it is the intent of the Legislature to place the obligation for educating consumers and creating mechanisms for delivery of care that will decrease the overutilization of emergency service on health insurers and providers.

(2) Health insurers shall provide on their websites information regarding appropriate utilization of emergency care services which shall include, but not be limited to, a list of alternative urgent care contracted providers, the types of services offered by these providers, and what to do in the event of a true emergency.

(3) Health insurers shall develop community emergency department diversion programs. Such programs may include, but not be limited to, enlisting providers to be on call to insurers after hours, coordinating care through local community resources, and incentives to providers for case management.

(4) As a disincentive for insureds to inappropriately use emergency department services, health insurers may require

higher copayments for nonemergency use of emergency departments and higher copayments for use of out-of-network emergency departments. For the purposes of this section, the term "emergency care" has the same meaning as provided in s. 395.002, and shall include services provided to rule out an emergency medical condition.

Section 22. Paragraph (b) of 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:

(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;

Section 23. Effective upon this act becoming a law, section 627.64872, Florida Statutes, is created to read:

627.64872 Florida Health Insurance Plan.--

(1) LEGISLATIVE INTENT; FLORIDA HEALTH INSURANCE PLAN.--

(a) The Legislature recognizes that to secure a more stable and orderly health insurance market, the establishment of a plan to assume risks deemed uninsurable by the private marketplace is required.

(b) The Florida Health Insurance Plan is created to make coverage available to individuals who have no other option for similar coverage, at a premium that is commensurate with the risk and benefits provided, and with benefit designs that are reasonable in relation to the general market. While plan operations may include supplementary funding, the plan shall fundamentally operate on sound actuarial principles, using basic insurance management techniques to ensure that the plan is run in an economical, cost-efficient, and sound manner, conserving plan resources to serve the maximum number of people possible in a sustainable fashion.

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

(a) "Board" means the board of directors of the plan.

(b) "Commission" means the Financial Services Commission.

(c) "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.

(d) "Director" means the director of the Office of Insurance Regulation.

(e) "Health insurance" means any hospital or medical expense incurred policy pursuant to this chapter or health maintenance organization subscriber contract pursuant to

chapter 641. The term does not include short term, accident, dental-only, vision-only, fixed indemnity, limited benefit, credit, or disability income insurance; coverage for onsite medical clinics; insurance coverage specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof, or other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191; benefits provided under a separate policy, certificate, or contract of insurance where there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor, such as for coverage only for a specified disease or illness; hospital indemnity or other fixed indemnity insurance; coverage offered as a separate policy, certificate, or contract of insurance, such as Medicare supplemental health insurance as defined under s. 1882(g)(1) of the Social Security Act; coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); similar supplemental coverage provided to coverage under a group health plan; 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.

(f) "Implementation" means the effective date on which the board is established.

(g) "Insurer" means any entity that provides health insurance in this state. For purposes of this section, insurer includes an insurance company with a valid certificate in accordance with chapter 624, a health maintenance organization with a valid certificate of authority in accordance with part I or part III of chapter 641, a prepaid health clinic authorized to transact business in this state pursuant to part II of chapter 641, multiple employer welfare arrangements authorized to transact business in this state pursuant to ss. 624.436-624.45, or a fraternal benefit society providing health benefits to its members as authorized pursuant to chapter 632.

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

(i) "Medicaid" means coverage under Title XIX of the Social Security Act.

(j) "Office" means the Office of Insurance Regulation of the Financial Services Commission.

(k) "Participating insurer" means any insurer providing health insurance to citizens of this state.

(l) "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 the state.

(m) "Plan" means the Florida Health Insurance Plan created in subsection (1).

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

(o) "Resident" means an individual who has been legally domiciled in this state for a period of at least 6 months with exception of residents deemed eligible under the federal Health Insurance Portability and Accountability Act of 1996.

(3) BOARD OF DIRECTORS.--

(a) 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 chair, and an additional eight members, five of whom shall be appointed by the Governor, at least three of whom shall be individuals not representative of insurers or health care providers, one of whom shall be appointed by the Chief Financial Officer, one of whom shall be appointed by the President of the Senate, and one of whom shall be appointed by the Speaker of the House of Representatives.

(b) The initial board members shall be appointed as follows: one-third of the members to serve a term of 2 years; one-third of the members to serve a term of 4 years; and one-third of the members to serve a term of 6 years. 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.

(c) Vacancies in the board shall be filled by the appointing authority, such authority being the Governor, the Chief Financial Officer, the President of the Senate, or the

Speaker of the House of Representatives. Board members may be removed by the appointing authority for cause.

(d) The board shall conduct its first meeting by September 1, 2004.

(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 s. 112.061.

(f) The board shall submit to the commission a plan of operation for the plan and any amendments thereto necessary or suitable to ensure 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 that adds to the financial viability of the plan. The plan of operation shall become effective upon approval in writing by the commission consistent with the date on which the coverage under this section must be made available. If the board fails to submit a suitable plan of operation within 1 year after the appointment of the board of directors, or at any time thereafter fails to submit suitable amendments to the plan of operation, the commission shall adopt such rules as are necessary or advisable to effectuate the provisions of 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 commission.

(g) The board shall take no action to implement the plan, other than the completion of the actuarial study authorized in subsection (6), until funds are appropriated for start-up costs and any projected deficits.

(4) 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 (11).

(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, plan eligibility requirements, and procedures for enrollment and 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 may be necessary and proper for the execution of the board's powers, duties, and obligations under this section.

(5) 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 section, including the authority, with the approval of the commission, 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 to:

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

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

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

4. Recover other amounts due the plan.

(d) Establish, and modify as appropriate, rates, rate schedules, rate adjustments, expense allowances, agents' commissions, claims 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. For purposes of this paragraph, usual and customary agent's commissions shall be paid for the initial placement of coverage with the plan and for one renewal only.

(e) Issue policies of insurance in accordance with the requirements of this section.

(f) Appoint appropriate legal, actuarial, investment, and other committees as necessary to provide technical assistance in the operation of the plan and develop and educate its policyholders regarding health savings accounts, policy and contract design, and any other function within the authority of the plan.

(g) Borrow money to effectuate 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, but not limited to, establishing or contracting with preferred provider organizations, health maintenance organizations, and other limited network provider arrangements.

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

(6)(a) Interim report.--No later than December 1, 2004, the board shall submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives an actuarial study to determine, including, but not limited to:

1. The impact the creation of this plan will have on the small group insurance market, specifically on the premiums paid by insureds. This shall include an estimate of the total

anticipated aggregate savings for all small employers in the state.

2. The number of individuals the pool could reasonably cover at various funding levels.

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

(b) Annual report.--No later than December 1, 2005, and annually thereafter, the board shall submit to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the substantive legislative committees of the Legislature a report which includes an independent actuarial study to determine, including, but not be limited to:

1. The impact the creation of the plan has on the small group and individual insurance market, specifically on the premiums paid by insureds. This shall include an estimate of the total anticipated aggregate savings for all small employers in the state.

