CHAPTER 2004-297

House Bill No. 1629

An act relating to affordable health care; providing a popular name; providing purpose; amending s. 381.026, F.S.; requiring certain licensed facilities to provide public Internet access to certain financial information; providing a definition; amending s. 381.734, F.S.; including participation by health care providers, small businesses, and health insurers in the Healthy Communities, Healthy People Program; requiring the Department of Health to provide public Internet access to certain public health programs; requiring the department to monitor and assess the effectiveness of such programs; requiring a report; requiring the Office of Program Policy and Government Accountability to evaluate the effectiveness of such programs; requiring a report; amending s. 395.1041, F.S.; authorizing hospitals to develop certain emergency room diversion programs; amending s. 395.1055, F.S.; requiring licensed facilities to make certain patient charge and performance outcome data available on Internet websites; amending s. 395.1065, F.S.; authorizing the Agency for Health Care Administration to charge a fine for failure to provide such information; amending s. 395.301, F.S.; requiring certain licensed facilities to provide prospective patients certain estimates of charges for services; requiring such facilities to provide patients with certain bill verification information; providing for a fine for failure to provide such information; providing charge limitations; requiring such facilities to establish a patient question review and response methodology; providing requirements; requiring certain licensed facilities to provide public Internet access to certain financial information; requiring posting of a notice of the availability of such information; amending s. 408.061, F.S.; requiring the Agency for Health Care Administration to require health care facilities, health care providers, and health insurers to submit certain information; providing requirements; requiring the agency to adopt certain risk and severity adjustment methodologies; requiring the agency to adopt certain rules; requiring certain information to be certified; amending s. 408.062, F.S.; requiring the agency to conduct certain health care costs and access research, analyses, and studies; expanding the scope of such studies to include collection of pharmacy retail price data, use of emergency departments, physician information, and Internet patient charge information availability; requiring a report; requiring the agency to conduct additional data-based studies and make recommendations to the Legislature; requiring the agency to develop and implement a strategy to adopt and use electronic health records; authorizing the agency to develop rules to protect electronic records confidentiality; requiring a report to the Governor and Legislature; amending s. 408.05, F.S.; requiring the agency to develop a plan to make performance outcome and financial data available to consumers for health care services comparison purposes; requiring submittal of the plan to the Governor and Legislature; requiring the agency to update the plan; requiring the agency

to make the plan available electronically; providing plan requirements; amending s. 409.9066, F.S.; requiring the agency to provide certain information relating to the Medicare prescription discount program; amending s. 408.7056, F.S.; renaming the Statewide Provider and Subscriber Assistance Program as the Subscriber Assistance Program; revising provisions to conform; expanding certain records availability provisions; revising membership provisions relating to a subscriber grievance hearing panel; revising a list of grievances the panel may consider; providing hearing procedures; amending s. 641.3154, F.S., to conform to the renaming of the Subscriber Assistance Program; amending s. 641.511, F.S., to conform to the renaming of the Subscriber Assistance Program; adopting and incorporating by reference the Employee Retirement Income Security Act of 1974, as implemented by federal regulations; amending s. 641.58, F.S., to conform to the renaming of the Subscriber Assistance Program; amending s. 408.909, F.S.; expanding a definition of "health flex plan entity" to include public-private partnerships; making a pilot health flex plan program apply permanently statewide; providing additional program requirements; creating s. 381.0271, F.S.; providing definitions; creating the Florida Patient Safety Corporation; authorizing the corporation to create additional not-for-profit corporate subsidiaries for certain purposes; specifying application of public records and public meetings requirements; exempting the corporation and subsidiaries from public procurement provisions; providing purposes; providing for a board of directors; providing for membership; authorizing the corporation to establish certain advisory committees; providing for organization of the corporation; providing for meetings; providing powers and duties of the corporation; requiring the corporation to collect, analyze, and evaluate patient safety data and related information; requiring the corporation to establish a reporting system to identify and report near misses relating to patient safety; requiring the corporation to work with state agencies to develop electronic health records; providing for an active library of evidence-based medicine and patient safety practices; requiring the corporation to develop and recommend core competencies in patient safety and public education programs; requiring an annual report; providing report requirements; authorizing the corporation to seek funding and apply for grants; requiring the Office of Program Policy Analysis and Government Accountability, the Department of Health, and the Agency for Health Care Administration to develop performance standards to evaluate the corporation; amending s. 409.91255, F.S.; expanding assistance to certain health centers to include community emergency room diversion programs and urgent care services; amending s. 627.410, F.S.; requiring insurers to file certain rates with the Office of Insurance Regulation; creating s. 627.64872, F.S.; providing legislative intent; creating the Florida Health Insurance Plan for certain purposes; providing definitions; providing exclusions; providing requirements for operation of the plan; providing for a board of directors; providing for appointment of members; providing for terms; specifying service without compensation; providing for travel and per diem expenses;

requiring a plan of operation; providing requirements; providing for powers of the plan; requiring reports to the Governor and Legislature; providing for an actuarial study; providing certain immunity from liability for plan obligations; authorizing the board to provide for indemnification of certain costs; requiring an annually audited financial statement; providing for eligibility for coverage under the plan; providing criteria, requirements, and limitations; specifying certain activity as an unfair trade practice; providing for a plan administrator; providing criteria; providing requirements; providing term limits for the plan administrator; providing duties; providing for paying the administrator; providing for premium rates for plan coverage; providing rate limitations; providing for sources of additional revenue; specifying benefits under the plan; providing criteria, requirements, and limitations; providing for nonduplication of benefits; providing for annual and maximum lifetime benefits; providing for tax exempt status; providing for abolition of the Florida Comprehensive Health Association upon implementation of the plan; providing for continued operation of the Florida Comprehensive Health Association until adoption of a plan of operation for the Florida Health Insurance Plan; providing for enrollment in the plan of persons enrolled in the association; requiring insurers to pay certain assessments to the board for certain purposes; providing criteria, requirements, and limitations for such assessments; providing for repeal of ss. 627.6488, 627.6489, 627.649, 627.6492, 627.6494, 627.6496, and 627.6498, F.S., relating to the Florida Comprehensive Health Association, upon implementation of the plan; amending s. 627.662, F.S.; providing for application of certain claim payment methodologies to certain types of insurance; providing for certain actions relating to inappropriate utilization of emergency care; amending s. 627.6699, F.S.; revising provisions requiring small employer carriers to offer certain health benefit plans; preserving a right to open enrollment for certain small groups; requiring small employer carriers to file and provide coverage under certain high deductible plans; including high deductible plans and health reimbursement arrangements under certain required plan provisions; creating the Small Employers Access Program; providing legislative intent; providing definitions; providing participation eligibility requirements and criteria; requiring the Office of Insurance Regulation to administer the program by selecting an insurer through competitive bidding; providing requirements; specifying insurer qualifications; providing duties of the insurer; providing a contract term; providing insurer reporting requirements; providing application requirements; providing for benefits under the program; requiring the office to annually report to the Governor and Legislature; creating ss. 627.6405 and 641.31097, F.S.; providing for decreasing inappropriate use of emergency care; providing legislative findings and intent; requiring health maintenance organizations and providers to provide certain information electronically and develop community emergency department diversion programs; authorizing health maintenance organizations to require higher copayments for certain uses of emergency departments; amending s. 627.9175, F.S.;

requiring certain health insurers to annually report certain coverage information to the office; providing requirements; deleting certain reporting requirements; retitling ch. 636, F.S.; designating ss. 636.002-636.067, F.S., as pt. I of ch. 636, F.S.; providing a part title; amending s. 636.003, F.S.; revising the definition of "prepaid limited health service organization" to exclude discount medical plan organizations; creating pt. II of ch. 636, F.S., consisting of ss. 636.202-636.244, F.S.; providing a part title; providing definitions; providing for regulation and operation of discount medical plan organizations; requiring corporate licensure before doing business as a discount medical plan; specifying application requirements; requiring license fees; providing for expiration and renewal of licenses; requiring such organizations to establish an Internet website; requiring publication of certain information on the website; specifying collection and deposit of the licensing fee; authorizing the office to examine or investigate the business affairs of such organizations; requiring examinations and investigations; authorizing the office to order production of documents and take statements; requiring organizations to pay certain expenses; specifying grounds for denial or revocation under certain circumstances; authorizing discount medical plan organizations to charge certain fees under certain circumstances; providing reimbursement requirements; prohibiting certain activities; requiring certain disclosures to prospective members; requiring provider agreements to provide services under a medical discount plan; providing agreement requirements; requiring forms and rates to be filed with the office; requiring annual reports to be filed with the office; providing requirements; providing for fines and administrative sanctions for failing to file annual reports; establishing minimum capital requirements; providing for suspension or revocation of licenses under certain circumstances; providing for suspension of enrollment of new members under certain circumstances; providing terms of suspensions; requiring notice of any change of an organization's name; requiring discount medical plan organizations to maintain provider names listings; specifying marketing requirements of discount medical plans; providing limitations; specifying fee disclosure requirements for bundling discount medical plans with other insurance products; authorizing the commission to adopt rules; applying insurer service of process requirements on discount medical plan organizations; requiring a security deposit; prohibiting levy on certain deposit assets or securities under certain circumstances; providing criminal penalties; authorizing the office to seek certain injunctive relief under certain circumstances; providing limitations; providing for civil actions for damages for certain violations; providing for awards of court costs and attorney fees; specifying application of unauthorized insurer provisions of law to unlicensed discount medical plan organizations; creating ss. 627.65626 and 627.6402, F.S.; providing for insurance rebates for healthy lifestyles; providing for rebate of certain premiums for participation in health wellness, maintenance, or improvement programs under certain circumstances; providing requirements; amending s. 641.31, F.S.; authorizing health maintenance organizations offering certain point-of-service riders to offer such riders to certain employers for certain

