A bill to be entitled

An act relating to health and human services; repealing s. 408.50, F.S., relating to prospective payment arrangements; repealing s. 408.70, F.S., relating to managed competition in health care markets; repealing s. 408.9091, F.S., relating to the Cover Florida Health Care Access Program; amending s. 627.6699, F.S., the Employee Health Care Access Act; deleting from the act provisions relating to the Florida Small Employer Health Reinsurance Program; amending ss. 112.363, 395.002, 395.003, 408.07, 458.345, 459.021, 627.642, 627.6475, 627.6487, 627.657, 627.6675, 641.3922, 945.603, and 1011.52, F.S.; conforming provisions to changes made by the act; providing effective dates.

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

Section 1. Section 408.50, Florida Statutes, is repealed.

Section 2. Section 408.70, Florida Statutes, is repealed.

Section 3. Effective January 1, 2014, section 408.9091, Florida Statutes, is repealed.

Section 4. Paragraph (d) of subsection (2) of section 112.363, Florida Statutes, is amended to read:

112.363 Retiree health insurance subsidy.—

(2) ELIGIBILITY FOR RETIREE HEALTH INSURANCE SUBSIDY.—

(d) Payment of the retiree health insurance subsidy shall be made only after coverage for health insurance for the retiree or beneficiary has been certified in writing to the Department

of Management Services. Participation in a former employer's group health insurance program is not a requirement for eligibility under this section. ~~Coverage issued pursuant to s. 408.9091 is considered health insurance for the purposes of this section.~~

Section 5. Subsection (23) of section 395.002, Florida Statutes, is amended to read

395.002 Definitions.—As used in this chapter:

(23) "Premises" means those buildings, beds, and equipment located at the address of the licensed facility and all other buildings, beds, and equipment for the provision of hospital, ambulatory surgical, or mobile surgical care located in such reasonable proximity to the address of the licensed facility as to appear to the public to be under the dominion and control of the licensee. For any licensee that is a teaching hospital as defined in s. 408.07(44) ~~(45)~~, reasonable proximity includes any buildings, beds, services, programs, and equipment under the dominion and control of the licensee that are located at a site with a main address that is within 1 mile of the main address of the licensed facility; and all such buildings, beds, and equipment may, at the request of a licensee or applicant, be included on the facility license as a single premises.

Section 6. Paragraph (b) of subsection (2) of section 395.003, Florida Statutes, is amended to read:

395.003 Licensure; denial, suspension, and revocation.—

(2)

(b) The agency shall, at the request of a licensee that is a teaching hospital as defined in s. 408.07(44) ~~(45)~~, issue a

single license to a licensee for facilities that have been previously licensed as separate premises, provided such separately licensed facilities, taken together, constitute the same premises as defined in s. 395.002(23). Such license for the single premises shall include all of the beds, services, and programs that were previously included on the licenses for the separate premises. The granting of a single license under this paragraph shall not in any manner reduce the number of beds, services, or programs operated by the licensee.

Section 7. Subsections (42) through (45) of section 408.07, Florida Statutes, are renumbered as subsections (41) through (44), respectively, and present subsection (41) of that section is amended to read:

408.07 Definitions.—As used in this chapter, with the exception of ss. 408.031-408.045, the term:

~~(41) "Prospective payment arrangement" means a financial agreement negotiated between a hospital and an insurer, health maintenance organization, preferred provider organization, or other third-party payor which contains, at a minimum, the elements provided for in s. 408.50.~~

Section 8. Subsection (1) of section 458.345, Florida Statutes, is amended to read:

458.345 Registration of resident physicians, interns, and fellows; list of hospital employees; prescribing of medicinal drugs; penalty.—

(1) Any person desiring to practice as a resident physician, assistant resident physician, house physician, intern, or fellow in fellowship training which leads to

subspecialty board certification in this state, or any person desiring to practice as a resident physician, assistant resident physician, house physician, intern, or fellow in fellowship training in a teaching hospital in this state as defined in s. 408.07(44)~~(45)~~ or s. 395.805(2), who does not hold a valid, active license issued under this chapter shall apply to the department to be registered and shall remit a fee not to exceed $300 as set by the board. The department shall register any applicant the board certifies has met the following requirements:

(a) Is at least 21 years of age.

(b) Has not committed any act or offense within or without the state which would constitute the basis for refusal to certify an application for licensure pursuant to s. 458.331.

(c) Is a graduate of a medical school or college as specified in s. 458.311(1)(f).

Section 9. Subsection (1) of section 459.021, Florida Statutes, is amended to read:

459.021 Registration of resident physicians, interns, and fellows; list of hospital employees; penalty.—

(1) Any person who holds a degree of Doctor of Osteopathic Medicine from a college of osteopathic medicine recognized and approved by the American Osteopathic Association who desires to practice as a resident physician, assistant resident physician, house physician, intern, or fellow in fellowship training which leads to subspecialty board certification in this state, or any person desiring to practice as a resident physician, assistant resident physician, house physician, intern, or fellow in

fellowship training in a teaching hospital in this state as defined in s. 408.07(44) ~~(45)~~ or s. 395.805(2), who does not hold an active license issued under this chapter shall apply to the department to be registered, on an application provided by the department, before commencing such a training program and shall remit a fee not to exceed $300 as set by the board.

Section 10. Subsection (3) of section 627.642, Florida Statutes, is amended to read:

627.642 Outline of coverage.—

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

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

(b) The name of the contract holder.

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

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

(e) A contact phone number or electronic address for authorizations and admission certifications.

(f) A phone number or electronic address whereby the covered person or hospital, physician, or other person rendering services covered by the policy may obtain benefits verification and information in order to estimate patient financial responsibility, in compliance with privacy rules under the

Health Insurance Portability and Accountability Act.