2. The actual number of individuals covered at the current funding and benefit level, the projected number of individuals that may seek coverage in the forthcoming fiscal year, and the projected funding needed to cover anticipated increase or decrease in plan participation.

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

4. A summarization of 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.

5. A review of the operation of the plan as to whether the plan has met the intent of this section.

(7) 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 shall be liable, and no cause of action of any nature may arise against a member or employee of the board, for any act or omission related to the performance of any powers and duties under this section, 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.

(8) 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.

(9) ELIGIBILITY.--

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

1. Evidence is provided that the person received at least two notices of rejection or refusal to issue substantially similar insurance for health reasons by one insurer. A rejection or refusal by an insurer offering only stoploss, excess of loss, or reinsurance coverage with respect to the applicant shall not be sufficient evidence under this paragraph; or

2. The person is enrolled in the Florida Comprehensive Health Association as of the date the plan is implemented.

(b) Each resident dependent of a person who is eligible for coverage under the plan shall also be eligible for such coverage.

(c) A person shall not be 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 such 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 or may main tain 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, Medicare, the state's children's health insurance program, or any other federal, state, or local government program that provides health benefits;

3. The person voluntarily terminated plan coverage unless 12 months have elapsed since such termination;

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

5. The person's premiums are paid for or reimbursed under any government-sponsored program or by any government agency or health care provider.

(d) 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 or nonrenewal of the policy;

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; or

6. Upon failure of the insured to pay for continued coverage.

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

(10) UNFAIR REFERRAL TO PLAN.--It is an unfair trade practice for the purposes of part IX of chapter 626 or s. 641.3901 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.

(11) 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.

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

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

(12) 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 prior to 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 prior to the end of the current period.

(13) DUTIES OF THE PLAN ADMINISTRATOR.--

(a) The plan administrator shall perform such functions relating to the plan as may be assigned to it, including, but not limited to:

1. Determination of eligibility.

2. Payment of claims.

3. Establishment of a premium billing procedure for collection of premiums from persons covered under the plan.

4. Other necessary functions to ensure timely payment of benefits to covered persons under the plan.

(b) The plan administrator 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.

(c) 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.

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

(15) FUNDING OF THE PLAN.--

(a) Premiums.--

1. The plan shall establish premium rates for plan coverage as provided in this section. 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 prior to use.

2. Initial rates for plan coverage shall be limited to 200 percent of rates established as applicable for individual standard risks as specified in s. 627.6675(3)(c). 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, but in no event shall premiums exceed the 200-percent rate

limitation provided in this section. Notwithstanding the 200-percent rate limitation, sliding scale premium surcharges based upon the insured's income may apply to all enrollees except those obtaining coverage in accordance with s. 627.6487, provided that such premiums do not exceed 300 percent of the standard risk rate.

(b) Sources of additional revenue.--Any deficit incurred by the plan shall be primarily 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 the board 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 ensure that plan enrollment does not exceed the number of residents it has estimated it has the financial capacity to insure.

(16) BENEFITS.--

(a) The benefits provided shall be the same as the standard and basic plans for small employers as outlined in s. 627.6699. The board shall also establish an option of alternative coverage such as catastrophic coverage that includes a minimum level of primary care coverage and a high deductible plan that meets the federal requirements of a health savings account.

(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 may be deemed appropriate and adopt benefit levels, deductibles, copayments, 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 for such condition 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 which was involuntarily terminated, provided application for pool coverage is made not later than 63 days following such involuntary termination. In such case, coverage under 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.

(17) NONDUPLICATION OF BENEFITS.--

(a) The plan shall be payor 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, 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 setoff against any amount recoverable under this paragraph.

(18) ANNUAL AND MAXIMUM BENEFITS.--Maximum benefits under the plan shall be determined by the board.

(19) TAXATION.--The plan is exempt from any tax imposed by this state. The plan shall apply for federal tax exemption status.

(20) COMBINING MEMBERSHIP OF THE FLORIDA COMPREHENSIVE HEALTH ASSOCIATION.--

(a)1. Upon implementation of the plan, the Florida Comprehensive Health Association is abolished and all high-risk individuals actively enrolled in the Florida Comprehensive Health Association shall be enrolled in the plan subject to its rules and requirements.

2. Persons formerly enrolled in the Florida Comprehensive Health Association are only eligible for the benefits authorized under subsection (18). Maximum lifetime benefits paid to an individual in the plan shall not exceed the amount established under subsection (18), and benefits previously paid for any individual by the Florida

Comprehensive Health Association shall be used in determining the total lifetime benefits paid under the plan.

3. Except as otherwise provided in this section, the Florida Comprehensive Health Association shall operate under the existing plan of operation without modification until the adoption of the new plan of operation for the Florida Health Insurance Plan.

(b)1. As a condition of doing business in this state, an insurer shall pay an assessment to the board in the amount prescribed by this paragraph. For operating losses incurred on or after July 1, 2004, by persons previously enrolled in the Florida Comprehensive Health Association, each insurer shall annually be assessed by the board in the following calendar year a portion of such incurred operating losses of the plan. Such portion shall be determined by multiplying such operating losses by a fraction, the numerator of which equals the insurer's earned premium pertaining to direct writings of health insurance in the state during the calendar year proceeding that for which the assessment is levied, and the denominator of which equals the total of all such premiums earned by participating insurers in the state during such calendar year.

2. The total of all assessments under this paragraph upon a participating insurer shall not exceed 1 percent of such insurer's health insurance premium earned in this state during the calendar year preceding the year for which the assessments were levied.

3. All rights, title, and interest in the assessment funds collected under this paragraph shall vest in this state. However, all of such funds and interest earned shall be used by the plan to pay claims and administrative expenses.

(c) If assessments and other receipts by the plan, board, or plan administrator exceed the actual losses and administrative expenses of the plan, the excess shall be held in interest and used by the board to offset future losses. As used in this subsection, the term "future losses" includes reserves for claims incurred but not reported.

(d) Each insurer's assessment shall be determined annually by the board or plan administrator based on annual statements and other reports deemed necessary by the board or plan administrator and filed with the board or plan administrator by the insurer. Any deficit incurred under the plan by persons previously enrolled in the Florida Comprehensive Health Association shall be recouped by the assessments against participating insurers by the board or plan administrator in the manner provided in paragraph (b), and the insurers may recover the assessment in the normal course of their respective businesses without time limitation.

(e) If a person enrolled in the Florida Comprehensive Health Association as of July 1, 2004, loses eligibility for participation in the plan, such person shall not be included in the calculation of incurred operational losses as described in paragraph (b) if the person later regains eligibility for participation in the plan.

(f) After all persons enrolled in the Florida Comprehensive Health Association as of July 1, 2004, are no longer eligible for participation in the plan, the plan, board, or plan administrator shall no longer be allowed to assess insurers in this state for incurred losses as described in paragraph (b).