employees; providing requirements and limitations; providing for application of certain claim payment methodologies to certain types of insurance; providing for rebate of certain premiums for participation in health wellness, maintenance, or improvement programs under certain circumstances; providing requirements; creating s. 626.593, F.S.; providing fee and commission limitations for health insurance agents; requiring a written contract for compensation; providing contract requirements; requiring a rebate of commission under certain circumstances; amending ss. 626.191 and 626.201, F.S.; clarifying certain application requirements; preserving certain rights to enrollment in certain health benefit coverage programs for certain groups under certain circumstances; creating s. 465.0244, F.S.; requiring each pharmacy to make available on its Internet website a link to certain performance outcome and financial data of the Agency for Health Care Administration and a notice of the availability of such information; amending s. 627.6499, F.S.; requiring each health insurer to make available on its Internet website a link to certain performance outcome and financial data of the Agency for Health Care Administration and a notice in policies of the availability of such information; amending s. 641.54, F.S.; requiring health maintenance organizations to make certain insurance financial information available to subscribers; requiring health maintenance organizations to make available on its Internet website a link to certain performance outcome and financial data of the Agency for Health Care Administration and a notice in policies of the availability of such information; repealing s. 408.02, F.S., relating to the development, endorsement, implementation, and evaluation of patient management practice parameters by the Agency for Health Care Administration; providing appropriations; providing effective dates.

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

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

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

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

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

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

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

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

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

WHEREAS, it is of vital importance and in the best interests of the people of the State of Florida that the issue of available, affordable health care insurance be addressed in a cohesive and meaningful manner, and

WHEREAS, there is general recognition that the issues surrounding the problem of access to affordable health insurance are complicated and multi-faceted, and

WHEREAS, on August 14, 2003, Speaker Johnnie Byrd created the Select Committee on Affordable Health Care for Floridians in an effort to address the issue of affordable and accessible employment-based insurance, and

WHEREAS, the Select Committee on Affordable Health Care for Floridians held public hearings with predetermined themes around the state, specifically, in Orlando, Miami, Jacksonville, Tampa, Pensacola, Boca Raton, and Tallahassee, from October through November 2003 to effectively probe the operation of the private insurance marketplace, to understand the health insurance market trends, to learn from past policy initiatives, and to identify, explore, and debate new ideas for change, and

WHEREAS, recommendations from the Select Committee on Affordable Health Care were adopted on February 4, 2004, to address the multifaceted issues attributed to the increase in health care cost, and

WHEREAS, these recommendations were presented to the Speaker of the House of Representatives in a final report from the committee on February 18, 2004, and subsequent legislation was drafted creating the "The 2004 Affordable Health Care for Floridians Act," NOW, THEREFORE,

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

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

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

Section 3. Paragraph (c) of subsection (4) of section 381.026, Florida Statutes, is amended to read:

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

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

(c) Financial information and disclosure.—

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

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

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

4. Each licensed facility not operated by the state shall make available to the public on its Internet website or by other electronic means a description of and a link to the performance outcome and financial data that is published by the agency pursuant to s. 408.05(3)(l). The facility shall place a notice in the reception area that such information is available electronically and the website address. The licensed facility may indicate that the pricing information is based on a compilation of charges for the average patient and that each patient's bill may vary from the average depending upon the severity of illness and individual resources consumed. The licensed facility may also indicate that the price of service is negotiable for eligible patients based upon the patient's ability to pay.

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

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

381.734 Healthy Communities, Healthy People Program.—

(1) The department shall develop and implement the Healthy Communities, Healthy People Program, a comprehensive and community-based health promotion and wellness program. The program shall be designed to reduce major behavioral risk factors associated with chronic diseases, including those chronic diseases identified in chapter 385, by enhancing the

knowledge, skills, motivation, and opportunities for individuals, organizations, health care providers, small businesses, health insurers, and communities to develop and maintain healthy lifestyles.

(3) The program shall include:

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

(4) The department shall make available on its Internet website, no later than October 1, 2004, and in a hard-copy format upon request, a listing of age-specific, disease-specific, and community-specific health promotion, preventive care, and wellness programs offered and established under the Healthy Communities, Healthy People Program. The website shall also provide residents with information to identify behavior risk factors that lead to diseases that are preventable by maintaining a healthy lifestyle. The website shall allow consumers to select by county or region disease-specific statistical information.

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

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

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

395.1041 Access to emergency services and care.—

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

Section 6. Paragraph (h) is added to subsection (1) of section 395.1055, Florida Statutes, to read:

395.1055 Rules and enforcement.—

(1) The agency shall adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part, which shall include reasonable and fair minimum standards for ensuring that:

(h) Licensed facilities make available on their Internet websites, no later than October 1, 2004, and in a hard-copy format upon request, a description of and a link to the patient charge and performance outcome data collected from licensed facilities pursuant to s. 408.061.

Section 7. Subsection (7) is added to section 395.1065, Florida Statutes, to read:

395.1065 Criminal and administrative penalties; injunctions; emergency orders; moratorium.—

(7) The agency shall impose a fine of $500 for each instance of the facility's failure to provide the information required by rules adopted pursuant to s. 395.1055(1)(h).

Section 8. Subsections (1), (2), and (3) of section 395.301, Florida Statutes, are amended, and subsections (7), (8), (9), and (10) are added to said section, to read:

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

(1) A licensed facility not operated by the state shall notify each patient during admission and at discharge of his or her right to receive an itemized bill upon request. Within 7 days following the patient's discharge or release from a licensed facility not operated by the state, ~~or within 7 days after the earliest date at which the loss or expense from the service may be determined,~~ the licensed facility providing the service shall, upon request, submit to the patient, or to the patient's survivor or legal guardian as may be appropriate, an itemized statement detailing in language comprehensible to an ordinary layperson the specific nature of charges or expenses incurred by the patient, which in the initial billing shall contain a statement of specific services received and expenses incurred for such items of service, enumerating in detail the constituent components of the services received within each department of the licensed facility and including unit price data on rates charged by the licensed facility, as prescribed by the agency.

(2)(a) Each such statement submitted pursuant to this section:

1.~~(a)~~ May not include charges of hospital-based physicians if billed separately.

2.~~(b)~~ May not include any generalized category of expenses such as "other" or "miscellaneous" or similar categories.

3.~~(c)~~ Shall list drugs by brand or generic name and not refer to drug code numbers when referring to drugs of any sort.

4.~~(d)~~ Shall specifically identify therapy treatment as to the date, type, and length of treatment when therapy treatment is a part of the statement.

(b) Any person receiving a statement pursuant to this section shall be fully and accurately informed as to each charge and service provided by the institution preparing the statement.

(3) On each ~~such~~ itemized statement submitted pursuant to subsection (1) there shall appear the words "A FOR-PROFIT (or NOT-FOR-PROFIT or PUBLIC) HOSPITAL (or AMBULATORY SURGICAL CENTER) LICENSED BY THE STATE OF FLORIDA" or substantially similar words sufficient to identify clearly and plainly the ownership status of the licensed facility. Each itemized statement must prominently display the phone number of the medical facility's patient liaison who is responsible for expediting the resolution of any billing dispute between the patient, or his or her representative, and the billing department.

(7) Each licensed facility not operated by the state shall provide, prior to provision of any nonemergency medical services, a written good-faith estimate of reasonably anticipated charges for the facility to treat the patient's condition upon written request of a prospective patient. The estimate shall be provided to the prospective patient within 7 business days after the receipt of the request. The estimate may be the average charges for that diagnosis related group or the average charges for that procedure. Upon request, the facility shall notify the patient of any revision to the good-faith estimate. Such estimate shall not preclude the actual charges from exceeding the estimate. The facility shall place a notice in the reception area that such information is available. Failure to provide the estimate within the provisions established pursuant to this section shall result in a fine of $500 for each instance of the facility's failure to provide the requested information.

(8) A licensed facility shall make available to a patient all records necessary for verification of the accuracy of the patient's bill within 30 business days after the request for such records. The verification information must be made available in the facility's offices. Such records shall be available to the patient prior to and after payment of the bill or claim. The facility may not charge the patient for making such verification records available; however, the facility may charge its usual fee for providing copies of records as specified in s. 395.3025.

(9) Each facility shall establish a method for reviewing and responding to questions from patients concerning the patient's itemized bill. Such response shall be provided within 30 days after the date a question is received. If the patient is not satisfied with the response, the facility must provide the patient with the address of the agency to which the issue may be sent for review.

(10) Each licensed facility shall make available on its Internet website a link to the performance outcome and financial data that is published by the Agency for Health Care Administration pursuant to s. 408.05(3)(l). The facility shall place a notice in the reception area that the information is available electronically and the facility's Internet website address.

Section 9. Subsection (1) of section 408.061, Florida Statutes, is amended to read:

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

(1) The agency shall ~~may~~ require the submission by health care facilities, health care providers, and health insurers of data necessary to carry out the agency's duties. Specifications for data to be collected under this section shall be developed by the agency with the assistance of technical advisory panels including representatives of affected entities, consumers, purchasers, and such other interested parties as may be determined by the agency.

(a) Data ~~to be~~ submitted by health care facilities, including the facilities as defined in chapter 395, shall ~~may~~ include, but are not limited to: case-mix data, patient admission and ~~or~~ discharge data, hospital emergency department data which shall include the number of patients treated in the emergency department of a licensed hospital reported by patient acuity level, data on hospital-acquired infections as specified by rule, data on complications as specified by rule, data on readmissions as specified by rule, with patient and provider-specific identifiers included, actual charge data by diagnostic groups, financial data, accounting data, operating expenses, expenses incurred for rendering services to patients who cannot or do not pay, interest charges, depreciation expenses based on the expected useful life of the property and equipment involved, and demographic data. The agency shall adopt nationally recognized risk adjustment methodologies or software consistent with the standards of the Agency for Healthcare Research and Quality and as selected by the agency for all data submitted as required by this section. Data may be obtained from documents such as, but not limited to: leases, contracts, debt instruments, itemized patient bills, medical record abstracts, and related diagnostic information. Reported data elements shall be reported electronically in accordance with Rule 59E-7.012, Florida Administrative Code. Data submitted shall be certified by the chief executive officer or an appropriate and duly authorized representative or employee of the licensed facility that the information submitted is true and accurate.

(b) Data to be submitted by health care providers may include, but are not limited to: Medicare and Medicaid participation, types of services offered to patients, amount of revenue and expenses of the health care provider, and such other data which are reasonably necessary to study utilization patterns. Data submitted shall be certified by the appropriate duly authorized representative or employee of the health care provider that the information submitted is true and accurate.

(c) Data to be submitted by health insurers may include, but are not limited to: claims, premium, administration, and financial information. Data submitted shall be certified by the chief financial officer, an appropriate and duly authorized representative, or an employee of the insurer that the information submitted is true and accurate.

(d) Data required to be submitted by health care facilities, health care providers, or health insurers shall not include specific provider contract

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

(e) A requirement to submit data shall be adopted by rule if the submission of data is being required of all members of any type of health care facility, health care provider, or health insurer. Rules are not required, however, for the submission of data for a special study mandated by the Legislature or when information is being requested for a single health care facility, health care provider, or health insurer.

Section 10. Subsections (1) and (4) of section 408.062, Florida Statutes, are amended, and subsection (5) is added to said section, to read:

408.062 Research, analyses, studies, and reports.—

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

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

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

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

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

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

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

(g) The development of physician information ~~payment~~ systems which are capable of providing data for health care consumers taking into account the amount of resources consumed, including such information at licensed facilities as defined in chapter 395, and the outcomes produced in the delivery of care.

(h) The collection of a statistically valid sample of data on the retail prices charged by pharmacies for the 50 most frequently prescribed medicines from any pharmacy licensed by this state as a special study authorized by the Legislature to be performed by the agency quarterly. If the drug is available generically, price data shall be reported for the generic drug and

price data of a brand-named drug for which the generic drug is the equivalent shall be reported. The agency shall make available on its Internet website for each pharmacy, no later than October 1, 2005, drug prices for a 30-day supply at a standard dose. The data collected shall be reported for each drug by pharmacy and by metropolitan statistical area or region and updated quarterly ~~The impact of subacute admissions on hospital revenues and expenses for purposes of calculating adjusted admissions as defined in s. 408.07~~.

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

(j) The making available on its Internet website no later than October 1, 2004, and in a hard-copy format upon request, of patient charge, volumes, length of stay, and performance outcome indicators collected from health care facilities pursuant to s. 408.061(1)(a) for specific medical conditions, surgeries, and procedures provided in inpatient and outpatient facilities as determined by the agency. In making the determination of specific medical conditions, surgeries, and procedures to include, the agency shall consider such factors as volume, severity of the illness, urgency of admission, individual and societal costs, and whether the condition is acute or chronic. Performance outcome indicators shall be risk adjusted or severity adjusted, as applicable, using nationally recognized risk adjustment methodologies or software consistent with the standards of the Agency for Healthcare Research and Quality and as selected by the agency. The website shall also provide an interactive search that allows consumers to view and compare the information for specific facilities, a map that allows consumers to select a county or region, definitions of all of the data, descriptions of each procedure, and an explanation about why the data may differ from facility to facility. Such public data shall be updated quarterly. The agency shall submit an annual status report on the collection of data and publication of performance outcome indicators to the Governor, the Speaker of the House of Representatives, the President of the Senate, and the substantive legislative committees with the first status report due January 1, 2005.

(4)(a) The agency shall ~~may~~ conduct data-based studies and evaluations and make recommendations to the Legislature and the Governor concerning exemptions, the effectiveness of limitations of referrals, restrictions on investment interests and compensation arrangements, and the effectiveness of public disclosure. Such analysis shall ~~may~~ include, but need not be limited to, utilization of services, cost of care, quality of care, and access to care. The agency may require the submission of data necessary to carry out this duty, which may include, but need not be limited to, data concerning ownership, Medicare and Medicaid, charity care, types of services offered to patients, revenues and expenses, patient-encounter data, and other data reasonably necessary to study utilization patterns and the impact of health care provider ownership interests in health-care-related entities on the cost, quality, and accessibility of health care.

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

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

Section 11. Paragraph (l) is added to subsection (3) of section 408.05, Florida Statutes, to read:

408.05 State Center for Health Statistics.—

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

(l) Develop, in conjunction with the State Comprehensive Health Information System Advisory Council, and implement a long-range plan for making available performance outcome and financial data that will allow consumers to compare health care services. The performance outcomes and financial data the agency must make available shall include, but is not limited to, pharmaceuticals, physicians, health care facilities, and health plans and managed care entities. The agency shall submit the initial plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives by March 1, 2005, and shall update the plan and report on the status of its implementation annually thereafter. The agency shall also make the plan and status report available to the public on its Internet website. As part of the plan, the agency shall identify the process and timeframes for implementation, any barriers to implementation, and recommendations of changes in the law that may be enacted by the Legislature to eliminate the barriers. As preliminary elements of the plan, the agency shall:

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

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

b. May consider such additional measures that are adopted by the Centers for Medicare and Medicaid Studies, National Quality Forum, the Joint Commission on Accreditation of Healthcare Organizations, the Agency for

Healthcare Research and Quality, or a similar national entity that establishes standards to measure the performance of health care providers, or by other states.

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

2. Make available performance measures, benefit design, and premium cost data from health plans licensed pursuant to chapter 627 or chapter 641. The agency shall determine which performance outcome and member and subscriber cost data to disclose, based upon input from the council. When determining which data to disclose, the agency shall consider information that may be required by either individual or group purchasers to assess the value of the product, which may include membership satisfaction, quality of care, current enrollment or membership, coverage areas, accreditation status, premium costs, plan costs, premium increases, range of benefits, copayments and deductibles, accuracy and speed of claims payment, credentials of physicians, number of providers, names of network providers, and hospitals in the network. Health plans shall make available to the agency any such data or information that is not currently reported to the agency or the office.

3. Determine the method and format for public disclosure of data reported pursuant to this paragraph. The agency shall make its determination based upon input from the Comprehensive Health Information System Advisory Council. At a minimum, the data shall be made available on the agency's Internet website in a manner that allows consumers to conduct an interactive search that allows them to view and compare the information for specific providers. The website must include such additional information as is determined necessary to ensure that the website enhances informed decision making among consumers and health care purchasers, which shall include, at a minimum, appropriate guidance on how to use the data and an explanation of why the data may vary from provider to provider. The data specified in subparagraph 1. shall be released no later than March 1, 2005. The data specified in subparagraph 2. shall be released no later than March 1, 2006.

Section 12. Subsection (3) of section 409.9066, Florida Statutes, is amended to read:

409.9066 Medicare prescription discount program.—

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

Section 13. Section 408.7056, Florida Statutes, is amended to read:

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

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

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

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

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

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

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

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

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

(2) The agency shall adopt and implement a program to provide assistance to subscribers ~~and providers~~, including those whose grievances are not resolved by the managed care entity to the satisfaction of the subscriber ~~or provider~~. The program shall consist of one or more panels that meet as often as necessary to timely review, consider, and hear grievances and recommend to the agency or the office any actions that should be taken concerning individual cases heard by the panel. The panel shall hear every grievance filed by subscribers ~~and providers~~ on behalf of subscribers, unless the grievance:

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

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

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

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

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

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

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

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

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

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

(k) Is limited to issues involving conduct of a health care provider or facility, staff member, or employee of a managed care entity which constitute grounds for disciplinary action by the appropriate professional licensing board and is not indicative of a pattern of inappropriate behavior, and the agency, office, or department has reported these grievances to the appropriate professional licensing board or to the health facility regulation section of the agency for possible investigation; ~~or~~

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

(3) The agency shall review all grievances within 60 days after receipt and make a determination whether the grievance shall be heard. Once the agency notifies the panel, the subscriber ~~or provider~~, and the managed care entity that a grievance will be heard by the panel, the panel shall hear the grievance either in the network area or by teleconference no later than 120 days after the date the grievance was filed. The agency shall notify the parties, in writing, by facsimile transmission, or by phone, of the time and place of the hearing. The panel may take testimony under oath, request certified copies of documents, and take similar actions to collect information and documentation that will assist the panel in making findings of fact and a recommendation. The panel shall issue a written recommendation, supported by findings of fact, to the ~~provider or~~ subscriber, to the managed care

entity, and to the agency or the office no later than 15 working days after hearing the grievance. If at the hearing the panel requests additional documentation or additional records, the time for issuing a recommendation is tolled until the information or documentation requested has been provided to the panel. The proceedings of the panel are not subject to chapter 120.