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

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

Section 11. Section 627.6475, Florida Statutes, is amended to read:

627.6475 Individual reinsurance pool.—

(1) PURPOSE.—The purpose of this section is to provide for the establishment of a reinsurance program for coverage of individuals who are eligible for issuance of individual health insurance from a health insurance issuer pursuant to s. 627.6487.

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

(a) ~~"Board," "carrier," and~~ "Health benefit plan" has ~~have~~ the same meaning ascribed in s. 627.6699(3)(j).

(b) "Health insurance issuer," "issuer," and "individual health insurance" have the same meaning ascribed in s. 627.6487(2).

~~(c) "Reinsuring carrier" means a health insurance issuer that elects to comply with the requirements set forth in subsection (7).~~

(c)~~(d)~~ "Risk-assuming carrier" means a health insurance

issuer that elects to comply with the requirements set forth in subsection (6).

(d) ~~(c)~~ "Eligible individual" has the same meaning ascribed in s. 627.6487(3).

(3) APPLICABILITY AND SCOPE.—This section applies to individual health insurance offered by a health insurance issuer to an eligible individual.

(4) MAINTENANCE OF RECORDS.—Each health insurance issuer that offers individual health insurance must maintain at its principal place of business a complete and detailed description of its rating practices and renewal practices, as required for small employer carriers pursuant to s. 627.6699(8).

(5) ISSUER'S ELECTION TO BECOME A RISK-ASSUMING CARRIER.—

(a) Each health insurance issuer that offers individual health insurance must elect to become a risk-assuming carrier ~~or a reinsuring carrier~~ for purposes of this section. Each such issuer must make an initial election, binding through December 31, 1999. The issuer's initial election must be made no later than October 31, 1997. By October 31, 1997, all issuers must file a final election, which is binding for 2 years, from January 1, 1998, through December 31, 1999, after which an election shall be binding for a period of 5 years. The office may permit an issuer to modify its election at any time for good cause shown, after a hearing.

~~(b) The office shall establish an application process for issuers seeking to change their status under this subsection.~~

(b) ~~(c)~~ An election to become a risk-assuming carrier is subject to approval under this subsection.

~~(d) An issuer that elects to cease participating as a reinsuring carrier and to become a risk-assuming carrier may not reinsure or continue to reinsure any individual health benefits plan under subsection (7) once the issuer becomes a risk-assuming carrier, and the issuer must pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured. An issuer that elects to cease participating as a risk-assuming carrier and to become a reinsuring carrier may reinsure individual health insurance under the terms set forth in subsection (7) and must pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured.~~

(6) ELECTION PROCESS TO BECOME A RISK-ASSUMING CARRIER.—

(a)1. A health insurance issuer that offers individual health insurance may become a risk-assuming carrier by filing with the office a designation of election under this subsection in a format and manner prescribed by the commission. The office shall approve the election of a health insurance issuer to become a risk-assuming carrier if the office finds that the issuer is capable of assuming that status pursuant to the criteria set forth in paragraph (b).

2. The office must approve or disapprove any designation as a risk-assuming carrier within 60 days after a filing.

(b) In determining whether to approve an application by an issuer to become a risk-assuming carrier, the office shall consider:

1. The issuer's financial ability to support the

assumption of the risk of individuals.

2. The issuer's history of rating and underwriting individuals.

3. The issuer's commitment to market fairly to all individuals in the state or its service area, as applicable.

~~4. The issuer's ability to assume and manage the risk of enrolling individuals without the protection of the reinsurance program provided in subsection (7).~~

(c) The office shall provide public notice of an issuer's designation of election under this subsection to become a risk-assuming carrier and shall provide at least a 21-day period for public comment prior to making a decision on the election. The office shall hold a hearing on the election at the request of the issuer.

(d) The office may rescind the approval granted to a risk-assuming carrier under this subsection if the office finds that the carrier no longer meets the criteria of paragraph (b).

~~(7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.—~~

~~(a) The individual health reinsurance program shall operate subject to the supervision and control of the board of the small employer health reinsurance program established pursuant to s. 627.6699(11). The board shall establish a separate, segregated account for eligible individuals reinsured pursuant to this section, which account may not be commingled with the small employer health reinsurance account.~~

~~(b) A reinsuring carrier may reinsure with the program coverage of an eligible individual, subject to each of the following provisions:~~

~~1. A reinsuring carrier may reinsure an eligible individual within 60 days after commencement of the coverage of the eligible individual.~~

~~2. The program may not reimburse a participating carrier with respect to the claims of a reinsured eligible individual until the carrier has paid incurred claims of at least $5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier is responsible for 10 percent of the next $50,000 and 5 percent of the next $100,000 of incurred claims during a calendar year, and the program shall reinsure the remainder.~~

~~3. The board shall annually adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment may not be less than the annual change in the medical component of the "Commerce Price Index for All Urban Consumers" of the Bureau of Labor Statistics of the United States Department of Labor, unless the board proposes and the office approves a lower adjustment factor.~~

~~4. A reinsuring carrier may terminate reinsurance for all reinsured eligible individuals on any plan anniversary.~~

~~5. The premium rate charged for reinsurance by the program to a health maintenance organization that is approved by the Secretary of Health and Human Services as a federally qualified health maintenance organization pursuant to 42 U.S.C. s. 300e(c)(2)(A) and that, as such, is subject to requirements that limit the amount of risk that may be ceded to the program, which~~

~~requirements are more restrictive than subparagraph 2., shall be reduced by an amount equal to that portion of the risk, if any, which exceeds the amount set forth in subparagraph 2., which may not be ceded to the program.~~