Section 24. Upon implementation, as defined in section 627.64872(2), Florida Statutes, and provided in section

627.64872(20), Florida Statutes, of the Florida Health Benefit Plan created under section 627.64872, Florida Statutes, sections 627.6488, 627.6489, 627.649, 627.6492, 627.6494, 627.6496, and 627.6498, Florida Statutes, are repealed.

Section 25. Subsections (12) and (13) are added to section 627.662, Florida Statutes, to read:

627.662 Other provisions applicable.--The following provisions apply to group health insurance, blanket health insurance, and franchise health insurance:

(12) Section 627.6044, relating to the use of specific methodology for payment of claims.

(13) Section 627.6405, relating to inappropriate utilization of emergency care.

Section 26. Paragraphs (c) and (d) of subsection (5), subsection (6), and subsection (12) of section 627.6699, Florida Statutes, are amended, subsections (15) and (16) of that section are renumbered as subsections (16) and (17), respectively, present subsection (15) of that section is amended, and new subsections (15) and (18) are added to that section, to read:

627.6699 Employee Health Care Access Act.--

(5) AVAILABILITY OF COVERAGE.--

(c) Every small employer carrier must, as a condition of transacting business in this state:

1. Offer and issue all small employer health benefit plans on a guaranteed-issue basis to every eligible small employer, with 2 to 50 eligible employees, that elects to be covered under such plan, agrees to make the required premium payments, and satisfies the other provisions of the plan. A rider for additional or increased benefits may be medically underwritten and may only be added to the standard health

benefit plan. The increased rate charged for the additional or increased benefit must be rated in accordance with this section.

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

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

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

(6) RESTRICTIONS RELATING TO PREMIUM RATES.--

(a) The commission may, by rule, establish regulations to administer this section and to assure that rating practices used by small employer carriers are consistent with the purpose of this section, including assuring that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans.

(b) For all small employer health benefit plans that are subject to this section and are issued by small employer carriers <u>to small employer groups with 2-25 eligible employees</u> 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 4 ~~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 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 2-25 ~~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 fewer ~~less~~ than 2 eligible employees may not exceed 150 percent of the rate determined for small employer groups of 2-25 ~~2-50~~ eligible employees. However, the carrier may charge excess losses of the experience pool consisting of small employer groups with fewer ~~less~~ than 2 eligible employees to the experience pool consisting of small employer groups with 2-25 ~~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 fewer ~~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 2-25 ~~2-50~~ eligible employees for the first annual renewal and 150 percent for subsequent annual renewals.

(c) For all small employer health benefit plans that are subject to this section, that are issued by small employer carriers before January 1, 1994, and that are renewed on or after January 1, 1995, renewal rates must be based on the same modified community rating standard applied to new business.

(d) Notwithstanding s. 627.401(2), this section and ss. 627.410 and 627.411 apply to any health benefit plan provided by a small employer carrier that is an insurer, and this section and s. 641.31 apply to any health benefit provided by a small employer carrier that is a health maintenance organization, that provides coverage to one or more employees of a small employer regardless of where the policy, certificate, or contract is issued or delivered, if

the health benefit plan covers employees or their covered dependents who are residents of this state.

(12) STANDARD, BASIC, HIGH DEDUCTIBLE, AND LIMITED HEALTH BENEFIT PLANS.--

(a)1. The Chief Financial Officer shall appoint a health benefit plan committee composed of four representatives of carriers which shall include at least two representatives of HMOs, at least one of which is a staff model HMO, two representatives of agents, four representatives of small employers, and one employee of a small employer. The carrier members shall be selected from a list of individuals recommended by the board. The Chief Financial Officer may require the board to submit additional recommendations of individuals for appointment.

2. The plans shall comply with all of the requirements of this subsection.

3. The plans must be filed with and approved by the office prior to issuance or delivery by any small employer carrier.

4. After approval of the revised health benefit plans, if the office determines that modifications to a plan might be appropriate, the Chief Financial Officer shall appoint a new health benefit plan committee in the manner provided in subparagraph 1. to submit recommended modifications to the office for approval.

(b)1. Each small employer carrier issuing new health benefit plans shall offer to any small employer, upon request, a standard health benefit plan, ~~and~~ a basic health benefit plan, and a high deductible plan that meets the requirements of a health savings account plan as defined by federal law, that meet ~~meets~~ the criteria set forth in this section.

2. For purposes of this subsection, the terms "standard health benefit plan," ~~and~~ "basic health benefit plan," and "high deductible plan"mean policies or contracts that a small employer carrier offers to eligible small employers that contain:

a. An exclusion for services that are not medically necessary or that are not covered preventive health services; and

b. A procedure for preauthorization by the small employer carrier, or its designees.

3. A small employer carrier may include the following managed care provisions in the policy or contract to control costs:

a. A preferred provider arrangement or exclusive provider organization or any combination thereof, in which a small employer carrier enters into a written agreement with the provider to provide services at specified levels of reimbursement or to provide reimbursement to specified providers. Any such written agreement between a provider and a small employer carrier must contain a provision under which the parties agree that the insured individual or covered member has no obligation to make payment for any medical service rendered by the provider which is determined not to be medically necessary. A carrier may use preferred provider arrangements or exclusive provider arrangements to the same extent as allowed in group products that are not issued to small employers.

b. A procedure for utilization review by the small employer carrier or its designees.

This subparagraph does not prohibit a small employer carrier from including in its policy or contract additional managed care and cost containment provisions, subject to the approval of the office, which have potential for controlling costs in a manner that does not result in inequitable treatment of insureds or subscribers. The carrier may use such provisions to the same extent as authorized for group products that are not issued to small employers.

4. The standard health benefit plan shall include:

a. Coverage for inpatient hospitalization;

b. Coverage for outpatient services;

c. Coverage for newborn children pursuant to s. 627.6575;

d. Coverage for child care supervision services pursuant to s. 627.6579;

e. Coverage for adopted children upon placement in the residence pursuant to s. 627.6578;

f. Coverage for mammograms pursuant to s. 627.6613;

g. Coverage for handicapped children pursuant to s. 627.6615;

h. Emergency or urgent care out of the geographic service area; and

i. Coverage for services provided by a hospice licensed under s. 400.602 in cases where such coverage would be the most appropriate and the most cost-effective method for treating a covered illness.

5. The standard health benefit plan and the basic health benefit plan may include a schedule of benefit limitations for specified services and procedures. If the committee develops such a schedule of benefits limitation for the standard health benefit plan or the basic health benefit

plan, a small employer carrier offering the plan must offer 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 plan associated with a health savings account 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, 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

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

employer carrier shall provide such employer group with a written statement that contains, at a minimum:

a. An explanation of those mandated benefits and providers that are not covered by the policy or contract;

b. An explanation of the managed care and cost control features of the policy or contract, along with all appropriate mailing addresses and telephone numbers to be used by insureds in seeking information or authorization; and

c. An explanation of the primary and preventive care features of the policy or contract.

Such disclosure statement must be presented in a clear and understandable form and format and must be separate from the policy or certificate or evidence of coverage provided to the employer group.

2. Before a small employer carrier issues a standard health benefit plan, a basic health benefit plan, or a limited benefit policy or contract, it must obtain from the prospective policyholder a signed written statement in which the prospective policyholder:

a. Certifies as to eligibility for coverage under the standard health benefit plan, basic health benefit plan, or limited benefit policy or contract;

b. Acknowledges the limited nature of the coverage and an understanding of the managed care and cost control features of the policy or contract;

c. Acknowledges that if misrepresentations are made regarding eligibility for coverage under a standard health benefit plan, a basic health benefit plan, or a limited benefit policy or contract, the person making such

misrepresentations forfeits coverage provided by the policy or contract; and

d. If a limited plan is requested, acknowledges that the prospective policyholder had been offered, at the time of application for the insurance policy or contract, the opportunity to purchase any health benefit plan offered by the carrier and that the prospective policyholder had rejected that coverage.

A copy of such written statement shall be provided to the prospective policyholder no later than at the time of delivery of the policy or contract, and the original of such written statement shall be retained in the files of the small employer carrier for the period of time that the policy or contract remains in effect or for 5 years, whichever period is longer.

3. Any material statement made by an applicant for coverage under a health benefit plan which falsely certifies as to the applicant's eligibility for coverage serves as the basis for terminating coverage under the policy or contract.

4. Each marketing communication that is intended to be used in the marketing of a health benefit plan in this state must be submitted for review by the office prior to use and must contain the disclosures stated in this subsection.

(e) A small employer carrier may not use any policy, contract, form, or rate under this section, including applications, enrollment forms, policies, contracts, certificates, evidences of coverage, riders, amendments, endorsements, and disclosure forms, until the insurer has filed it with the office and the office has approved it under ss. 627.410 and 627.411 and this section.

(15) SMALL EMPLOYERS ACCESS PROGRAM.--

(a) Popular name.--This subsection may be referred to by the popular name "The Small Employers Access Program."

(b) Intent.--The Legislature finds that increased access to health care coverage for small employers with up to 25 employees could improve employees' health and reduce the incidence and costs of illness and disabilities among residents in this state. Many employers do not offer health care benefits to their employees citing the increased cost of this benefit. It is the intent of the Legislature to create the Small Business Health Plan to provide small employers the option and ability to provide health care benefits to their employees at an affordable cost through the creation of purchasing pools for employers with up to 25 employees, and rural hospital employers and nursing home employers regardless of the number of employees.

(c) Definitions.--For purposes of this subsection, the term:

1. "Fair commission" means a commission structure determined by the insurers and reflected in the insurers' rate filings made pursuant to this subsection.

2. "Insurer" means any entity that provides health insurance in this state. For purposes of this subsection, insurer includes an insurance company holding a certificate of authority pursuant to chapter 624 or a health maintenance organization holding a certificate of authority pursuant to chapter 641, which qualifies to provide coverage to small employer groups pursuant to this section.

3. "Mutually supported benefit plan" means an optional alternative coverage plan developed within a defined geographic region which may include, but is not limited to, a minimum level of primary care coverage in which the percentage

of the premium is distributed among the employer, the employee, and community-generated revenue either alone or in conjunction with federal matching funds.

4. "Office" means the Office of Insurance Regulation of the Department of Financial Services.

5. "Participating insurer" means any insurer providing health insurance to small employers that has been selected by the office in accordance with this subsection for its designated region.

6. "Program" means the Small Employer Access Program as created by this subsection.

(d) Eligibility.--

1. Any small employer group of up to 25 employees.

2. Any municipality, county, school district, or hospital located in a rural community as defined in s. 288.0636(2)(b).

3. Nursing home employers may participate.

4. Each dependent of a person eligible for coverage is also eligible to participate.

5. Any small employer that is actively engaged in business, has its principal place of business in this state, employed up to 25 eligible employees on business days during the preceding calendar year, and employs at least 2 employees on the first day of the plan year may participate.

Coverage for 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.

(e) Administration.--

1. The office shall by competitive bid, in accordance with current state law, select an insurer to provide coverage through the program to eligible small employers within an established geographical area 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 subsection.

2. The office shall evaluate bids submitted based upon criteria established by the office, which shall include, but not be limited to:

a. The insurer's proven ability to handle 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.

d. The financial condition and stability of the insurer.

e. The insurer's ability to develop an optional mutually supported benefit plan.

The office may use any financial information available to it through its regulatory duties to make this evaluation.

(f) Insurer qualifications.--The insurer shall be a duly authorized insurer or health maintenance organization.

(g) Duties of the insurer.--The insurer shall:

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

2. Maintain employer awareness of the program.

3. Demonstrate the ability to use delivery of cost-effective health care services.

4. Encourage, educate, advise, and administer the effective use of health savings accounts by covered employees and dependents.

5. 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 may be specified in the request for proposal.

(h) Contract term.--The contract term shall not exceed 3 years. At least 6 months prior to 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 shall be made at least 3 months prior to the end of the current period. If a protest is filed and not resolved by the end of the contract period, the contract with the existing administrator may be extended for a period not to exceed 6 months. During the contract extension period, the administrator shall be paid at a rate to be negotiated by the office.

(i) 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.

(j) 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 agent must be appointed to at least one insurer.

(k) Benefits.--The benefits provided by the plan shall be the same as the coverage required for small employers under subsection (12). Upon the approval of the office, the insurer may also establish an optional mutually supported benefit plan which is an alternative plan developed within a defined geographic region of this state or any other such alternative plan which will carry out the intent of this subsection. Any small employer carrier issuing new health benefit plans may offer a benefit plan with coverages similar to, but not less than, any alternative coverage plan developed pursuant to this subsection.

(l) 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.

(16)~~(15)~~ APPLICABILITY OF OTHER STATE LAWS.--

(a) Except as expressly provided in this section, a law requiring coverage for a specific health care service or

benefit, or a law requiring reimbursement, utilization, or consideration of a specific category of licensed health care practitioner, does not apply to a standard or basic health benefit plan policy or contract or a limited benefit policy or contract offered or delivered to a small employer unless that law is made expressly applicable to such policies or contracts. A law restricting or limiting deductibles, coinsurance, copayments, or annual or lifetime maximum payments does not apply to any health plan policy, including a standard or basic health benefit plan policy or contract, offered or delivered to a small employer unless such law is made expressly applicable to such policy or contract. However, every small employer carrier must offer to eligible small employers the standard benefit plan and the basic benefit plan, as required by subsection (5), as such plans have been approved by the office pursuant to subsection (12).

(b) Except as provided in this section, a standard or basic health benefit plan policy or contract or limited benefit policy or contract offered to a small employer is not subject to any provision of this code which:

1. Inhibits a small employer carrier from contracting with providers or groups of providers with respect to health care services or benefits;

2. Imposes any restriction on a small employer carrier's ability to negotiate with providers regarding the level or method of reimbursing care or services provided under a health benefit plan; or

3. Requires a small employer carrier to either include a specific provider or class of providers when contracting for health care services or benefits or to exclude any class of

providers that is generally authorized by statute to provide such care.

(c) Any second tier assessment paid by a carrier pursuant to paragraph (11)(j) may be credited against assessments levied against the carrier pursuant to s. 627.6494.

(d) Notwithstanding chapter 641, a health maintenance organization is authorized to issue contracts providing benefits equal to the standard health benefit plan, the basic health benefit plan, and the limited benefit policy authorized by this section.

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

Section 27. Section 627.9175, Florida Statutes, is amended to read:

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

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

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

(b) Information on all health and accident insurance policies and prepaid limited health service organizations and

health maintenance organization contracts in force and issued in the previous year. Such information shall include, but not be limited to, direct premiums earned, direct losses incurred, number of policies, number of certificates, number of covered lives, number or the percentage of claims denied and claims meeting prompt pay requirements, and the average number of days taken to pay claims.~~as to policies of individual health insurance:~~

~~(a) A summary of typical benefits, exclusions, and limitations for each type of individual policy form currently being issued in the state. The summary shall include, as appropriate:~~

~~1. The deductible amount;~~

~~2. The coinsurance percentage;~~

~~3. The out-of-pocket maximum;~~

~~4. Outpatient~~ benefits;

~~5. Inpatient benefits; and~~

~~6. Any exclusions for preexisting conditions.~~

~~The commission shall determine other appropriate benefits, exclusions, and limitations to be reported for inclusion in the consumer's guide published pursuant to this section.~~

~~(b) A schedule of rates for each type of individual policy form reflecting typical variations by age, sex, region of the state, or any other applicable factor which is in use and is determined to be appropriate for inclusion by the commission.~~

The commission may establish rules governing ~~shall provide by rule a uniform format for~~ the submission of ~~this~~ information described in this section, including the use of uniform

formats and electronic data transmission ~~order to allow for meaningful comparisons of premiums charged for comparable benefits. The office shall provide this information to the department, which shall publish annually a consumer's guide which summarizes and compares the information required to be reported under this subsection~~.

(2)(a) Every insurer transacting health insurance in this state shall report annually to the office, not later than April 1, information relating to any measure the insurer has implemented or proposes to implement during the next calendar year for the purpose of containing health insurance costs or cost increases. The reports shall identify each measure and the forms to which the measure is applied, shall provide an explanation as to how the measure is used, and shall provide an estimate of the cost effect of the measure.

(b) The commission shall promulgate forms to be used by insurers in reporting information pursuant to this subsection and shall utilize such forms to analyze the effects of health care cost containment programs used by health insurers in this state.

(c) The office shall analyze the data reported under this subsection and shall annually make available to the department which shall provide to the public a summary of its findings as to the types of cost containment measures reported and the estimated effect of these measures.

Section 28. (1) Effective January 1, 2005, chapter 636, Florida Statutes, is redesignated as "Prepaid Limited Health Service Organizations and Discount Medical Plan Organizations."

(2) Effective January 1, 2005, sections 636.002-636.067, Florida Statutes, are designated as part I of

chapter 636, Florida Statutes, entitled "Prepaid Limited Health Service Organizations."

Section 29. Effective January 1, 2005, section 636.002, Florida Statutes, is amended to read:

636.002 Short title.--This part ~~Sections 1-57, chapter 93-148, Laws of Florida,~~ may be cited as the "Prepaid Limited Health Service Organization Act of Florida."

Section 30. Effective January 1, 2005, 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. 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 is licensed pursuant to part II of this chapter as a discount medical plan organization~~, 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~~.

Section 31. Effective January 1, 2005, part II of chapter 636, Florida Statutes, consisting of sections 636.202, 636.204, 636.206, 636.208, 636.210, 636.212, 636.214, 636.216, 636.218, 636.220, 636.222, 636.224, 636.226, 636.228, 636.230, 636.232, 636.234, 636.236, 636.238, 636.240, 636.242, and 636.244, is created to read:

Part II

Discount Medical Plan Organizations

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

(1) "Commission" means the Financial Services Commission.

(2) "Discount medical plan" means a business arrangement or contract in which a person, in exchange for fees, dues, charges, or other consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount.

(3) "Discount medical plan organization" means a person who, in exchange for fees, dues, charges, or other consideration, provides members a discount medical plan.

(4) "Marketer" means a person that markets, promotes, sells, or distributes a discount medical plan, including a private label entity which places its name on and markets or distributes a discount medical plan, but does not operate a discount medical plan.

(5) "Medical services" means any care, service, or treatment of an illness or a dysfunction of, or injury to, the human body, including, but not limited to, physician care, inpatient care, hospital surgical services, emergency services, ambulance services, dental care services, vision care services, mental health services, substance abuse

services, chiropractic services, podiatric care services, laboratory services, medical equipment and supplies. The term does not include pharmaceutical supplies or prescriptions.

(6) "Member" means any person who pays fees, dues, charges, or other consideration for the right to receive the benefits of a discount medical plan.

(7) "Office" means the Office of Insurance Regulation of the Financial Services Commission.

(8) "Provider" means any person that contracts, directly or indirectly, with a discount medical plan organization to provide medical services to members.

(9) "Provider network" means an entity that negotiates on behalf of more than one provider with a discount medical plan organization to provide medical services to members.

636.204 License.--

(1) A person may not conduct business in this state as a discount medical plan organization unless the person:

(a) Is a corporation, either incorporated under the laws of this state, or, if a foreign corporation, is authorized to transact business in this state; and

(b) Is licensed as a discount medical plan organization by the office.

(2) An application for a license to operate as a discount medical plan organization must be filed with the office on a form prescribed by the commission. The application must be sworn to by an officer or authorized representative of the applicant and must be accompanied by the following:

(a) A copy of the applicant's articles of incorporation, including all amendments.

(b) A copy of the corporate bylaws.

(c) A list of the names, addresses, official positions, and biographical information of the individuals responsible for conducting the applicant's affairs, including, but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the officers, contracted management company personnel, and any person or entity owning or having the right to acquire 10 percent or more of the voting securities of the applicant. The list must fully disclose the extent and nature of any contract or arrangement between any individual who is responsible for conducting the applicant's affairs and the discount medical plan organization, including any possible conflicts of interest.

(d) A complete biographical statement, on forms prescribed by the commission, an independent investigation report, and a set of fingerprints, as provided in chapter 624, from each individual identified in subsection (c).

(e) A statement describing the applicant, its facilities, and personnel and the medical services it proposes to offer.

(f) A copy of any form contract used by the applicant with any provider or provider network regarding the provision of medical services to members.

(g) A copy of any form contract used by the applicant with any person listed in subsection (c).

(h) A copy of any form contract used by the applicant with any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any function, including, but not limited to, marketing, administration, enrollment, investment management, and subcontracting for the provision of health services to members.

(i) A copy of the applicant's most recent financial statements that have been audited by an independent certified public accountant.

(j) A description of the applicant's proposed method of marketing.

(k) A description of the member's complaint procedures to be established and maintained by the applicant.

(l) The fee for issuance of a license.

(m) Such other information as the commission or office may request from the applicant.

(3) The office shall issue a license that expires 1 year after the date of issuance, and each year on that date thereafter. The office shall renew the license if the licensee pays the annual license fee of $50 and if the licensee is in compliance with this part.

(4) Before the office issues a license, each medical discount plan organization must establish a website in order to conform with the requirements of s. 636.226.

(5) The license fee under this section is $50 per year, per licensee. All amounts collected shall be deposited in the General Revenue Fund.

(6) This part does not require a provider who provides discounts to his or her own patients to obtain and maintain a license as a discount medical plan organization.

636.206 Examinations and investigations.--

(1) The office may examine or investigate any discount medical plan organization. The office may order any discount medical plan organization or applicant to produce any records, books, files, advertising and solicitation materials, or other information and may take statements under oath to determine whether the discount medical plan organization or applicant is

in violation of the law or is acting contrary to the public interest. The expenses incurred in conducting an examination or investigation must be paid by the discount medical plan organization or applicant. Examinations and investigations must be conducted as provided in chapter 624 and a discount medical plan organization is subject to all applicable provisions of the Florida Insurance Code.

(2) Failure by a discount medical plan organization to pay the costs incurred under this section is grounds for denial or revocation of a license.

636.208 Permitted activities of a discount medical plan.--A discount medical plan organization may engage in the following activities:

(1) Charge a monthly fee to its members. However, if a discount medical plan charges a fee for a time period exceeding 1 month, it must, in the event of cancellation of the membership by either party, make a pro rata reimbursement of the fee to the member.

(2) Enter into contracts with a provider or provider network in which the provider or provider network agrees to provide medical services at a discount to plan members.

636.210 Prohibited activities of a discount medical plan.--

(1) A discount medical plan organization may not:

(a) Use in its advertisements, marketing material, brochures, or discount cards the term "insurance" except as otherwise authorized in this part;

(b) Use in its advertisements, marketing material, brochures, or discount cards the terms "affordable healthcare", "health plan", "coverage", "co-pay", "co-payments", "pre-existing conditions", "guaranteed issue",

"premium" or other terms that could reasonably mislead a person into believing the discount medical plan was health insurance;

(c) Have restrictions on free access to plan providers, including, but not limited to, waiting periods and notification periods; or

(d) Pay providers any fees for medical services.

(2) A discount medical plan organization is prohibited from collecting or accepting money from a member for payment to a provider for specific medical services furnished or to be furnished to the member unless it has an active certificate of authority from the office to act as an administrator.

636.212 Disclosures.--The following disclosures must be made in writing to any prospective member, and must be on the first page of any advertisements, marketing material, or brochures relating to a discount medical plan. The disclosures must be printed in not less than 10-point type or no smaller than the largest type on the page if larger than 10-point type, and must state that:

(1) The plan is not insurance;

(2) The plan does not make payments directly to providers of medical services;

(3) The plan member is obligated to pay to the provider the full amount of the discounted fees; and

(4) The corporate name and the locations of the licensed discount medical plan organization.

636.214 Provider agreements.--

(1) A provider offering medical services to a member under a discount medical plan must provide the service under a written agreement with the organization. The agreement may be

entered into directly by the provider or by a provider network to which the provider belongs.

(2) A provider agreement must contain the following:

(a) A list of the services and products to be delivered at a discount;

(b) A statement specifying the amount of the discounts offered or, alternatively, a fee schedule that reflects the provider's discounted rates; and

(c) A statement that the provider will not charge members more than the discounted rates.

(3) A provider agreement between a discount medical plan organization and a provider network shall require the provider network to have written agreements with each provider. An agreement must:

(a) Contain the elements described in subsection (2);

(b) Authorize the provider network to contract with the medical discount medical plan organization on behalf of the provider; and

(c) Require the provider network to maintain an up-to-date list of the providers with whom it has a contract and to deliver that list to the discount medical plan organization each month.

(4) The discount medical plan organization shall maintain a copy of each active provider agreement.

636.216 Form and rate filings.--

(1) All fees charged to members must be filed with the office and must be approved by the office before they can be imposed on a member. The discount medical plan organization has the burden of proof that the fees charged bear a reasonable relation to the benefits received by the member.

(2) There must be a written agreement between the discount medical plan organization and the member specifying the benefits under the discount medical plan and complying with the disclosure requirements of this part.

(3) Any form used by the discount medical plan organization, including the written agreement between the organization and the member, must first be filed with and approved by the office. Every form filed shall be identified by a unique form number placed in the lower left corner of each form.

(4) If the office disapproves any filing, the office shall notify the discount medical plan organization in writing and must specify the reasons why the office disapproved the filing. The discount medical plan organization has 21 days from the date it receives the disapproval notice to request a hearing before the office under chapter 120.

636.218 Annual reports.--

(1) Each discount medical plan organization must file with the office an annual report no later than 3 months after the end of the organization's fiscal year.

(2) The report must be on a form and in a format prescribed by the commission and must include:

(a) Audited financial statements prepared in accordance with generally accepted accounting principles and certified by an independent certified public accountant. The financial statements shall include the organization's balance sheet, income statement, and statement of changes in cash flow for the preceding year.

(b) A list of the names and residence addresses of all persons responsible for the conduct of its affairs, together with a disclosure of the extent and nature of any contracts or

arrangements between these persons and the discount medical plan organization, including any possible conflicts of interest.

(c) The number of discount medical plan members.

(d) Such other information relating to the performance of the discount medical plan organization that is required by the commission or office.

(3) A discount medical plan organization that fails to file an annual report in the form and within the time required by this section shall forfeit up to $500 for each day for the first 10 days during which the report is delinquent and shall forfeit up to $1,000 for each day after the first 10 days during which the report is delinquent. Upon notice by the office, the organization may no longer enroll new members or do business in this state until the organization complies with this section. The office shall deposit all sums collected by it under this section to the credit of the Insurance Regulatory Trust Fund. The office may not collect more than $50,000 for each delinquent report.

636.220 Minimum capital requirements.--

(1) Each discount medical plan organization must at all times maintain a net worth of at least $150,000.

(2) The office may not issue a license unless the medical discount medical plan organization has a net worth of at least $150,000.

636.222 Suspension or revocation of license; suspension of enrollment of new members; terms of suspension.--

(1) The office may suspend the authority of a discount medical plan organization to enroll new members, may revoke a license issued to a discount medical plan organization, or may

order compliance if it finds that any of the following conditions exist:

(a) The organization is not operating in compliance with this part.

(b) The discount medical plan organization does not have the minimum net worth as required by this part.

(c) The organization has advertised, merchandised, or attempted to merchandise its services in a manner as to misrepresent its services or capacity for service or has engaged in deceptive, misleading, or unfair practices with respect to advertising or merchandising.

(d) The discount medical plan organization is not fulfilling its obligations as a discount medical plan organization.

(e) The continued operation of the discount medical plan organization would be hazardous to its members.

(2) If the office has cause to believe that grounds for the suspension or revocation of a license exist, it shall notify the discount medical plan organization in writing specifically stating the grounds for suspension or revocation and shall pursue a hearing on the matter in accordance with chapter 120.

(3) If the license of a discount medical plan organization is surrendered or revoked, the organization must proceed, immediately following the effective date of the order of revocation, to wind up its affairs transacted under the license. It may not engage in any further advertising, solicitation, collecting of fees, or renewal of contracts.

(4) The office shall, in its order suspending the authority of a discount medical plan organization to enroll new members, specify the period during which the suspension is

to be in effect and the conditions, if any, which must be met by the discount medical plan organization before reinstatement of its license to enroll new members. The order of suspension is subject to rescission or modification by further order of the office before expiration of the suspension period. Reinstatement may not be made unless requested by the discount medical plan organization. However, the office may not grant reinstatement if it finds that the circumstances for which the suspension occurred still exist or are likely to recur.

636.224 Notice of change of name or address of discount medical plan organization.--Each discount medical plan organization must notify the office at least 30 days in advance of any change in the discount medical plan organization's name, address, principal business address, or mailing address.

636.226 Provider name listing.--

(1) Each discount medical plan organization must maintain an up-to-date list of the names and addresses of the providers with whom it has a contract to deliver medical services. The list must be stored on its website, the Internet address of which must be prominently displayed on all its advertisements, marketing material, brochures, and discount cards.

(2) This section applies to providers with whom the discount medical plan organization has contracted directly and to those who are members of a provider network with which the discount medical plan organization has a contract to deliver medical services.

636.228 Marketing of discount medical plans.--

(1) All advertisements, marketing material, brochures, and discount cards used by marketers must be approved in writing for use by the discount medical plan organization.

(2) The discount medical plan organization shall have an executed written agreement with a marketer before the marketer marketing, promoting, selling, or distributing the discount medical plan.

(3) A person may not act in the capacity of a marketer unless licensed as an agent as defined in s. 626.015(2).

(4) A person may not act as a marketer for a discount medical plan program unless appointed by the discount medical plan program, using a form prescribed by the commission.

636.230 Bundling discount medical plans with other insurance products.--When a marketer or discount medical plan organization sells a discount medical plan along with any other product, the fees for each product must be itemized separately and provided to the members in writing.

636.232 Rules.--The commission may adopt rules to administer this part, including rules for the licensing of discount medical plan organizations; establishing standards for evaluating forms, advertisements, marketing material, brochures, and discount cards; the collection of data; disclosures to plan members; and rules defining terms used in this act.

636.234 Service of process on a discount medical plan organization.--Sections 624.422 and 624.423 apply to a discount medical plan organization as if a discount medical plan organization were an insurer.

636.236 Security deposit.--

(1) A licensed discount medical plan organization must deposit, and maintain deposited in trust with the department,

securities eligible for deposit under s. 625.52, in order that the office might protect plan members. The securities must, at all times, have a value of not less than $35,000.

(2) A judgment creditor or other claimant of a discount medical plan organization, other than the office or the Department of Financial Services, does not have the right to levy upon any of the assets or securities held in this state as a deposit under this section.

636.238 Penalties for violation of this part.--

(1) Except as provided in subsection (2), a person who violates this part commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(2) A person who operates as or aids and abets another operating as a discount medical plan organization in violation of s. 636.204(1) commits a felony punishable as provided for in s. 624.401(4)(b), as if the unlicensed discount medical plan organization were an unauthorized insurer, and the fees, dues, charges, or other consideration collected from the members by the unlicensed discount medical plan organization or marketer were insurance premium.

(3) A person who collects fees for purported membership in a discount medical plan but fails to provide the promised benefits commits a theft punishable as provided in s. 812.014.

636.240 Injunction.--

(1) In addition to the penalties and other enforcement provisions of this act, the office may commence an action for temporary and permanent injunctive relief if:

(a) A discount medical plan is operated by a person that is not licensed under this part.

(b) A person, entity, or discount medical plan organization has engaged in any activity prohibited by this act or any rule adopted under this act.

(2) Venue for any proceeding bought under this section shall be in the Circuit Court for Leon County.

(3) The office's authority to seek injunctive relief is not conditioned on having conducted any proceeding under chapter 120.

636.242 Civil remedies.--Any person injured by a person acting in violation of this part may bring a civil action against the person committing the violation in the circuit court of the county in which the alleged violator resides or has a principal place of business or in the county where the alleged violation occurred. If the defendant is found to have injured the plaintiff, the defendant is liable for damages and the court may also award the prevailing plaintiff court costs and reasonable attorney's fees. If so awarded, the court costs and attorney's fees must be included in the judgment or decree rendered in the case. If it appears to the court that the suit brought by the plaintiff is frivolous or brought for purposes of harassment, the court may award the defendant court costs and reasonable attorney's fees and may apply sanctions against the plaintiff in accordance with chapter 57.

636.244 Unlicensed discount medical plan organizations.--Sections 626.901 through 626.912 apply to the activities of an unlicensed discount medical plan organization as if an unlicensed discount medical plan organization were an unauthorized insurer.

Section 32. Section 627.65626, Florida Statutes, is created to read:

627.65626 Insurance rebates for healthy lifestyles.--

(1) Any rate, rating schedule, or rating manual for a health insurance policy filed with the office shall provide for an appropriate rebate of premiums paid in the last calendar year when the majority of members of a health plan have enrolled and maintained participation in any health wellness, maintenance, or improvement program offered by the employer. The employer must provide evidence of demonstrative maintenance or improvement of the enrollees' health status as determined by assessments of agreed-upon health status indicators between the employer and the health insurer, including, but not limited to, reduction in weight, body mass index, and smoking cessation. Any rebate provided by the health insurer is presumed to be appropriate unless credible data demonstrates otherwise, but shall not exceed 10 percent of paid premiums.

(2) The premium rebate authorized by this section shall be effective for an insured on an annual basis, unless the number of participating employees becomes less than the majority of the employees eligible for participation in the wellness program.

Section 33. Section 627.6402, Florida Statutes, is created to read:

627.6402 Insurance rebates for healthy lifestyles.--

(1) Any rate, rating schedule, or rating manual for an individual health insurance policy filed with the office shall provide for an appropriate rebate of premiums paid in the last calendar year when the individual covered by such plan is enrolled in and maintains participation in any health wellness, maintenance, or improvement program approved by the health plan. The individual must provide evidence of

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

(2) The premium rebate authorized by this section shall be effective for an insured on an annual basis, unless the individual fails to maintain or improve his or her health status while participating in an approved wellness program, or credible evidence demonstrates that the individual is not participating in the approved wellness program.

Section 34. Subsection (38) of section 641.31, Florida Statutes, is amended, and subsection (40) is added to that section, to read:

641.31 Health maintenance contracts.--

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

(b) A health maintenance organization offering a point-of-service rider under this subsection must have a valid certificate of authority issued under the provisions of the chapter, must have been licensed under this chapter for a minimum of 3 years, and must at all times that it has riders in effect maintain a minimum surplus of $5 million. A health maintenance organization offering a point-of-service rider to its contract providing comprehensive health care services may offer the rider to employers who have employees living and working outside the health maintenance organization's approved geographic service area without having to obtain a health care provider certificate, as long as the master group contract is issued to an employer that maintains its primary place of business within the health maintenance organization's approved service area. Any member or subscriber that lives and works outside the health maintenance organization's service area and elects coverage under the health maintenance organization's point-of-service rider must provide a statement to the health maintenance organization which indicates that the member or subscriber understands the limitations of his or her policy and that only those benefits under the point-of-service rider will be covered when services are provided outside the service area.

(c) Premiums paid in for the point-of-service riders may not exceed 15 percent of total premiums for all health plan products sold by the health maintenance organization offering the rider. If the premiums paid for point-of-service riders exceed 15 percent, the health maintenance organization must notify the office and, once this fact is known, must immediately cease offering such a rider until it is in compliance with the rider premium cap.

(d) Notwithstanding the limitations of deductibles and copayment provisions in this part, a point-of-service rider may require the subscriber to pay a reasonable copayment for each visit for services provided by a noncontracted provider chosen at the time of the service. The copayment by the subscriber may either be a specific dollar amount or a percentage of the reimbursable provider charges covered by the contract and must be paid by the subscriber to the noncontracted provider upon receipt of covered services. The point-of-service rider may require that a reasonable annual deductible for the expenses associated with the point-of-service rider be met and may include a lifetime maximum benefit amount. The rider must include the language required by s. 627.6044 and must comply with copayment limits described in s. 627.6471. Section 641.3154 does not apply to a point-of-service rider authorized under this subsection.

(e) The point-of-service rider must contain provisions that comply with s. 627.6044.

(f)~~(e)~~ The term "point of service" may not be used by a health maintenance organization except with riders permitted under this section or with forms approved by the office in which a point-of-service product is offered with an indemnity carrier.

(g)~~(f)~~ A point-of-service rider must be filed and approved under ss. 627.410 and 627.411.

(40)(a) Any rate, rating schedule, or rating manual for a health maintenance organization policy filed with the office shall provide for an appropriate rebate of premiums paid in the last calendar year when the individual covered by such plan is enrolled in and maintains participation in any health wellness, maintenance, or improvement program approved

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

(b) The premium rebate authorized by this section shall be effective for an insured on an annual basis, unless the individual fails to maintain or improve his or her health status while participating in an approved wellness program, or credible evidence demonstrates that the individual is not participating in the approved wellness program.

Section 35. Notwithstanding the amendment to section 627.6699(5)(c), Florida Statutes, by this act, any right to an open enrollment offer of health benefit coverage for groups of fewer than two employees, pursuant to section 627.6699(5)(c), Florida Statutes, as it existed immediately before the effective date of this act, shall remain in full force and effect until the enactment of section 627.64872, Florida Statutes, and the subsequent date upon which such plan begins to accept new risks or members.

Section 36. Section 465.0244, Florida Statutes, is created to read:

465.0244 Information disclosure.--Every pharmacy 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 place in the area where customers

receive filled prescriptions notice that such information is available electronically and the address of its Internet website.

Section 37. Section 627.6499, Florida Statutes, is amended to read:

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 38. 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, 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, 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 required by s. 627.64725 notice that such information is available electronically and the address of its Internet website.

Section 39. Section 408.02, Florida Statutes, is repealed.

Section 40. Subsection (3) of section 766.1016, Florida Statutes, is repealed.

Section 41. The sum of $250,000 is appropriated from the Insurance Regulatory Trust Fund in the Department of Financial Services to the Office of Insurance Regulation for the purpose of implementing the provisions in this act relating to the Small Employers Access Program.

Section 42. The sum of $350,000 in nonrecurring general revenue funds is appropriated to the Agency for Health Care Administration to support the establishment of and to contract with the Florida Patient Safety Corporation to implement the provisions of section 16 of this act during the 2004-2005 fiscal year.

Section 43. The sum of $113,500 in nonrecurring general revenue funds is appropriated to the Florida State University College of Medicine for the purpose of conducting the study required in section 17 of this act during the 2004-2005 fiscal year.

Section 44. The sum of $250,000 in nonrecurring general funds is appropriated to the board of the Florida

Health Insurance Plan to contract for an independent actuarial study for the interim report that the board is required to submit pursuant to section 627.64872, Florida Statutes, as created by this act.

Section 45. The sum of $2 million in nonrecurring general revenue funds is appropriated to the Agency for Health Care Administration for its activities during the 2004-2005 fiscal year related to developing and implementing a strategy for the adoption and use of electronic health records.

Section 46. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2004.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR
CS for SB 2910

Revises requirements for health care facilities to publish the average cost of certain services.

Requires health care facilities, providers, and health insurers to submit data to the Agency for Health Care Administration (AHCA) and for AHCA to make performance outcome and financial data available to consumers.

Revises the requirements for the Florida Health Insurance Plan.

Revises requirements for the Health Flex Program, which is expanded statewide.

Provides that policies for small employers with 26 to 50 employees would no longer be subject to the modified community rating requirements and the rates for such policies would not be required to be filed with or approved by the Office of Insurance Regulation.

Revises requirements for small group policies.

Requires persons who provide access to any discounted medical services to be licensed by the Office of Insurance Regulation.

Require health insurers to provide for a rebate of premiums when the majority of members of a health plan have maintained participation in a wellness program.

Creates the Florida Patient Safety Corporation to assist health care providers to improve the quality and safety of health care rendered and to reduce harm to patients.

Requires the Patient Safety Center at the Florida State University College of Medicine to conduct a study on hospitals.

Requires patient safety officers and patient safety committees at licensed facilities to recommend improvements in the patient safety measures.

Requires AHCA to develop and implement a strategy for the adoption and use of electronic health records.

Allows hospitals and federally quality health centers to develop emergency room diversion programs.

Renames the Statewide Provider and Subscriber Assistance Program as the Subscriber Assistance Program and revises requirements for the program.

Makes appropriations.