SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/CS/SB 2910

SPONSOR: Banking and Insurance Committee, Health, Aging, and Long-term Care Committee and Senator Peaden

SUBJECT: Affordable Health Care

DATE: April 1, 2004 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Harkey	Wilson	HC	Fav/CS
2.	Deffenbaugh	Deffenbaugh	BI	Fav/CS
3.			AHS	
4.			AP	
5.				
6.				

I. Summary:

CS for CS for SB 2910 includes the following provisions:

Availability of Health Information ("Transparency")

- Requires health care facilities not operated by the state to publish the average cost of the top 50 inpatient and top 50 outpatient services provided.
- Requires health care facilities to provide an estimate of charges for the proposed service upon request of a prospective patient who does not have insurance or whose insurer or HMO does not have a contract with the hospital and an emergency medical condition does not exist or the service is not a covered service.
- Requires health care facilities, providers, and health insurers to submit data to the Agency for Health Care Administration (AHCA) and for AHCA to make performance outcome and financial data available to consumers, including retail prices for the 50 most frequently prescribed medicines for licensed pharmacies, and outcome data for specified medical conditions and procedures.

Health Insurance

- Creates the Florida Health Insurance Plan as the high risk pool for uninsurable medical risks, to replace the Florida Comprehensive Health Association. The plan must be approved by the Financial Services Commission but the plan cannot be implemented until funds are appropriated for start-up costs and any projected deficits. No appropriations for this purpose are provided.
- Expands of the Health Flex Program statewide.

- Provides that policies for small employers with 26 to 50 employees would no longer be subject to the modified community rating requirements and the rates for such policies would not be required to be filed with or approved by the Office of Insurance Regulation.
- Deletes the requirement that small group carriers guaranty-issue policies to one-life groups if there is enrollment availability in the Florida Health Insurance Plan.
- Provides that an individual is not entitled to guaranteed issuance of an individual health insurance policy if that person is eligible for coverage under the Florida Health Insurance Plan and such plan is accepting new enrollment.
- Requires small group carriers to offer a high deductible plan that meets the federal requirements of a health savings account plan.
- Authorizes the Office of Insurance Regulation to select an insurer, through competitive bidding, to provide coverage to small employers with 25 or fewer employees within established geographical areas.
- Requires persons who provide access to any discounted medical services to be licensed by the Office of Insurance Regulation.
- Require health insurers to provide for a rebate of premiums when the majority of members of a health plan have maintained participation in a wellness program.

Patient Safety

- Creates the Florida Patient Safety Corporation to assist health care providers to improve the quality and safety of health care rendered and to reduce harm to patients.
- Requires the Patient Safety Center at the Florida State University College of Medicine to conduct a study on hospitals implementing computerized physician order entry and other information technologies related to patient safety.
- Requires patient safety officers and patient safety committees at licensed facilities to recommend improvements in the patient safety measures.
- Requires AHCA to develop and implement a strategy for the adoption and use of electronic health records.

Other

- Allows hospitals and federally quality health centers to develop emergency room diversion programs.
- Renames the Statewide Provider and Subscriber Assistance Program as the Subscriber Assistance Program, limits the program to hearing grievances filed by subscribers of managed care plans, requires managed care entities to provide internal grievance records, and provides greater flexibility in the composition of the panel.

Appropriations

- $350,000 in general revenue funds to AHCA for the establishment of the Florida Patient Safety Corporation.
- $113,500 in general revenue funds to the Florida State University College of Medicine for the purpose of conducting the study on hospitals implementing computerized physician order entry.
- $250,000 in general funds to the board of the Florida Health Insurance Plan to contract for an independent actuarial study.

- $2 million in general revenue to AHCA to implement a strategy for the adoption and use of electronic health records.
- $250,000 from the Insurance Regulatory Trust Fund to OIR to implement the provisions in this act relating to the Small Employer Access Program.

This bill amends the following sections of the Florida Statutes: 381.026, 381.734, 395.1012, 395.1041, 395.301, 408.05, 408.061, 408.062, 408.7056, 408.909, 409.9066, 409.91255, 641.31, 641.3154, 641.511, 641.54, 641.58, 627.410, 627.6487, 627.6499, 627.662, 627.6699, and 627.9175.

The bill creates the following sections of the Florida Statutes: 381.0271, 465.0244, 624.6405, 627.6402, 627.64872, and 627.65626, and creates parts I and II of ch. 636.

The bill repeals the following sections of the Florida Statutes: 408.02, 766.1016(3)

The bill repeals the following sections of the Florida Statutes upon implementation of the Florida Health Insurance Plan: 627.6488, 627.6489, 627.649, 627.6492, 627.6494, 627.6496, and 627.6498.

II. Present Situation:

Governor's Task Force on Access to Affordable Health Insurance

The Governor's Task force on Access to Affordable Health Insurance (Governor's Task Force) was created for the purpose of identifying factors that contribute to rising health care costs which prevent Floridians from obtaining health insurance coverage. A recent study by the Kaiser Family Foundation ranks Florida sixth in the nation in percent of population without health insurance coverage, with 18 percent of Floridians uninsured during 2001-2002. The Governor's Task Force was charged with recommending policies that will improve access to health insurance at affordable, predictable costs, while maintaining consumer choice. The Governor's Task force was co-chaired by Lieutenant Governor Toni Jennings and Chief Financial Officer Tom Gallagher and was comprised of 17 members representing business leaders, health policy experts, health care providers, consumers, and legislators.

The Governor's Task Force final report[1] contained numerous recommendations to improve Floridian's access to affordable health insurance, including:

Expanding the Health Flex Program statewide as a means of offering basic, lower-cost health care coverage to uninsured workers who have low incomes;
Establishing purchasing pools for small employers;
Creation of health plans for uninsurable and HIPAA-eligible individuals
Encouraging the use of evidence-based medicine; and
Encouraging the development of an electronic medical record that could be used statewide.

[1] Final Report of the Governor's Task Force on Access to Affordable Health Insurance. http://www.fdhc.state.fl.us/affordable_health_insurance/PDFs/task_force_report_021504_final.pdf

The House Select Committee on Affordable Health Care for Floridians was also appointed on August 14, 2003. After seven public hearings and three committee meetings, 88 policy options were examined and reviewed. The "Policy Options -- Pros and Cons" section of the report provides a narrative regarding each of the options. The committee narrowed the list of policy options from 88 to 13 that were recommended to the Speaker of the House.

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.

The structure of the Florida health coverage market and the regulations that govern its operations are based on health plan type and size. The types of health plans are generally categorized as self-insured plans, large group health plans, small group health plans, individual health plans, out-of-state group plans, and persons insured in the state's high-risk pool, the Florida Comprehensive Health Association.

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) preemption of state laws. As a result, less than 30 percent of Florida's population has health insurance that is governed by state insurance laws. In fact, of Florida's 16.1 million residents in 2002:

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

Consequences of Lack of Health Insurance

Uninsured patients are often reluctant to use health services, and therefore wait until there is a crisis. They receive fewer preventive services and less regular care for chronic disease.

Not only does the lack of insurance affect the health and well being of U.S. and Florida residents, but there is a 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 Social Services 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 funding 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.

Florida Comprehensive Health Association

Many states have created health insurance risk pools to address the needs of the under-insured and uninsured. High-risk pools provide a safety net for otherwise uninsurable individuals; however, they typically enroll a relatively small number of individuals. Reasons for low enrollment include: limited funding, lack of public awareness, and the relatively high expense.

As enacted under chs. 82-243 and 82-386, Laws of Florida, the Florida Comprehensive Health Association (FCHA)[2] provides health insurance to individuals who, due to their health status or inability to afford coverage, are unable to obtain health insurance coverage in the private market. Throughout the early years of the program, enrollment and insurance fund losses were low; however, by 1989, enrollment and losses had increased substantially. Legislation was enacted to prohibit the FCHA from issuing policies to new applicants after July 1, 1991.

The FCHA currently provides coverage for approximately 500 individuals. The FCHA Summary of Plan Activities for 2002 reports that the net loss for calendar year 2002 was $4.6 million, which resulted in an assessment against health insurers of about 0.03 percent of premiums written in Florida, which totaled about $13.9 billion. The $4.6 million net loss amounted to net loss per policyholder of $8,131. The FCHA states that the net loss per policyholder remains high due to the FCHA's shrinking population.

The following table from the FHCA Summary of Plan Activities for 2002 shows the net loss that was assessed against health insurers, the net loss per FCHA policyholder, and the net loss as a percentage of the total premium assessment base for the period 1991 - 2002:

[2] Originally termed the State Comprehensive Health Association.

FCHA Assessments (Net Loss) for 1991 - 2002

Year	Number of Policyholders at Year End	Net Loss	Assessment Base	Net Loss per FCHA Policyholder	Net Loss as a Percentage of Assessment Base
1991	4,832	$5.6 mil.	$5.565 bil.	$1.156	0.10%
1992	4,326	$7.1 mil.	$6.852 bil.	$1,650	0.10%
1993	3,476	$5.8 mil.	$7.186 bil.	$1,667	0.08%
1994	2,387	$11.8 mil.	$6.905 bil.	$4,950	0.17%
1995	1,689	$9.8 mil.	$7.836 bil.	$5,814	0.13%
1996	1,418,	$3.2 mil.	$8.238 bil.	$2,273	0.04%
1997	1,095	$1.9 mil.	$9.793 bil.	$1,767	0.02%
1998	916	$4.9 mil.	$9.793 bil.	$5,341	0.05%
1999	811	$4.0 mil.	$12.760 bil.	$4,957	0.03%
2000	709	$5.4 mil.	$11.497 bil.	$7,629	0.05%
2001	638	$7.7 mil.	$12.537 bil.	$12,109	0.06%
2002	571	$4.6 mil.	$13.866 bil.	$8,131	0.03%

The FCHA has not published an annual report for 2003, but the Office of Insurance Regulation reports that for 2003, the FCHA had a net loss of $2.89 million and that this was lower than prior years primarily as a result of some decreases in reserving. For cash flow purposes, the assessment will most likely be closer to $4.0 million.

In 2002, FHCA policyholders paid an average premium of $3,663 per policyholder. The average annual premium for FCHA policyholders who did not have Medicare was $4,872, while the average annual premium for FHCA policyholders who also had Medicare was $1.656. The $3,663 average premium in 2002 has remained relatively constant since 1991, when the average premium was $3,823.

In its 2002 FCHA Summary of Plan Activities, the Director of the Office of Insurance Regulation, who is the chair of the FHCA board, wrote that the revitalization of a stable high-risk health insurance pool would provide many benefits to the individual and small group markets, including: 1) easing the financial burden to carriers of providing mandatory coverage for those HIPAA eligible individuals with serious health problems; 2) removing incentives by medically uninsurable individuals to "game the market" and qualify for guaranteed-issue small-group coverage and that removing these risks would improve carrier loss ratios and improve rates for the rest of the small group market; and 3) providing an avenue of insurance for those individuals who cannot pass health underwriting in the individual market.

Effective July 1, 1990, the FCHA was amended to require the FCHA to pattern its coverage after the state group health insurance program including benefits, exclusions, and other limitations, except as otherwise provided by law. The major medical expense coverage under FCHA includes a $500,000 lifetime limit per covered life. The FCHA provides for an annual deductible in the amount of $1,000 or more, as approved by the Office of Insurance Regulation (OIR or Office). The FCHA provides for a 12-month exclusion of insurance coverage with respect to a condition

that manifested itself within 6 months of the effective date of the coverage or medical advice or treatment recommended or received within a period of 6 months before the effective date of the coverage.

A precondition for FCHA eligibility is that the applicant be rejected by at least 2 insurers offering coverage substantially similar to the FCHA's coverage and the market assistance plan has been unsuccessful in finding an insurer to accept the application. Rejection is defined as an offer of coverage with a material underwriting restriction or an offer of coverage at a rate greater than the FCHA's rate. Therefore, the rejection may or may not be due to a determination that an applicant is literally uninsurable.

Legislative changes in 1990 required the FCHA board or administrator to verify the residency of an applicant and to prohibit the enrollment of a person who is eligible for Medicaid, unless such person has an illness or disease that requires supplies or medication that are covered by the FCHA, but that are not covered by the Medicaid program; or the person is not receiving benefits under Medicaid. In addition, the law was clarified to allow FCHA to terminate an enrollee immediately if the enrollee ceases to meet the eligibility requirements.

The Office annually establishes the standard risk rate that is used for determining premiums for the FCHA under s. 627.6498(4)(a), F.S. Under s. 627.6675, F.S., the Office uses reasonable actuarial techniques and standards adopted by rule. As currently provided, the maximum rates for the FCHA are 200 percent, 225 percent, and 250 percent of this standard risk rate for low, medium, and high-risk individuals, respectively.

As a condition of doing business in Florida, health insurers are required to pay assessments to fund the deficits of the FCHA. Companies subject to the assessment include all health insurance companies, health maintenance organizations, fraternal benefit societies, multiple employer welfare arrangements, and prepaid health clinics. Self-funded employers and governmental entities are not subject to the assessment.

The board assesses each insurer annually a portion of incurred operating losses of the FCHA, based on the insurer's market share in Florida as measured by premium volume. The total of all assessments per participating insurer is capped at 1 percent of such insurer's health insurance premium earned in Florida during the calendar year proceeding the year for which the assessment is levied.

Guaranteed Availability of Individual Coverage under the Health Insurance Portability and Accountability Act

In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) which requires insurers issuing individual health insurance policies to guarantee the issuance of coverage to persons who previously were covered for at least 18 months with qualifying coverage and meet other eligibility criteria. The Act allows each state to craft alternative methods of guaranteeing availability of coverage. Each state must ensure that its provisions comport with HIPAA and do not diminish the federal requirements, but states may provide more favorable treatment for the individual.

In 1997, Florida enacted legislation to conform state law to HIPAA, which included an alternative mechanism that was deemed to be acceptable by the federal Health Care Finance Administration (HCFA). In order to be eligible for guaranteed-issuance of individual coverage under HIPAA and Florida's conforming legislation in s. 627.6487, F.S., an individual must have had prior creditable coverage for at least 18 months, without a break in coverage of more than 63 days, and not be eligible for any other group coverage, Medicare or Medicaid. Under federal law, the individual's most recent prior coverage must have been under a group plan, a governmental plan, or church plan. However, Florida has since expanded the eligibility criteria under state law to also include persons whose most recent coverage was under an individual plan that is terminated die to the insurer becoming insolvent or discontinuing the offering of individual coverage in the state, or due to the insured no longer living in the service area in Florida of the insurer.

The Florida law, in effect, provides two mechanisms for guaranteeing access to individual coverage. The first method is an individual conversion policy that must be offered by the insurer or HMO that issued the prior group coverage. The insurer or HMO must offer at least two conversion policy options, one being the standard benefit plan that small group carriers must to offer small employers. The maximum premium is limited to 200 percent of the standard risk rate, which is a statewide average rate computed annually by the Office of Insurance Regulation. If the individual is not eligible for a conversion policy issued pursuant to Florida requirements, the second method allows eligible individuals to purchase an individual policy from any insurance company or HMO issuing individual coverage in the state. This generally includes persons who were previously covered under a self-insured employer's plan or who move to Florida after terminating coverage from previous employment in another state. It also applies to persons whose previous coverage was under an individual plan that was terminated for specified reasons. The insurer or HMO must offer each of their two most popular policy forms, based on statewide premium volume. This is referred to as the federal fall back method, since it is the method that applies under HIPAA if a state fails to enact an alternative mechanism.

Florida's Patient's Bill of Rights

The Florida Patient's Bill of Rights and Responsibilities includes a listing of rights related to individual dignity, basic information rights, the right to grievances, the right to obtain information related to accepted payment by the facility, the right to be provided a reasonable estimate of the expected charges, the right to access to emergency care, and the right to know if the treatment is for the purpose of experimental research. In addition, the current statutes specify the responsibilities of a patient of a health care facility and or health care provider.

Health Flex Plan Pilot Program

The Health Flex Plan pilot program was created by the Florida Legislature during the 2002 Session. The pilot program permits entities to develop alternative health care coverage plans, referred to as health flex plans, for uninsured persons who have a family income equal to or less than 200 percent of the federal poverty level. The goal of the program is to improve the affordability and availability of heath care coverage for low-income Floridians who are unable to obtain health coverage, by encouraging the development of alternative approaches to traditional health insurance that still provide basic and preventative health care services.

A health flex plan is permitted to take measures that are impermissible for regular providers of health care coverage. The health flex plan may limit or exclude benefits that are otherwise required by law for insurers offering coverage in Florida (s. 408.909(3), F.S.). The plan may also cap the total amount of claims paid per year per enrollee, and may limit the number of enrollees (s. 408.909(3), F.S.).

A health flex plan may be developed and implemented by health insurers, HMOs, health care provider-sponsored organizations, local governments, heath care districts, or other community-based organizations (s. 408.909(2), F.S.). Current law specifies that the Agency must develop guidelines for reviewing health flex plan applications and must disapprove or withdraw approval of plans that do not meet minimum standards for quality of care and access to care. The Office must also develop guidelines for reviewing health flex plan applications and must disapprove or withdraw approval of plans that:

- Contain any ambiguous, inconsistent, or misleading provisions, or exceptions or conditions that deceptively affect or limit the benefits purported to be assumed in the general coverage provided by the plan;
- Provide benefits that are unreasonable in relation to the premium charged, contain provisions that are unfair or inequitable or contrary to the public policy of this state or that encourage misrepresentation, or result in unfair discrimination in sales practices; or
- Cannot demonstrate that the health flex plan is financially sound and that the applicant has the ability to underwrite or finance the benefits provided. (s. 408.909(3), F.S.)

The statute attempts to target the pilot programs in areas of the state that have the greatest number of the uninsured poor. The statute authorizes the Agency and the Office to approve health flex plans in the three areas of the state having the highest number of uninsured persons (s. 408.909(3), F.S.). These areas are in northern Florida (Escambia, Santa Rosa, Okaloosa, Walton, Holmes, Washington, Bay, Jackson, Calhoun, Gulf, Franklin, Liberty, Gadsden, Leon, Wakulla, Jefferson, Taylor, Hamilton, Suwannee, Lafayette, Dixie, Levy, Citrus, Sumter, Columbia, Baker, Union, Bradford, Putnam, Clay, Duval and Madison counties), south Florida (Miami-Dade and Broward county), and Hillsborough County. The statute also authorizes the issuance of health flex plans in Indian River County.

Eligibility to enroll in a health flex plan is limited to Florida residents who are under 65 years of age and have a family income equal to or less than 200 percent of the federal poverty level (s. 408.909(5), F.S.). The enrollee must not be covered by a private insurance policy, must not be eligible for coverage through a public health insurance program such as Medicare, Medicaid, or KidCare, and must not have been covered at any time during the past 6 months. The enrollee must also have applied for health care coverage through an approved plan and agree to make any payments required for participation, including periodic payments or payments due at the time health care services are provided.

The Agency must evaluate the pilot program and its effects on the entities that seek approval as health flex plans, as well as the number of enrollees and the scope of the coverage afforded (s. 408.909(9), F.S.). The Agency and the Office are mandated to assess the health flex plans and their potential applicability in other settings. The Agency and the Office submitted a report due

January 1, 2004, regarding the applicability of health flex programs to other areas of the state, to the Governor, President of the Senate, and Speaker of the House of Representatives. The report states that several health insurers and governmental entities in areas of the state currently not covered by the program have contacted the Agency to express interest in establishing health flex plans. