By the Committees on Health, Aging and Long-Term Care; Banking and Insurance; and Senators Latvala, Brown-Waite, Silver, Geller, Campbell, Kurth, Mitchell, Dawson and Klein

317-2158B-00

A bill to be entitled

An act relating to health care; providing a short title; amending s. 395.701, F.S.; reducing an assessment against hospitals for outpatient services; amending s. 395.7015, F.S.; reducing an assessment against certain health care entities; amending s. 408.904, F.S.; increasing benefits for certain persons who receive hospital outpatient services; amending s. 408.905, F.S.; increasing benefits furnished by Medicaid providers to recipients of hospital outpatient services; amending s. 905.908, F.S.; increasing reimbursement to hospitals for outpatient care; amending s. 409.912, F.S.; providing for a contract with and reimbursement of an entity in Pasco or Pinellas County that provides in-home physician services to Medicaid recipients with degenerative neurological diseases; providing for future repeal; providing appropriations; amending s. 400.471, F.S.; deleting the certificate-of-need requirement for licensure of Medicare-certified home health agencies; amending s. 408.032, F.S.; adding definitions of "exemption" and "mental health services"; revising the term "health service"; deleting the definitions of "home health agency," "institutional health service," "intermediate care facility," "multifacility project," and "respite care"; amending s. 408.033, F.S.; deleting references to the state health plan;

amending s. 408.034, F.S.; deleting a reference to licensing of home health agencies by the Agency for Health Care Administration; amending s. 408.035, F.S.; deleting obsolete certificate-of-need review criteria and revising other criteria; amending s. 408.036, F.S.; revising provisions relating to projects subject to review; deleting references to Medicare-certified home health agencies; deleting the review of certain acquisitions; specifying the types of bed increases subject to review; deleting cost overruns from review; deleting review of combinations or division of nursing home certificates of need; providing for expedited review of certain conversions of licensed hospital beds; deleting the requirement for an exemption for initiation or expansion of obstetric services, provision of respite care services, establishment of a Medicare-certified home health agency, or provision of a health service exclusively on an outpatient basis; providing exemptions for combinations or divisions of nursing home certificates of need and additions of certain hospital beds and nursing home beds within specified limitations; requiring a fee for each request for exemption; amending s. 408.037, F.S.; deleting reference to the state health plan; amending ss. 408.038, 408.039, 408.044, and 408.045, F.S.; replacing "department" with "agency"; clarifying the opportunity to

challenge an intended award of a certificate of need; amending s. 408.040, F.S.; deleting an obsolete reference; revising the format of conditions related to Medicaid; creating a certificate-of-need workgroup within the Agency for Health Care Administration; providing for expenses; providing membership, duties, and meetings; providing for termination; amending s. 651.118, F.S.; excluding a specified number of beds from a time limit imposed on extension of authorization for continuing care residential community providers to use sheltered beds for nonresidents; requiring a facility to report such use after the expiration of the extension; repealing s. 400.464(3), F.S., relating to home health agency licenses provided to certificate-of-need exempt entities; providing applicability; reducing the allocation of funds and positions from the Health Care Trust Fund in the Agency for Health Care Administration; amending s. 216.136, F.S.; creating the Mandated Health Insurance Benefits and Providers Estimating Conference; providing for membership and duties of the conference; providing duties of legislative committees that have jurisdiction over health insurance matters; amending s. 624.215, F.S.; providing that certain legislative proposals must be submitted to and assessed by the conference, rather than the Agency for Health Care Administration; amending

guidelines for assessing the impact of a proposal to legislatively mandate certain health coverage; providing prerequisites to legislative consideration of such proposals; requiring physicians and hospitals to post a sign and provide a statement informing patients about the toll-free health care hotline; amending s. 408.7056, F.S.; providing additional definitions for the Statewide Provider and Subscriber Assistance Program; amending s. 627.654, F.S.; providing for insuring small employers under policies issued to small employer health alliances; providing requirements for participation; providing limitations; providing for insuring spouses and dependent children; allowing a single master policy to include alternative health plans; amending s. 627.6571, F.S.; including small employer health alliances within policy nonrenewal or discontinuance, coverage modification, and application provisions; amending s. 627.6699, F.S.; revising restrictions relating to premium rates to authorize small employer carriers to modify rates under certain circumstances and to authorize carriers to issue group health insurance policies to small employer health alliances under certain circumstances; requiring carriers issuing a policy to an alliance to allow appointed agents to sell such a policy; amending ss. 240.2995, 240.2996,

240.512, 381.0406, 395.3035, and 627.4301, F.S.; conforming cross-references; defining the term "managed care"; repealing ss. 408.70(3), 408.701, 408.702, 408.703, 408.704, 408.7041, 408.7042, 408.7045, 408.7055, and 408.706, F.S., relating to community health purchasing alliances; amending s. 627.6699, F.S.; modifying definitions; requiring small employer carriers to begin to offer and issue all small employer benefit plans on a specified date; deleting the requirement that basic and standard small employer health benefit plans be issued; providing additional requirements for determining premium rates for benefit plans; providing for applicability of the act to plans provided by small employer carriers that are insurers or health maintenance organizations notwithstanding the provisions of certain other specified statutes under specified conditions; amending s. 641.27, F.S.; providing for payment by a health maintenance organization of fees to outside examiners appointed by the Department of Insurance; providing for application of federal solvency requirements to provider-sponsored organizations; providing that part IV of ch. 628, F.S., applies to health maintenance organizations; creating s. 641.275, F.S.; providing legislative intent that the rights of subscribers who are covered under health maintenance organization contracts be recognized and summarized; requiring health

maintenance organizations to operate in conformity with such rights; requiring organizations to provide subscribers with a copy of their rights; listing specified requirements for organizations that are currently required by other statutes; authorizing administrative penalties for enforcing the rights specified in s. 641.275, F.S.; amending s. 641.28, F.S.; revising award of attorney's fees in civil actions under certain circumstances; amending s. 641.3917, F.S.; authorizing civil actions against health maintenance organizations by certain persons under certain circumstances; providing requirements and procedures; providing for liability for damages and attorney's fees; prohibiting punitive damages under certain circumstances; requiring the advance posting of discovery costs; amending s. 440.11, F.S.; establishing exclusive liability of health maintenance organizations; providing application; providing a legislative declaration; providing an appropriation; amending ss. 641.31, 641.315, 641.3155, F.S.; prohibiting a health maintenance organization from restricting a provider's ability to provide in-patient hospital services to a subscriber; requiring payment for medically necessary in-patient hospital services; amending s. 641.51, F.S., relating to quality assurance program requirements for certain

managed-care organizations; allowing the rendering of adverse determinations by physicians licensed in Florida or states with similar requirements; requiring the submission of facts and documentation pertaining to rendered adverse determinations; providing timeframe for organizations to submit facts and documentation to providers and subscribers in writing; requiring an authorized representative to sign the notification; providing effective dates.

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

Section 1. This act may be cited as the "Health Care Protection Act of 2000."

Section 2. Subsection (2) of section 395.701, Florida Statutes, is amended to read:

395.701 Annual assessments on net operating revenues to fund public medical assistance; administrative fines for failure to pay assessments when due; exemption.--

(2) There is imposed upon each hospital an assessment in an amount equal to 1.5 percent of the annual net operating revenue for inpatient services and an assessment in an amount equal to 1 percent of the annual net operating revenue for outpatient services for each hospital, such revenue to be determined by the agency, based on the actual experience of the hospital as reported to the agency. Within 6 months after the end of each hospital fiscal year, the agency shall certify the amount of the assessment for each hospital. The assessment shall be payable to and collected by the agency in

equal quarterly amounts, on or before the first day of each calendar quarter, beginning with the first full calendar quarter that occurs after the agency certifies the amount of the assessment for each hospital. All moneys collected pursuant to this subsection shall be deposited into the Public Medical Assistance Trust Fund.

Section 3. Subsection (2) of section 395.7015, Florida Statutes, is amended to read:

395.7015 Annual assessment on health care entities.--

(2) There is imposed an annual assessment against certain health care entities as described in this section:

(a) The assessment shall be equal to 1 ~~1.5~~ percent of the annual net operating revenues of health care entities. The assessment shall be payable to and collected by the agency. Assessments shall be based on annual net operating revenues for the entity's most recently completed fiscal year as provided in subsection (3).

(b) For the purpose of this section, "health care entities" include the following:

1. Ambulatory surgical centers and mobile surgical facilities licensed under s. 395.003. This subsection shall only apply to mobile surgical facilities operating under contracts entered into on or after July 1, 1998.

2. Clinical laboratories licensed under s. 483.091, excluding any hospital laboratory defined under s. 483.041(5), any clinical laboratory operated by the state or a political subdivision of the state, any clinical laboratory which qualifies as an exempt organization under s. 501(c)(3) of the Internal Revenue Code of 1986, as amended, and which receives 70 percent or more of its gross revenues from services to charity patients or Medicaid patients, and any blood, plasma,

or tissue bank procuring, storing, or distributing blood, plasma, or tissue either for future manufacture or research or distributed on a nonprofit basis, and further excluding any clinical laboratory which is wholly owned and operated by 6 or fewer physicians who are licensed pursuant to chapter 458 or chapter 459 and who practice in the same group practice, and at which no clinical laboratory work is performed for patients referred by any health care provider who is not a member of the same group.

3. Diagnostic-imaging centers that are freestanding outpatient facilities that provide specialized services for the identification or determination of a disease through examination and also provide sophisticated radiological services, and in which services are rendered by a physician licensed by the Board of Medicine under s. 458.311, s. 458.313, or s. 458.317, or by an osteopathic physician licensed by the Board of Osteopathic Medicine under s. 459.006, s. 459.007, or s. 459.0075. For purposes of this paragraph, "sophisticated radiological services" means the following: magnetic resonance imaging; nuclear medicine; angiography; arteriography; computed tomography; positron emission tomography; digital vascular imaging; bronchography; lymphangiography; splenography; ultrasound, excluding ultrasound providers that are part of a private physician's office practice or when ultrasound is provided by two or more physicians licensed under chapter 458 or chapter 459 who are members of the same professional association and who practice in the same medical specialties; and such other sophisticated radiological services, excluding mammography, as adopted in rule by the board.

Section 4. Paragraph (c) of subsection (2) of section 408.904, Florida Statutes, is amended to read:

408.904 Benefits.--

(2) Covered health services include:

(c) Hospital outpatient services. Those services provided to a member in the outpatient portion of a hospital licensed under part I of chapter 395, up to a limit of$1,500 ~~$1,000~~ per calendar year per member, that are preventive, diagnostic, therapeutic, or palliative.

Section 5. Subsection (6) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(6) HOSPITAL OUTPATIENT SERVICES.--The agency shall pay for preventive, diagnostic, therapeutic, or palliative care and other services provided to a recipient in the outpatient portion of a hospital licensed under part I of chapter 395, and provided under the direction of a licensed physician or licensed dentist, except that payment for such care and services is limited to$1,500~~$1,000~~ per state fiscal

year per recipient, unless an exception has been made by the agency, and with the exception of a Medicaid recipient under age 21, in which case the only limitation is medical necessity.

Section 6. Paragraph (a) of subsection (1) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.--Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(1) Reimbursement to hospitals licensed under part I of chapter 395 must be made prospectively or on the basis of negotiation.

