HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1629 Affordable Health Care
SPONSOR(S): Farkas
TIED BILLS: None. **IDEN./SIM. BILLS:** HB 701, HB 779, SB 2910(s)

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care		Rawlins	Collins
2) Insurance			
3) Finance & Tax			
4) Health Appropriations (Sub)			
5) Appropriations			

SUMMARY ANALYSIS

HB 1629 creates the Affordable Health Care for Floridians Act.

The double digit increase in health insurance premiums and rise in health care cost have contributed to the lack of accessibility to employment-based health insurance. This has prompted policymakers around the nation to propose a range of approaches for expanding health insurance coverage and reducing health care cost. In Florida, in an effort to address the issue of affordable and accessible employment-based insurance, on August 14, 2003, Speaker Johnnie Byrd created the Select Committee on Affordable Health Care for Floridians and appointed Representative Frank Farkas, D.C., Chairman.

To seek opinions of a wide range of stakeholders, public hearings with predetermined themes were conducted around the state, specifically in Orlando, Miami, Jacksonville, Tampa, Pensacola, Boca Raton, and Tallahassee from October through November, 2003. The challenge for the committee is to effectively probe the operation of the private insurance market place, to understand the health insurance market trends, to learn from past policy initiatives, and to identify, explore, and debate new ideas for change.

This bill essentially represents many of the recommendations of the Select Committee on Affordable Health Care for Floridians. Significant provisions affecting the health insurance markets include:

- ✓ Creation of the Florida Health Insurance Plan as the high risk pool for uninsurable medical risks, replacing the Florida Comprehensive Health Care Association;
- ✓ Expansion of the Health Flex Program statewide;
- ✓ Modification of the Small Employers Health Access Act to eliminate one-life groups, contingent on the Florida Health Insurance Plan accepting new enrollment;
- ✓ Creation of the Small Employers Access Program to provide additional options for small businesses of up to 25 employees;
- ✓ Requirement that certain plans providing discount medical services be licensed as prepaid health plans;
- ✓ Creation of a new agent license line called “insurance advisor;”
- ✓ Updating the ability of the Office of Insurance Regulation to regularly collect data from insurers describing the health insurance marketplace; and
- ✓ Requirement that all individual and group health insurance policies and HMO contracts offer coverage providing speech, language, swallowing, and hearing disorders.

In an effort to make a more “transparent” health care market, hospitals and the Agency for Health Care Administration required to post pricing information on procedures performed in Florida hospitals. This bill will increase consumer awareness regarding the cost of health care treatment in hospitals and encourage comparison shopping.
See “FISCAL IMPACT ON STATE GOVERNMENT” section.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. DOES THE BILL:

1. Reduce government?	Yes[]	No[X]	N/A[]
2. Lower taxes?	Yes[]	No[X]	N/A[]
3. Expand individual freedom?	Yes[X]	No[]	N/A[]
4. Increase personal responsibility?	Yes[X]	No[]	N/A[]
5. Empower families?	Yes[X]	No[]	N/A[]

For any principle that received a “no” above, please explain:

This bill creates a state subsidized high risk pool for the uninsurable and uses an assessment against insurers to cover a portion of the cost of the pool.

B. EFFECT OF PROPOSED CHANGES:

Present Situation

More than 240 million people in the United States have health insurance today through a variety of private and public sources. As of 2002, 12.2 million out of 16.1 million Florida residents had health insurance. Of those Floridians with insurance, more than eight million were covered by private insurance or self-insurance plans operated by large employers. Another 2.5 million were covered by Medicare, mainly elderly adults, and another 1.7 million low-income citizens were covered by Medicaid.

Select Committee on Affordable Health Care for Floridians

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Climate of the Florida Health Insurance Market

Florida residents and employers spent $12.5 billion in health insurance premiums, as reported in calendar year 2000. Spending for all privately and publicly funded personal health care services and products (e.g., hospital care, physician services, nursing home care, prescription drugs, etc.) exceeded $60 billion in 1998.

While health economists debate the overall effect of rising health expenditures, many believe that the national health care system is at a breaking point, including many stakeholders in Florida. Many agree that the nation's health care system is too costly, inefficient, unfair and in need of an overhaul. Former U.S. Secretaries of Health warn that “the real inequities in the U.S. system -- which ranks first in the

world in cost and 35th in overall efficiency, according to World Health Organization surveys -- aren't much closer to resolution than they were during the quarter of a century that they presided over it."