(4) If, upon receiving a proper patient authorization along with a properly filed grievance, the agency requests ~~medical~~ records from a health care provider or managed care entity, the health care provider or managed care entity that has custody of the records has 10 days to provide the records to the agency. Records include medical records, communication logs associated with the grievance both to and from the subscriber, and contracts. Failure to provide requested ~~medical~~ records may result in the imposition of a fine of up to $500. Each day that records are not produced is considered a separate violation.

(5) Grievances that the agency determines pose an immediate and serious threat to a subscriber's health must be given priority over other grievances. The panel may meet at the call of the chair to hear the grievances as quickly as possible but no later than 45 days after the date the grievance is filed, unless the panel receives a waiver of the time requirement from the subscriber. The panel shall issue a written recommendation, supported by findings of fact, to the office or the agency within 10 days after hearing the expedited grievance.

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

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

(b) Medical intervention is no longer necessary; or

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

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

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

ommendation, or 72 hours after receipt of a recommendation in an expedited grievance, furnish to the agency or office written evidence in opposition to the recommendation or findings of fact of the panel.

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

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

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

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

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

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

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

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

(12) Every managed care entity shall submit a quarterly report to the agency, the office, and the department listing the number and the nature of

all subscribers' and providers' grievances which have not been resolved to the satisfaction of the subscriber or provider after the subscriber or provider follows the entire internal grievance procedure of the managed care entity. The agency shall notify all subscribers and providers included in the quarterly reports of their right to file an unresolved grievance with the panel.

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

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

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

Section 14. Paragraph (c) of subsection (4) of section 641.3154, Florida Statutes, is amended to read:

641.3154 Organization liability; provider billing prohibited.—

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

(c) The office or agency makes a final determination that the organization is required to pay for such services subsequent to a recommendation

made by the ~~Statewide Provider and~~ Subscriber Assistance Panel pursuant to s. 408.7056; or

Section 15. Subsection (1), paragraphs (b) and (e) of subsection (3), paragraph (d) of subsection (4), subsection (5), paragraph (g) of subsection (6), and subsections (9), (10), and (11) of section 641.511, Florida Statutes, are amended to read:

641.511 Subscriber grievance reporting and resolution requirements.—

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

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

(b) The names of the appropriate employees or a list of grievance departments that are responsible for implementing the organization's grievance procedure. The list must include the address and the toll-free telephone number of each grievance department, the address of the agency and its toll-free telephone hotline number, and the address of the ~~Statewide Provider and~~ Subscriber Assistance Program and its toll-free telephone number.

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

(4)

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

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

tolled until such information is provided. After the organization receives the requested information, the time allowed for completion of the grievance process resumes. The Employee Retirement Income Security Act of 1974, as implemented by 29 C.F.R. 2560.503-1, is adopted and incorporated by reference as applicable to all organizations that administer small and large group health plans that are subject to 29 C.F.R. 2560.503-1. The claims procedures of the regulations of the Employee Retirement Income Security Act of 1974 as implemented by 29 C.F.R. 2560.503-1 shall be the minimum standards for grievance processes for claims for benefits for small and large group health plans that are subject to 29 C.F.R. 2560.503-1.

(6)

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

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

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

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

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

Section 16. Subsection (4) of section 641.58, Florida Statutes, is amended to read:

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

(4) The moneys received and deposited into the Health Care Trust Fund shall be used to defray the expenses of the agency in the discharge of its administrative and regulatory powers and duties under this part, including conducting an annual survey of the satisfaction of members of health maintenance organizations; contracting with physician consultants for the ~~Statewide Provider and~~ Subscriber Assistance Panel; maintaining offices and necessary supplies, essential equipment, and other materials, salaries and expenses of required personnel; and discharging the administrative and regulatory powers and duties imposed under this part.

Section 17. Paragraph (f) of subsection (2) and subsections (3) and (9) of section 408.909, Florida Statutes, are amended to read:

408.909 Health flex plans.—

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

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

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

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

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

1. Contain any ambiguous, inconsistent, or misleading provisions or any exceptions or conditions that deceptively affect or limit the benefits pur-

ported to be assumed in the general coverage provided by the health flex plan;

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

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

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

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

Section 18. Section 381.0271, Florida Statutes, is created to read:

381.0271 Florida Patient Safety Corporation.—

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

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

(b) "Corporation" means the Florida Patient Safety Corporation.

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

(2) CREATION.—

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

(b) The corporation and any authorized and approved subsidiary are not an agency as defined in s. 20.03(11).

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

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

(e) The corporation is a patient safety organization as defined in s. 766.1016.

(3) PURPOSE.—

(a) The purpose of the corporation is to serve as a learning organization dedicated to assisting health care providers in this state to improve the quality and safety of health care rendered and to reduce harm to patients. The corporation shall promote the development of a culture of patient safety in the health care system in this state. The corporation shall not regulate health care providers in this state.

(b) In fulfilling its purpose, the corporation shall work with a consortium of patient safety centers and other patient safety programs.

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

(a) The chair of the Florida Council of Medical School Deans.

(b) Two representatives with expertise in patient safety issues for the authorized health insurer and authorized health maintenance organization with the largest market shares, respectively, as measured by premiums written in the state for the most recent calendar year, appointed by such insurer.

(c) A representative of an authorized medical malpractice insurer appointed by the Florida Insurance Council.

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

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

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

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

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

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

(j) A dentist with expertise in patient safety, appointed by the Florida Dental Association.

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

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

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

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

(a) A scientific research advisory committee that includes, at a minimum, a representative from each patient safety center or other patient safety program in the universities of the state who are physicians licensed pursuant to chapter 458 or chapter 459, with experience in patient safety and evidenced-based medicine. The duties of the advisory committee shall include, but not be limited to, the analysis of existing data and research to improve patient safety and encourage evidence-based medicine.

(b) A technology advisory committee that includes, at a minimum, a representative of a hospital that has implemented a computerized physician order entry system and a health care provider that has implemented an electronic medical records system. The duties of the advisory committee shall include, but not be limited to, implementation of new technologies, including electronic medical records.

(c) A health care provider advisory committee that includes, at a minimum, representatives of hospitals, ambulatory surgical centers, physicians, nurses, and pharmacists licensed in this state and a representative of the Veterans Integrated Service Network 8, Virginia Patient Safety Center. The duties of the advisory committee shall include, but not be limited to, promotion of a culture of patient safety that reduces errors.

(d) A health care consumer advisory committee that includes, at a minimum, representatives of businesses that provide health insurance coverage to their employees, consumer advocacy groups, and representatives of patient safety organizations. The duties of the advisory committee shall include, but not be limited to, incentives to encourage patient safety and the efficiency and quality of care.

(e) A state agency advisory committee that includes, at a minimum, a representative from each state agency that has regulatory responsibilities related to patient safety. The duties of the advisory committee shall include, but not be limited to, interagency coordination of patient safety efforts.

(f) A litigation alternatives advisory committee that includes, at a minimum, representatives of medical malpractice attorneys for plaintiffs and defendants and a representative of each law school in the state. The duties of the advisory committee shall include, but not be limited to, alternatives systems to compensate for injuries.

(g) An education advisory committee that includes, at a minimum, the associate dean for education, or the equivalent position, as a representative from each medicine, nursing, public health, or allied health service to provide advice on the development, implementation, and measurement of core

competencies for patient safety to be considered for incorporation in the educational programs of the universities and colleges of this state.

(6) ORGANIZATION; MEETINGS.—

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

1. Eliciting appointments for the initial board of directors.

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

3. Drafting articles of incorporation for the board of directors and, upon request of the board of directors, delivering articles of incorporation to the Department of State for filing.

4. Drafting proposed bylaws for the corporation.

5. Paying fees related to incorporation.

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

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

(7) POWERS AND DUTIES.—

(a) In addition to the powers and duties prescribed in chapter 617, and the articles and bylaws adopted under that chapter, the corporation shall, directly or through contract:

1. Secure staff necessary to properly administer the corporation.

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

3. Establish a "near-miss" patient safety reporting system. The purpose of the near-miss reporting system is to: identify potential systemic problems that could lead to adverse incidents; enable publication of systemwide alerts

of potential harm; and facilitate development of both facility-specific and statewide options to avoid adverse incidents and improve patient safety. The reporting system shall record "near misses" submitted by hospitals, birthing centers, and ambulatory surgical centers and other providers. For the purpose of the reporting system:

a. The term "near miss" means any potentially harmful event that could have had an adverse result but, through chance or intervention in which, harm was prevented.

b. The near-miss reporting system shall be voluntary and anonymous and independent of mandatory reporting systems used for regulatory purposes.

c. Near-miss data submitted to the corporation is patient safety data as defined in s. 766.1016.

d. Reports of near-miss data shall be published on a regular basis and special alerts shall be published as needed regarding newly identified, significant risks.

e. Aggregated data shall be made available publicly.

f. The corporation shall report the performance and results of the near-miss project in its annual report.

4. Work collaboratively with the appropriate state agencies in the development of electronic health records.

5. Provide for access to an active library of evidence-based medicine and patient safety practices, together with the emerging evidence supporting their retention or modification, and make this information available to health care practitioners, health care facilities, and the public. Support for implementation of evidence-based medicine shall include:

a. A report to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Agency for Health Care Administration by January 1, 2005, on:

(I) The ability to join or support efforts for the use of evidence-based medicine already underway, such as those of the Leapfrog Group, the international group Bandolier, and the Healthy Florida Foundation.

(II) The means by which to promote research using Medicaid and other data collected by the Agency for Health Care Administration to identify and quantify the most cost-effective treatment and interventions, including disease management and prevention programs.

(III) The means by which to encourage development of systems to measure and reward providers who implement evidence-based medical practices.

(IV) The review of other state and private initiatives and published literature for promising approaches and the dissemination of information about them to providers.

(V) The encouragement of the Florida health care boards under the Department of Health to regularly publish findings related to the cost-effectiveness of disease-specific, evidence-based standards.

(VI) Public and private sector initiatives related to evidence-based medicine and communication systems for the sharing of clinical information among caregivers.

(VII) Regulatory barriers that interfere with the sharing of clinical information among caregivers.

b. An implementation plan reported to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Agency for Health Care Administration by September 1, 2005, that must include, but need not be limited to: estimated costs and savings, capital investment requirements, recommended investment incentives, initial committed provider participation by region, standards of functionality and features, a marketing plan, and implementation schedules for key components.

6. Develop and recommend core competencies in patient safety that can be incorporated into the undergraduate and graduate curricula in schools of medicine, nursing, and allied health in the state.

7. Develop and recommend programs to educate the public about the role of health care consumers in promoting patient safety.

8. Provide recommendations for interagency coordination of patient safety efforts in the state.

(b) In carrying out its powers and duties, the corporation may also:

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

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

3. Recommend continuing medical education regarding patient safety to practicing health care practitioners.

4. Study and facilitate the testing of alternative systems of compensating injured patients as a means of reducing and preventing medical errors and promoting patient safety.

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

(8) ANNUAL REPORT.—By December 1, 2004, the corporation shall prepare a report on the startup activities of the corporation and any proposals for legislative action that are needed for the corporation to fulfill its purposes under this section. By December 1 of each year thereafter, the

corporation shall prepare a report for the preceding fiscal year. The report, at a minimum, must include:

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

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

(c) Policies and programs that have been implemented and their outcomes.

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

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

(f) An assessment of the ability of the corporation to fulfill the duties specified in this section and the appropriateness of those duties for the corporation.

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

(9) FUNDING.—The corporation is required to seek private sector funding and apply for grants to accomplish its goals and duties.

(10) PERFORMANCE EXPECTATIONS.—The Office of Program Policy Analysis and Government Accountability, the Agency for Health Care Administration, and the Department of Health shall develop performance standards by which to measure the success of the corporation in fulfilling the purposes established in this section. Using the performance standards, the Office of Program Policy Analysis and Government Accountability shall conduct a performance audit of the corporation during 2006 and shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2007.

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

409.91255 Federally qualified health center access program.—

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

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

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

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

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

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

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

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

Section 20. Paragraph (a) of subsection (6) of section 627.410, Florida Statutes, is amended to read:

627.410 Filing, approval of forms.—

(6)(a) An insurer shall not deliver or issue for delivery or renew in this state any health insurance policy form until it has filed with the office a copy of every applicable rating manual, rating schedule, change in rating manual, and change in rating schedule; if rating manuals and rating schedules are not applicable, the insurer must file with the office ~~order~~ applicable premium rates and any change in applicable premium rates. This paragraph does not apply to group health insurance policies, effectuated and delivered in this state, insuring groups of 51 or more persons, except for Medicare supplement insurance, long-term care insurance, and any coverage under which the increase in claim costs over the lifetime of the contract due to advancing age or duration is prefunded in the premium.

Section 21. Section 627.64872, Florida Statutes, is created to read:

627.64872 Florida Health Insurance Plan.—

(1) LEGISLATIVE INTENT.—

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

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

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

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

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

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

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

Medical Program of the Uniformed Services (CHAMPUS); similar supplemental coverage provided to coverage under a group health plan; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent selfinsurance.

(e) "Implementation" means the effective date after the first meeting of the board when legal authority and administrative ability exists for the board to subsume the transfer of all statutory powers, duties, functions, assets, records, personnel, and property of the Florida Comprehensive Health Association as specified in s. 627.6488.

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

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

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

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

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

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

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

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

(n) "Resident" means an individual who has been legally domiciled in this state for a period of at least 6 months.

(3) BOARD OF DIRECTORS.—

(a) The plan shall operate subject to the supervision and control of the board. The board shall consist of the director or his or her designated representative, who shall serve as a member of the board and shall be its chair, and an additional eight members, five of whom shall be appointed by the

Governor, at least two of whom shall be individuals not representative of insurers or health care providers, one of whom shall be appointed by the President of the Senate, one of whom shall be appointed by the Speaker of the House of Representatives, and one of whom shall be appointed by the Chief Financial Officer.

(b) The term to be served on the board by the director of the Office of Insurance Regulation shall be determined by continued employment in such position. The remaining initial board members shall serve for a period of time as follows: two members appointed by the Governor and the members appointed by the President of the Senate and the Speaker of the House of Representatives shall serve a term of 2 years; and three members appointed by the Governor and the Chief Financial Officer shall serve a term of 4 years. Subsequent board members shall serve for a term of 3 years. A board member's term shall continue until his or her successor is appointed.

(c) Vacancies on the board shall be filled by the appointing authority, such authority being the Governor, the President of the Senate, the Speaker of the House of Representatives, or the Chief Financial Officer. The appointing authority may remove board members for cause.

(d) The director, or his or her recognized representative, shall be responsible for any organizational requirements necessary for the initial meeting of the board which shall take place no later than September 1, 2004.

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

(f) The board shall submit to the Financial Services Commission a plan of operation for the plan and any amendments thereto necessary or suitable to ensure the fair, reasonable, and equitable administration of the plan. The plan of operation shall ensure that the plan qualifies to apply for any available funding from the Federal Government that adds to the financial viability of the plan. The plan of operation shall become effective upon approval in writing by the Financial Services Commission consistent with the date on which the coverage under this section must be made available. If the board fails to submit a suitable plan of operation within 1 year after the appointment of the board of directors, or at any time thereafter fails to submit suitable amendments to the plan of operation, the Financial Services Commission shall adopt such rules as are necessary or advisable to effectuate the provisions of this section. Such rules shall continue in force until modified by the office or superseded by a plan of operation submitted by the board and approved by the Financial Services Commission.

(4) PLAN OF OPERATION.—The plan of operation shall:

(a) Establish procedures for operation of the plan.

(b) Establish procedures for selecting an administrator in accordance with subsection (11).

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

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

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

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

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

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

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

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

(c) Take such legal action as is necessary to:

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

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

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

4. Recover other amounts due the plan.

(d) Establish, and modify as appropriate, rates, rate schedules, rate adjustments, expense allowances, agents' commissions, claims reserve formulas, and any other actuarial functions appropriate to the operation of the plan. Rates and rate schedules may be adjusted for appropriate factors such as age, sex, and geographic variation in claim cost and shall take into consideration appropriate factors in accordance with established actuarial and underwriting practices. For purposes of this paragraph, usual and customary agent's commissions shall be paid for the initial placement of coverage with the plan and for one renewal only.

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

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

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

(h) Employ and fix the compensation of employees.

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

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

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

(l) Design, use, contract, or otherwise arrange for the delivery of cost-effective health care services, including, but not limited to, establishing or contracting with preferred provider organizations, health maintenance organizations, and other limited network provider arrangements.

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

(n) Subsume the transfer of statutory powers, duties, functions, assets, records, personnel, and property of the Florida Comprehensive Health Association as specified in ss. 627.6488, 627.6489, 627.649, 627.6492, 627.6496, 627.6498, and 627.6499, unless otherwise specified by law.

(6) INTERIM REPORT; ANNUAL REPORT.—

(a) By no later than December 1, 2004, the board shall report to the Governor, the President of the Senate, and the Speaker of the House of Representatives the results of an actuarial study conducted by the board to determine, including, but not limited to:

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

2. The number of individuals the pool could reasonably cover at various funding levels, specifically, the number of people the pool may cover at each of those funding levels.

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

4. The effect on the individual and small group market by including in the Florida Health Insurance Plan persons eligible for coverage under s. 627.6487, as well as the cost of including these individuals.

The board shall take no action to implement the Florida Health Insurance Plan, other than the completion of the actuarial study authorized in this paragraph, until funds are appropriated for startup cost and any projected deficits.

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

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

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

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

4. A summarization of the activities of the plan in the preceding calendar year, including the net written and earned premiums, plan enrollment, the expense of administration, and the paid and incurred losses.

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

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

(8) AUDITED FINANCIAL STATEMENT.—No later than June 1 following the close of each calendar year, the plan shall submit to the Financial Services Commission an audited financial statement prepared in accordance with statutory accounting principles as adopted by the National Association of Insurance Commissioners.

(9) ELIGIBILITY.—

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

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

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

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

(c) A person shall not be eligible for coverage under the plan if:

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

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

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

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

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

(d) Coverage shall cease:

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

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

3. Upon the death of the covered person;

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

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

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

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

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

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

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

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

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

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

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

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

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

(13) DUTIES OF THE PLAN ADMINISTRATOR.—

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

1. Determination of eligibility.

2. Payment of claims.

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

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

(b) The plan administrator shall submit regular reports to the board regarding the operation of the plan. The frequency, content, and form of the reports shall be specified in the contract between the board and the plan administrator.

(c) On March 1 following the close of each calendar year, the plan administrator shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the board and the Governor on a form prescribed by the Governor.

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

(15) FUNDING OF THE PLAN.—

(a) Premiums.—

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

2. Initial rates for plan coverage shall be limited to no more than 300 percent of rates established for individual standard risks as specified in s. 627.6675(3)(c). Subject to the limits provided in this paragraph, subsequent rates shall be established to provide fully for the expected costs of claims, including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein, but in no event shall premiums exceed the 300-percent rate limitation provided in this section. Notwithstanding the 300-percent rate limitation, sliding scale premium surcharges based upon the insured's income may apply to all enrollees.

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

capacity to insure during that year so that costs do not exceed income. The board shall take steps necessary to ensure that plan enrollment does not exceed the number of residents it has estimated it has the financial capacity to insure.

(16) BENEFITS.—

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

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

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

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

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

(17) NONDUPLICATION OF BENEFITS.—

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

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

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

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

(20) COMBINING MEMBERSHIP OF THE FLORIDA COMPREHENSIVE HEALTH ASSOCIATION; ASSESSMENT.—

(a)1. Upon implementation of the Florida Health Insurance Plan, the Florida Comprehensive Health Association, as specified in s. 627.6488, is abolished as a separate nonprofit entity and shall be subsumed under the board of directors of the Florida Health Insurance Plan. All individuals actively enrolled in the Florida Comprehensive Health Association shall be enrolled in the plan subject to its rules and requirements, except as otherwise specified in this section. Maximum lifetime benefits paid to an individual in the plan shall not exceed the amount established under subsection (16), and benefits previously paid for any individual by the Florida Comprehensive Health Association shall be used in the determination of total lifetime benefits paid under the plan.

2. All persons enrolled in the Florida Comprehensive Health Association upon implementation of the Florida Health Insurance Plan are only eligible for the benefits authorized under subsection (16). Persons identified by this section shall convert to the benefits authorized under subsection (16) no later than January 1, 2005.

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

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

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

3. All rights, title, and interest in the assessment funds collected under this paragraph shall vest in this state. However, all of such funds and

interest earned shall be used by the plan to pay claims and administrative expenses.

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

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

(e) If a person actively enrolled in the Florida Comprehensive Health Association after implementation of the plan loses eligibility for participation in the Florida Comprehensive Health Association, such person shall not be included in the calculation of the assessment if the person later regains eligibility for participation in the plan.

(f) When all persons actively enrolled in the Florida Comprehensive Health Association as of the date of implementation of the plan are no longer eligible for participation in the Florida Comprehensive Health Association, the board of directors and plan administrator shall no longer be allowed to assess insurers in this state for incurred losses in the Florida Comprehensive Health Association.

Section 22. Upon implementation, as defined in s. 627.64872(2), Florida Statutes, and as provided in s. 627.64872(20), Florida Statutes, of the Florida Health Insurance Plan created under s. 627.64872, Florida Statutes, sections 627.6488, 627.6489, 627.649, 627.6492, 627.6494, 627.6496, and 627.6498, Florida Statutes, are repealed.

Section 23. Subsections (12) and (13) are added to section 627.662, Florida Statutes, to read:

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

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

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

Section 24. Paragraphs (c) and (d) of subsection (5), paragraph (b) of subsection (6), and subsection (12) of section 627.6699, Florida Statutes, are

amended, subsections (15) and (16) of said section are renumbered as subsections (16) and (17), respectively, present subsection (15) of said section is amended, and new subsections (15) and (18) are added to said section, to read:

627.6699 Employee Health Care Access Act.—

(5) AVAILABILITY OF COVERAGE.—

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

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

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

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

(d) A small employer carrier must file with the office, in a format and manner prescribed by the committee, a standard health care plan, a high deductible plan that meets the federal requirements of a health savings account plan or a health reimbursement arrangement, and a basic health care plan to be used by the carrier. The provisions of this section requiring the filing of a high deductible plan are effective September 1, 2004.

(6) RESTRICTIONS RELATING TO PREMIUM RATES.—

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

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

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

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

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

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

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

5. Any adjustments in rates for claims experience, health status, or duration of coverage may not be charged to individual employees or dependents.

For a small employer's policy, such adjustments may not result in a rate for the small employer which deviates more than 15 percent from the carrier's approved rate. Any such adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer. A small employer carrier may make an adjustment to a small employer's renewal premium, not to exceed 10 percent annually, due to the claims experience, health status, or duration of coverage of the employees or dependents of the small employer. Semiannually, small group carriers shall report information on forms adopted by rule by the commission, to enable the office to monitor the relationship of aggregate adjusted premiums actually charged policyholders by each carrier to the premiums that would have been charged by application of the carrier's approved modified community rates. If the aggregate resulting from the application of such adjustment exceeds the premium that would have been charged by application of the approved modified community rate by 4 ~~5~~ percent for the current reporting period, the carrier shall limit the application of such adjustments only to minus adjustments beginning not more than 60 days after the report is sent to the office. For any subsequent reporting period, if the total aggregate adjusted premium actually charged does not exceed the premium that would have been charged by application of the approved modified community rate by 4 ~~5~~ percent, the carrier may apply both plus and minus adjustments. A small employer carrier may provide a credit to a small employer's premium based on administrative and acquisition expense differences resulting from the size of the group. Group size administrative and acquisition expense factors may be developed by each carrier to reflect the carrier's experience and are subject to office review and approval.

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

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

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

b. If a carrier separates the experience of small employer groups as provided in sub-subparagraph a., the rate to be charged to small employer groups of less than 2 eligible employees may not exceed 150 percent of the rate determined for small employer groups of 2-50 eligible employees. However, the carrier may charge excess losses of the experience pool consisting of small employer groups with less than 2 eligible employees to the experience pool consisting of small employer groups with 2-50 eligible employees

so that all losses are allocated and the 150-percent rate limit on the experience pool consisting of small employer groups with less than 2 eligible employees is maintained. Notwithstanding s. 627.411(1), the rate to be charged to a small employer group of fewer than 2 eligible employees, insured as of July 1, 2002, may be up to 125 percent of the rate determined for small employer groups of 2-50 eligible employees for the first annual renewal and 150 percent for subsequent annual renewals.

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

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

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

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

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

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

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

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

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

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

a. A preferred provider arrangement or exclusive provider organization or any combination thereof, in which a small employer carrier enters into

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

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

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

4. The standard health benefit plan shall include:

a. Coverage for inpatient hospitalization;

b. Coverage for outpatient services;

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

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

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

f. Coverage for mammograms pursuant to s. 627.6613;

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

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

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

5. The standard health benefit plan and the basic health benefit plan may include a schedule of benefit limitations for specified services and procedures. If the committee develops such a schedule of benefits limitation for the standard health benefit plan or the basic health benefit plan, a small employer carrier offering the plan must offer the employer an option for increasing the benefit schedule amounts by 4 percent annually.

6. The basic health benefit plan shall include all of the benefits specified in subparagraph 4.; however, the basic health benefit plan shall place addi-

tional restrictions on the benefits and utilization and may also impose additional cost containment measures.

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

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

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

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

(d)1. Upon offering coverage under a standard health benefit plan, a basic health benefit plan, or a limited benefit policy or contract for any small employer, the small employer carrier shall provide such employer group with a written statement that contains, at a minimum:

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

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

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

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

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

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

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

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

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

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

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

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

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

(15) SMALL EMPLOYERS ACCESS PROGRAM.—

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

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

(c) Definitions.—For purposes of this subsection:

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

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

3. "Mutually supported benefit plan" means an optional alternative coverage plan developed within a defined geographic region which may include, but is not limited to, a minimum level of primary care coverage in which the percentage of the premium is distributed among the employer, the employee, and community-generated revenue either alone or in conjunction with federal matching funds.

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

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

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

(d) Eligibility.—

1. Any small employer that is actively engaged in business, has its principal place of business in this state, employs up to 25 eligible employees on business days during the preceding calendar year, employs at least 2 employees on the first day of the plan year, and has had no prior coverage for the last 6 months may participate.

2. Any municipality, county, school district, or hospital employer located in a rural community as defined in s. 288.0656(2)(b), may participate.

3. Nursing home employers may participate.

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

Any employer participating in the program must do so until the end of the term for which the carrier providing the coverage is obligated to provide such coverage to the program. Coverage for a small employer group that ceases to meet the eligibility requirements of this section may be terminated at the end of the policy period for which the necessary premiums have been paid.

(e) Administration.—

1. The office shall by competitive bid, in accordance with current state law, select an insurer to provide coverage through the program to eligible small employers within an established geographical area of this state. The office may develop exclusive regions for the program similar to those used by the Healthy Kids Corporation. However the office is not precluded from developing, in conjunction with insurers, regions different from those used by the Healthy Kids Corporation if the office deems that such a region will carry out the intentions of this subsection.

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

a. The insurer's proven ability to handle health insurance coverage to small employer groups.

b. The efficiency and timeliness of the insurer's claim processing procedures.

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

d. The financial condition and stability of the insurer.

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

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

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

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

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

2. Maintain employer awareness of the program.

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

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

5. Serve for a period specified in the contract between the office and the insurer, subject to removal for cause and subject to any terms, conditions, and limitations of the contract between the office and the insurer as may be specified in the request for proposal.

(h) Contract term.—The contract term shall not exceed 3 years. At least 6 months prior to the expiration of each contract period, the office shall invite eligible entities, including the current insurer, to submit bids to serve

as the insurer for a designated geographic area. Selection of the insurer for the succeeding period shall be made at least 3 months prior to the end of the current period. If a protest is filed and not resolved by the end of the contract period, the contract with the existing administrator may be extended for a period not to exceed 6 months. During the contract extension period, the administrator shall be paid at a rate to be negotiated by the office.

(i) Insurer reporting requirements.—On March 1 following the close of each calendar year, the insurer shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the office on a form prescribed by the office.

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

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

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

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

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

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

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

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

3. Requires a small employer carrier to either include a specific provider or class of providers when contracting for health care services or benefits or to exclude any class of providers that is generally authorized by statute to provide such care.

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

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

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

Section 25. Section 627.6405, Florida Statutes, is created to read:

627.6405 Decreasing inappropriate utilization of emergency care.—

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

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

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

(4) As a disincentive for insureds to inappropriately use emergency department services for nonemergency care, health insurers may require higher copayments for urgent care or primary care provided in an emergency department and higher copayments for use of out-of-network emergency departments. Higher copayments may not be charged for the utilization of the emergency department for emergency care. For the purposes of this section, the term "emergency care" has the same meaning as provided in s. 395.002, and shall include services provided to rule out an emergency medical condition.

Section 26. Section 641.31097, Florida Statutes, is created to read:

641.31097 Decreasing inappropriate utilization of emergency care.—

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

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

(3) Health maintenance organizations shall develop community emergency department diversion programs. Such programs may include at the discretion of the health maintenance organization, but not be limited to, enlisting providers to be on call to subscribers after hours, coordinating care through local community resources, and providing incentives to providers for case management.

(4) As a disincentive for subscribers to inappropriately use emergency department services for nonemergency care, health maintenance organizations may require higher copayments for urgent care or primary care provided in an emergency department and higher copayments for use of out-of-

network emergency departments. Higher copayments may not be charged for the utilization of the emergency department for emergency care. For the purposes of this section, the term "emergency care" has the same meaning as provided in s. 395.002 and shall include services provided to rule out an emergency medical condition.

Section 27. Subsection (1) of section 627.9175, Florida Statutes, is amended to read:

627.9175 Reports of information on health and accident insurance.—

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

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

(b) Information on all health and accident insurance policies and prepaid limited health service organizations and health maintenance organization contracts in force and issued in the previous year. Such information shall include, but not be limited to, direct premiums earned, direct losses incurred, number of policies, number of certificates, number of covered lives, and the average number of days taken to pay claims. ~~as to policies of individual health insurance:~~

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

~~1. The deductible amount;~~

~~2. The coinsurance percentage;~~

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

~~4. Outpatient benefits;~~

~~5. Inpatient benefits; and~~

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

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

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

The commission may establish rules governing ~~shall provide by rule a uniform format for~~ the submission of ~~this~~ information described in this section, including the use of uniform formats and electronic data transmission ~~order to allow for meaningful comparisons of premiums charged for comparable benefits. The office shall provide this information to the department, which shall publish annually a consumer's guide which summarizes and compares the information required to be reported under this subsection~~.

Section 28. Chapter 636, Florida Statutes, entitled "Prepaid Limited Health Service Organizations," is retitled as "Prepaid Limited Health Service Organizations and Discount Medical Plan Organizations."

Section 29. Sections 636.002 through 636.067, Florida Statutes, are designated as part I of chapter 636, Florida Statutes, and entitled "Prepaid Limited Health Service Organizations."

Section 30. Paragraph (c) of subsection (7) of section 636.003, Florida Statutes, is amended to read:

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

(7) "Prepaid limited health service organization" means any person, corporation, partnership, or any other entity which, in return for a prepayment, undertakes to provide or arrange for, or provide access to, the provision of a limited health service to enrollees through an exclusive panel of providers. Prepaid limited health service organization does not include:

(c) Any person who is licensed pursuant to part II as a discount medical plan organization~~, in exchange for fees, dues, charges or other consideration, provides access to a limited health service provider without assuming any responsibility for payment for the limited health service or any portion thereof~~.

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

PART II

DISCOUNT MEDICAL PLAN ORGANIZATIONS

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

(1) "Discount medical plan" means a business arrangement or contract in which a person, in exchange for fees, dues, charges, or other consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. The term "discount medical plan" does not include any product regulated under chapter 627, chapter 641, or part I of chapter 636.

(2) "Discount medical plan organization" means an entity which, in exchange for fees, dues, charges, or other consideration, provides access for

plan members to providers of medical services and the right to receive medical services from those providers at a discount. The term "discount medical plan" does not include any product regulated under chapter 627, chapter 641, or part I of chapter 636.

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

(4) "Medical services" means any care, service, or treatment of illness or dysfunction of, or injury to, the human body, including, but not limited to, physician care, inpatient care, hospital surgical services, emergency services, ambulance services, dental care services, vision care services, mental health services, substance abuse services, chiropractic services, podiatric care services, laboratory services, and medical equipment and supplies. The term does not include pharmaceutical supplies or prescriptions.

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

(6) "Provider" means any person or institution which is contracted, directly or indirectly, with a discount medical plan organization to provide medical services to members.

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

636.204 License required.—

(1) Before doing business in this state as a discount medical plan organization, an entity must be a corporation, incorporated under the laws of this state or, if a foreign corporation, authorized to transact business in this state, and must possess a license as a discount medical plan organization from the office.

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

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

(b) A copy of the corporation's bylaws.

(c) A list of the names, addresses, official positions, and biographical information of the individuals who are responsible for conducting the applicant's affairs, including, but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the officers, contracted management company personnel, and

any person or entity owning or having the right to acquire 10 percent or more of the voting securities of the applicant. Such listing must fully disclose the extent and nature of any contracts or arrangements between any individual who is responsible for conducting the applicant's affairs and the discount medical plan organization, including any possible conflicts of interest.

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

(e) A statement generally describing the applicant, its facilities and personnel, and the medical services to be offered.

(f) A copy of the form of all contracts made or to be made between the applicant and any providers or provider networks regarding the provision of medical services to members.

(g) A copy of the form of any contract made or arrangement to be made between the applicant and any person listed in paragraph (c).

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

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

(j) A description of the proposed method of marketing.

(k) A description of the subscriber complaint procedures to be established and maintained.

(l) The fee for issuance of a license.

(m) Such other information as the commission or office may reasonably require to make the determinations required by this part.

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

(4) Prior to licensure by the office, each discount medical plan organization must establish an Internet website so as to conform to the requirements of s. 636.226.

(5) The license fee under subsection (2) is $50 per year per licensee. All amounts collected shall be deposited into the General Revenue Fund.

(6) Nothing in this part requires a provider who provides discounts to his or her own patients to obtain and maintain a license as a discount medical plan organization.

636.206 Examinations and investigations.—

(1) The office may examine or investigate the business and affairs of any discount medical plan organization. The office may order any discount medical plan organization or applicant to produce any records, books, files, advertising and solicitation materials, or other information and may take statements under oath to determine whether the discount medical plan organization or applicant is in violation of the law or is acting contrary to the public interest. The expenses incurred in conducting any examination or investigation must be paid by the discount medical plan organization or applicant. Examinations and investigations must be conducted as provided in chapter 624, and discount medical plan organizations are subject to all applicable provisions of the insurance code.

(2) Failure by the discount medical plan organization to pay the expenses incurred under subsection (1) is grounds for denial or revocation.

636.208 Fees.—A discount medical plan organization may charge a reasonable one-time processing fee and a periodic charge. If a discount medical plan charges for a time period in excess of one month, the plan must, in the event of cancellation of the membership by either party, make a pro rata reimbursement of the fees to the member.

636.210 Prohibited activities of a discount medical plan organization.—

(1) A discount medical plan organization may not:

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

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

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

(d) Pay providers any fees for medical services.

(2) A discount medical plan organization may not collect or accept money from a member for payment to a provider for specific medical services furnished or to be furnished to the member unless the organization has an active certificate of authority from the office to act as an administrator.

636.212 Disclosures.—The following disclosures must be made in writing to any prospective member and must be on the first page of any advertisements, marketing materials, or brochures relating to a discount medical

plan. The disclosures must be printed in not less than 12-point type or no smaller than the largest type on the page if larger than 12-point type:

(1) That the plan is not a health insurance policy.

(2) That the plan provides discounts at certain health care providers for medical services.

(3) That the plan does not make payments directly to the providers of medical services.

(4) That the plan member is obligated to pay for all health care services but will receive a discount from those health care providers who have contracted with the discount plan organization.

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

636.214 Provider agreements.—

(1) All providers offering medical services to members under a discount medical plan must provide such services pursuant to a written agreement. The agreement may be entered into directly by the provider or by a provider network to which the provider belongs.

(2) A provider agreement must provide the following:

(a) A list of the services and products to be provided at a discount.

(b) The amount or amounts of the discounts or, alternatively, a fee schedule which reflects the provider's discounted rates.

(c) That the provider will not charge members more than the discounted rates.

(3) A provider agreement between a discount medical plan organization and a provider network shall require that the provider network have written agreements with its providers which:

(a) Contain the terms described in subsection (2).

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

(c) Require the network to maintain an up-to-date list of its contracted providers and to provide that list on a monthly basis to the discount medical plan organization.

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

636.216 Form filings.—

(1) All charges to members must be filed with the office and any charge to members greater than $30 per month or $360 per year must be approved

by the office before the charges can be used. The discount medical plan organization has the burden of proof that the charges bear a reasonable relation to the benefits received by the member.

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

(3) All forms used, including the written agreement pursuant to subsection (2), must first be filed with and approved by the office. Every form filed shall be identified by a unique form number placed in the lower left corner of each form.

(4) If such filings are disapproved, the office shall notify the discount medical plan organization and shall specify in the notice the reasons for disapproval. The discount medical plan organization has 21 days from the date of receipt of notice to request a hearing before the office pursuant to chapter 120.

636.218 Annual reports.—

(1) Each discount medical plan organization must file with the office, within 3 months after the end of each fiscal year, an annual report.

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

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

(b) A list of the names and residence addresses of all persons responsible for the conduct of the organization's affairs, together with a disclosure of the extent and nature of any contracts or arrangements between such persons and the discount medical plan organization, including any possible conflicts of interest.

(c) The number of discount medical plan members.

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

(3) Every discount medical plan organization which fails to file an annual report in the form and within the time required by this section shall forfeit up to $500 for each day for the first 10 days during which the neglect continues and shall forfeit up to $1,000 for each day after the first 10 days during which the neglect continues; and, upon notice by the office to that effect, the organization's authority to enroll new members or to do business in this state ceases while such default continues. The office shall deposit all sums collected by the office under this section to the credit of the Insurance

Regulatory Trust Fund. The office may not collect more than $50,000 for each report.

636.220 Minimum capital requirements.—

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

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

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

(1) The office may suspend the authority of a discount medical plan organization to enroll new members, revoke any license issued to a discount medical plan organization, or order compliance if the office finds that any of the following conditions exist:

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

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

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

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

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

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

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

(4) The office shall, in its order suspending the authority of a discount medical plan organization to enroll new members, specify the period during which the suspension is to be in effect and the conditions, if any, which must be met by the discount medical plan organization prior to reinstatement of its license to enroll new members. The order of suspension is subject to rescission or modification by further order of the office prior to the expiration of the suspension period. Reinstatement may not be made unless requested

by the discount medical plan organization; however, the office may not grant reinstatement if it finds that the circumstances for which the suspension occurred still exist or are likely to recur.

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

636.226 Provider name listing.—Each discount medical plan organization must maintain an up-to-date list of the names and addresses of the providers with which it has contracted, on an Internet website page, the address of which shall be prominently displayed on all its advertisements, marketing materials, brochures, and discount cards. This section applies to those providers with whom the discount medical plan organization has contracted directly, as well as those who are members of a provider network with which the discount medical plan organization has contracted.

636.228 Marketing of discount medical plans.—

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

(2) The discount medical plan organization shall have an executed written agreement with a marketer prior to the marketer's marketing, promoting, selling, or distributing the discount medical plan and shall be responsible and financially liable for any acts of its marketers that do not comply with the provisions of this part.

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

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

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

636.236 Security deposit.—

(1) A licensed discount medical plan organization must deposit and maintain deposited in trust with the department securities eligible for deposit under s. 625.52, having at all times a value of not less than $35,000, for use by the office in protecting plan members.

(2) No judgment creditor or other claimant of a discount medical plan organization, other than the office or department, shall have the right to levy upon any of the assets or securities held in this state as a deposit under subsection (1).

636.238 Penalties for violation of this part.—

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

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

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

636.240 Injunctions.—

(1) In addition to the penalties and other enforcement provisions of this part, the office may seek both temporary and permanent injunctive relief when:

(a) A discount medical plan is being operated by any person or entity that is not licensed pursuant to this part.

(b) Any person, entity, or discount medical plan organization has engaged in any activity prohibited by this part or any rule adopted pursuant to this part.

(2) The venue for any proceeding bought pursuant to this section shall be in the Circuit Court of Leon County.

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

636.242 Civil remedies.—Any person damaged by the acts of a person in violation of this part may bring a civil action against the person committing the violation in the circuit court of the county in which the alleged violator resides or has a principal place of business or in the county in which the alleged violation occurred. Upon an adverse adjudication, the defendant is liable for damages, together with court costs and reasonable attorney's fees incurred by the plaintiff. When so awarded, court costs and attorney's fees must be included in the judgment or decree rendered in the case. If it appears to the court that the suit brought by the plaintiff is frivolous or brought for purposes of harassment, the court may apply sanctions in accordance with chapter 57.

636.244 Unlicensed discount medical plan organizations.—The provisions of ss. 626.901-626.912 apply to the activities of an unlicensed discount medical plan organization as if the unlicensed discount medical plan organization were an unauthorized insurer.

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

627.65626 Insurance rebates for healthy lifestyles.—

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

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

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

627.6402 Insurance rebates for healthy lifestyles.—

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

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

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

641.31 Health maintenance contracts.—

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

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

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

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

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

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

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

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

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

Section 35. Section 626.191, Florida Statutes, is amended to read:

626.191 Repeated applications.—The failure of an applicant to secure a license upon an application shall not preclude the applicant ~~him or her~~ from applying again as many times as desired, but the department or office shall not give consideration to or accept any further application by the same individual for a similar license dated or filed within 30 days subsequent to the date the department or office denied the last application, except as provided in s. 626.281.

Section 36. Subsection (1) of section 626.201, Florida Statutes, is amended to read:

626.201 Investigation.—

(1) The department or office may propound any reasonable interrogatories in addition to those contained in the application, to any applicant for license or appointment, or on any renewal, reinstatement, or continuation thereof, relating to the applicant's ~~his or her~~ qualifications, residence, prospective place of business, and any other matter which, in the opinion of the department or office, is deemed necessary or advisable for the protection of the public and to ascertain the applicant's qualifications.

Section 37. Section 626.593, Florida Statutes, is created to read:

626.593 Insurance agent; written contract for compensation.—

(1) No person licensed as an insurance agent may receive any fee or commission or any other thing of value in addition to the rates filed pursuant to chapter 627 for examining any group health insurance or any group health benefit plan for the purpose of giving or offering advice, counsel, recommendation, or information in respect to terms, conditions, benefits, coverage, or premium of any such policy or contract unless such compensation is based upon a written contract signed by the party to be charged and specifying or clearly defining the amount or extent of such compensation and informing the party to be charged that any commission received from an insurer will be rebated to the party in accordance with subsection (3). In addition, all compensation to be paid to the insurance agent must be disclosed in the contract.

(2) A copy of every such contract shall be retained by the licensee for not less than 3 years after such services have been fully performed.

(3) Notwithstanding the provisions of s. 626.572, all commissions received by an insurance agent from an insurer in connection with the issuance of a policy, when a separate fee or other consideration has been paid to the insurance agent by an insured, shall be rebated to the insured or other party being charged within 30 days after receipt of such commission by the insurance agent.

(4) This section is subject to the unfair insurance trade practices provisions of s. 626.9541(1)(g).

Section 38. Notwithstanding the amendment to s. 627.6699(5)(c), Florida Statutes, by this act, any right to an open enrollment offer of health benefit coverage for groups of fewer than two employees, pursuant to s. 627.6699(5)(c), Florida Statutes, as it existed immediately before the effective date of this act, shall remain in full force and effect until the enactment of s. 627.64872, Florida Statutes, and the subsequent date upon which such plan begins to accept new risks or members.

Section 39. Section 465.0244, Florida Statutes, is created to read:

465.0244 Information disclosure.—Every pharmacy shall make available on its Internet website a link to the performance outcome and financial data that is published by the Agency for Health Care Administration pursuant to s. 408.05(3)(l) and shall place in the area where customers receive filled prescriptions notice that such information is available electronically and the address of its Internet website.

Section 40. Section 627.6499, Florida Statutes, is amended to read:

627.6499 Reporting by insurers and third-party administrators.—

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

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

Section 41. Subsections (6) and (7) are added to section 641.54, Florida Statutes, to read:

641.54 Information disclosure.—

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

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

Section 42. Section 408.02, Florida Statutes, is repealed.

Section 43. The sum of $250,000 is appropriated from the Insurance Regulatory Trust Fund in the Department of Financial Services to the Office of Insurance Regulation for the purpose of implementing the provisions in this act relating to the Small Employers Access Program.

Section 44. The sum of $250,000 is appropriated from the Insurance Regulatory Trust Fund to enable the board of the Florida Health Insurance Plan to conduct an actuarial study required under s. 627.64872, Florida Statutes.

Section 45. The sum of $169,069 is appropriated from the Insurance Regulatory Trust Fund in the Department of Financial Services to the Office of Insurance Regulation, and three full-time equivalent positions are authorized, for the purpose of implementing the provisions in this act relating to the regulation of Discount Medical Plan Organizations.

Section 46. The sum of $650,000 is appropriated from the General Revenue Fund to the Agency for Health Care Administration for the purposes of implementing the Florida Patient Safety Corporation. The sum of $350,000 shall be used as startup funds for the Florida Patient Safety Corporation and $300,000 shall be used for the "near miss" project within the Florida Patient Safety Corporation.

Section 47. The sum of $1,136,171 is appropriated from the General Revenue Fund to the Agency for Health Care Administration, and 11 full-time equivalent positions are authorized, for the purposes of implementing the provisions of this act relating to the reporting of performance and cost data for hospitals, physicians, and pharmacies.

Section 48. Except as otherwise provided herein, this act shall take effect July 1, 2004.

Approved by the Governor June 14, 2004.

Filed in Office Secretary of State June 14, 2004.