(a) Reimbursement for inpatient care is limited as provided for in s. 409.905(5). Reimbursement for hospital outpatient care is limited to$1,500~~$1,000~~ per state fiscal year per recipient, except for:

1. Such care provided to a Medicaid recipient under age 21, in which case the only limitation is medical necessity;

2. Renal dialysis services; and

3. Other exceptions made by the agency.

Section 7. Paragraph (e) is added to subsection (3) of section 409.912, Florida Statutes, to read:

409.912 Cost-effective purchasing of health care.--The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services.

(3) The agency may contract with:

(e) An entity in Pasco County or Pinellas County that provides in-home physician services to Medicaid recipients having degenerative neurological diseases in order to test the cost-effectiveness of enhanced home-based medical care. The entity providing the services shall be reimbursed on a fee-for-service basis at a rate not less than comparable

Medicare reimbursement rates. The agency may apply for waivers of federal regulations necessary to implement such program. This paragraph expires July 1, 2002.

Section 8. The Legislature shall appropriate each fiscal year from the General Revenue Fund to the Public Medical Assistance Trust Fund an amount sufficient to replace the funds lost due to the reduction by this act of the assessment on other health care entities under section 395.7015, Florida Statutes, and the reduction by this act in the assessment on hospitals under section 395.701, Florida Statutes, and to maintain federal approval of the reduced amount of funds deposited into the Public Medical Assistance Trust Fund under section 395.701, Florida Statutes, as state matching funds for the state's Medicaid program.

Section 9. The sum of $28.3 million is appropriated from the General Revenue Fund to the Agency for Health Care Administration for the purpose of implementing this act. However, such appropriation shall be reduced by an amount equal to any similar appropriation for the same purpose which is contained in other legislation adopted during the 2000 legislative session and which becomes a law.

Section 10. Subsections (2) and (11) of section 400.471, Florida Statutes, are amended to read:

400.471 Application for license; fee; provisional license; temporary permit.--

(2) The applicant must file with the application satisfactory proof that the home health agency is in compliance with this part and applicable rules, including:

(a) A listing of services to be provided, either directly by the applicant or through contractual arrangements with existing providers;

(b) The number and discipline of professional staff to be employed; and

(c) Proof of financial ability to operate.

~~If the applicant has applied for a certificate of need under ss. 408.0331-408.045 within the preceding 12 months, the applicant may submit the proof required during the certificate-of-need process along with an attestation that there has been no substantial change in the facts and circumstances underlying the original submission.~~

(11) The agency may not issue a license designated as certified to a home health agency that fails to ~~receive a certificate of need under ss. 408.031-408.045 or that fails to~~ satisfy the requirements of a Medicare certification survey from the agency.

Section 11. Section 408.032, Florida Statutes, is amended to read:

408.032 Definitions.--As used in ss. 408.031-408.045, the term:

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

(2) "Capital expenditure" means an expenditure, including an expenditure for a construction project undertaken by a health care facility as its own contractor, which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance, which is made to change the bed capacity of the facility, or substantially change the services or service area of the health care facility, health service provider, or hospice, and which includes the cost of the studies, surveys, designs, plans, working drawings, specifications, initial financing

costs, and other activities essential to acquisition, improvement, expansion, or replacement of the plant and equipment.

(3) "Certificate of need" means a written statement issued by the agency evidencing community need for a new, converted, expanded, or otherwise significantly modified health care facility, health service, or hospice.

(4) "Commenced construction" means initiation of and continuous activities beyond site preparation associated with erecting or modifying a health care facility, including procurement of a building permit applying the use of agency-approved construction documents, proof of an executed owner/contractor agreement or an irrevocable or binding forced account, and actual undertaking of foundation forming with steel installation and concrete placing.

(5) "District" means a health service planning district composed of the following counties:

District 1.--Escambia, Santa Rosa, Okaloosa, and Walton Counties.

District 2.--Holmes, Washington, Bay, Jackson, Franklin, Gulf, Gadsden, Liberty, Calhoun, Leon, Wakulla, Jefferson, Madison, and Taylor Counties.

District 3.--Hamilton, Suwannee, Lafayette, Dixie, Columbia, Gilchrist, Levy, Union, Bradford, Putnam, Alachua, Marion, Citrus, Hernando, Sumter, and Lake Counties.

District 4.--Baker, Nassau, Duval, Clay, St. Johns, Flagler, and Volusia Counties.

District 5.--Pasco and Pinellas Counties.

District 6.--Hillsborough, Manatee, Polk, Hardee, and Highlands Counties.

District 7.--Seminole, Orange, Osceola, and Brevard Counties.

District 8.--Sarasota, DeSoto, Charlotte, Lee, Glades, Hendry, and Collier Counties.

District 9.--Indian River, Okeechobee, St. Lucie, Martin, and Palm Beach Counties.

District 10.--Broward County.

District 11.--Dade and Monroe Counties.

(6) "Exemption" means the process by which a proposal that would otherwise require a certificate of need may proceed without a certificate of need.

(7)~~(6)~~ "Expedited review" means the process by which certain types of applications are not subject to the review cycle requirements contained in s. 408.039(1), and the letter of intent requirements contained in s. 408.039(2).

(8)~~(7)~~ "Health care facility" means a hospital, long-term care hospital, skilled nursing facility, hospice, ~~intermediate care facility,~~or intermediate care facility for the developmentally disabled. A facility relying solely on spiritual means through prayer for healing is not included as a health care facility.

(9)~~(8)~~ "Health services" means diagnostic, curative, or rehabilitative services and includes ~~alcohol treatment, drug abuse treatment, and~~ mental health services. Obstetric services are not health services for purposes of ss. 408.031-408.045.

~~(9) "Home health agency" means an organization, as defined in s. 400.462(4), that is certified or seeks certification as a Medicare home health service provider.~~

(10) "Hospice" or "hospice program" means a hospice as defined in part VI of chapter 400.

(11) "Hospital" means a health care facility licensed under chapter 395.

~~(12) "Institutional health service" means a health service which is provided by or through a health care facility and which entails an annual operating cost of $500,000 or more. The agency shall, by rule, adjust the annual operating cost threshold annually using an appropriate inflation index.~~

~~(13) "Intermediate care facility" means an institution which provides, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who, because of their mental or physical condition, require health-related care and services above the level of room and board.~~

(12)~~(14)~~ "Intermediate care facility for the developmentally disabled" means a residential facility licensed under chapter 393 and certified by the Federal Government pursuant to the Social Security Act as a provider of Medicaid services to persons who are mentally retarded or who have a related condition.

(13)~~(15)~~ "Long-term care hospital" means a hospital licensed under chapter 395 which meets the requirements of 42 C.F.R. s. 412.23(e) and seeks exclusion from the Medicare prospective payment system for inpatient hospital services.

(14) "Mental health services" means inpatient services provided in a hospital licensed under chapter 395 and listed on the hospital license as psychiatric beds for adults; psychiatric beds for children and adolescents; intensive residential treatment beds for children and adolescents; substance abuse beds for adults; or substance abuse beds for children and adolescents.

~~(16) "Multifacility project" means an integrated residential and health care facility consisting of independent living units, assisted living facility units, and nursing home beds certificated on or after January 1, 1987, where:~~

~~(a) The aggregate total number of independent living units and assisted living facility units exceeds the number of nursing home beds.~~

~~(b) The developer of the project has expended the sum of $500,000 or more on the certificated and noncertificated elements of the project combined, exclusive of land costs, by the conclusion of the 18th month of the life of the certificate of need.~~

~~(c) The total aggregate cost of construction of the certificated element of the project, when combined with other, noncertificated elements, is $10 million or more.~~

~~(d) All elements of the project are contiguous or immediately adjacent to each other and construction of all elements will be continuous.~~

(15)~~(17)~~ "Nursing home geographically underserved area" means:

(a) A county in which there is no existing or approved nursing home;

(b) An area with a radius of at least 20 miles in which there is no existing or approved nursing home; or

(c) An area with a radius of at least 20 miles in which all existing nursing homes have maintained at least a 95 percent occupancy rate for the most recent 6 months or a 90 percent occupancy rate for the most recent 12 months.

~~(18) "Respite care" means short-term care in a licensed health care facility which is personal or custodial and is provided for chronic illness, physical infirmity, or~~

~~advanced age for the purpose of temporarily relieving family members of the burden of providing care and attendance.~~

(16)~~(19)~~ "Skilled nursing facility" means an institution, or a distinct part of an institution, which is primarily engaged in providing, to inpatients, skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

(17)~~(20)~~ "Tertiary health service" means a health service which, due to its high level of intensity, complexity, specialized or limited applicability, and cost, should be limited to, and concentrated in, a limited number of hospitals to ensure the quality, availability, and cost-effectiveness of such service. Examples of such service include, but are not limited to, organ transplantation, specialty burn units, neonatal intensive care units, comprehensive rehabilitation, and medical or surgical services which are experimental or developmental in nature to the extent that the provision of such services is not yet contemplated within the commonly accepted course of diagnosis or treatment for the condition addressed by a given service. The agency shall establish by rule a list of all tertiary health services.

(18)~~(21)~~ "Regional area" means any of those regional health planning areas established by the agency to which local and district health planning funds are directed to local health councils through the General Appropriations Act.

Section 12. Paragraph (b) of subsection (1) and paragraph (a) of subsection (3) of section 408.033, Florida Statutes, are amended to read:

408.033 Local and state health planning.--

(1) LOCAL HEALTH COUNCILS.--

(b) Each local health council may:

1. Develop a district or regional area health plan that permits ~~is consistent with the objectives and strategies in the state health plan, but that shall permit~~ each local health council to develop strategies and set priorities for implementation based on its unique local health needs. The district or regional area health plan must contain preferences for the development of health services and facilities, which may be considered by the agency in its review of certificate-of-need applications. The district health plan shall be submitted to the agency and updated periodically. The district health plans shall use a uniform format and be submitted to the agency according to a schedule developed by the agency in conjunction with the local health councils. The schedule must provide for ~~coordination between the development of the state health plan and the district health plans and for~~ the development of district health plans by major sections over a multiyear period. The elements of a district plan which are necessary to the review of certificate-of-need applications for proposed projects within the district may be adopted by the agency as a part of its rules.

2. Advise the agency on health care issues and resource allocations.

3. Promote public awareness of community health needs, emphasizing health promotion and cost-effective health service selection.

4. Collect data and conduct analyses and studies related to health care needs of the district, including the needs of medically indigent persons, and assist the agency and other state agencies in carrying out data collection activities that relate to the functions in this subsection.

5. Monitor the onsite construction progress, if any, of certificate-of-need approved projects and report council findings to the agency on forms provided by the agency.

6. Advise and assist any regional planning councils within each district that have elected to address health issues in their strategic regional policy plans with the development of the health element of the plans to address the health goals and policies in the State Comprehensive Plan.

7. Advise and assist local governments within each district on the development of an optional health plan element of the comprehensive plan provided in chapter 163, to assure compatibility with the health goals and policies in the State Comprehensive Plan and district health plan. To facilitate the implementation of this section, the local health council shall annually provide the local governments in its service area, upon request, with:

a. A copy and appropriate updates of the district health plan;

b. A report of hospital and nursing home utilization statistics for facilities within the local government jurisdiction; and

c. Applicable agency rules and calculated need methodologies for health facilities and services regulated under s. 408.034 for the district served by the local health council.

8. Monitor and evaluate the adequacy, appropriateness, and effectiveness, within the district, of local, state, federal, and private funds distributed to meet the needs of the medically indigent and other underserved population groups.

9. In conjunction with the Agency for Health Care Administration, plan for services at the local level for persons infected with the human immunodeficiency virus.

10. Provide technical assistance to encourage and support activities by providers, purchasers, consumers, and local, regional, and state agencies in meeting the health care goals, objectives, and policies adopted by the local health council.

11. Provide the agency with data required by rule for the review of certificate-of-need applications and the projection of need for health services and facilities in the district.

(3) DUTIES AND RESPONSIBILITIES OF THE AGENCY.--

(a) The agency, in conjunction with the local health councils, is responsible for the coordinated planning of ~~all~~ health care services in the state ~~and for the preparation of the state health plan~~.