The structure of the Florida health coverage market and the regulations that govern its operations are based on health plan type and size. For purposes of this report, and by Florida law, the types of health plans discussed in this report are categorized as:

- Self-insured plans;
- Large group health plans;
- Small group health plans;
- Individual health plans;
- Out-of-State Groups; and
- High-risk Pool.

Most fully-insured private health coverage in Florida is issued through an employer group – a small group, which is defined by Florida law as one to 50 employees, or a large group, 51 employees or more. Many larger Florida employers provide coverage by self-insuring and establishing contracts with private insurance companies to provide "stop loss" reinsurance and administrative services, thus taking advantage of the Employment Retirement Income Security Act (ERISA) protections from state laws. As a result, less than 30 percent of Florida's population is governed by state insurance laws. In fact, of Florida's 16.1 million residents in 2002:

- 4.8 million are in Florida insurance market (fully-insured plans, large groups, small groups, and individual plans);
- 4.3 million are governed by only federal law (ERISA, aka: self-insured plans);
- 1.7 million are enrolled in Medicaid;
- 2.5 million are enrolled in the Medicare program; and
- 2.8 million are uninsured.

Consequences of Lack of Health Insurance

Research has found that patients who are uninsured for even short periods of time are more likely to receive too little medical care and to receive it too late, to be sicker and to die sooner. They are reluctant to use health services, often waiting until there is a crisis. They receive fewer preventive services, less regular care for chronic disease, and poorer care in the hospital.

Not only does the lack of insurance affect the health and well being of U.S. and Florida residents, but there is a resounding rippling affect on the economy. In 2001, the cost of medical care for uninsured residents in the U.S. totaled $98.9 billion. The Florida Hospital Association reports that in 2002 cost for uncompensated care provided in Florida hospitals amounted to $1.51 billion.

Studies estimate that the potential economic value to be gained in better health outcomes from uninterrupted coverage for all Americans is estimated to be between $65 and $130 billion each year, which is currently being lost per year in lost productivity. Each uninsured U.S. resident loses between $1,645 and $3,280 per year in lost wages and benefits and in the value that improved quality of life and longer lifespan would provide.

The state's budget is also strained by increasing numbers of uninsured. The Medicaid Enrollment and Expenditure Estimating Conference estimates that Florida's Medicaid expenditures will approach $14 billion in FY 2004-05, resulting in a $526 million deficit in general revenue for that year.

As state budgets are stretched, funding care for Florida residents falls on the local communities where care is provided. Counties are mandated by state law to contribute to the state Medicaid program. For fiscal year 2002-2003, counties contributed approximately $162 million. Counties are required to pay

for eligible Medicaid recipients' inpatient hospital stay from day 11 through day 45, with this responsibility being increased by the state several years ago. Counties are currently funding inpatient hospital days at approximately $115 million statewide.

Cost Drivers Increasing Health Expenditures

The health policy research literature suggests that the growth in health care spending in the mid-1990s was a collective result of three factors: 1) inefficiencies in the provision of health services; 2) continued large returns to providers; and 3) investment in new technology. But the public testimony presented to the Select Committee and the independent research reviewed by Committee staff identified other factors that many experts said had a more significant effect on health care costs than these three concepts.

During public testimony, the Select Committee was presented with a significant amount of data and research on what are considered the most influential cost drivers of health care expenditures, such as:

Consumer Demand. The increase in demand from consumers is attributed to the increase of utilization of health care services. In the 1990s, trends in managed care began eroding its ability to restrain costs, further increasing national health care spending. Consumer demand called for less restrictive managed care options and an erosion of plans' ability to negotiate steep price discounts. Increased consumer demand for prescription medications, particularly new products, is the primary factor behind managed care plans' increased drug spending according to the literature review. Consumer demand induced by drug manufacturer advertising is cited as a major contributing factor to the increases in prescription drug use.

New Technology. Advancements in medical science, such as new drugs, medical devices, biologicals, and new medical and surgical procedures have contributed to increased life expectancy, decreased mortality and improved quality of life. However, these new advancements have greatly contributed to the nation's rapidly rising health care cost. One analysis showed that the availability of new diagnostic and therapeutic approaches, and increased use of established approaches, account for one half to two-thirds of the annual increase in U.S. health care spending that is not attributable to inflation in the economy as a whole.