~~6. The board may consider adjustments to the premium rates charged for reinsurance by the program or carriers that use effective cost-containment measures, including high-cost case management, as defined by the board.~~

~~7. A reinsuring carrier shall apply its case-management and claims-handling techniques, including, but not limited to, utilization review, individual case management, preferred provider provisions, other managed-care provisions, or methods of operation consistently with both reinsured business and nonreinsured business.~~

~~(c)1. The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring eligible individuals pursuant to this section. The methodology must include a system for classifying individuals which reflects the types of case characteristics commonly used by carriers in this state. The methodology must provide for the development of basic reinsurance premium rates, which shall be multiplied by the factors set for them in this paragraph to determine the premium rates for the program. The basic reinsurance premium rates shall be established by the board, subject to the approval of the office, and shall be set at levels that reasonably approximate gross premiums charged to eligible individuals for individual health insurance by health insurance issuers. The premium rates~~

~~set by the board may vary by geographical area, as determined under this section, to reflect differences in cost. An eligible individual may be reinsured for a rate that is five times the rate established by the board.~~

~~2. The board shall periodically review the methodology established, including the system of classification and any rating factors, to ensure that it reasonably reflects the claims experience of the program. The board may propose changes to the rates that are subject to the approval of the office.~~

~~(d) If individual health insurance for an eligible individual is entirely or partially reinsured with the program pursuant to this section, the premium charged to the eligible individual for any rating period for the coverage issued must be the same premium that would have been charged to that individual if the health insurance issuer elected not to reinsure coverage for that individual.~~

~~(e)1. Before March 1 of each calendar year, the board shall determine and report to the office the program net loss in the individual account for the previous year, including administrative expenses for that year and the incurred losses for that year, taking into account investment income and other appropriate gains and losses.~~

~~2. Any net loss in the individual account for the year shall be recouped by assessing the carriers as follows:~~

~~a. The operating losses of the program shall be assessed in the following order subject to the specified limitations. The first tier of assessments shall be made against reinsuring carriers in an amount that may not exceed 5 percent of each~~

~~reinsuring carrier's premiums for individual health insurance. If such assessments have been collected and additional moneys are needed, the board shall make a second tier of assessments in an amount that may not exceed 0.5 percent of each carrier's health benefit plan premiums.~~

~~b. Except as provided in paragraph (f), risk-assuming carriers are exempt from all assessments authorized pursuant to this section. The amount paid by a reinsuring carrier for the first tier of assessments shall be credited against any additional assessments made.~~

~~c. The board shall equitably assess reinsuring carriers for operating losses of the individual account based on market share. The board shall annually assess each carrier a portion of the operating losses of the individual account. The first tier of assessments shall be determined by multiplying the operating losses by a fraction, the numerator of which equals the reinsuring carrier's earned premium pertaining to direct writings of individual health insurance in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of all such premiums earned by reinsuring carriers in the state during that calendar year. The second tier of assessments shall be based on the premiums that all carriers, except risk-assuming carriers, earned on all health benefit plans written in this state. The board may levy interim assessments against reinsuring carriers to ensure the financial ability of the plan to cover claims expenses and administrative expenses paid or estimated to be paid in the operation of the plan for the calendar year prior to

~~the association's anticipated receipt of annual assessments for that calendar year. Any interim assessment is due and payable within 30 days after receipt by a carrier of the interim assessment notice. Interim assessment payments shall be credited against the carrier's annual assessment. Health benefit plan premiums and benefits paid by a carrier that are less than an amount determined by the board to justify the cost of collection may not be considered for purposes of determining assessments.~~

~~d. Subject to the approval of the office, the board shall adjust the assessment formula for reinsuring carriers that are approved as federally qualified health maintenance organizations by the Secretary of Health and Human Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent, if any, that restrictions are placed on them which are not imposed on other carriers.~~

~~3. Before March 1 of each year, the board shall determine and file with the office an estimate of the assessments needed to fund the losses incurred by the program in the individual account for the previous calendar year.~~

~~4. If the board determines that the assessments needed to fund the losses incurred by the program in the individual account for the previous calendar year will exceed the amount specified in subparagraph 2., the board shall evaluate the operation of the program and report its findings and recommendations to the office in the format established in s. 627.6699(11) for the comparable report for the small employer reinsurance program.~~

~~(f) Notwithstanding paragraph (e), the administrative expenses of the program shall be recouped by assessing risk-~~

~~assuming carriers and reinsuring carriers, and such amounts may not be considered part of the operating losses of the plan for the purposes of this paragraph. Each carrier's portion of such administrative expenses shall be determined by multiplying the total of such administrative expenses by a fraction, the numerator of which equals the carrier's earned premium pertaining to direct writing of individual health benefit plans in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of such premiums earned by all carriers in the state during such calendar year.~~

~~(g) Except as otherwise provided in this section, the board and the office shall have all powers, duties, and responsibilities with respect to carriers that issue and reinsure individual health insurance, as specified for the board and the office in s. 627.6699(11) with respect to small employer carriers, including, but not limited to, the provisions of s. 627.6699(11) relating to:~~

~~1. Use of assessments that exceed the amount of actual losses and expenses.~~

~~2. The annual determination of each carrier's proportion of the assessment.~~

~~3. Interest for late payment of assessments.~~

~~4. Authority for the office to approve deferment of an assessment against a carrier.~~

~~5. Limited immunity from legal actions or carriers.~~

~~6. Development of standards for compensation to be paid to agents. Such standards shall be limited to those specifically~~

~~enumerated in s. 627.6699(13)(d).~~

~~7. Monitoring compliance by carriers with this section.~~

(7)~~(8)~~ STANDARDS TO ASSURE FAIR MARKETING.—

(a) Each health insurance issuer that offers individual health insurance shall actively market coverage to eligible individuals in the state. The provisions of s. 627.6699(11)~~(13)~~ that apply to small employer carriers that market policies to small employers ~~shall~~ also apply to health insurance issuers that offer individual health insurance with respect to marketing policies to individuals.