Section 13. Subsection (2) of section 408.034, Florida Statutes, is amended to read:

408.034 Duties and responsibilities of agency; rules.--

(2) In the exercise of its authority to issue licenses to health care facilities and health service providers, as provided under chapters 393, 395, and parts II~~, IV,~~ and VI of chapter 400, the agency may not issue a license to any health care facility, health service provider, hospice, or part of a health care facility which fails to receive a certificate of need or an exemption for the licensed facility or service.

Section 14. Section 408.035, Florida Statutes, is amended to read:

408.035 Review criteria.--

~~(1)~~ The agency shall determine the reviewability of applications and shall review applications for certificate-of-need determinations for health care facilities and health services in context with the following criteria:

(1)~~(a)~~ The need for the health care facilities and health services being proposed in relation to the applicable district health plan~~, except in emergency circumstances that pose a threat to the public health~~.

(2)~~(b)~~ The availability, quality of care, efficiency, ~~appropriateness,~~accessibility, and extent of utilization of~~,~~ ~~and adequacy of like and~~ existing health care facilities and health services in the service district of the applicant.

(3)~~(c)~~ The ability of the applicant to provide quality of care and the applicant's record of providing quality of care.

~~(d) The availability and adequacy of other health care facilities and health services in the service district of the applicant, such as outpatient care and ambulatory or home care services, which may serve as alternatives for the health care facilities and health services to be provided by the applicant.~~

~~(e) Probable economies and improvements in service which may be derived from operation of joint, cooperative, or shared health care resources.~~

(4)~~(f)~~ The need in the service district of the applicant for special health care ~~equipment and~~ services that are not reasonably and economically accessible in adjoining areas.

(5)~~(g)~~ The needs of ~~need for~~ research and educational facilities, including, but not limited to, facilities with institutional training programs and community training

programs for health care practitioners and for doctors of osteopathic medicine and medicine at the student, internship, and residency training levels.

(6)~~(h)~~ The availability of resources, including health personnel, management personnel, and funds for capital and operating expenditures, for project accomplishment and operation.~~; the effects the project will have on clinical needs of health professional training programs in the service district; the extent to which the services will be accessible to schools for health professions in the service district for training purposes if such services are available in a limited number of facilities; the availability of alternative uses of such resources for the provision of other health services; and~~

(7) The extent to which the proposed services will enhance access to health care for ~~be accessible to all~~ residents of the service district.

(8)~~(i)~~ The immediate and long-term financial feasibility of the proposal.

~~(j) The special needs and circumstances of health maintenance organizations.~~

~~(k) The needs and circumstances of those entities that provide a substantial portion of their services or resources, or both, to individuals not residing in the service district in which the entities are located or in adjacent service districts. Such entities may include medical and other health professions, schools, multidisciplinary clinics, and specialty services such as open-heart surgery, radiation therapy, and renal transplantation.~~

(9)~~(l)~~ The extent to which the proposal will foster competition that promotes quality and cost-effectiveness.~~The probable impact of the proposed project on the costs of~~

~~providing health services proposed by the applicant, upon consideration of factors including, but not limited to, the effects of competition on the supply of health services being proposed and the improvements or innovations in the financing and delivery of health services which foster competition and service to promote quality assurance and cost-effectiveness.~~

(10)~~(m)~~ The costs and methods of the proposed construction, including the costs and methods of energy provision and the availability of alternative, less costly, or more effective methods of construction.

(11)~~(n)~~ The applicant's past and proposed provision of health care services to Medicaid patients and the medically indigent.

~~(o) The applicant's past and proposed provision of services that promote a continuum of care in a multilevel health care system, which may include, but are not limited to, acute care, skilled nursing care, home health care, and assisted living facilities.~~

(12)~~(p)~~ The applicant's designation as a Gold Seal Program nursing facility pursuant to s. 400.235, when the applicant is requesting additional nursing home beds at that facility.

~~(2) In cases of capital expenditure proposals for the provision of new health services to inpatients, the agency shall also reference each of the following in its findings of fact:~~

~~(a) That less costly, more efficient, or more appropriate alternatives to such inpatient services are not available and the development of such alternatives has been studied and found not practicable.~~

~~(b) That existing inpatient facilities providing inpatient services similar to those proposed are being used in an appropriate and efficient manner.~~

~~(c) In the case of new construction or replacement construction, that alternatives to the construction, for example, modernization or sharing arrangements, have been considered and have been implemented to the maximum extent practicable.~~

~~(d) That patients will experience serious problems in obtaining inpatient care of the type proposed, in the absence of the proposed new service.~~

~~(e) In the case of a proposal for the addition of beds for the provision of skilled nursing or intermediate care services, that the addition will be consistent with the plans of other agencies of the state responsible for the provision and financing of long-term care, including home health services.~~

Section 15. Section 408.036, Florida Statutes, is amended to read:

408.036 Projects subject to review.--

(1) APPLICABILITY.--Unless exempt under subsection (3), all health-care-related projects, as described in paragraphs (a)-(h)~~(k)~~, are subject to review and must file an application for a certificate of need with the agency. The agency is exclusively responsible for determining whether a health-care-related project is subject to review under ss. 408.031-408.045.

(a) The addition of beds by new construction or alteration.

(b) The new construction or establishment of additional health care facilities, including a replacement

health care facility when the proposed project site is not located on the same site as the existing health care facility.

(c) The conversion from one type of health care facility to another~~, including the conversion from one level of care to another, in a skilled or intermediate nursing facility, if the conversion effects a change in the level of care of 10 beds or 10 percent of total bed capacity of the skilled or intermediate nursing facility within a 2-year period. If the nursing facility is certified for both skilled and intermediate nursing care, the provisions of this paragraph do not apply~~.

(d) An ~~Any~~ increase in the total licensed bed capacity of a health care facility.

(e) ~~Subject to the provisions of paragraph (3)(i),~~The establishment of a ~~Medicare-certified home health agency, the establishment of a~~ hospice or hospice inpatient facility, except as provided in s. 408.043 ~~or the direct provision of such services by a health care facility or health maintenance organization for those other than the subscribers of the health maintenance organization; except that this paragraph does not apply to the establishment of a Medicare-certified home health agency by a facility described in paragraph (3)(h)~~.

~~(f) An acquisition by or on behalf of a health care facility or health maintenance organization, by any means, which acquisition would have required review if the acquisition had been by purchase.~~

(f)~~(g)~~ The establishment of inpatient ~~institutional~~ health services by a health care facility, or a substantial change in such services.

~~(h) The acquisition by any means of an existing health care facility by any person, unless the person provides the agency with at least 30 days' written notice of the proposed acquisition, which notice is to include the services to be offered and the bed capacity of the facility, and unless the agency does not determine, within 30 days after receipt of such notice, that the services to be provided and the bed capacity of the facility will be changed.~~

~~(i) An increase in the cost of a project for which a certificate of need has been issued when the increase in cost exceeds 20 percent of the originally approved cost of the project, except that a cost overrun review is not necessary when the cost overrun is less than $20,000.~~

(g)~~(j)~~ An increase in the number of beds for acute care, nursing home care beds, specialty burn units, neonatal intensive care units, comprehensive rehabilitation, mental health services, or hospital-based distinct part skilled nursing units, or at a long-term care hospital ~~psychiatric or rehabilitation beds~~.

(h)~~(k)~~ The establishment of tertiary health services.

(2) PROJECTS SUBJECT TO EXPEDITED REVIEW.--Unless exempt pursuant to subsection (3), projects subject to an expedited review shall include, but not be limited to:

~~(a) Cost overruns, as defined in paragraph (1)(i).~~

(a)~~(b)~~ Research, education, and training programs.

(b)~~(c)~~ Shared services contracts or projects.

(c)~~(d)~~ A transfer of a certificate of need.

(d)~~(e)~~ A 50-percent increase in nursing home beds for a facility incorporated and operating in this state for at least 60 years on or before July 1, 1988, which has a licensed nursing home facility located on a campus providing a variety

of residential settings and supportive services. The increased nursing home beds shall be for the exclusive use of the campus residents. Any application on behalf of an applicant meeting this requirement shall be subject to the base fee of $5,000 provided in s. 408.038.

~~(f) Combination within one nursing home facility of the beds or services authorized by two or more certificates of need issued in the same planning subdistrict.~~

~~(g) Division into two or more nursing home facilities of beds or services authorized by one certificate of need issued in the same planning subdistrict. Such division shall not be approved if it would adversely affect the original certificate's approved cost.~~

(e)~~(h)~~ Replacement of a health care facility when the proposed project site is located in the same district and within a 1-mile radius of the replaced health care facility.

(f) The conversion of mental health services beds licensed under chapter 395 or hospital-based distinct part skilled nursing unit beds to general acute care beds; the conversion of mental health services beds between or among the licensed bed categories defined as beds for mental health services; or the conversion of general acute care beds to beds for mental health services.

1. Conversion under this paragraph shall not establish a new licensed bed category at the hospital but shall apply only to categories of beds licensed at that hospital.

2. Beds converted under this paragraph must be licensed and operational for at least 12 months before the hospital may apply for additional conversion affecting beds of the same type.

The agency shall develop rules to implement the provisions for expedited review, including time schedule, application content which may be reduced from the full requirements of s. 408.037(1), and application processing.

(3) EXEMPTIONS.--Upon request, the following projects are subject to ~~supported by such documentation as the agency requires, the agency shall grant an~~ exemption from the provisions of subsection (1):

~~(a) For the initiation or expansion of obstetric services.~~

(a)~~(b)~~ For replacement of ~~any expenditure to replace or renovate any part of~~ a licensed health care facility on the same site, provided that the number of ~~licensed~~ beds in each licensed bed category will not increase ~~and, in the case of a replacement facility, the project site is the same as the facility being replaced~~.

~~(c) For providing respite care services. An individual may be admitted to a respite care program in a hospital without regard to inpatient requirements relating to admitting order and attendance of a member of a medical staff.~~

(b)~~(d)~~ For hospice services or ~~home health services provided by a rural hospital, as defined in s. 395.602, or~~ for swing beds in a ~~such~~ rural hospital, as defined in s. 395.602, in a number that does not exceed one-half of its licensed beds.

(c)~~(e)~~ For the conversion of licensed acute care hospital beds to Medicare and Medicaid certified skilled nursing beds in a rural hospital, as defined in s. 395.602, so long as the conversion of the beds does not involve the construction of new facilities. The total number of skilled nursing beds, including swing beds, may not exceed one-half of

the total number of licensed beds in the rural hospital as of July 1, 1993. Certified skilled nursing beds designated under this paragraph, excluding swing beds, shall be included in the community nursing home bed inventory. A rural hospital which subsequently decertifies any acute care beds exempted under this paragraph shall notify the agency of the decertification, and the agency shall adjust the community nursing home bed inventory accordingly.

(d)~~(f)~~ For the addition of nursing home beds at a skilled nursing facility that is part of a retirement community that provides a variety of residential settings and supportive services and that has been incorporated and operated in this state for at least 65 years on or before July 1, 1994. All nursing home beds must not be available to the public but must be for the exclusive use of the community residents.

(e)~~(g)~~ For an increase in the bed capacity of a nursing facility licensed for at least 50 beds as of January 1, 1994, under part II of chapter 400 which is not part of a continuing care facility if, after the increase, the total licensed bed capacity of that facility is not more than 60 beds and if the facility has been continuously licensed since 1950 and has received a superior rating on each of its two most recent licensure surveys.

~~(h) For the establishment of a Medicare-certified home health agency by a facility certified under chapter 651; a retirement community, as defined in s. 400.404(2)(g); or a residential facility that serves only retired military personnel, their dependents, and the surviving dependents of deceased military personnel. Medicare-reimbursed home health services provided through such agency shall be offered~~

~~exclusively to residents of the facility or retirement community or to residents of facilities or retirement communities owned, operated, or managed by the same corporate entity. Each visit made to deliver Medicare-reimbursable home health services to a home health patient who, at the time of service, is not a resident of the facility or retirement community shall be a deceptive and unfair trade practice and constitutes a violation of ss. 501.201-501.213.~~

~~(i) For the establishment of a Medicare-certified home health agency. This paragraph shall take effect 90 days after the adjournment sine die of the next regular session of the Legislature occurring after the legislative session in which the Legislature receives a report from the Director of Health Care Administration certifying that the federal Health Care Financing Administration has implemented a per-episode prospective pay system for Medicare-certified home health agencies.~~

(f)~~(j)~~ For an inmate health care facility built by or for the exclusive use of the Department of Corrections as provided in chapter 945. This exemption expires when such facility is converted to other uses.

~~(k) For an expenditure by or on behalf of a health care facility to provide a health service exclusively on an outpatient basis.~~

(g)~~(l)~~ For the termination of an inpatient ~~a~~ health care service.

(h)~~(m)~~ For the delicensure of beds. A request for exemption ~~An application~~ submitted under this paragraph must identify the number, the category of beds ~~classification~~, and the name of the facility in which the beds to be delicensed are located.

(i)~~(n)~~ For the provision of adult inpatient diagnostic cardiac catheterization services in a hospital.

1. In addition to any other documentation otherwise required by the agency, a request for an exemption submitted under this paragraph must comply with the following criteria:

a. The applicant must certify it will not provide therapeutic cardiac catheterization pursuant to the grant of the exemption.

b. The applicant must certify it will meet and continuously maintain the minimum licensure requirements adopted by the agency governing such programs pursuant to subparagraph 2.

c. The applicant must certify it will provide a minimum of 2 percent of its services to charity and Medicaid patients.

2. The agency shall adopt licensure requirements by rule which govern the operation of adult inpatient diagnostic cardiac catheterization programs established pursuant to the exemption provided in this paragraph. The rules shall ensure that such programs:

a. Perform only adult inpatient diagnostic cardiac catheterization services authorized by the exemption and will not provide therapeutic cardiac catheterization or any other services not authorized by the exemption.

b. Maintain sufficient appropriate equipment and health personnel to ensure quality and safety.

c. Maintain appropriate times of operation and protocols to ensure availability and appropriate referrals in the event of emergencies.

d. Maintain appropriate program volumes to ensure quality and safety.

e. Provide a minimum of 2 percent of its services to charity and Medicaid patients each year.

3.a. The exemption provided by this paragraph shall not apply unless the agency determines that the program is in compliance with the requirements of subparagraph 1. and that the program will, after beginning operation, continuously comply with the rules adopted pursuant to subparagraph 2. The agency shall monitor such programs to ensure compliance with the requirements of subparagraph 2.

b.(I) The exemption for a program shall expire immediately when the program fails to comply with the rules adopted pursuant to sub-subparagraphs 2.a., b., and c.

(II) Beginning 18 months after a program first begins treating patients, the exemption for a program shall expire when the program fails to comply with the rules adopted pursuant to sub-subparagraphs 2.d. and e.

(III) If the exemption for a program expires pursuant to sub-sub-subparagraph (I) or sub-sub-subparagraph (II), the agency shall not grant an exemption pursuant to this paragraph for an adult inpatient diagnostic cardiac catheterization program located at the same hospital until 2 years following the date of the determination by the agency that the program failed to comply with the rules adopted pursuant to subparagraph 2.

~~4. The agency shall not grant any exemption under this paragraph until the adoption of the rules required under this paragraph, or until March 1, 1998, whichever comes first. However, if final rules have not been adopted by March 1, 1998, the proposed rules governing the exemptions shall be used by the agency to grant exemptions under the provisions of this paragraph until final rules become effective.~~

(j)~~(o)~~ For ~~any expenditure to provide~~ mobile surgical facilities and related health care services provided under contract with the Department of Corrections or a private correctional facility operating pursuant to chapter 957.

(k)~~(p)~~ For state veterans' nursing homes operated by or on behalf of the Florida Department of Veterans' Affairs in accordance with part II of chapter 296 for which at least 50 percent of the construction cost is federally funded and for which the Federal Government pays a per diem rate not to exceed one-half of the cost of the veterans' care in such state nursing homes. These beds shall not be included in the nursing home bed inventory.

(l) For combination within one nursing home facility of the beds or services authorized by two or more certificates of need issued in the same planning subdistrict. An exemption granted under this paragraph shall extend the validity period of the certificates of need to be consolidated by the length of the period beginning upon submission of the exemption request and ending with issuance of the exemption. The longest validity period among the certificates shall be applicable to each of the combined certificates.

(m) For division into two or more nursing home facilities of beds or services authorized by one certificate of need issued in the same planning subdistrict. An exemption granted under this paragraph shall extend the validity period of the certificate of need to be divided by the length of the period beginning upon submission of the exemption request and ending with issuance of the exemption.

(n) For the addition of hospital beds licensed under chapter 395 for acute care, mental health services, or a hospital-based distinct part skilled nursing unit in a number

that may not exceed 10 total beds or 10 percent of the licensed capacity of the bed category being expanded, whichever is greater. Beds for specialty burn units, neonatal intensive care units, or comprehensive rehabilitation, or at a long-term care hospital, may not be increased under this paragraph.

1. In addition to any other documentation otherwise required by the agency, a request for exemption submitted under this paragraph must:

a. Certify that the prior 12-month average occupancy rate for the category of licensed beds being expanded at the facility meets or exceeds 80 percent or, for a hospital-based distinct part skilled nursing unit, the prior 12-month average occupancy rate meets or exceeds 96 percent.

b. Certify that any beds of the same type authorized for the facility under this paragraph before the date of the current request for an exemption have been licensed and operational for at least 12 months.

2. The timeframes and monitoring process specified in s. 408.040(2)(a)-(c) apply to any exemption issued under this paragraph.

3. The agency shall count beds authorized under this paragraph as approved beds in the published inventory of hospital beds until the beds are licensed.

(o) For the addition of acute care beds, as authorized by rule consistent with s. 395.003(4), in a number that may not exceed 10 total beds or 10 percent of licensed bed capacity, whichever is greater, for temporary beds in a hospital that has experienced high seasonal occupancy within the prior 12-month period or in a hospital that must respond to emergency circumstances.

(p) For the addition of nursing home beds licensed under chapter 400 in a number not exceeding 10 total beds or 10 percent of the number of beds licensed in the facility being expanded, whichever is greater.

1. In addition to any other documentation required by the agency, a request for exemption submitted under this paragraph must:

a. Effective until June 30, 2001, certify that the facility has not had any class I or class II deficiencies within the 30 months preceding the request for addition.

b. Effective on July 1, 2001, certify that the facility has been designated as a Gold Seal nursing home under s. 400.235.

c. Certify that the prior 12-month average occupancy rate for the nursing home beds at the facility meets or exceeds 96 percent.

d. Certify that any beds authorized for the facility under this paragraph before the date of the current request for an exemption have been licensed and operational for at least 12 months.

2. The timeframes and monitoring process specified in s. 408.040(2)(a)-(c) apply to any exemption issued under this paragraph.

3. The agency shall count beds authorized under this paragraph as approved beds in the published inventory of nursing home beds until the beds are licensed.

(4) A request for exemption under ~~this~~ subsection(3) may be made at any time and is not subject to the batching requirements of this section. The request shall be supported by such documentation as the agency requires by rule. The

agency shall assess a fee of $250 for each request for exemption submitted under subsection (3).

Section 16. Paragraph (a) of subsection (1) of section 408.037, Florida Statutes, is amended to read:

408.037 Application content.--

(1) An application for a certificate of need must contain:

(a) A detailed description of the proposed project and statement of its purpose and need in relation to the local health plan ~~and the state health plan~~.

Section 17. Section 408.038, Florida Statutes, is amended to read:

408.038 Fees.--The agency ~~department~~ shall assess fees on certificate-of-need applications. Such fees shall be for the purpose of funding the functions of the local health councils and the activities of the agency ~~department~~ and shall be allocated as provided in s. 408.033. The fee shall be determined as follows:

(1) A minimum base fee of $5,000.

(2) In addition to the base fee of $5,000, 0.015 of each dollar of proposed expenditure, except that a fee may not exceed $22,000.

Section 18. Subsections (3) and (4) and paragraphs (a) and (b) of subsection (6) of section 408.039, Florida Statutes, are amended to read:

408.039 Review process.--The review process for certificates of need shall be as follows:

(3) APPLICATION PROCESSING.--

(a) An applicant shall file an application with the agency ~~department~~, and shall furnish a copy of the application to the local health council and the agency ~~department~~. Within

15 days after the applicable application filing deadline established by agency ~~department~~ rule, the staff of the agency ~~department~~ shall determine if the application is complete. If the application is incomplete, the staff shall request specific information from the applicant necessary for the application to be complete; however, the staff may make only one such request. If the requested information is not filed with the agency ~~department~~ within 21 days of the receipt of the staff's request, the application shall be deemed incomplete and deemed withdrawn from consideration.

(b) Upon the request of any applicant or substantially affected person within 14 days after notice that an application has been filed, a public hearing may be held at the agency's ~~department's~~ discretion if the agency ~~department~~ determines that a proposed project involves issues of great local public interest. The public hearing shall allow applicants and other interested parties reasonable time to present their positions and to present rebuttal information. A recorded verbatim record of the hearing shall be maintained. The public hearing shall be held at the local level within 21 days after the application is deemed complete.

(4) STAFF RECOMMENDATIONS.--

(a) The agency's ~~department's~~ review of and final agency action on applications shall be in accordance with the district health plan, and statutory criteria, and the implementing administrative rules. In the application review process, the agency ~~department~~ shall give a preference, as defined by rule of the agency ~~department~~, to an applicant which proposes to develop a nursing home in a nursing home geographically underserved area.

(b) Within 60 days after all the applications in a review cycle are determined to be complete, the agency ~~department~~ shall issue its State Agency Action Report and Notice of Intent to grant a certificate of need for the project in its entirety, to grant a certificate of need for identifiable portions of the project, or to deny a certificate of need. The State Agency Action Report shall set forth in writing its findings of fact and determinations upon which its decision is based. If a finding of fact or determination by the agency ~~department~~ is counter to the district health plan of the local health council, the agency ~~department~~ shall provide in writing its reason for its findings, item by item, to the local health council. If the agency ~~department~~ intends to grant a certificate of need, the State Agency Action Report or the Notice of Intent shall also include any conditions which the agency ~~department~~ intends to attach to the certificate of need. The agency ~~department~~ shall designate by rule a senior staff person, other than the person who issues the final order, to issue State Agency Action Reports and Notices of Intent.

(c) The agency ~~department~~ shall publish its proposed decision set forth in the Notice of Intent in the Florida Administrative Weekly within 14 days after the Notice of Intent is issued.

(d) If no administrative hearing is requested pursuant to subsection (5), the State Agency Action Report and the Notice of Intent shall become the final order of the agency ~~department~~. The agency ~~department~~ shall provide a copy of the final order to the appropriate local health council.

(6) JUDICIAL REVIEW.--

(a) A party to an administrative hearing for an application for a certificate of need has the right, within not more than 30 days after the date of the final order, to seek judicial review in the District Court of Appeal pursuant to s. 120.68. The agency ~~department~~ shall be a party in any such proceeding.

(b) In such judicial review, the court shall affirm the final order of the agency ~~department~~, unless the decision is arbitrary, capricious, or not in compliance with ss. 408.031-408.045.

Section 19. Subsections (1) and (2) of section 408.040, Florida Statutes, are amended to read:

408.040 Conditions and monitoring.--

(1)(a) The agency may issue a certificate of need predicated upon statements of intent expressed by an applicant in the application for a certificate of need. Any conditions imposed on a certificate of need based on such statements of intent shall be stated on the face of the certificate of need.