Emergency Departments. Emergency departments are misused and overused nationwide and Florida is no exception. The Center for Studying Health System Change reports that there was a 16.3 percent increase in emergency department visits between 1996-97 and 2000-01. During the same period, population increased by only 4.4 percent. Surprisingly, the majority of the increase in use is from insured patients. Inappropriate utilization of services, whether its ED usage or the demand for more expensive diagnostic treatments, contributes to the overall growth in health care spending.

Other cost drivers of health care expenditures may be categorized as:

- Drugs, Medical Devices, and Medical Advances ;
- General Price Inflation (Consumer Price Index);
- Rising Provider Expenses;
- Government Mandates and Regulation;
- Increased Consumer Demand;
- Litigation and Risk Management; and
- Other Categories (Fraud and Abuse, Miscellaneous).

Cost Savers

There were several cost savers identified through staff research and public testimony of the Select Committee. Of these, the promotion of evidence-based medicine to guide clinical practice, and the use

of cost containment strategies were identified as some of the best ways to increase affordability in the employment-based market.

However, the most significant cost saver identified, and virtually unanimously agreed to by both stakeholders and researchers, was the need to establish "transparency" back into the health coverage system. The argument is that the current system blocks the real cost of health care utilization from the direct consumer, the patient/employee. The employment-based coverage system subsidizes this utilization so that consumer demand is disconnected to an awareness of true costs. Advocates of transparency believe that finding ways to make the full cost of health care open and apparent to each consumer would help them make better choices and reduce overall costs. When taken to the extreme, the advocates suggest making each individual more responsible for their utilization and consequences of over utilization, through pricing of health insurance products, and incentives for healthier lifestyles.

Final Recommendations

After seven public hearings held throughout the state and three committee meetings, 88 policy options were examined and reviewed by the members of the Select Committee. The "Policy Options -- Pros and Cons" section of the report provides a narrative regarding each of the options. Many of the recommendations fell outside the charge of the committee and members were able to narrow the list of policy options from 88 to a list of 13 (that list was a consolidation of approximately 28 options).

The Select Committee met on February 4, 2004, and considered the narrowed list of options and voted unanimously to forward the recommendations to the Speaker. The recommendations are crafted as both short and long term-approaches in providing choice and competition in the marketplace, while controlling health insurance cost.

The recommendations of the Select Committee on Affordable Health Care for Floridians are incorporated into HB 1629.

HB 1629

HB 1629 creates "The 2004 Affordable Health Care for Floridians Act."

<u>TRANSPARENCIES</u>

Currently, hospitals and ambulatory surgical centers are required to submit discharge data on a quarterly basis to the Agency for Health Care Administration. The State Center for Health Statistics collects three types of discharge information from 261 inpatient healthcare facilities and Ambulatory Patient Data is collected from 526 freestanding ambulatory surgical centers, lithotripsy centers, cardiac catheterization laboratories, and short-term acute care hospitals. The data is used for information guides and research by many that are interested in the health of Florida residents.

The bill revises the powers and duties of the Agency for Health Care Administration (agency) to include the price information to be made available on the Agency and health care facilities website.

The bill moves forward due dates for licensed health care facilities to report data specified in 59B-9.010 through 59B-9.020, F.A.C. and 59E-7.011 through 59E-7.016, F.A.C. Facilities will need to adjust their internal procedures to meet the new schedule.

The bill requires the agency to add to its website information comparing the readmission rates, complication rates, mortality rates, infection rates, and the use of computerized drug order systems, using risk-adjusted data if applicable, at licensed facilities for not less than 100 inpatient and outpatient diagnostic and therapeutic conditions and procedures.

ELECTRONIC MEDICAL RECORDS ADVISORY PANEL

The bill creates a nine-member advisory council to guide the Agency in the development of policies on electronic medical records and the development of technology required for sharing clinical information among caregivers. The bill requires the Agency to provide staff support to the council and gives the Agency the authority to enter into contracts necessary to create a statewide medical records system. The panel must meet quarterly and advise on the issues specified in statute. Members must serve without compensation but are entitled to per diem and travel expenses. The advisory council terminates July 1, 2007. The bill allocates $2 million from General Revenue to fund the activities of this task.

EVIDENCED-BASED MEDICINE ADVISORY PANEL

The bill creates the panel to guide the Agency and the Department of Health in the development of policies and technology to further evidence-based medicine. The panel is comprised of nine members. The panel must meet quarterly and advise on the issues specified in statute. Members must serve without compensation but are entitled to per diem and travel expenses. The Agency must provide staff support to the panel and may enter into contracts to carry out the provision of this section. A report is due by November 30, 2004, and annually thereafter. The panel is abolished on July 1, 2007.

HEALTH INSURANCE

Significant provisions affecting the health insurance markets include:

- ✓ Creation of the Florida Health Insurance Plan as the high risk pool for uninsurable medical risks, replacing the Florida Comprehensive Health Care Association;
- ✓ Expansion of the Health Flex Program statewide;
- ✓ Modification of the Small Employers Health Access Act to eliminate one-life groups, contingent on the Florida Health Insurance Plan accepting new enrollment;
- ✓ Creation of the Small Employers Access Program to provide additional options for small businesses of up to 25 employees;
- ✓ Requirement that certain plans providing discount medical services to be licensed as prepaid health plans;
- ✓ Creation of a new agent license line called “insurance advisor”;
- ✓ Updating the ability of the Office of Insurance Regulation to regularly collect data from insurers describing the health insurance marketplace; and
- ✓ Requirement that all individual and group health insurance policies and HMO contracts offer coverage providing speech, language, swallowing, and hearing disorders.

HEALTH FLEX PLANS

The bill expands eligibility statewide by eliminating the “pilot” status and permits public-private partnerships to participate in the program. The bill requires an offering of a catastrophic insurance plan option and requires OIR to oversee health flex plan advertisement and marketing procedures. The bill requires AHCA and OIR to report on Health Flex progress to the Governor and legislature by January 1, 2005.

FLORIDA HEALTH INSURANCE PLAN

The bill establishes the Florida Health Insurance Plan as the state’s high risk pool. The FHIP is run by a nine person Board of Directors and chaired by the OIR Director. There are four governor appointees; two Senate appointees; and two House appointees. The bill requires the initial meeting of the board to occur no later than December 1, 2004. The bill requires that a majority of the board must be composed of individuals who are not representatives of insurers or health care providers without further definition.

Eligible Individuals: Residents deemed medically uninsurable by the marketplace; individuals eligible for coverage as described in s. 627.6487, F.S. (HIPPA Eligibles); and current FCHA enrollees.

Benefit Plans: Standard and basic benefit plans as described in s. 627.6699, F.S. with an additional alternative catastrophic coverage as determined by the board.

Funding: Funding of the high risk pool is accomplished through three mechanisms:

(1) Premiums, initially capped at 200% of standard risk rate, subject to a sliding surcharge based on the insured's income.
(2) Assessments of health insurers and HMO's to cover deficits incurred in excess of premiums provided by previous FCHA enrollees.
(3) General revenue to cover deficits incurred in excess of new enrollees in the plan.

Final approval of the operational plan of the Florida Health Insurance Plan is exclusive to the Governor. For all other residual market plans, the plan of operations is approved by the Office of Insurance Regulation. Upon the opening of the FHIP, the Florida Comprehensive Health Association is statutorily repealed.

SMALL GROUP MARKET REFORMS

There are several reforms to the small group market designed to enhance flexibility of the coverages offered. The bill requires:

- ✓ the offering of a high deductible plan that meets the federal requirements of a health savings account; and
- ✓ a limit of the allowable variation from the approved rate for cumulative use of health status and claims experience rating factors to 2%.

The bill creates the Small Employers Access Program to allow the development of distinctive, innovative, and flexible benefit plans exclusively offered in defined geographical areas to small businesses up to 25 employees.

The bill allows health insurers to require higher copayments for nonemergency use of emergency rooms.

ONE LIFE GROUPS

The bill amends s. 627.6487, F.S., making individuals ineligible for guaranteed issue in the small group market if the Florida Health Insurance Plan is accepting new enrollment.

DATA COLLECTION

The bill amends s. 627.9175, F.S., authorizing the annual collection of market data from health insurers, prepaid plans, and HMO's and provides the FSC with rulemaking authority governing the submission of such information.

DISCOUNT PLANS

The bill amends s. 636.003, F.S., to require plans providing discounted medical services to be licensed as prepaid limited health services organizations if charges in such plans exceed $15 per month or $180 per year.

SPEECH, LANGUAGE, SWALLOWING, AND HEARING

The bill amends the provision of law governing the small, individual and HMO insurance market requiring the offering of optional coverage for speech, language, swallowing, and hearing disorders in individual health insurance policies.

LIMITED INSURANCE AGENT LICENSE

Sections 28-37 Amend various insurance agent and agency statutes associated with creating the license of "investment advisor," allowing insurance agents to act on behalf of the consumer and shop for the best plan available. Insurance agents may collect a fee for their service under proper disclosure.

PRACTICE PARAMETERS

The Health Care Reform Act of 1993 required AHCA to develop and implement scientifically sound practice parameters. At the time of its passage, national standards were limited to specialized provider and practitioner groups and were not generally available to payers, purchasers or consumers.

Today, the National Guideline Clearinghouse is available as a public resource for evidence-based clinical practice guidelines. This is sponsored by the Agency for Health Care Research and Quality (AHRQ) and the U.S. Department of Health and Human Services sponsors, in partnership with the American Medical Association and the American Association of Health Plans-Health Insurance Association of America.

The National Guideline Clearinghouse is accessible on the Internet at: www.guideline.gov. The medical community would be able to access and use the dynamically updated parameters of the National Guideline Clearinghouse.

The bill repeals the requirement that AHCA develop practice parameters, thus eliminating the duplicative and costly development of practice parameters that are now widely available to the medical community.

STATEWIDE PROVIDE AND SUBSCRIBER ASSISTANCE PROGRAM

This bill amends Section 408.7056, Florida Statutes, as follows:

The current program title "Statewide Provider and Subscriber Assistance Program" is misleading to subscribers and providers, and causes particular confusion among providers, who incorrectly believe that their billing problems can be resolved by the program. The Program title "Subscriber Assistance Program" more accurately portrays the purpose and function of the program, and is more user friendly.

Currently, the Program has authority to require managed care plans to provide only "medical" records within a specified time frame; yet panel frequently requires other records, in addition to the medical records, to arrive at its conclusion and make its recommendation The bill incorporate grievance file and other requested records with the medical records, and more importantly, would permit fines to be applied when records other than medical records are not supplied as requested, i.e., telephone logs, correspondence, grievance hearing records, billing statements, premium/rate change notices, formulary lists, contracts, etc.

Flexibility in the numbers and makeup of the panel members from the agency and the department will ensure a balance of perspective regarding subscribers' issues heard by the panel.

- ✓ Clarification of the use of a physician with expertise only as necessary.

- ✓ Clarification that the panel may contract with a medical director and/or a primary care physician.

- ✓ Clarification that a contracted medical director or primary care physician is not a voting panel member.

There is no statutory direction for conducting a panel hearing with less than full membership. Specific member attendance poses potential scheduling difficulties due to the probability of unavoidable last minute absenteeism by some panel members. Last minute cancellation unnecessarily delays the grievance process and causes inconvenience for those scheduled and assembled for the hearing. This bill establishes a quorum to enhance the ability of the Panel to review the subscriber grievances in a timely manner as directed in section 408.7056, Florida Statutes.

HEALTHY COMMUNITIES, HEALTHY PEOPLE PROGRAM

The Healthy Communities, Healthy People Program is a comprehensive community-based health promotion and wellness program. It is designed to encourage healthy lifestyles and behaviors to reduce the incidence of disease and increase life expectancy. Specific programs that contribute to the Healthy Communities, Healthy People Program include: Chronic Disease Health Promotion and Education Program; Heart Disease and Stroke Prevention Program; Obesity Prevention Program; Diabetes Education and Control Program; Arthritis Education Program; Comprehensive Cancer Control Program; and the Coordinated School Health Program.

This bill requires the DOH to include health care providers and small businesses and health insurers in the organizations that the Healthy Communities, Healthy People program serves. It requires DOH to provide information about DOH's health promotion and wellness programs and healthy lifestyle information on its Internet web page.

FEDERALLY QUALIFIED COMMUNITY HEALTH CENTERS

DOH serves informally as a liaison between health centers funded under Section 330 of the Public Health Service Act (42 U.S. C. 254b et seq) and the state. Commonly known as community health centers, these health centers provide primary health services to medically underserved populations. In calendar year 2002, the 30 federal grantees in Florida provided care to 501,193 patients, of whom 54.9 percent were uninsured and 24.6 percent were Medicaid patients. Seventy-six percent of the patients served during 2002 had incomes below 200 percent of the federal poverty level. Federal funds provided to the health centers do not flow through DOH or any other state agency, funds flow from the federal government directly to the community health centers.

DOH administers the Community Health Center Access Program Act (s. 409.91255, F.S.) passed by the Legislature in 2002 to provide state funding to provide comprehensive primary and preventive care services to uninsured populations in Florida. The program currently funds nine community health centers providing services to 35,000 persons through a combination of state, local and Medicaid dollars that total $4,868,549.

The bill permits CHDs and community health centers to treat non-emergency patients in conjunction with local hospital emergency room diversion programs. The bill requires DOH to include "urgent care" in an expansion program for community health centers and permits the centers to participate in community diversion programs.

C. SECTION DIRECTORY:

Section 1. Creates a popular name for this act as “The 2004 Affordable Health Care for Floridians Act.”

Section 2. Specifies the purpose of the act is to address lower health insurance premiums by mitigating overall health care costs.

Section 3. Amends s. 381.026, F.S., requiring certain licensed facilities to provide public Internet access to certain financial information; expanding the Florida Patient's Bill of Rights and Responsibilities to include a right to certain price and procedure comparison information.

Section 4. Amends s. 381.734, F.S., including participation by health care providers, small businesses, and health insurers in the Healthy Communities, Healthy People Program; requiring the Department of Health to provide public Internet access to certain public health programs; requiring the department to monitor and assess the effectiveness of such programs; requiring a report; requiring the Auditor General to investigate the effectiveness of such programs; requiring a report; requiring the department to develop certain community emergency room diversion programs; and authorizing the department to provide certain private sector incentives for certain purposes.

Section 5. Amends s. 395.1041, F.S., authorizing hospitals to develop certain emergency room diversion programs.

Section 6. Amends s. 395.301, F.S., requiring certain licensed facilities to provide public Internet access to certain financial information; and requiring certain licensed facilities to provide prospective patients certain estimates of charges for services.

Section 7. Amends s. 408.061, F.S., requiring the Agency for Health Care Administration to require health care facilities, health care providers, and health insurers to submit certain information; requiring health care facilities and health insurers to provide certain information quarterly; and deleting an onsite inspection authorization requirement.

Section 8. Amends s. 408.062, F.S., requiring the agency to conduct certain health care costs and access research, analyses, and studies; expanding the scope of such studies to include use of emergency departments and Internet patient charge information availability; requiring a report; and requiring the agency to conduct additional data-based studies and make recommendations to the Legislature.

Section 9. Amends s. 408.7056,F.S., renaming the Statewide Provider and Subscriber Assistance Program as the Subscriber Assistance Program; revising provisions to conform; expanding certain records availability provisions; revising membership provisions relating to a subscriber grievance hearing panel; and providing hearing procedures.

Section 10. Amends s. 641.3154, F.S., to conform to the renaming of the Subscriber Assistance Program.

Section 11. Amends s. 641.511, F.S., to conform to the renaming of the Subscriber Assistance Program; and adopting and incorporating by reference the Employee Retirement Income Security Act of 1974, as implemented by federal regulations.

Section 12. Amends s. 641.58, F.S., to conform to the renaming of the Subscriber Assistance Program;

Section 13. Amends s. 408.909, F.S., expanding a definition of "health flex plan entity" to include public-private partnerships; making a pilot health flex plan program apply permanently statewide; and providing additional program requirements.

Section 14. Creates s. 408.919, F.S., creating the Statewide Electronic Medical Records Advisory Council for certain purposes; requiring the agency to provide staff support; authorizing the agency to contract to assist the council in creating an electronic medical records system; providing for appointment of council members and meetings; providing responsibilities of the council; requiring an annual status report to the Governor and Legislature; specifying service without compensation; and providing for per diem and travel expenses; providing for future repeal.

Section 15. Creates the Statewide Evidenced-based Medicine Panel for certain purposes; requiring the Agency for Health Care Administration to provide staff support; authorizing the agency to contract to assist the panel in creating a statewide evidence-based medicine program; providing for appointment of panel members and meetings; providing responsibilities of the panel; requiring an annual status report to the Governor and Legislature; specifying service without compensation; providing for per diem and travel expenses; and providing for future abolition of the panel.

Section 16. Amends s. 409.91255, F.S., expanding assistance to certain health centers to include urgent care services.

Section 17. Amends s. 627.410, F.S., requiring insurers to file certain rates with the Office of Insurance Regulation.

Section 18. Amends s. 627.6487, F.S., creating a definition.

Section 19. Creates s. 627.64872, F.S., providing legislative intent; creating the Florida Health Insurance Plan for certain purposes; providing definitions; providing requirements for operation of the plan; providing for a board of directors; providing for appointment of members; providing for terms; specifying service without compensation; providing for travel and per diem expenses; requiring a plan of operation; providing requirements; providing for powers of the plan; requiring reports to the Governor and Legislature; providing certain immunity from liability for plan obligations; authorizing the board to provide for indemnification of certain costs; requiring an annually audited financial statement; providing for eligibility for coverage under the plan; providing criteria; requirements, and limitations; specifying certain activity as an unfair trade practice; providing for a plan administrator; providing criteria; providing requirements; providing term limits for the plan administrator; providing duties; providing for paying the administrator; providing for funding mechanisms of the plan; specifying benefits under the plan; providing criteria, requirements, and limitations; providing for nonduplication of benefits; providing for annual and maximum lifetime benefits; providing for tax exempt status; providing for abolition of the Florida Comprehensive Health Association upon implementation of the plan; providing for enrollment in the plan of persons enrolled in the association; requiring insurers to pay certain assessments to the board for certain purposes; and providing criteria, requirements, and limitations for such assessments.

Section 20. Provides for repeal of ss. 627.6488, 627.6489, 627.649, 627.6492, 627.6494, 627.6496, 627.6498, and 627.6499, F.S., relating to the Florida Comprehensive Health Association upon implementation of the plan.

Section 21. Amends s. 627.662, F.S., providing for application of certain claim payment methodologies to certain types of insurance.

Section 22. Amends s. 627.6699, F.S., revising provisions requiring small employer carriers to offer certain health benefit plans; requiring small employer carriers to file and provide coverage under certain high deductible plans; including high deductible plans under certain required plan provisions; creating the Small Employers Access Program; providing legislative intent; providing definitions; providing participation eligibility requirements and criteria; requiring the Office of Insurance Regulation to administer the program by selecting an insurer through competitive bidding; providing requirements; specifying insurer qualifications; providing duties of the insurer; providing a contract term; providing insurer reporting requirements; providing application requirements; providing for benefits under the

program; requiring the office to annually report to the Governor and Legislature; and authorizing health insurers to require higher copayments for certain uses of emergency departments.

Section 23. Amends s. 627.9175, F.S., requiring certain health insurers to annually report certain coverage information to the office; providing requirements; deleting certain reporting requirements.

Section 24. Amend s. 636.003, F.S., revising the definition of "prepaid limited health service organization" to exclude provision of discounted medical service programs;

Sections 25 and 26. Create ss. 627.6410 and 627.66912, F.S., requiring certain insurers to provide for additional coverage for certain additional disorders; providing for additional premiums; and providing limitations and exceptions.

Section 27. Amends s. 641.31, F.S., providing for application of certain claim payment methodologies to certain types of insurance; requiring health maintenance contracts to provide for additional coverage for certain additional disorders; providing for additional premiums; providing limitations and exceptions.

Section 28. Amends s. 626.015, F.S., defining an insurance advisor.

Sections 29 through 37. Amend ss. 626.016, 626.342, 626.536, 626.561, 626.572, and 626.601, F.S., to include application of such provisions to insurance advisors; providing penalties; and clarifying certain application requirements.

Section 38. Amends s. 626.6115, F.S., providing additional grounds for adverse actions against insurance agency licensure.

Sections 39 through 42. Amend ss. 624.509, 626.7845, 626.292, and 626.321, F.S.; correcting cross references; preserving certain rights to enrollment in certain health benefit coverage for certain groups under certain circumstances.

Section 43. Ensures open enrollment of health benefit coverage for groups of fewer than two employees, notwithstanding the amendment to s .627.6699 (5)(c), F.S.

Section 44. Repeals s. 408.02, F.S., relating to the development, endorsement, implementation, and evaluation of patient management practice parameters by the Agency for Health Care Administration.

Sections 45 and 46. Provide appropriations of $250,000 from the Insurance Regulatory Trust Fund for implementing provisions in this act related to the Small Business Health plan; and $2 million from general revenue for funding activities related to the Statewide Electronic Medical Records Advisory Council provided under s.408.919, F.S.

Section 47. Provides an effective date of October 1, 2004.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   Information not available at the time of the analysis.

2. Expenditures:

Fiscal Impact for Office of Insurance Regulation:

FISCAL IMPACT ON STATE AGENCIES:	(FY 04-05) Amount / FTE	(FY 05 06)* Amount / FTE	(FY 06-07)* Amount / FTE
Expenditures			
Recurring	$155,386.	$159,271	$163,253
Non-Recurring	$ 13,683		
Total	$169,069	$159,271	$163,253

Fiscal Impact for the Department of Health

	(FY 04-05)	(FY05-06)
Develop & Print Healthy Communities, Healthy People Annual Report	$ 5,000	$ 5,000
Total Estimated Expenditures	$ 5,000	$ 5,000

Fiscal Impact on the Agency for Health Care Administration

Total Revenues and Expenditures:

Sub-Total Non-Recurring Revenues	$2,000,000	$0
Sub-Total Recurring Revenues		$0
Total Revenues	$2,000,000	$0
Sub-Total Non-Recurring Expenditures	$2,520,984	$0
Sub-Total Recurring Expenditures	$2,628,839	$2,771,785
Total Expenditures 8.0 FTEs	$5,149,823	$2,771,785
Difference (Total Revenues minus Total Expenditures):	($3,149,823)	($2,771,785)
TOTAL FISCAL IMPACT:	**($3,316,094)**	**($2, 940,039)**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Carriers will incur modest costs associated with the development and filing of new forms associated with the mandated offer of additional coverages.

Carriers will incur certain costs associated with Florida Health Insurance Plan.
Significant costs are associated with achieving licensing and solvency requirements required of specified discount medical plans.

The opening of the Florida Health Insurance Plan is eventually opened to new enrollment, small businesses should experience modest declines in future premium increases.
One person groups would experience significant declines in medical premiums.
Uninsurable risks would find medical coverage available, potentially decreasing out of pocket expenditures for medical care.

Individuals and groups seeking coverage for speech, language, swallowing, and hearing disorders would find such coverage more readily available for an appropriate additional cost.

Small businesses and the uninsured may find affordable coverage through the expansion of Health Flex program or the creation of the Small Employers Access Program.

The bill has a significant impact on health care facilities and health care providers who are required to submit various new data elements to the Agency. Many of the requirements in this bill are designed to increase competition among health providers.
Florida's uninsured population, small employer groups, rural hospitals, and nursing home employees are expected to benefit from both the establishment of the Florida Health Insurance Plan and the establishment of Purchasing pools. Health care providers and consumers will benefit from the Statewide Electronic Medical Records Data System, and the proliferation of the use of Statewide Evidence-based Medicine.

This bill will increase consumer awareness regarding the cost of health care treatment in hospitals and to encourage comparison shopping. Employers and the general population may benefit from additional information about licensed hospital and ambulatory surgical center prices

D. FISCAL COMMENTS:

Comments provided by the Department of Health:

As required in Section 4 of the bill: The DOH does not currently publish an annual report on the Healthy Communities, Healthy People Program. Various individual program disease-specific reports and a biennial Chronic Disease Report are currently published. The Healthy Communities, Healthy People Program is comprised of several disease specific and community-based programs that develop reports based upon the requirements of the individual funding sources. The implementation of an annual report to be distributed to the Governor and Legislative staff that combines information from the various programs will require additional staff time and the resources to develop and print.

Comments provided by the Agency for Health Care Administration:

Funding of Expenditures Comments: Only the Statewide Electronic Medical Records Advisory Council Task is funded at $2.0 million for the first year. The total cost to the Agency is estimated at $3,149,823 for the first year and $2,771,785 for the second year.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill provides rulemaking authority to Office of Insurance Regulation, Department of Financial Services, Agency for Health Care Administration, and the Department of Health necessary to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The sponsor of the bill will offer a strike everything amendment that will changes most sections of this bill based on other bills currently sponsored in the House.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES