

1 A bill to be entitled

2 An act relating to plans, policies, contracts, and
3 programs for the provision of health care services;
4 amending s. 408.909, F.S.; revising eligibility
5 requirements for participation in health flex plans;
6 amending s. 627.4236, F.S.; redefining the term "bone
7 marrow transplant" for purposes of required coverage for
8 certain procedures to include nonablative therapy having
9 life-prolonging intent; amending s. 627.642, F.S.;

10 requiring an identification card containing specified
11 information to be given to insureds who have health and
12 accident insurance; requiring certain insurers to provide
13 to certain service providers by an Internet website
14 certain information relating to a covered person;
15 providing criteria; specifying time requirements for such
16 insurers to implement such requirements; amending s.
17 627.657, F.S.; requiring an identification card containing
18 specified information to be given to insureds under group
19 health insurance policies; requiring certain insurers to
20 provide to certain service providers by an Internet
21 website certain information relating to a covered person;
22 providing criteria; specifying time requirements for such
23 insurers to implement such requirements; amending s.
24 627.6699, F.S.; revising a provision relating to
25 applicability and scope of the Employee Health Care Access
26 Act; amending s. 636.204, F.S.; revising a license
27 application provision for discount medical plan

28 organizations; amending s. 636.206, F.S.; revising
29 examination and investigative authority; amending s.
30 636.210, F.S.; providing an exception to prohibited
31 activities; amending s. 636.216, F.S.; providing exception
32 to review of certain charges to members of the plan;
33 amending s. 636.218, F.S.; removing certain information
34 from the annual report; amending s. 636.220, F.S.;
35 revising certain minimum capital requirements of discount
36 medical plan organizations; revising commission rulemaking
37 authority; amending s. 636.230, F.S.; providing
38 requirements with respect to the bundling of discount
39 medical plans with insurance products; amending s. 641.31,
40 F.S.; requiring an identification card to be given to
41 persons having health care services through a health
42 maintenance contract; requiring certain health maintenance
43 organizations to provide to certain service providers by
44 an Internet website certain information relating to a
45 covered person; providing criteria; specifying time
46 requirements for such health maintenance organizations to
47 implement such requirements; amending s. 641.316, F.S.;
48 redefining the term "fiscal intermediary services
49 organization"; revising registration requirements for
50 fiscal intermediary services organizations; amending ss.
51 383.145, 641.185, 641.2018, 641.3107, 641.3922, and
52 641.513, F.S.; conforming cross-references to changes made
53 by the act; providing application; reenacting and amending
54 s. 409.9102, F.S.; directing the Agency for Health Care

55 Administration, in consultation with the Office of
56 Insurance Regulation and the Department of Children and
57 Family Services, to amend the Medicaid state plan that
58 established the Florida Long-Term Care Partnership Program
59 for purposes of compliance with provisions of the Social
60 Security Act; establishing a qualified state Long-Term
61 Care Insurance Partnership Program in Florida; providing
62 duties of the program; requiring consultation with the
63 Office of Insurance Regulation and the Department of
64 Children and Family Services for the creation of standards
65 for certain information; providing rulemaking authority to
66 the agency for implementation of s. 409.9102, F.S.;
67 providing rulemaking authority to the department regarding
68 determination of eligibility for certain services;
69 creating s. 627.94075, F.S.; providing rulemaking
70 authority to the Financial Services Commission for the
71 implementation of a qualified state Long-Term Care
72 Insurance Partnership Program in Florida; repealing ss. 1
73 and 2 of ch. 2005-252, Laws of Florida, to delete
74 conflicting provisions relating to the determination of
75 eligibility for nursing and rehabilitative services and
76 the establishment of the Florida Long-Term Care
77 Partnership Program that were contingent upon amendment to
78 the Social Security Act; amending s. 4 of ch. 2005-252,
79 Laws of Florida, to delete a contingency in an effective
80 date; requiring the Office of Program Policy Analysis and
81 Government Accountability to submit a report on the

82 implementation of a qualified state Long-Term Care
83 Insurance Partnership Program in Florida to the Governor
84 and Legislature; providing an effective date.

85

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

87

88 Section 1. Subsection (5) of section 408.909, Florida
89 Statutes, is amended to read:

90 408.909 Health flex plans.--

91 (5) ELIGIBILITY.--Eligibility to enroll in an approved
92 health flex plan is limited to residents of this state who:

93 (a)1. Are 64 years of age or younger;

94 2.~~(b)~~ Have a family income equal to or less than 250 ~~200~~
95 percent of the federal poverty level;

96 3.~~(e)~~ Are eligible under a federally approved Medicaid
97 demonstration waiver and reside in Palm Beach County or Miami-
98 Dade County;

99 4.~~(d)~~ Are not covered by a private insurance policy and
100 are not eligible for coverage through a public health insurance
101 program, such as Medicare or Medicaid, unless specifically
102 authorized under subparagraph 3. ~~paragraph (e)~~, or another
103 public health care program, such as KidCare, and have not been
104 covered at any time during the past 6 months; and

105 5.~~(e)~~ Have applied for health care coverage through an
106 approved health flex plan and have agreed to make any payments
107 required for participation, including periodic payments or
108 payments due at the time health care services are provided; or

109 (b) Are part of an employer group where at least 75
110 percent of the employees have a family income equal to or less
111 than 250 percent of the federal poverty level and the employee
112 group is not covered by a private health insurance policy and
113 has not been covered at any time during the past 6 months. If
114 the health flex plan entity is a health insurer, health plan, or
115 health maintenance organization properly licensed under Florida
116 law, only 50 percent of the employees must meet the income
117 requirements for the purposes of this paragraph.

118 Section 2. Subsection (1) of section 627.4236, Florida
119 Statutes, is amended to read:

120 627.4236 Coverage for bone marrow transplant procedures.--

121 (1) As used in this section, the term "bone marrow
122 transplant" means human blood precursor cells administered to a
123 patient to restore normal hematological and immunological
124 functions following ablative or nonablative therapy with
125 curative or life-prolonging intent. Human blood precursor cells
126 may be obtained from the patient in an autologous transplant or
127 from a medically acceptable related or unrelated donor, and may
128 be derived from bone marrow, circulating blood, or a combination
129 of bone marrow and circulating blood. If chemotherapy is an
130 integral part of the treatment involving bone marrow
131 transplantation, the term "bone marrow transplant" includes both
132 the transplantation and the chemotherapy.

133 Section 3. Subsections (3) and (4) are added to section
134 627.642, Florida Statutes, to read:

135 627.642 Outline of coverage.--

136 (3) In addition to the outline of coverage, a policy as
137 specified in s. 627.6699(3)(k) must be accompanied by an
138 identification card that contains, at a minimum:

139 (a) The name of the organization issuing the policy or
140 name of the organization administering the policy, whichever
141 applies.

142 (b) The name of the contract holder.

143 (c) The type of plan only if the health plan is filed with
144 the state, an indication that the plan is self-funded, or the
145 name of the network.

146 (d) The member identification number, contract number, and
147 policy or group number, if applicable.

148 (e) A contact phone number or electronic address for
149 authorizations.

150 (f) A phone number or electronic address whereby the
151 covered person or hospital, physician, or other person rendering
152 services covered by the policy may determine if the plan is
153 insured and may obtain a benefits verification in order to
154 estimate patient financial responsibility, in compliance with
155 privacy rules under the Health Insurance Portability and
156 Accountability Act.

157 (g) The national plan identifier, in accordance with the
158 compliance date set forth by the federal Department of Health
159 and Human Services.

160
161 The identification card must present the information in a
162 readily identifiable manner or, alternatively, the information

163 may be embedded on the card and available through magnetic
164 stripe or smart card. The information may also be provided
165 through other electronic technology.

166 (4) (a) An insurer that issues a health insurance policy
167 shall provide a hospital, physician, or other person rendering
168 services covered by the policy electronic access to the covered
169 person's eligibility and benefits information through a secure
170 Internet website. The eligibility and benefits information shall
171 comply with the transaction standards specified in ANSI ASC X12N
172 270 for health care claim eligibility inquiries and ANSI ASC
173 X12N 271 for health care claim eligibility responses, or
174 successor transaction standards, pursuant to the Health
175 Insurance Portability and Accountability Act.

176 (b) An insurer shall develop an implementation plan to
177 comply with paragraph (a) no later than March 31, 2007, and
178 shall make the eligibility and benefits information described in
179 this subsection available through a secure Internet website no
180 later than July 1, 2007.

181 Section 4. Present subsection (2) of section 627.657,
182 Florida Statutes, is renumbered as subsection (4), and new
183 subsections (2) and (3) are added to that section, to read:

184 627.657 Provisions of group health insurance policies.--

185 (2) The medical policy as specified in s. 627.6699(3)(k)
186 must be accompanied by an identification card that contains, at
187 a minimum:

188 (a) The name of the organization issuing the policy or
189 name of the organization administering the policy, whichever
190 applies.

191 (b) The name of the certificateholder.

192 (c) The type of plan only if the health plan is filed with
193 the state, an indication that the plan is self-funded, or the
194 name of the network.

195 (d) The member identification number, contract number, and
196 policy or group number, if applicable.

197 (e) A contact phone number or electronic address for
198 authorizations.

199 (f) A phone number or electronic address whereby the
200 covered person or hospital, physician, or other person rendering
201 services covered by the policy may determine if the plan is
202 insured and may obtain a benefits verification in order to
203 estimate patient financial responsibility, in compliance with
204 privacy rules under the Health Insurance Portability and
205 Accountability Act.

206 (g) The national plan identifier, in accordance with the
207 compliance date set forth by the federal Department of Health
208 and Human Services.

209

210 The identification card must present the information in a
211 readily identifiable manner or, alternatively, the information
212 may be embedded on the card and available through magnetic
213 stripe or smart card. The information may also be provided
214 through other electronic technology.

215 (3) (a) An insurer that issues a group health insurance
216 policy shall provide a hospital, physician, or other person
217 rendering services covered by the policy electronic access to
218 the covered person's eligibility and benefits information
219 through a secure Internet website. The eligibility and benefits
220 information shall comply with the transaction standards
221 specified in ANSI ASC X12N 270 for health care claim eligibility
222 inquiries and ANSI ASC X12N 271 for health care claim
223 eligibility responses, or successor transaction standards,
224 pursuant to the Health Insurance Portability and Accountability
225 Act.

226 (b) An insurer shall develop an implementation plan to
227 comply with paragraph (a) no later than March 31, 2007, and
228 shall make the eligibility and benefits information described in
229 this subsection available through a secure Internet website no
230 later than July 1, 2007.

231 Section 5. Paragraph (a) of subsection (4) of section
232 627.6699, Florida Statutes, is amended to read:

233 627.6699 Employee Health Care Access Act.--

234 (4) APPLICABILITY AND SCOPE.--

235 (a)1. This section applies to a health benefit plan that
236 provides coverage to employees of a small employer in this
237 state, unless the coverage is marketed directly to the
238 individual employee, and the employer does not contribute
239 directly or indirectly to the premiums or facilitate the
240 administration of the coverage in any manner. For the purposes
241 of this subparagraph, an employer is not deemed to be

242 contributing to the premiums or facilitating the administration
243 of coverage if the employer;

244 a. Does not contribute to the premium and merely collects
245 the premiums for coverage from an employee's wages or salary
246 through payroll deduction and submits payment for the premiums
247 of one or more employees in a lump sum to a carrier; or

248 b. Directly or indirectly establishes or administers a
249 health reimbursement account plan for its employees.

250 2. A carrier authorized to issue group or individual
251 health benefit plans under this chapter or chapter 641 may offer
252 coverage as described in this paragraph to individual employees
253 without being subject to this section if the employer has not
254 had a group health benefit plan in place in the prior 6 months.
255 A carrier authorized to issue group or individual health benefit
256 plans under this chapter or chapter 641 may offer coverage as
257 described in this subparagraph to employees that are not
258 eligible employees as defined in this section, whether or not
259 the small employer has a group health benefit plan in place. A
260 carrier that offers coverage as described in this subparagraph
261 must provide a cancellation notice to the primary insured at
262 least 10 days prior to canceling the coverage for nonpayment of
263 premium.

264 Section 6. Paragraph (i) of subsection (2) of section
265 636.204, Florida Statutes, is amended to read:

266 636.204 License required.--

267 (2) An application for a license to operate as a discount
268 medical plan organization must be filed with the office on a

269 form prescribed by the commission. Such application must be
270 sworn to by an officer or authorized representative of the
271 applicant and be accompanied by the following, if applicable:

272 (i) A copy of the applicant's most recent financial
273 statements audited by an independent certified public
274 accountant. An applicant that is a subsidiary of a parent entity
275 that is publicly traded and that prepares audited financial
276 statements reflecting the consolidated operations of the parent
277 entity and the subsidiary may submit ~~petition the office to~~
278 ~~accept~~, in lieu of the audited financial statement of the
279 applicant, the audited financial statement of the parent entity
280 and a written guaranty by the parent entity that the minimum
281 capital requirements of the applicant required by this part will
282 be met by the parent entity.

283 Section 7. Subsection (1) of section 636.206, Florida
284 Statutes, is amended to read:

285 636.206 Examinations and investigations.--

286 (1) The office may examine or investigate the business and
287 affairs of any discount medical plan organization if the
288 commissioner has reason to believe that the discount medical
289 plan organization is not complying with the requirements of this
290 act. The office may order any discount medical plan organization
291 or applicant to produce any records, books, files, advertising
292 and solicitation materials, or other information and may take
293 statements under oath to determine whether the discount medical
294 plan organization or applicant is in violation of the law or is
295 acting contrary to the public interest. The expenses incurred in

296 | conducting any examination or investigation must be paid by the
 297 | discount medical plan organization or applicant. Examinations
 298 | and investigations must be conducted as provided in chapter 624.

299 | Section 8. Subsection (1) of section 636.210, Florida
 300 | Statutes, is amended to read:

301 | 636.210 Prohibited activities of a discount medical plan
 302 | organization.--

303 | (1) A discount medical plan organization may not:

304 | (a) Use in its advertisements, marketing material,
 305 | brochures, and discount cards the term "insurance" except as
 306 | otherwise provided in this part or as a disclaimer of any
 307 | relationship between discount medical plan organization benefits
 308 | and insurance;

309 | (b) Use in its advertisements, marketing material,
 310 | brochures, and discount cards the terms "health plan,"
 311 | "coverage," "copay," "copayments," "preexisting conditions,"
 312 | "guaranteed issue," "premium," "PPO," "preferred provider
 313 | organization," or other terms in a manner that could reasonably
 314 | mislead a person into believing the discount medical plan was
 315 | health insurance;

316 | (c) Have restrictions on free access to plan providers,
 317 | except for hospital services, including, but not limited to,
 318 | waiting periods and notification periods; or

319 | (d) Pay providers any fees for medical services.

320 | Section 9. Subsection (1) of section 636.216, Florida
 321 | Statutes, is amended to read:

322 | 636.216 Charge or form filings.--

323 (1) All charges to members must be filed with the office.
324 ~~and~~ Any charge to members greater than \$30 per month or \$360 per
325 year for access to healthcare services, other than those
326 provided by physicians licensed under chapter 458 or chapter 459
327 or by hospitals licensed under chapter 395, must be approved by
328 the office before the charges can be used. Any charge to members
329 greater than \$60 dollars per month or \$720 per year for
330 healthcare services that include services provided by physicians
331 licensed under chapters 458 and 459 or by hospitals licensed
332 under chapter 395 must be approved by the office before the
333 charges can be used. The discount medical plan organization has
334 the burden of proof that the charges bear a reasonable relation
335 to the benefits received by the member.

336 Section 10. Subsection (2) of section 636.218, Florida
337 Statutes, is amended to read:

338 636.218 Annual reports.--

339 (2) Such reports must be on forms prescribed by the
340 commission and must include:

341 ~~(a) Audited financial statements prepared in accordance~~
342 ~~with generally accepted accounting principles certified by an~~
343 ~~independent certified public accountant, including the~~
344 ~~organization's balance sheet, income statement, and statement of~~
345 ~~changes in cash flow for the preceding year. An organization~~
346 ~~that is a subsidiary of a parent entity that is publicly traded~~
347 ~~and that prepares audited financial statements reflecting the~~
348 ~~consolidated operations of the parent entity and the~~
349 ~~organization may petition the office to accept, in lieu of the~~

350 ~~audited financial statement of the organization, the audited~~
351 ~~financial statement of the parent entity and a written guaranty~~
352 ~~by the parent entity that the minimum capital requirements of~~
353 ~~the organization required by this part will be met by the parent~~
354 ~~entity.~~

355 (a)~~(b)~~ If different from the initial application or the
356 last annual report, a list of the names and residence addresses
357 of all persons responsible for the conduct of the organization's
358 affairs, together with a disclosure of the extent and nature of
359 any contracts or arrangements between such persons and the
360 discount medical plan organization, including any possible
361 conflicts of interest.

362 (b)~~(e)~~ The number of discount medical plan members in the
363 state.

364 (c)~~(d)~~ Such other information relating to the performance
365 of the discount medical plan organization as is reasonably
366 required by the commission or office.

367 Section 11. Subsection (1) of section 636.220, Florida
368 Statutes, is amended to read:

369 636.220 Minimum capital requirements.--

370 (1) Each discount medical plan organization must at all
371 times maintain a net worth of at least \$150,000 and each
372 discount medical plan organization shall certify in writing
373 under oath at licensure and annually that the minimum
374 capitalization requirements of this part are satisfied.

375 Section 12. Section 636.230, Florida Statutes, is amended
376 to read:

377 636.230 Bundling discount medical plans with insurance
378 ~~ether~~ products.--When a marketer or discount medical plan
379 organization sells a discount medical plan together with any
380 insurance ether product, the fees for the discount medical plan
381 must be provided in writing to the member if the fees exceed \$30
382 per month for access to healthcare services other than those
383 provided by physicians licensed under chapter 458 or chapter 459
384 or by hospitals licensed under chapter 395 or \$60 dollars per
385 month for healthcare services which include services provided by
386 physicians licensed under chapter 458 or chapter 459 or by
387 hospitals licensed under chapter 395.

388 Section 13. Present subsections (5) through (40) of
389 section 641.31, Florida Statutes, are renumbered as subsections
390 (7) through (42), respectively, and new subsections (5) and (6)
391 are added to that section, to read:

392 641.31 Health maintenance contracts.--

393 (5) The contract, certificate, or member handbook must be
394 accompanied by an identification card that contains, at a
395 minimum:

396 (a) The name of the organization offering the contract or
397 name of the organization administering the contract, whichever
398 applies.

399 (b) The name of the subscriber.

400 (c) A statement that the health plan is a health
401 maintenance organization. Only a health plan with a certificate
402 of authority issued under this chapter may be identified as a
403 health maintenance organization.

404 (d) The member identification number, contract number, and
405 group number, if applicable.

406 (e) A contact phone number or electronic address for
407 authorizations.

408 (f) A phone number or electronic address whereby the
409 covered person or hospital, physician, or other person rendering
410 services covered by the contract may determine if the plan is
411 insured and may obtain a benefits verification in order to
412 estimate patient financial responsibility, in compliance with
413 privacy rules under the Health Insurance Portability and
414 Accountability Act.

415 (g) The national plan identifier, in accordance with the
416 compliance date set forth by the federal Department of Health
417 and Human Services.

418
419 The identification card must present the information in a
420 readily identifiable manner or, alternatively, the information
421 may be embedded on the card and available through magnetic
422 stripe or smart card. The information may also be provided
423 through other electronic technology.

424 (6) (a) A health maintenance organization shall provide a
425 hospital, physician, or other person rendering services covered
426 by the policy electronic access to the covered person's
427 eligibility and benefits information through a secure Internet
428 website. The eligibility and benefits information shall comply
429 with the transaction standards specified in ANSI ASC X12N 270
430 for health care claim eligibility inquiries and ANSI ASC X12N

431 271 for health care claim eligibility responses, or successor
432 transaction standards, pursuant to the Health Insurance
433 Portability and Accountability Act.

434 (b) A health maintenance organization shall develop an
435 implementation plan to comply with paragraph (a) no later than
436 March 31, 2007, and shall make the eligibility and benefits
437 information described in this subsection available through a
438 secure Internet website no later than July 1, 2007.

439 Section 14. Paragraph (j) of subsection (3) of section
440 383.145, Florida Statutes, is amended to read:

441 383.145 Newborn and infant hearing screening.--

442 (3) REQUIREMENTS FOR SCREENING OF NEWBORNS; INSURANCE
443 COVERAGE; REFERRAL FOR ONGOING SERVICES.--

444 (j) The initial procedure for screening the hearing of the
445 newborn or infant and any medically necessary followup
446 reevaluations leading to diagnosis shall be a covered benefit,
447 reimbursable under Medicaid as an expense compensated
448 supplemental to the per diem rate for Medicaid patients enrolled
449 in MediPass or Medicaid patients covered by a fee for service
450 program. For Medicaid patients enrolled in HMOs, providers shall
451 be reimbursed directly by the Medicaid Program Office at the
452 Medicaid rate. This service may not be considered a covered
453 service for the purposes of establishing the payment rate for
454 Medicaid HMOs. All health insurance policies and health
455 maintenance organizations as provided under ss. 627.6416,
456 627.6579, and 641.31(32)~~(30)~~, except for supplemental policies
457 that only provide coverage for specific diseases, hospital

458 indemnity, or Medicare supplement, or to the supplemental
459 policies, shall compensate providers for the covered benefit at
460 the contracted rate. Nonhospital-based providers shall be
461 eligible to bill Medicaid for the professional and technical
462 component of each procedure code.

463 Section 15. Paragraphs (b) and (i) of subsection (1) of
464 section 641.185, Florida Statutes, are amended to read:

465 641.185 Health maintenance organization subscriber
466 protections.--

467 (1) With respect to the provisions of this part and part
468 III, the principles expressed in the following statements shall
469 serve as standards to be followed by the commission, the office,
470 the department, and the Agency for Health Care Administration in
471 exercising their powers and duties, in exercising administrative
472 discretion, in administrative interpretations of the law, in
473 enforcing its provisions, and in adopting rules:

474 (b) A health maintenance organization subscriber should
475 receive quality health care from a broad panel of providers,
476 including referrals, preventive care pursuant to s. 641.402(1),
477 emergency screening and services pursuant to ss. 641.31(14)~~(12)~~
478 and 641.513, and second opinions pursuant to s. 641.51.

479 (i) A health maintenance organization subscriber should
480 receive timely and, if necessary, urgent grievances and appeals
481 within the health maintenance organization pursuant to ss.
482 641.228, 641.31(7)~~(5)~~, 641.47, and 641.511.

483 Section 16. Subsection (1) of section 641.2018, Florida
484 Statutes, is amended to read:

485 641.2018 Limited coverage for home health care
 486 authorized.--

487 (1) Notwithstanding other provisions of this chapter, a
 488 health maintenance organization may issue a contract that limits
 489 coverage to home health care services only. The organization and
 490 the contract shall be subject to all of the requirements of this
 491 part that do not require or otherwise apply to specific benefits
 492 other than home care services. To this extent, all of the
 493 requirements of this part apply to any organization or contract
 494 that limits coverage to home care services, except the
 495 requirements for providing comprehensive health care services as
 496 provided in ss. 641.19(4), (11), and (12), and 641.31(1), except
 497 ss. 641.31(11)(~~9~~), (14)(~~12~~), (~~17~~), (18), (19), (20), (21), (23),
 498 and (26)(~~24~~) and 641.31095.

499 Section 17. Section 641.3107, Florida Statutes, is amended
 500 to read:

501 641.3107 Delivery of contract.--Unless delivered upon
 502 execution or issuance, a health maintenance contract,
 503 certificate of coverage, or member handbook shall be mailed or
 504 delivered to the subscriber or, in the case of a group health
 505 maintenance contract, to the employer or other person who will
 506 hold the contract on behalf of the subscriber group within 10
 507 working days from approval of the enrollment form by the health
 508 maintenance organization or by the effective date of coverage,
 509 whichever occurs first. However, if the employer or other person
 510 who will hold the contract on behalf of the subscriber group
 511 requires retroactive enrollment of a subscriber, the

512 organization shall deliver the contract, certificate, or member
 513 handbook to the subscriber within 10 days after receiving notice
 514 from the employer of the retroactive enrollment. This section
 515 does not apply to the delivery of those contracts specified in
 516 s. 641.31(15)~~(13)~~.

517 Section 18. Paragraph (a) of subsection (7) of section
 518 641.3922, Florida Statutes, is amended to read:

519 641.3922 Conversion contracts; conditions.--Issuance of a
 520 converted contract shall be subject to the following conditions:

521 (7) REASONS FOR CANCELLATION; TERMINATION.--The converted
 522 health maintenance contract must contain a cancellation or
 523 nonrenewability clause providing that the health maintenance
 524 organization may refuse to renew the contract of any person
 525 covered thereunder, but cancellation or nonrenewal must be
 526 limited to one or more of the following reasons:

527 (a) Fraud or intentional misrepresentation, subject to the
 528 limitations of s. 641.31(25)~~(23)~~, in applying for any benefits
 529 under the converted health maintenance contract.

530 Section 19. Subsection (4) of section 641.513, Florida
 531 Statutes, is amended to read:

532 641.513 Requirements for providing emergency services and
 533 care.--

534 (4) A subscriber may be charged a reasonable copayment, as
 535 provided in s. 641.31(14)~~(12)~~, for the use of an emergency room.

536 Section 20. Paragraph (b) of subsection (2) and subsection
 537 (6) of section 641.316, Florida Statutes, are amended to read:

538 641.316 Fiscal intermediary services.--

539 (2)
 540 (b) The term "fiscal intermediary services organization"
 541 means a person or entity that ~~which~~ performs fiduciary or fiscal
 542 intermediary services to health care professionals who contract
 543 with health maintenance organizations other than ~~a fiscal~~
 544 ~~intermediary services organization owned, operated, or~~
 545 ~~controlled by~~ a hospital licensed under chapter 395, an insurer
 546 licensed under chapter 624, a third-party administrator licensed
 547 under chapter 626, a prepaid limited health service organization
 548 licensed under chapter 636, a health maintenance organization
 549 licensed under this chapter, or physician group practices as
 550 defined in s. 456.053(3)(h) and providing services under the
 551 scope of licenses of the members of the group practice.

552 (6) Any fiscal intermediary services organization, other
 553 than ~~a fiscal intermediary services organization owned,~~
 554 ~~operated, or controlled by~~ a hospital licensed under chapter
 555 395, an insurer licensed under chapter 624, a third-party
 556 administrator licensed under chapter 626, a prepaid limited
 557 health service organization licensed under chapter 636, a health
 558 maintenance organization licensed under this chapter, or
 559 physician group practices as defined in s. 456.053(3)(h), and
 560 providing services under the scope of licenses of the members of
 561 the group practice, must register with the office and meet the
 562 requirements of this section. In order to register as a fiscal
 563 intermediary services organization, the organization must comply
 564 with ss. 641.21(1)(c), and (d), and (j), and 641.22(6), and
 565 641.27. The fiscal intermediary services organization must also

566 comply with the provisions of ss. 641.3155, 641.3156, and
567 641.51(4). Should the office determine that the fiscal
568 intermediary services organization does not meet the
569 requirements of this section, the registration shall be denied.
570 In the event that the registrant fails to maintain compliance
571 with the provisions of this section, the office may revoke or
572 suspend the registration. In lieu of revocation or suspension of
573 the registration, the office may levy an administrative penalty
574 in accordance with s. 641.25.

575 Section 21. Section 409.9102, Florida Statutes, as created
576 by section 2 of chapter 2005-252, Laws of Florida, is reenacted
577 and amended to read:

578 (Substantial rewording of section. See
579 s. 409.9102, F.S., for present text.)

580 409.9102 A qualified state Long-Term Care Insurance
581 Partnership Program in Florida.--The Agency for Health Care
582 Administration, in consultation with the Office of Insurance
583 Regulation and the Department of Children and Family Services,
584 is directed to establish a qualified state Long-Term Care
585 Insurance Partnership Program in Florida, in compliance with the
586 requirements of s. 1917(b) of the Social Security Act, as
587 amended.

588 (1) The program shall:

589 (a) Provide incentives for an individual to obtain or
590 maintain insurance to cover the cost of long-term care.

591 (b) Provide a mechanism to qualify for coverage of the
592 costs of long-term care needs under Medicaid without first being

593 required to substantially exhaust his or her assets, including a
594 provision for the disregard of any assets in an amount equal to
595 the insurance benefit payments that are made to or on behalf of
596 an individual who is a beneficiary under the program.

597 (c) Alleviate the financial burden on the state's medical
598 assistance program by encouraging the pursuit of private
599 initiatives.

600 (2) The Agency for Health Care Administration, in
601 consultation with the Office of Insurance Regulation and the
602 Department of Children and Family Services, and in accordance
603 with federal guidelines, shall create standards for long-term
604 care partnership program information distributed to individuals
605 through insurance companies offering approved long-term care
606 partnership program policies.

607 (3) The Agency for Health Care Administration is
608 authorized to amend the Medicaid state plan and adopt rules
609 pursuant to ss. 120.536(1) and 120.54 to implement this section.

610 (4) The Department of Children and Family Services, when
611 determining eligibility for Medicaid long-term care services for
612 an individual who is the beneficiary of an approved long-term
613 care partnership program policy, shall reduce the total
614 countable assets of the individual by an amount equal to the
615 insurance benefit payments that are made to or on behalf of the
616 individual. The department is authorized to adopt rules pursuant
617 to ss. 120.536(1) and 120.54 to implement this subsection.

618 Section 22. Section 627.94075, Florida Statutes, is
619 created to read:

620 627.94075 A qualified state Long-Term Care Insurance
 621 Partnership Program in Florida.--The commission may adopt rules
 622 pursuant to ss. 120.536(1) and 120.54 to implement applicable
 623 provisions of a qualified state Long-Term Care Insurance
 624 Partnership Program in Florida in accordance with the
 625 requirements of s. 1917(b) of the Social Security Act, as
 626 amended, any applicable federal guidelines, and any rules
 627 necessary to ensure program compliance by insurers as provided
 628 in s. 409.9102.

629 Section 23. Sections 1 and 2 of chapter 2005-252, Laws of
 630 Florida, are repealed.

631 Section 24. Section 4 of chapter 2005-252, Laws of
 632 Florida, is amended to read:

633 Section 4. This act shall take effect upon becoming a law,
 634 ~~except that the amendments to section 409.905, Florida Statutes,~~
 635 ~~and the newly created section 409.9102, Florida Statutes,~~
 636 ~~provided in this act shall take effect contingent upon amendment~~
 637 ~~to section 1917(b)(1)(c) of the Social Security Act by the~~
 638 ~~United States Congress to delete the "May 14, 1993," deadline~~
 639 ~~for approval by states of long term care partnership plans.~~

640 Section 25. The Office of Program Policy Analysis and
 641 Government Accountability is directed to prepare a report on the
 642 implementation of a qualified state Long-Term Care Insurance
 643 Partnership Program in Florida. The report shall include data on
 644 the number and value of policies sold and the geographic areas
 645 in which the policies were purchased, a demographic description
 646 of the policyholders, and other information necessary to

647 | evaluate the program. The report shall be provided to the
648 | Governor, the President of the Senate, and the Speaker of the
649 | House of Representatives by January 31, 2009.

650 | Section 26. This act shall take effect January 1, 2007,
651 | and shall apply to identification cards issued for policies or
652 | certificates issued or renewed on or after that date.