~~1. Any certificate of need issued for construction of a new hospital or for the addition of beds to an existing hospital shall include a statement of the number of beds approved by category of service, including rehabilitation or psychiatric service, for which the agency has adopted by rule a specialty-bed-need methodology. All beds that are approved, but are not covered by any specialty-bed-need methodology, shall be designated as general.~~

(b)~~2.~~ The agency may consider, in addition to the other criteria specified in s. 408.035, a statement of intent by the applicant that a specified ~~to designate a~~ percentage of the annual patient days at ~~beds of~~ the facility will be utilized ~~for use~~ by patients eligible for care under Title XIX

of the Social Security Act. Any certificate of need issued to a nursing home in reliance upon an applicant's statements that ~~to provide~~ a specified percentage ~~number~~ of annual patient days will be utilized ~~beds for use~~ by residents eligible for care under Title XIX of the Social Security Act must include a statement that such certification is a condition of issuance of the certificate of need. The certificate-of-need program shall notify the Medicaid program office and the Department of Elderly Affairs when it imposes conditions as authorized in this paragraph ~~subparagraph~~ in an area in which a community diversion pilot project is implemented.

(c)~~(b)~~ A certificateholder may apply to the agency for a modification of conditions imposed under paragraph (a) or paragraph (b). If the holder of a certificate of need demonstrates good cause why the certificate should be modified, the agency shall reissue the certificate of need with such modifications as may be appropriate. The agency shall by rule define the factors constituting good cause for modification.

(d)~~(c)~~ If the holder of a certificate of need fails to comply with a condition upon which the issuance of the certificate was predicated, the agency may assess an administrative fine against the certificateholder in an amount not to exceed $1,000 per failure per day. In assessing the penalty, the agency shall take into account as mitigation the relative lack of severity of a particular failure. Proceeds of such penalties shall be deposited in the Public Medical Assistance Trust Fund.

(2)(a) Unless the applicant has commenced construction, if the project provides for construction, unless the applicant has incurred an enforceable capital expenditure

commitment for a project, if the project does not provide for construction, or unless subject to paragraph (b), a certificate of need shall terminate 18 months after the date of issuance~~, except in the case of a multifacility project, as defined in s. 408.032, where the certificate of need shall terminate 2 years after the date of issuance~~. The agency shall monitor the progress of the holder of the certificate of need in meeting the timetable for project development specified in the application with the assistance of the local health council as specified in s. 408.033(1)(b)5., and may revoke the certificate of need, if the holder of the certificate is not meeting such timetable and is not making a good-faith ~~good faith~~ effort, as defined by rule, to meet it.

(b) A certificate of need issued to an applicant holding a provisional certificate of authority under chapter 651 shall terminate 1 year after the applicant receives a valid certificate of authority from the Department of Insurance.

(c) The certificate-of-need validity period for a project shall be extended by the agency, to the extent that the applicant demonstrates to the satisfaction of the agency that good-faith ~~good faith~~ commencement of the project is being delayed by litigation or by governmental action or inaction with respect to regulations or permitting precluding commencement of the project.

~~(d) If an application is filed to consolidate two or more certificates as authorized by s. 408.036(2)(f) or to divide a certificate of need into two or more facilities as authorized by s. 408.036(2)(g), the validity period of the certificate or certificates of need to be consolidated or divided shall be extended for the period beginning upon~~

~~submission of the application and ending when final agency action and any appeal from such action has been concluded. However, no such suspension shall be effected if the application is withdrawn by the applicant.~~

Section 20. Section 408.044, Florida Statutes, is amended to read:

408.044 Injunction.--Notwithstanding the existence or pursuit of any other remedy, the agency ~~department~~ may maintain an action in the name of the state for injunction or other process against any person to restrain or prevent the pursuit of a project subject to review under ss. 408.031-408.045, in the absence of a valid certificate of need.

Section 21. Section 408.045, Florida Statutes, is amended to read:

408.045 Certificate of need; competitive sealed proposals.--

(1) The application, review, and issuance procedures for a certificate of need for an intermediate care facility for the developmentally disabled may be made by the agency ~~department~~ by competitive sealed proposals.

(2) The agency ~~department~~ shall make a decision regarding the issuance of the certificate of need in accordance with the provisions of s. 287.057(15), rules adopted by the agency ~~department~~ relating to intermediate care facilities for the developmentally disabled, and the criteria in s. 408.035, as further defined by rule.

(3) Notification of the decision shall be issued to all applicants not later than 28 calendar days after the date responses to a request for proposal are due.

(4) The procedures provided for under this section are exempt from the batching cycle requirements and the public hearing requirement of s. 408.039.

(5) The agency ~~department~~ may use the competitive sealed proposal procedure for determining a certificate of need for other types of health care facilities and services if the agency ~~department~~ identifies an unmet health care need and when funding in whole or in part for such health care facilities or services is authorized by the Legislature.

Section 22. (1)(a) There is created a certificate-of-need workgroup staffed by the Agency for Health Care Administration.

(b) Workgroup participants shall be responsible for only the expenses that they generate individually through workgroup participation. The agency shall be responsible for expenses incidental to the production of any required data or reports.

(2) The workgroup shall consist of 30 members, 10 appointed by the Governor, 10 appointed by the President of the Senate, and 10 appointed by the Speaker of the House of Representatives. The workgroup chairperson shall be selected by majority vote of a quorum present. Sixteen members shall constitute a quorum. The membership shall include, but not be limited to, representatives from health care provider organizations, health care facilities, individual health care practitioners, local health councils, and consumer organizations, and persons with health care market expertise as a private-sector consultant.

(3) Appointment to the workgroup shall be as follows:

(a) The Governor shall appoint one representative each from the hospital industry; nursing home industry; hospice

industry; local health councils; a consumer organization; and three health care market consultants, one of whom is a recognized expert on hospital markets, one of whom is a recognized expert on nursing home or long-term-care markets, and one of whom is a recognized expert on hospice markets; one representative from the Medicaid program; and one representative from a health care facility that provides a tertiary service.

(b) The President of the Senate shall appoint a representative of a for-profit hospital, a representative of a not-for-profit hospital, a representative of a public hospital, two representatives of the nursing home industry, two representatives of the hospice industry, a representative of a consumer organization, a representative from the Department of Elderly Affairs involved with the implementation of a long-term-care community diversion program, and a health care market consultant with expertise in health care economics.

(c) The Speaker of the House of Representatives shall appoint a representative from the Florida Hospital Association, a representative of the Association of Community Hospitals and Health Systems of Florida, a representative of the Florida League of Health Systems, a representative of the Florida Health Care Association, a representative of the Florida Association of Homes for the Aging, three representatives of Florida Hospices and Palliative Care, one representative of local health councils, and one representative of a consumer organization.

(4) The workgroup shall study issues pertaining to the certificate-of-need program, including the impact of trends in health care delivery and financing. The workgroup shall study

issues relating to implementation of the certificate-of-need program.

(5) The workgroup shall meet at least annually, at the request of the chairperson. The workgroup shall submit an interim report by December 31, 2001, and a final report by December 31, 2002. The workgroup is abolished effective July 1, 2003.

Section 23. Subsection (7) of section 651.118, Florida Statutes, is amended to read:

651.118 Agency for Health Care Administration; certificates of need; sheltered beds; community beds.--

(7) Notwithstanding the provisions of subsection (2), at the discretion of the continuing care provider, sheltered nursing home beds may be used for persons who are not residents of the facility and who are not parties to a continuing care contract for a period of up to 5 years after the date of issuance of the initial nursing home license. A provider whose 5-year period has expired or is expiring may request the Agency for Health Care Administration for an extension, not to exceed 30 percent of the total sheltered nursing home beds, if the utilization by residents of the facility in the sheltered beds will not generate sufficient income to cover facility expenses, as evidenced by one of the following:

(a) The facility has a net loss for the most recent fiscal year as determined under generally accepted accounting principles, excluding the effects of extraordinary or unusual items, as demonstrated in the most recently audited financial statement; or

(b) The facility would have had a pro forma loss for the most recent fiscal year, excluding the effects of

extraordinary or unusual items, if revenues were reduced by the amount of revenues from persons in sheltered beds who were not residents, as reported on by a certified public accountant.

The agency shall be authorized to grant an extension to the provider based on the evidence required in this subsection. The agency may request a facility to use up to 25 percent of the patient days generated by new admissions of nonresidents during the extension period to serve Medicaid recipients for those beds authorized for extended use if there is a demonstrated need in the respective service area and if funds are available. A provider who obtains an extension is prohibited from applying for additional sheltered beds under the provision of subsection (2), unless additional residential units are built or the provider can demonstrate need by facility residents to the Agency for Health Care Administration. The 5-year limit does not apply to up to five sheltered beds designated for inpatient hospice care as part of a contractual arrangement with a hospice licensed under part VI of chapter 400. A facility that uses such beds after the 5-year period shall report such use to the Agency for Health Care Administration.For purposes of this subsection, "resident" means a person who, upon admission to the facility, initially resides in a part of the facility not licensed under part II of chapter 400.

Section 24. Subsection (3) of section 400.464, Florida Statutes, is repealed.

Section 25. Applications for certificates of need submitted under section 408.031-408.045, Florida Statutes,

before the effective date of this act shall be governed by the law in effect at the time the application was submitted.

Section 26. The General Appropriations Act for Fiscal Year 2000-2001 shall be reduced by 4 FTE and $260,719 from the Health Care Trust Fund in the Agency for Health Care Administration for purposes of implementing the provisions of sections 10 through 25 of this act.

Section 27. Subsection (12) is added to section 216.136, Florida Statutes, to read:

216.136 Consensus estimating conferences; duties and principals.--

(12) MANDATED HEALTH INSURANCE BENEFITS AND PROVIDERS ESTIMATING CONFERENCE.--

(a) Duties.--The Mandated Health Insurance Benefits and Providers Estimating Conference shall:

1. Develop and maintain, with the Department of Insurance, a system and program of data collection to assess the impact of mandated benefits and providers, including costs to employers and insurers, impact of treatment, cost savings in the health care system, number of providers, and other appropriate data.

2. Prescribe the format, content, and timing of information that is to be submitted to the conference and used by the conference in its assessment of proposed and existing mandated benefits and providers. Such format, content, and timing requirements are binding upon all parties submitting information for the conference to use in its assessment of proposed and existing mandated benefits and providers.

3. Provide assessments of proposed and existing mandated benefits and providers and other studies of mandated benefits and provider issues as requested by the Legislature

or the Governor. When a legislative measure containing a mandated health insurance benefit or provider is proposed, the standing committee of the Legislature which has jurisdiction over the proposal shall request that the conference prepare and forward to the Governor and the Legislature a study that provides, for each measure, a cost-benefit analysis that assesses the social and financial impact and the medical efficacy according to prevailing medical standards of the proposed mandate. The conference has 12 months after the committee makes its request in which to complete and submit the conference's report. The standing committee may not consider such a proposed legislative measure until 12 months after it has requested the report and has received the conference's report on the measure.

4. The standing committees of the Legislature which have jurisdiction over health insurance matters shall request that the conference assess the social and financial impact and the medical efficacy of existing mandated benefits and providers. The committees shall submit to the conference by January 1, 2001, a schedule of evaluations that sets forth the respective dates by which the conference must have completed its evaluations of particular existing mandates.

(b) Principals.--The Executive Office of the Governor, the Insurance Commissioner, the Agency for Health Care Administration, the Director of the Division of Economic and Demographic Research of the Joint Legislative Management Committee, and professional staff of the Senate and the House of Representatives who have health insurance expertise, or their designees, are the principals of the Mandated Health Insurance Benefits and Providers Estimating Conference. The

responsibility of presiding over sessions of the conference shall be rotated among the principals.

Section 28. Section 624.215, Florida Statutes, is amended to read:

624.215 Proposals for legislation which mandates health benefit coverage; review by Legislature.--

(1) LEGISLATIVE INTENT.--The Legislature finds that there is an increasing number of proposals which mandate that certain health benefits be provided by insurers and health maintenance organizations as components of individual and group policies. The Legislature further finds that many of these benefits provide beneficial social and health consequences which may be in the public interest. However, the Legislature also recognizes that most mandated benefits contribute to the increasing cost of health insurance premiums. Therefore, it is the intent of the Legislature to conduct a systematic review of current and proposed mandated or mandatorily offered health coverages and to establish guidelines for such a review. This review will assist the Legislature in determining whether mandating a particular coverage is in the public interest.

(2) MANDATED HEALTH COVERAGE; REPORT TO THE MANDATED HEALTH INSURANCE BENEFITS AND PROVIDERS ESTIMATING CONFERENCE ~~AGENCY FOR HEALTH CARE ADMINISTRATION AND LEGISLATIVE COMMITTEES~~; GUIDELINES FOR ASSESSING IMPACT.--Every person or organization seeking consideration of a legislative proposal which would mandate a health coverage or the offering of a health coverage by an insurance carrier, health care service contractor, or health maintenance organization as a component of individual or group policies, shall submit to the Mandated Health Insurance Benefits and Providers Estimating Conference

~~Agency for Health Care Administration and the legislative committees having jurisdiction~~ a report which assesses the social and financial impacts of the proposed coverage. Guidelines for assessing the impact of a proposed mandated or mandatorily offered health coverage must~~, to the extent that information is available, shall~~ include:

(a) To what extent is the treatment or service generally used by a significant portion of the population.

(b) To what extent is the insurance coverage generally available.

(c) If the insurance coverage is not generally available, to what extent does the lack of coverage result in persons avoiding necessary health care treatment.

(d) If the coverage is not generally available, to what extent does the lack of coverage result in unreasonable financial hardship.

(e) The level of public demand for the treatment or service.

(f) The level of public demand for insurance coverage of the treatment or service.

(g) The level of interest of collective bargaining agents in negotiating for the inclusion of this coverage in group contracts.

(h) A report, prepared by a certified actuary, of the extent to which ~~To what extent will~~ the coverage will increase or decrease the cost of the treatment or service.

(i) A report, prepared by a certified actuary, of the extent to which ~~To what extent will~~ the coverage will increase the appropriate uses of the treatment or service.

(j) A report, prepared by a certified actuary, of the extent to which ~~To what extent will~~ the mandated treatment or

service will be a substitute for a more expensive treatment or service.

(k) A report, prepared by a certified actuary, of the extent to which ~~To what extent will~~ the coverage will increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.

(l) A report, prepared by a certified actuary, as to the impact of this coverage on the total cost of health care.

The standing committee of the Legislature which has jurisdiction over the legislative proposal must request and receive a report from the Mandated Health Insurance Benefits and Providers Estimating Conference before the committee considers the proposal. The committee may not consider a legislative proposal that would mandate a health coverage or the offering of a health coverage by an insurance carrier, health care service contractor, or health maintenance organization until after the committee's request to the Mandated Health Insurance Benefits and Providers Estimating Conference has been answered. As used in this section, the term "health coverage mandate" includes mandating the use of a type of provider.

Section 29. Effective January 1, 2001, a physician licensed under chapter 458, Florida Statutes, or chapter 459, Florida Statutes, or a hospital licensed under chapter 395, Florida Statutes, shall provide a consumer-assistance notice in the form of a sign that is prominently displayed in the reception area and clearly noticeable by all patients and in the form of a written statement that is given to each person to whom medical services are being provided. Such a sign or statement must state that consumer information regarding a

doctor, hospital, or health plan is available through a toll-free number and website maintained by the Agency for Health Care Administration. In addition, the sign and statement must state that any complaint regarding medical services received or the patient's health plan may be submitted through the toll-free number. The agency, in cooperation with other appropriate agencies, shall establish the consumer-assistance program and provide physicians and hospitals with information regarding the toll-free number and website and with signs for posting in facilities at no cost to the provider.

Section 30. Subsection (1) of 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 Insurance.

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

Section 31. Section 627.654, Florida Statutes, is amended to read:

627.654 Labor union, ~~and~~ association, and small employer health alliance groups.--

(1)(a) A group of individuals may be insured under a policy issued to an association, including a labor union, which association has a constitution and bylaws and not less than 25 individual members and which has been organized and has been maintained in good faith for a period of 1 year for purposes other than that of obtaining insurance, or to the trustees of a fund established by such an association, which association or trustees shall be deemed the policyholder, insuring at least 15 individual members of the association for the benefit of persons other than the officers of the association, the association or trustees.

(b) A small employer, as defined in s. 627.6699 and including the employer's eligible employees and the spouses

and dependents of such employees, may be insured under a policy issued to a small employer health alliance by a carrier as defined in s. 627.6699. A small employer health alliance must be organized as a not-for-profit corporation under chapter 617. Notwithstanding any other law, if a small-employer member of an alliance loses eligibility to purchase health care through the alliance solely because the business of the small-employer member expands to more than 50 and fewer than 75 eligible employees, the small-employer member may, at its next renewal date, purchase coverage through the alliance for not more than 1 additional year. A small employer health alliance shall establish conditions of participation in the alliance by a small employer, including, but not limited to:

1. Assurance that the small employer is not formed for the purpose of securing health benefit coverage.

2. Assurance that the employees of a small employer have not been added for the purpose of securing health benefit coverage.

(2) No such policy of insurance as defined in subsection (1) may be issued to any such association or alliance, unless all individual members of such association, or all small-employer members of an alliance, or all of any class or classes thereof, are declared eligible and acceptable to the insurer at the time of issuance of the policy.

(3) Any such policy issued under paragraph (1)(a)may insure the spouse or dependent children with or without the member being insured.

(4) A single master policy issued to an association, labor union, or small-employer health alliance may include more than one health plan from the same insurer or affiliated

insurer group as alternatives for an employer, employee, or member to select.

Section 32. Paragraph (f) of subsection (2), paragraph (b) of subsection (4), and subsection (6) of section 627.6571, Florida Statutes, are amended to read:

627.6571 Guaranteed renewability of coverage.--

(2) An insurer may nonrenew or discontinue a group health insurance policy based only on one or more of the following conditions:

(f) In the case of health insurance coverage that is made available only through one or more bona fide associations as defined in subsection (5) or through one or more small employer health alliances as described in s. 627.654(1)(b), the membership of an employer in the association or in the small employer health alliance, on the basis of which the coverage is provided, ceases, but only if such coverage is terminated under this paragraph uniformly without regard to any health-status-related factor that relates to any covered individuals.

(4) At the time of coverage renewal, an insurer may modify the health insurance coverage for a product offered:

(b) In the small-group market if, for coverage that is available in such market other than only through one or more bona fide associations as defined in subsection (5) or through one or more small employer health alliances as described in s. 627.654(1)(b), such modification is consistent with s. 627.6699 and effective on a uniform basis among group health plans with that product.

(6) In applying this section in the case of health insurance coverage that is made available by an insurer in the small-group market or large-group market to employers only

through one or more associations or through one or more small employer health alliances as described in s. 627.654(1)(b), a reference to "policyholder" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

Section 33. Paragraph (h) of subsection (5), and paragraph (a) of subsection (12) of section 627.6699, Florida Statutes, are amended to read:

627.6699 Employee Health Care Access Act.--

(5) AVAILABILITY OF COVERAGE.--

(h) All health benefit plans issued under this section must comply with the following conditions:

1. For employers who have fewer than two employees, a late enrollee may be excluded from coverage for no longer than 24 months if he or she was not covered by creditable coverage continually to a date not more than 63 days before the effective date of his or her new coverage.

2. Any requirement used by a small employer carrier in determining whether to provide coverage to a small employer group, including requirements for minimum participation of eligible employees and minimum employer contributions, must be applied uniformly among all small employer groups having the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier, except that a small employer carrier that participates in, administers, or issues health benefits pursuant to s. 381.0406 which do not include a preexisting condition exclusion may require as a condition of offering such benefits that the employer has had no health insurance coverage for its employees for a period of at least 6 months. A small employer carrier may vary application of minimum participation

requirements and minimum employer contribution requirements only by the size of the small employer group.

3. In applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider as an eligible employee employees or dependents who have qualifying existing coverage in an employer-based group insurance plan or an ERISA qualified self-insurance plan in determining whether the applicable percentage of participation is met. However, a small employer carrier may count eligible employees and dependents who have coverage under another health plan that is sponsored by that employer ~~except if such plan is offered pursuant to s. 408.706~~.

4. A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage, unless the employer size has changed, in which case the small employer carrier may apply the requirements that are applicable to the new group size.

5. If a small employer carrier offers coverage to a small employer, it must offer coverage to all the small employer's eligible employees and their dependents. A small employer carrier may not offer coverage limited to certain persons in a group or to part of a group, except with respect to late enrollees.

6. A small employer carrier may not modify any health benefit plan issued to a small employer with respect to a small employer or any eligible employee or dependent through riders, endorsements, or otherwise to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

7. An initial enrollment period of at least 30 days must be provided. An annual 30-day open enrollment period must be offered to each small employer's eligible employees and their dependents. A small employer carrier must provide special enrollment periods as required by s. 627.65615.

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

(a)1. By May 15, 1993, the commissioner 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 commissioner may require the board to submit additional recommendations of individuals for appointment. ~~As alliances are established under s. 408.702, each alliance shall also appoint an additional member to the committee.~~

2. The committee shall develop changes to the form and level of coverages for the standard health benefit plan and the basic health benefit plan, and shall submit the forms, and levels of coverages to the department by September 30, 1993. The department must approve such forms and levels of coverages by November 30, 1993, and may return the submissions to the committee for modification on a schedule that allows the department to grant final approval by November 30, 1993.

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

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

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

Section 34. Subsection (1) of section 240.2995, Florida Statutes, is amended to read:

240.2995 University health services support organizations.--

(1) Each state university is authorized to establish university health services support organizations which shall have the ability to enter into, for the benefit of the university academic health sciences center, and arrangements with other entities as providers ~~for accountable health partnerships, as defined in s. 408.701, and providers~~ in other integrated health care systems or similar entities. To the extent required by law or rule, university health services support organizations shall become licensed as insurance companies, pursuant to chapter 624, or be certified as health maintenance organizations, pursuant to chapter 641. University health services support organizations shall have sole responsibility for the acts, debts, liabilities, and obligations of the organization. In no case shall the state or university have any responsibility for such acts, debts, liabilities, and obligations incurred or assumed by university health services support organizations.

Section 35. Paragraph (a) of subsection (2) of section 240.2996, Florida Statutes, is amended to read:

240.2996 University health services support organization; confidentiality of information.--

(2) The following university health services support organization's records and information are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution:

(a) Contracts for managed care arrangements~~, as managed care is defined in s. 408.701,~~ under which the university health services support organization provides health care services, including preferred provider organization contracts, health maintenance organization contracts, alliance network arrangements, and exclusive provider organization contracts, and any documents directly relating to the negotiation, performance, and implementation of any such contracts for managed care arrangements or alliance network arrangements. As used in this paragraph, the term "managed care" means systems or techniques generally used by third-party payors or their agents to affect access to and control payment for health care services. Managed-care techniques most often include one or more of the following: prior, concurrent, and retrospective review of the medical necessity and appropriateness of services or site of services; contracts with selected health care providers; financial incentives or disincentives related to the use of specific providers, services, or service sites; controlled access to and coordination of services by a case manager; and payor efforts to identify treatment alternatives and modify benefit restrictions for high-cost patient care.

The exemptions in this subsection are subject to the Open Government Sunset Review Act of 1995 in accordance with s. 119.15 and shall stand repealed on October 2, 2001, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 36. Paragraph (b) of subsection (8) of section 240.512, Florida Statutes, is amended to read:

240.512 H. Lee Moffitt Cancer Center and Research Institute.--There is established the H. Lee Moffitt Cancer Center and Research Institute at the University of South Florida.

(8)

(b) Proprietary confidential business information is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution. However, the Auditor General and Board of Regents, pursuant to their oversight and auditing functions, must be given access to all proprietary confidential business information upon request and without subpoena and must maintain the confidentiality of information so received. As used in this paragraph, the term "proprietary confidential business information" means information, regardless of its form or characteristics, which is owned or controlled by the not-for-profit corporation or its subsidiaries; is intended to be and is treated by the not-for-profit corporation or its subsidiaries as private and the disclosure of which would harm the business operations of the not-for-profit corporation or its subsidiaries; has not been intentionally disclosed by the corporation or its subsidiaries unless pursuant to law, an order of a court or administrative body, a legislative proceeding pursuant to s. 5, Art. III of the State Constitution, or a private agreement

that provides that the information may be released to the public; and which is information concerning:

1. Internal auditing controls and reports of internal auditors;

2. Matters reasonably encompassed in privileged attorney-client communications;

3. Contracts for managed-care arrangements~~, as managed care is defined in s. 408.701,~~ including preferred provider organization contracts, health maintenance organization contracts, and exclusive provider organization contracts, and any documents directly relating to the negotiation, performance, and implementation of any such contracts for managed-care arrangements;

4. Bids or other contractual data, banking records, and credit agreements the disclosure of which would impair the efforts of the not-for-profit corporation or its subsidiaries to contract for goods or services on favorable terms;

5. Information relating to private contractual data, the disclosure of which would impair the competitive interest of the provider of the information;

6. Corporate officer and employee personnel information;

7. Information relating to the proceedings and records of credentialing panels and committees and of the governing board of the not-for-profit corporation or its subsidiaries relating to credentialing;

8. Minutes of meetings of the governing board of the not-for-profit corporation and its subsidiaries, except minutes of meetings open to the public pursuant to subsection (9);

9. Information that reveals plans for marketing services that the corporation or its subsidiaries reasonably expect to be provided by competitors;

10. Trade secrets as defined in s. 688.002, including reimbursement methodologies or rates; or

11. The identity of donors or prospective donors of property who wish to remain anonymous or any information identifying such donors or prospective donors. The anonymity of these donors or prospective donors must be maintained in the auditor's report.

As used in this paragraph, the term "managed care" means systems or techniques generally used by third-party payors or their agents to affect access to and control payment for health care services. Managed-care techniques most often include one or more of the following: prior, concurrent, and retrospective review of the medical necessity and appropriateness of services or site of services; contracts with selected health care providers; financial incentives or disincentives related to the use of specific providers, services, or service sites; controlled access to and coordination of services by a case manager; and payor efforts to identify treatment alternatives and modify benefit restrictions for high-cost patient care.

Section 37. Subsection (14) of section 381.0406, Florida Statutes, is amended to read:

381.0406 Rural health networks.--

(14) NETWORK FINANCING.--Networks may use all sources of public and private funds to support network activities. Nothing in this section prohibits networks from becoming managed care providers~~, or accountable health partnerships,~~

~~provided they meet the requirements for an accountable health partnership as specified in s. 408.706~~.

Section 38. Paragraph (a) of subsection (2) of section 395.3035, Florida Statutes, is amended to read:

395.3035 Confidentiality of hospital records and meetings.--

(2) The following records and information of any hospital that is subject to chapter 119 and s. 24(a), Art. I of the State Constitution are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution:

(a) Contracts for managed care arrangements~~, as managed care is defined in s. 408.701,~~ under which the public hospital provides health care services, including preferred provider organization contracts, health maintenance organization contracts, exclusive provider organization contracts, and alliance network arrangements, and any documents directly relating to the negotiation, performance, and implementation of any such contracts for managed care or alliance network arrangements. As used in this paragraph, the term "managed care" means systems or techniques generally used by third-party payors or their agents to affect access to and control payment for health care services. Managed-care techniques most often include one or more of the following: prior, concurrent, and retrospective review of the medical necessity and appropriateness of services or site of services; contracts with selected health care providers; financial incentives or disincentives related to the use of specific providers, services, or service sites; controlled access to and coordination of services by a case manager; and payor

efforts to identify treatment alternatives and modify benefit restrictions for high-cost patient care.

Section 39. Paragraph (b) of subsection (1) of section 627.4301, Florida Statutes, is amended to read:

627.4301 Genetic information for insurance purposes.--

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

(b) "Health insurer" means an authorized insurer offering health insurance as defined in s. 624.603, a self-insured plan as defined in s. 624.031, a multiple-employer welfare arrangement as defined in s. 624.437, a prepaid limited health service organization as defined in s. 636.003, a health maintenance organization as defined in s. 641.19, a prepaid health clinic as defined in s. 641.402, a fraternal benefit society as defined in s. 632.601, ~~an accountable health partnership as defined in s. 408.701,~~ or any health care arrangement whereby risk is assumed.

Section 40. Subsection (3) of section 408.70, and sections 408.701, 408.702, 408.703, 408.704, 408.7041, 408.7042, 408.7045, 408.7055, and 408.706, Florida Statutes, are repealed.

Section 41. Paragraph (n) of subsection (3), paragraph (c) of subsection (5), and paragraphs (b) and (d) of subsection (6) of section 627.6699, Florida Statutes, are amended to read:

627.6699 Employee Health Care Access Act.--

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

(n) "Modified community rating" means a method used to develop carrier premiums which spreads financial risk across a large population and allows adjustments for age, gender, family composition, tobacco usage, and geographic area as determined under paragraph (5)(j); claims experience, health

status, or duration of coverage as permitted under subparagraph (6)(b)5.; and administrative and acquisition expenses as permitted under subparagraph (6)(b)6.

(5) AVAILABILITY OF COVERAGE.--

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

1. Beginning July 1, 2000, ~~January 1, 1994,~~ offer and issue all small employer health benefit plans on a guaranteed-issue basis to every eligible small employer, with 2 ~~3~~ 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. Beginning August 1, 2000 ~~April 15, 1994~~, 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 less than ~~one or~~ 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.

3. ~~Offer to eligible small employers the standard and basic health benefit plans.~~ This paragraph ~~subparagraph~~ 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.

(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 subparagraphs 5. and 6.

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 department 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 department 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 department. 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.~~Carriers participating in the alliance program, in accordance with ss. 408.70-408.706, may apply a different community rate to business written in that program.~~

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 department to enable the department to monitor the relationship of aggregate adjusted premiums actually charged policyholders by each carrier to the premiums that would have been charged by application of the carrier's approved modified community rates. If the aggregate resulting from the application of such adjustment exceeds the premium that would have been charged by application of the approved modified community rate by 5 percent for the current reporting period, the carrier shall limit the application of such adjustments only to minus adjustments beginning not more than 60 days after the report is sent to the department. For any subsequent reporting period, if the total aggregate adjusted premium actually charged does not exceed the premium that would have been charged by application of the approved modified community

rate by 5 percent, the carrier may apply both plus and minus adjustments. A small employer carrier may provide a credit to a small employer's premium based on administrative and acquisition expense differences resulting from the size of the group. Group size administrative and acquisition expense factors may be developed by each carrier to reflect the carrier's experience and are subject to department 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.

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

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

Section 42. Subsection (2) of section 641.27, Florida Statutes, is amended to read:

641.27 Examination by the department.--

(2) The department may contract, at reasonable fees for work performed, with qualified, impartial outside sources to perform audits or examinations or portions thereof pertaining to the qualification of an entity for issuance of a certificate of authority or to determine continued compliance with the requirements of this part, in which case the payment must be made, directly to the contracted examiner by the health maintenance organization examined, in accordance with the rates and terms agreed to by the department and the examiner. Any contracted assistance shall be under the direct supervision of the department. The results of any contracted assistance shall be subject to the review of, and approval, disapproval, or modification by, the department.

Section 43. Application of federal solvency requirements to provider-sponsored organizations.--The solvency requirements of sections 1855 and 1856 of the Balanced Budget Act of 1997 and rules adopted by the Secretary of the United States Department of Health and Human Services apply to a health maintenance organization that is a provider-sponsored organization rather than the solvency requirements of part I of chapter 64, Florida Statutes. However, if the provider-sponsored organization does not meet the solvency requirements of this part, the organization is limited to the issuance of Medicare+Choice plans to eligible individuals. For the purposes of this section, the terms "Medicare+Choice plans," "provider-sponsored organizations,"

and "solvency requirements" have the same meaning as defined in the federal act and federal rules and regulations.

Section 44. Insurance holding companies.--Part IV of chapter 628, Florida Statutes, applies to health maintenance organizations licensed under part I of chapter 641, Florida Statutes.

Section 45. Section 641.275, Florida Statutes, is created to read:

641.275 Subscriber's rights under health maintenance contracts; required notice.--

(1) It is the intent of the Legislature that the rights of subscribers who are covered under health maintenance organization contracts be recognized and summarized in a statement of subscriber rights. An organization may not require a subscriber to waive his or her rights as a condition of coverage or treatment and must operate in conformity with such rights.

(2) Each organization must provide subscribers with a copy of their rights as set forth in this section, in such form as approved by the department.

(3) An organization shall:

(a) Ensure that health care services provided to subscribers are rendered under reasonable standards of quality of care consistent with the prevailing standards of medical practice in the community, as required by s. 641.51;

(b) Have a quality assurance program for health care services, as required by s. 641.51;

(c) Not modify the professional judgment of a physician unless the course of treatment is inconsistent with the prevailing standards of medical practice in the community, as required by s. 641.51;

(d) Not restrict a provider's ability to communicate information to the subscriber/patient regarding medical care options that are in the best interest of the subscriber/patient, as required by s. 641.315(8);

(e) Provide for standing referrals to specialists for subscribers with chronic and disabling conditions, as required by s. 641.51;

(f) Allow a female subscriber to select an obstetrician/gynecologist as her primary care physician, as required by s. 641.19(13)(e);

(g) Provide direct access, without prior authorization, for a female subscriber to visit a obstetrician/gynecologist, as required by s. 641.51(10);

(h) Provide direct access, without prior authorization, to a dermatologist, as required by s. 641.31(33);

(i) Not limit coverage for the length of stay in a hospital for a mastectomy for any time period that is less than that determined to be medically necessary by the treating physician, as required by s. 641.31(33);

(j) Not limit coverage for the length of a maternity or newborn stay in a hospital or for follow-up care outside the hospital to any time period less than that determined to be medically necessary by the treating provider, as required by s. 641.31(18);

(k) Not exclude coverage for bone marrow transplant procedures determined by the Agency for Health Care Administration to not be experimental, as required by s. 627.4236;

(l) Not exclude coverage for drugs on the ground that the drug is not approved by the U.S. Food and Drug Administration, as required by s. 627.4239;

(m) Give the subscriber the right to a second medical opinion as required by s. 641.51(4);

(n) Allow subscribers to continue treatment from a provider after the provider's contract with the organization has been terminated, as required by s. 641.51(7);

(o) Establish a procedure for resolving subscriber grievances, including review of adverse determinations by the organization and expedited review of urgent subscriber grievances, as required by s. 641.511;

(p) Notify subscribers of the right to an independent external review of grievances not resolved by the organization, as required by s. 408.7056;

(q) Provide, without prior authorization, coverage for emergency services and care, as required by s. 641.513;

(r) Not require or solicit genetic information or use genetic test results for any insurance purposes, as required by s. 627.4310;

(s) Promptly pay or deny claims as required by s. 641.3155;

(t) Provide information to subscribers regarding benefits, limitations, resolving grievances, emergency services and care, treatment by non-contract providers, list of contract providers, authorization and referral process, the process used to determine whether services are medically necessary, quality assurance program, prescription drug benefits and use of a drug formulary, confidentiality and disclosure of medical records, process of determining experimental or investigational medical treatments, and

process used to examine qualifications of contract providers, as required by ss. 641.31, 641.495, and 641.54.

(4) The statement of rights in subsection (3) is a summary of selected requirements for organizations contained in other sections of the Florida Statutes. This section does not alter the requirements of such other sections.

(5)(a) The department may impose a fine against a health maintenance organization for a violation of this section which refers to a section in this part or in chapter 627. Such fines shall be in the amounts specified in s. 641.25.

(b) The agency may impose a fine against a health maintenance organization for a violation of this section which refers to a section in part III of this chapter or in chapter 408. Such fines shall be in the amounts specified in s. 641.52.

Section 46. Section 641.28, Florida Statutes, is amended to read:

641.28 Civil remedy.--

(1) In any civil action brought to enforce the terms and conditions of a health maintenance organization contract:

(a) If the civil action is filed before or within 60 days after the subscriber or enrollee filed a notice of intent to sue with the statewide provider and subscriber assistance program established pursuant to s. 408.7056 or a notice pursuant to s. 641.3917, the prevailing party is entitled to recover reasonable attorney's fees and court costs.

(b) If the civil action is filed more than 60 days after the subscriber or enrollee filed a notice of intent to sue with the statewide provider and subscriber assistance program established pursuant to s. 408.7056 or a notice

pursuant to s. 641.3917, and the subscriber or enrollee receives a final judgment or decree against the health maintenance organization in favor of the subscriber or enrollee, the court shall enter a judgment or decree against the health maintenance organization in favor of the subscriber or enrollee for reasonable attorney's fees and court costs.

(2) This section shall not be construed to authorize a civil action against the department, its employees, or the Insurance Commissioner or against the Agency for Health Care Administration, its employees, or the director of the agency.

Section 47. Paragraphs (c), (d), and (e) are added to subsection (10) of section 641.3903, Florida Statutes, and subsection (15) is added to that section, to read:

641.3903 Unfair methods of competition and unfair or deceptive acts or practices defined.--The following are defined as unfair methods of competition and unfair or deceptive acts or practices:

(10) ILLEGAL DEALINGS IN PREMIUMS; EXCESS OR REDUCED CHARGES FOR HEALTH MAINTENANCE COVERAGE.--

(c) Cancelling or otherwise terminating any health maintenance contract or coverage, or requiring execution of a consent to rate endorsement, during the stated contract term for the purpose of offering to issue, or issuing, a similar or identical contract to the same subscriber or enrollee with the same exposure at a higher premium rate or continuing an existing contract with the same exposure at an increased premium.

(d) Issuing a nonrenewal notice on any health maintenance organization contract, or requiring execution of a consent to rate endorsement, for the purpose of offering to issue, or issuing, a similar or identical contract to the same

subscriber or enrollee at a higher premium rate or continuing an existing contract at an increased premium without meeting any applicable notice requirements.

(e) Cancelling or issuing a nonrenewal notice on any health maintenance organization contract without complying with any applicable cancellation or nonrenewal provision required under the Florida Insurance Code.

(15) REFUSAL TO COVER.--In addition to other provisions of this code, the refusal to cover, or continue to cover, any individual solely because of:

(a) Race, color, creed, marital status, sex, or national origin;

(b) The residence, age, or lawful occupation of the individual, unless there is a reasonable relationship between the residence, age, or lawful occupation of the individual and the coverage issued or to be issued; or

(c) The fact that the enrollee or applicant had been previously refused insurance coverage or health maintenance organization coverage by any insurer or health maintenance organization when such refusal to cover or continue to cover for this reason occurs with such frequency as to indicate a general business practice.

Section 48. Section 641.3917, Florida Statutes, is amended to read:

641.3917 Civil liability.--The provisions of this part are cumulative to rights under the general civil and common law, and no action of the department shall abrogate such rights to damage or other relief in any court.

(1) Any person to whom a duty is owed may bring a civil action against a health maintenance organization when such person suffers damages as a result of:

(a) A violation of s. 641.3903(5)(a), (b), (c)1.-7., (10), or (15) by the health maintenance organization; or

(b) The health maintenance organization's failure to provide a covered service when in good faith the health maintenance organization should have provided the service if it had acted fairly and honestly toward its subscriber or enrollee and with due regard for his or her interests and, in the independent medical judgment of a contract treating physician or other physician authorized by the health maintenance organization, the service is medically necessary.

However, a person pursuing a remedy under this section need not prove that such acts were committed or performed with such frequency as to indicate a general business practice.

(2)(a) As a condition precedent to bringing an action under this section, the department and the health maintenance organization must have been given 60 days' written notice of the violation. If the department returns a notice for lack of specificity, the 60-day time period does not begin until a proper notice is filed.

(b) The notice must be on a form provided by the department and must state with specificity the following information and such other information as the department requires:

1. The provision of law, including the specific language of the law, which the health maintenance organization has allegedly violated.

2. The facts and circumstances giving rise to the violation.

3. The name of any individual involved in the violation.

4. Any reference to specific contract language that is relevant to the violation.

5. A statement that the notice is given in order to perfect the right to pursue the civil remedy authorized by this section.

(c) Within 20 days after receipt of the notice, the department may return any notice that does not provide the specific information required by this section, and the department shall indicate the specific deficiencies contained in the notice. A determination by the department to return a notice for lack of specificity is exempt from the requirements of chapter 120.

(d) No action shall lie under this section if, within 60 days after filing notice, the damages are paid or the circumstances giving rise to the violation are corrected.

(e) The health maintenance organization that is the recipient of a notice filed under this section shall report to the department on the disposition of the alleged violation.

(f) The applicable statute of limitations for an action under this section shall be tolled for a period of 65 days by the mailing of the notice required by this subsection or the mailing of a subsequent notice required by this subsection.

(3) Upon adverse adjudication at trial or upon appeal, the health maintenance organization is liable for damages, together with court costs and reasonable attorney's fees, incurred by the plaintiff.

(4) Punitive damages shall not be awarded under this section unless the acts giving rise to the violation occur with such frequency as to indicate a general business practice and are either willful, wanton, and malicious or are in

reckless disregard for the rights of any subscriber or enrollee. Any person who pursues a claim under this subsection shall post, in advance, the costs of discovery. Such costs shall be awarded to the health maintenance organization if no punitive damages are awarded to the plaintiff.

(5) This section shall not be construed to authorize a class action suit against a health maintenance organization or a civil action against the department, its employees, or the Insurance Commissioner, or against the Agency for Health Care Administration, its employees, or the director of the agency or to create a cause of action when a health maintenance organization refuses to pay a claim for reimbursement on the grounds that the charge for a service was unreasonably high or that the service provided was not medically necessary.

(6)(a) The civil remedy specified in this section does not preempt any other remedy or cause of action provided for pursuant to any other law or pursuant to the common law of this state. Any person may obtain a judgment under either the common law remedy of bad faith or the remedy provided in this section, but is not entitled to a judgment under both remedies. This section does not create a common law cause of action. The damages recoverable under this section include damages that are a reasonably foreseeable result of a specified violation of this section by the health maintenance organization and may include an award or judgment in an amount that exceeds contract limits.

(b) This section does not create a cause of action for medical malpractice. Such an action is subject to the provisions of chapter 766.

(c) This section does not apply to the provision of medical care, treatment, or attendance pursuant to chapter 440.

Section 49. Subsection (4) of section 440.11, Florida Statutes, is amended to read:

440.11 Exclusiveness of liability.--

(4) Notwithstanding the provisions of s. 624.155 or s. 641.3917, the liability of a carrier or a health maintenance organization to an employee or to anyone entitled to bring suit in the name of the employee shall be as provided in this chapter, which shall be exclusive and in place of all other liability.

Section 50. The Legislature finds that the provisions of this act will fulfill an important state interest.

Section 51. The sum of $112,000 is appropriated from the Insurance Commissioner's Regulatory Trust Fund to the Department of Insurance and three positions are authorized for the purposes of carrying out the provisions of sections 46 through 49 of this act.

Section 52. Subsection (39) is added to section 641.31, Florida Statutes, to read:

641.31 Health maintenance contracts.--

(39) A health maintenance organization contract may not prohibit or restrict a subscriber from receiving in-patient services in a contracted hospital from a contracted primary care or admitting physician if such services are determined by the organization to be medically necessary and covered services under the organization's contract with the contract holder.

Section 53. Subsection (11) is added to section 641.315, Florida Statutes, to read:

641.315 Provider contracts.--

(11) A contract between a health maintenance organization and a contracted primary-care or admitting physician may not contain any provision that prohibits such physician from providing in-patient services in a contracted hospital to a subscriber if such services are determined by the organization to be medically necessary and covered services under the organization's contract with the contract holder.

Section 54. Subsection (5) is added to section 641.3155, Florida Statutes, to read:

641.3155 Provider contracts; payment of claims.--

(5) A health maintenance organization shall pay a contracted primary-care or admitting physician, pursuant to such physician's contract, for providing in-patient services in a contracted hospital to a subscriber, if such services are determined by the organization to be medically necessary and covered services under the organization's contract with the contract holder.

Section 55. Present subsections (4), (5), (6), (7), (8), (9), and (10) of section 641.51, Florida Statutes, are redesignated as subsections (5), (6), (7), (8), (9), (10), and (11), respectively, and a new subsection (4) is added to that section to read:

641.51 Quality assurance program; second medical opinion requirement.--

(4) The organization shall ensure that only a physician licensed under chapter 458 or chapter 459; or an M.D. or D.O. physician with an active, unencumbered license in another state with similar licensing requirements may render an adverse determination regarding a service provided by a

physician licensed in this state. The organization shall submit to the treating provider and the subscriber written notification regarding the organization's adverse determination within 2 working days after the subscriber or provider is notified of the adverse determination. The written notification must include the utilization review criteria or benefits provisions used in the adverse determination, identify the physician who rendered the adverse determination, and be signed by an authorized representative of the organization or the physician who renders the adverse determination. The organization must include with the notification of an adverse determination information concerning the appeal process for adverse determinations.

Section 56. This act shall take effect July 1, 2000, and apply to contracts issued or renewed on or after that date, except as otherwise provided in this act and except that the amendment to section 395.701, Florida Statutes, by this act shall take effect only upon the receipt by the Agency for Health Care Administration of written confirmation from the federal Health Care Financing Administration that the changes contained in such amendment will not adversely affect the use of the remaining assessments as state match for the state's Medicaid program.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN COMMITTEE SUBSTITUTE FOR CS/SB 2154, CS/SB 1900 and SB 282

This bill combines provisions of CS/CS/SB 162, CS/SB 420, CS/SB 866, CS/SB 954, CS/SB 1300, SB 1534, CS/SB 1900, CS/SB 2086, SB 2152, CS/SB 2154, and SB 2612. The bill includes provisions relating to: assessments on certain health care entities to fund the Public Medical Assistance Trust Fund; Medicaid reimbursement limits on hospital outpatient services; the certificate-of-need program; mandated health insurance benefits; consumer-assistance notices by physicians and hospitals and a consumer assistance program; small employer health alliances; the Employee Health Care Access Act and rating restrictions on small group insurance; regulation of health maintenance organizations; health maintenance organization subscribers' rights; civil liability of health maintenance organizations; mandatory use of "hospitalists" by health maintenance organizations; and adverse determinations by health maintenance organizations.