(b) A violation of this section by a health insurance issuer or an agent is an unfair trade practice under s. 626.9541 or ss. 641.3903 and 641.3907.

(8)~~(9)~~ RULEMAKING AUTHORITY.—The commission may adopt rules to administer this section, including rules governing compliance by carriers.

Section 12. Subsection (9) of section 627.6487, Florida Statutes, is amended to read:

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

(9) Each health insurance issuer that offers individual health insurance coverage to an eligible individual shall elect to become a risk-assuming carrier ~~or a reinsuring carrier~~, as provided by s. 627.6475.

Section 13. Subsection (2) of section 627.657, Florida Statutes, is amended to read:

627.657 Provisions of group health insurance policies.—

(2) The medical policy as specified in s.

627.6699(3) (j) ~~(k)~~ must be accompanied by an identification card that contains, at a minimum:

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

(b) The name of the certificateholder.

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

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

(e) A contact phone number or electronic address for authorizations and admission certifications.

(f) A phone number or electronic address whereby the covered person or hospital, physician, or other person rendering services covered by the policy may obtain benefits verification and information in order to estimate patient financial responsibility, in compliance with privacy rules under the Health Insurance Portability and Accountability Act.

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

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

Section 14. Subsection (11) of section 627.6675, Florida Statutes, is amended to read:

627.6675 Conversion on termination of eligibility.—Subject to all of the provisions of this section, a group policy delivered or issued for delivery in this state by an insurer or nonprofit health care services plan that provides, on an expense-incurred basis, hospital, surgical, or major medical expense insurance, or any combination of these coverages, shall provide that an employee or member whose insurance under the group policy has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy, and under any group policy providing similar benefits that the terminated group policy replaced, for at least 3 months immediately prior to termination, shall be entitled to have issued to him or her by the insurer a policy or certificate of health insurance, referred to in this section as a "converted policy." A group insurer may meet the requirements of this section by contracting with another insurer, authorized in this state, to issue an individual converted policy, which policy has been approved by the office under s. 627.410. An employee or member shall not be entitled to a converted policy if termination of his or her insurance under the group policy occurred because he or she failed to pay any required contribution, or because any discontinued group coverage was replaced by similar group coverage within 31 days after discontinuance.

(11) ALTERNATIVE PLANS.—The insurer shall, in addition to

the option required by subsection (10), offer the standard health benefit plan, as established pursuant to s. 627.6699(10)~~(12)~~. The insurer may, at its option, also offer alternative plans for group health conversion in addition to the plans required by this section.

Section 15. Subsections (10) and (12) through (17) of section 627.6699, Florida Statutes, are renumbered as subsections (9) and (10) through (15), respectively, and present subsections (2), (3), (9), (10), and (11), paragraph (a) of present subsection (12), paragraph (e) of present subsection (13), paragraph (k) of present subsection (15), and paragraphs (a), (c), and (d) of present subsection (16) of that section are amended, to read:

627.6699 Employee Health Care Access Act.—

(2) PURPOSE AND INTENT.—The purpose and intent of this section is to promote the availability of health insurance coverage to small employers regardless of their claims experience or their employees' health status, to establish rules regarding renewability of that coverage, to establish limitations on the use of exclusions for preexisting conditions, to provide for development of a standard health benefit plan and a basic health benefit plan to be offered to all small employers~~, to provide for establishment of a reinsurance program for coverage of small employers~~, and to improve the overall fairness and efficiency of the small group health insurance market.

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

(a) "Actuarial certification" means a written statement,

by a member of the American Academy of Actuaries or another person acceptable to the office, that a small employer carrier is in compliance with subsection (6), based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the carrier in establishing premium rates for applicable health benefit plans.

(b) "Basic health benefit plan" and "standard health benefit plan" mean low-cost health care plans developed pursuant to subsection (10) ~~(12)~~.

~~(c) "Board" means the board of directors of the program.~~

(c)~~(d)~~ "Carrier" means a person who provides health benefit plans in this state, including an authorized insurer, a health maintenance organization, a multiple-employer welfare arrangement, or any other person providing a health benefit plan that is subject to insurance regulation in this state. However, the term does not include a multiple-employer welfare arrangement, which multiple-employer welfare arrangement operates solely for the benefit of the members or the members and the employees of such members, and was in existence on January 1, 1992.

(d)~~(e)~~ "Case management program" means the specific supervision and management of the medical care provided or prescribed for a specific individual, which may include the use of health care providers designated by the carrier.

(e)~~(f)~~ "Creditable coverage" has the same meaning ascribed in s. 627.6561.

(f)~~(g)~~ "Dependent" means the spouse or child of an eligible employee, subject to the applicable terms of the health

benefit plan covering that employee.

(g) ~~(h)~~ "Eligible employee" means an employee who works full time, having a normal workweek of 25 or more hours, and who has met any applicable waiting-period requirements or other requirements of this act. The term includes a self-employed individual, a sole proprietor, a partner of a partnership, or an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include a part-time, temporary, or substitute employee.

(h) ~~(i)~~ "Established geographic area" means the county or counties, or any portion of a county or counties, within which the carrier provides or arranges for health care services to be available to its insureds, members, or subscribers.

(i) ~~(j)~~ "Guaranteed-issue basis" means an insurance policy that must be offered to an employer, employee, or dependent of the employee, regardless of health status, preexisting conditions, or claims history.

(j) ~~(k)~~ "Health benefit plan" means any hospital or medical policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract. The term does not include accident-only, specified disease, individual hospital indemnity, credit, dental-only, vision-only, Medicare supplement, long-term care, or disability income insurance; similar supplemental plans provided under a separate policy, certificate, or contract of insurance, which cannot duplicate coverage under an underlying health plan and are specifically designed to fill gaps in the underlying health

plan, coinsurance, or deductibles; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical-payment insurance.

(k) ~~(l)~~ "Late enrollee" means an eligible employee or dependent as defined under s. 627.6561(1)(b).

(l) ~~(m)~~ "Limited benefit policy or contract" means a policy or contract that provides coverage for each person insured under the policy for a specifically named disease or diseases, a specifically named accident, or a specifically named limited market that fulfills an experimental or reasonable need, such as the small group market.

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

(n) ~~(o)~~ "Participating carrier" means any carrier that issues health benefit plans in this state except a small employer carrier that elects to be a risk-assuming carrier.

~~(p) "Plan of operation" means the plan of operation of the program, including articles, bylaws, and operating rules, adopted by the board under subsection (11).~~

~~(q) "Program" means the Florida Small Employer Carrier Reinsurance Program created under subsection (11).~~

(o) ~~(r)~~ "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

~~(s) "Reinsuring carrier" means a small employer carrier that elects to comply with the requirements set forth in subsection (11).~~

(p) ~~(t)~~ "Risk-assuming carrier" means a small employer carrier that elects to comply with the requirements set forth in subsection (9) ~~(10)~~.

(q) ~~(u)~~ "Self-employed individual" means an individual or sole proprietor who derives his or her income from a trade or business carried on by the individual or sole proprietor which results in taxable income as indicated on IRS Form 1040, schedule C or F, and which generated taxable income in one of the 2 previous years.

(r) ~~(v)~~ "Small employer" means, in connection with a health benefit plan with respect to a calendar year and a plan year, any person, sole proprietor, self-employed individual, independent contractor, firm, corporation, partnership, or association that is actively engaged in business, has its principal place of business in this state, employed an average of at least 1 but not more than 50 eligible employees on business days during the preceding calendar year the majority of whom were employed in this state, employs at least 1 employee on the first day of the plan year, and is not formed primarily for purposes of purchasing insurance. In determining the number of eligible employees, companies that are an affiliated group as defined in s. 1504(a) of the Internal Revenue Code of 1986, as

amended, are considered a single employer. For purposes of this section, a sole proprietor, an independent contractor, or a self-employed individual is considered a small employer only if all of the conditions and criteria established in this section are met.

(s) ~~(w)~~ "Small employer carrier" means a carrier that offers health benefit plans covering eligible employees of one or more small employers.

~~(9) SMALL EMPLOYER CARRIER'S ELECTION TO BECOME A RISK-ASSUMING CARRIER OR A REINSURING CARRIER.~~

~~(a) A small employer carrier must elect to become either a risk-assuming carrier or a reinsuring carrier. By October 31, 1993, all small employer carriers must file a final election, which is binding for 2 years, from January 1, 1994, through December 31, 1995, after which an election shall be binding for a period of 5 years. Any carrier that is not a small employer carrier and intends to become a small employer carrier must file its designation when it files the forms and rates it intends to use for small employer group health insurance; such designation shall be binding for 2 years after the date of approval of the forms and rates, and any subsequent designation is binding for 5 years. The office may permit a carrier to modify its election at any time for good cause shown, after a hearing.~~

~~(b) The commission shall establish an application process for small employer carriers seeking to change their status under this subsection.~~

~~(c) An election to become a risk-assuming carrier is subject to approval under subsection (10).~~

~~(d) A small employer carrier that elects to cease participating as a reinsuring carrier and to become a risk-assuming carrier is prohibited from reinsuring or continuing to reinsure any small employer health benefits plan under subsection (11) as soon as the carrier becomes a risk-assuming carrier and must pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured. A small employer carrier that elects to cease participating as a risk-assuming carrier and to become a reinsuring carrier is permitted to reinsure small employer health benefit plans under the terms set forth in subsection (11) and must pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured.~~

(9)~~(10)~~ ELECTION PROCESS TO BECOME A RISK-ASSUMING CARRIER.—

(a)1. ~~A small employer carrier may become a risk-assuming carrier by filing with the office a designation of election under subsection (9) in a format and manner prescribed by the commission.~~ The office shall approve the election of a small employer carrier to become a risk-assuming carrier if the office finds that the carrier is capable of assuming that status pursuant to the criteria set forth in paragraph (b).

2. The office must approve or disapprove any designation as a risk-assuming carrier within 60 days after filing.

(b) In determining whether to approve an application by a small employer carrier to become a risk-assuming carrier, the office shall consider:

1. The carrier's financial ability to support the assumption of the risk of small employer groups.

2. The carrier's history of rating and underwriting small employer groups.

3. The carrier's commitment to market fairly to all small employers in the state or its service area, as applicable.

~~4. The carrier's ability to assume and manage the risk of enrolling small employer groups without the protection of the reinsurance program provided in subsection (11).~~

~~(c) A small employer carrier that becomes a risk-assuming carrier pursuant to this subsection is not subject to the assessment provisions of subsection (11).~~

~~(d) The office shall provide public notice of a small employer carrier's designation of election under subsection (9) to become a risk-assuming carrier and shall provide at least a 21-day period for public comment prior to making a decision on the election. The office shall hold a hearing on the election at the request of the carrier.~~

(c)~~(e)~~ The office may rescind the approval granted to a risk-assuming carrier under this subsection if the office finds that the carrier no longer meets the criteria of paragraph (b).

~~(11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.—~~

~~(a) There is created a nonprofit entity to be known as the "Florida Small Employer Health Reinsurance Program."~~

~~(b)1. The program shall operate subject to the supervision and control of the board.~~

~~2. Effective upon this act becoming a law, the board shall consist of the director of the office or his or her designee,~~

~~who shall serve as the chairperson, and 13 additional members who are representatives of carriers and insurance agents and are appointed by the director of the office and serve as follows:~~

~~a. Five members shall be representatives of health insurers licensed under chapter 624 or chapter 641. Two members shall be agents who are actively engaged in the sale of health insurance. Four members shall be employers or representatives of employers. One member shall be a person covered under an individual health insurance policy issued by a licensed insurer in this state. One member shall represent the Agency for Health Care Administration and shall be recommended by the Secretary of Health Care Administration.~~

~~b. A member appointed under this subparagraph shall serve a term of 4 years and shall continue in office until the member's successor takes office, except that, in order to provide for staggered terms, the director of the office shall designate two of the initial appointees under this subparagraph to serve terms of 2 years and shall designate three of the initial appointees under this subparagraph to serve terms of 3 years.~~

~~3. The director of the office may remove a member for cause.~~

~~4. Vacancies on the board shall be filled in the same manner as the original appointment for the unexpired portion of the term.~~

~~(c)1. The board shall submit to the office a plan of operation to assure the fair, reasonable, and equitable administration of the program. The board may at any time submit~~

~~to the office any amendments to the plan that the board finds to be necessary or suitable.~~

~~2. The office shall, after notice and hearing, approve the plan of operation if it determines that the plan submitted by the board is suitable to assure the fair, reasonable, and equitable administration of the program and provides for the sharing of program gains and losses equitably and proportionately in accordance with paragraph (j).~~

~~3. The plan of operation, or any amendment thereto, becomes effective upon written approval of the office.~~

~~(d) The plan of operation must, among other things:~~

~~1. Establish procedures for handling and accounting for program assets and moneys and for an annual fiscal reporting to the office.~~

~~2. Establish procedures for selecting an administering carrier and set forth the powers and duties of the administering carrier.~~

~~3. Establish procedures for reinsuring risks.~~

~~4. Establish procedures for collecting assessments from participating carriers to provide for claims reinsured by the program and for administrative expenses, other than amounts payable to the administrative carrier, incurred or estimated to be incurred during the period for which the assessment is made.~~

~~5. Provide for any additional matters at the discretion of the board.~~

~~(e) The board shall recommend to the office market conduct requirements and other requirements for carriers and agents, including requirements relating to:~~

~~1. Registration by each carrier with the office of its intention to be a small employer carrier under this section;~~

~~2. Publication by the office of a list of all small employer carriers, including a requirement applicable to agents and carriers that a health benefit plan may not be sold by a carrier that is not identified as a small employer carrier;~~

~~3. The availability of a broadly publicized, toll-free telephone number for access by small employers to information concerning this section;~~

~~4. Periodic reports by carriers and agents concerning health benefit plans issued; and~~

~~5. Methods concerning periodic demonstration by small employer carriers and agents that they are marketing or issuing health benefit plans to small employers.~~

~~(f) The program has the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to groups or individuals. In addition thereto, the program has specific authority to:~~

~~1. Enter into contracts as necessary or proper to carry out the provisions and purposes of this act, including the authority to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions.~~

~~2. Sue or be sued, including taking any legal action necessary or proper for recovering any assessments and penalties~~

~~for, on behalf of, or against the program or any carrier.~~

~~3. Take any legal action necessary to avoid the payment of improper claims against the program.~~

~~4. Issue reinsurance policies, in accordance with the requirements of this act.~~

~~5. Establish rules, conditions, and procedures for reinsurance risks under the program participation.~~

~~6. Establish actuarial functions as appropriate for the operation of the program.~~

~~7. Assess participating carriers in accordance with paragraph (j), and make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Interim assessments shall be credited as offsets against any regular assessments due following the close of the calendar year.~~

~~8. Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the program, and in any other function within the authority of the program.~~

~~9. Borrow money to effect the purposes of the program. Any notes or other evidences of indebtedness of the program which are not in default constitute legal investments for carriers and may be carried as admitted assets.~~

~~10. To the extent necessary, increase the $5,000 deductible reinsurance requirement to adjust for the effects of inflation.~~

~~(g) A reinsuring carrier may reinsure with the program coverage of an eligible employee of a small employer, or any~~

~~dependent of such an employee, subject to each of the following provisions:~~

~~1. With respect to a standard and basic health care plan, the program must reinsure the level of coverage provided; and, with respect to any other plan, the program must reinsure the coverage up to, but not exceeding, the level of coverage provided under the standard and basic health care plan.~~

~~2. Except in the case of a late enrollee, a reinsuring carrier may reinsure an eligible employee or dependent within 60 days after the commencement of the coverage of the small employer. A newly employed eligible employee or dependent of a small employer may be reinsured within 60 days after the commencement of his or her coverage.~~

~~3. A small employer carrier may reinsure an entire employer group within 60 days after the commencement of the group's coverage under the plan. The carrier may choose to reinsure newly eligible employees and dependents of the reinsured group pursuant to subparagraph 1.~~

~~4. The program may not reimburse a participating carrier with respect to the claims of a reinsured employee or dependent until the carrier has paid incurred claims of at least $5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier shall be responsible for 10 percent of the next $50,000 and 5 percent of the next $100,000 of incurred claims during a calendar year and the program shall reinsure the remainder.~~

~~5. The board annually shall adjust the initial level of claims and the maximum limit to be retained by the carrier to~~

~~reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the "Consumer Price Index for All Urban Consumers" of the Bureau of Labor Statistics of the Department of Labor, unless the board proposes and the office approves a lower adjustment factor.~~

~~6. A small employer carrier may terminate reinsurance for all reinsured employees or dependents on any plan anniversary.~~

~~7. The premium rate charged for reinsurance by the program to a health maintenance organization that is approved by the Secretary of Health and Human Services as a federally qualified health maintenance organization pursuant to 42 U.S.C. s. 300e(c)(2)(A) and that, as such, is subject to requirements that limit the amount of risk that may be ceded to the program, which requirements are more restrictive than subparagraph 4., shall be reduced by an amount equal to that portion of the risk, if any, which exceeds the amount set forth in subparagraph 4. which may not be ceded to the program.~~

~~8. The board may consider adjustments to the premium rates charged for reinsurance by the program for carriers that use effective cost containment measures, including high-cost case management, as defined by the board.~~

~~9. A reinsuring carrier shall apply its case-management and claims-handling techniques, including, but not limited to, utilization review, individual case management, preferred provider provisions, other managed care provisions or methods of operation, consistently with both reinsured business and~~

~~nonreinsured business.~~

~~(h)1. The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of basic reinsurance premium rates, which shall be multiplied by the factors set for them in this paragraph to determine the premium rates for the program. The basic reinsurance premium rates shall be established by the board, subject to the approval of the office, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard and basic health benefit plan. The premium rates set by the board may vary by geographical area, as determined under this section, to reflect differences in cost. The multiplying factors must be established as follows:~~

~~a. The entire group may be reinsured for a rate that is 1.5 times the rate established by the board.~~

~~b. An eligible employee or dependent may be reinsured for a rate that is 5 times the rate established by the board.~~

~~2. The board periodically shall review the methodology established, including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the~~

~~rates which shall be subject to the approval of the office.~~

~~(i) If a health benefit plan for a small employer issued in accordance with this subsection is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued must be consistent with the requirements relating to premium rates set forth in this section.~~

~~(j)1. Before July 1 of each calendar year, the board shall determine and report to the office the program net loss for the previous year, including administrative expenses for that year, and the incurred losses for the year, taking into account investment income and other appropriate gains and losses.~~

~~2. Any net loss for the year shall be recouped by assessment of the carriers, as follows:~~

~~a. The operating losses of the program shall be assessed in the following order subject to the specified limitations. The first tier of assessments shall be made against reinsuring carriers in an amount which shall not exceed 5 percent of each reinsuring carrier's premiums from health benefit plans covering small employers. If such assessments have been collected and additional moneys are needed, the board shall make a second tier of assessments in an amount which shall not exceed 0.5 percent of each carrier's health benefit plan premiums. Except as provided in paragraph (n), risk-assuming carriers are exempt from all assessments authorized pursuant to this section. The amount paid by a reinsuring carrier for the first tier of assessments shall be credited against any additional assessments made.~~

~~b. The board shall equitably assess carriers for operating losses of the plan based on market share. The board shall annually assess each carrier a portion of the operating losses of the plan. The first tier of assessments shall be determined by multiplying the operating losses by a fraction, the numerator of which equals the reinsuring carrier's earned premium pertaining to direct writings of small employer health benefit plans in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of all such premiums earned by reinsuring carriers in the state during that calendar year. The second tier of assessments shall be based on the premiums that all carriers, except risk-assuming carriers, earned on all health benefit plans written in this state. The board may levy interim assessments against carriers to ensure the financial ability of the plan to cover claims expenses and administrative expenses paid or estimated to be paid in the operation of the plan for the calendar year prior to the association's anticipated receipt of annual assessments for that calendar year. Any interim assessment is due and payable within 30 days after receipt by a carrier of the interim assessment notice. Interim assessment payments shall be credited against the carrier's annual assessment. Health benefit plan premiums and benefits paid by a carrier that are less than an amount determined by the board to justify the cost of collection may not be considered for purposes of determining assessments.~~

~~c. Subject to the approval of the office, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved as federally qualified health~~

~~maintenance organizations by the Secretary of Health and Human Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.~~

~~3. Before July 1 of each year, the board shall determine and file with the office an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.~~

~~4. If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified in subparagraph 2., the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the office within 180 days following the end of the calendar year in which the losses were incurred. The evaluation shall include an estimate of future assessments, the administrative costs of the program, the appropriateness of the premiums charged and the level of carrier retention under the program, and the costs of coverage for small employers. If the board fails to file a report with the office within 180 days following the end of the applicable calendar year, the office may evaluate the operations of the program and implement such amendments to the plan of operation the office deems necessary to reduce future losses and assessments.~~

~~5. If assessments exceed the amount of the actual losses and administrative expenses of the program, the excess shall be held as interest and used by the board to offset future losses or to reduce program premiums. As used in this paragraph, the~~

~~term "future losses" includes reserves for incurred but not reported claims.~~

~~6. Each carrier's proportion of the assessment shall be determined annually by the board, based on annual statements and other reports considered necessary by the board and filed by the carriers with the board.~~

~~7. Provision shall be made in the plan of operation for the imposition of an interest penalty for late payment of an assessment.~~

~~8. A carrier may seek, from the office, a deferment, in whole or in part, from any assessment made by the board. The office may defer, in whole or in part, the assessment of a carrier if, in the opinion of the office, the payment of the assessment would place the carrier in a financially impaired condition. If an assessment against a carrier is deferred, in whole or in part, the amount by which the assessment is deferred may be assessed against the other carriers in a manner consistent with the basis for assessment set forth in this section. The carrier receiving such deferment remains liable to the program for the amount deferred and is prohibited from reinsuring any individuals or groups in the program if it fails to pay assessments.~~

~~(k) Neither the participation in the program as reinsuring carriers, the establishment of rates, forms, or procedures, nor any other joint or collective action required by this act, may be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its carriers either jointly or separately.~~

~~(l) The board, as part of the plan of operation, shall develop standards setting forth the manner and levels of compensation to be paid to agents for the sale of basic and standard health benefit plans. In establishing such standards, the board shall take into consideration the need to assure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide ongoing service to the small employer, the levels of compensation currently used in the industry, and the overall costs of coverage to small employers selecting these plans.~~

~~(m) The board shall monitor compliance with this section, including the market conduct of small employer carriers, and shall report to the office any unfair trade practices and misleading or unfair conduct by a small employer carrier that has been reported to the board by agents, consumers, or any other person. The office shall investigate all reports and, upon a finding of noncompliance with this section or of unfair or misleading practices, shall take action against the small employer carrier as permitted under the insurance code or chapter 641. The board is not given investigatory or regulatory powers, but must forward all reports of cases or abuse or misrepresentation to the office.~~

~~(n) Notwithstanding paragraph (j), the administrative expenses of the program shall be recouped by assessment of risk-assuming carriers and reinsuring carriers and such amounts shall not be considered part of the operating losses of the plan for the purposes of this paragraph. Each carrier's portion of such administrative expenses shall be determined by multiplying the~~

~~total of such administrative expenses by a fraction, the numerator of which equals the carrier's earned premium pertaining to direct writing of small employer health benefit plans in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of such premiums earned by all carriers in the state during such calendar year.~~

~~(o) The board shall advise the office, the Agency for Health Care Administration, the department, other executive departments, and the Legislature on health insurance issues. Specifically, the board shall:~~

~~1. Provide a forum for stakeholders, consisting of insurers, employers, agents, consumers, and regulators, in the private health insurance market in this state.~~

~~2. Review and recommend strategies to improve the functioning of the health insurance markets in this state with a specific focus on market stability, access, and pricing.~~

~~3. Make recommendations to the office for legislation addressing health insurance market issues and provide comments on health insurance legislation proposed by the office.~~

~~4. Meet at least three times each year. One meeting shall be held to hear reports and to secure public comment on the health insurance market, to develop any legislation needed to address health insurance market issues, and to provide comments on health insurance legislation proposed by the office.~~

~~5. Issue a report to the office on the state of the health insurance market by September 1 each year. The report shall include recommendations for changes in the health insurance~~

~~market, results from implementation of previous recommendations, and information on health insurance markets.~~

(10)~~(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 insurance commissioner ~~board~~. The Chief Financial Officer may require the insurance commissioner ~~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.

(11)~~(13)~~ STANDARDS TO ASSURE FAIR MARKETING.—

(e) A small employer carrier shall provide reasonable compensation~~, as provided under the plan of operation of the program,~~ to an agent, if any, for the sale of a basic or

standard health benefit plan.

(13)~~(15)~~ SMALL EMPLOYERS ACCESS PROGRAM.—

(k) Benefits.—The benefits provided by the plan shall be the same as the coverage required for small employers under subsection (10) ~~(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.

(14)~~(16)~~ 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 (10) ~~(12)~~.

~~(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.~~

(c)~~(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.

Section 16. Subsection (10) of section 641.3922, Florida Statutes, is amended to read:

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

(10) ALTERNATE PLANS.—The health maintenance organization shall offer a standard health benefit plan as established pursuant to s. 627.6699(10)~~(12)~~. The health maintenance organization may, at its option, also offer alternative plans for group health conversion in addition to those required by this section, provided any alternative plan is approved by the office or is a converted policy, approved under s. 627.6675 and issued by an insurance company authorized to transact insurance in this state. Approval by the office of an alternative plan shall be based on compliance by the alternative plan with the provisions of this part and the rules promulgated thereunder, applicable provisions of the Florida Insurance Code and rules

promulgated thereunder, and any other applicable law.

Section 17. Subsections (10) through (15) of section 945.603, Florida Statutes, are renumbered as subsections (9) through (14), respectively, and present subsection (10) of that section is amended to read:

945.603 Powers and duties of authority.—The purpose of the authority is to assist in the delivery of health care services for inmates in the Department of Corrections by advising the Secretary of Corrections on the professional conduct of primary, convalescent, dental, and mental health care and the management of costs consistent with quality care, by advising the Governor and the Legislature on the status of the Department of Corrections' health care delivery system, and by assuring that adequate standards of physical and mental health care for inmates are maintained at all Department of Corrections institutions. For this purpose, the authority has the authority to:

~~(10) Coordinate the development of prospective payment arrangements as described in s. 408.50 when appropriate for the acquisition of inmate health care services.~~

Section 18. Paragraph (e) of subsection (2) of section 1011.52, Florida Statutes, is amended to read:

1011.52 Appropriation to first accredited medical school.—

(2) In order for a medical school to qualify under the provisions of this section and to be entitled to the benefits herein, such medical school:

(e) Must have in place an operating agreement with a government-owned hospital that is located in the same county as

the medical school and that is a statutory teaching hospital as defined in s. 408.07(44) ~~(45)~~. The operating agreement shall provide for the medical school to maintain the same level of affiliation with the hospital, including the level of services to indigent and charity care patients served by the hospital, which was in place in the prior fiscal year. Each year, documentation demonstrating that an operating agreement is in effect shall be submitted jointly to the Department of Education by the hospital and the medical school prior to the payment of moneys from the annual appropriation.

Section 19. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2011.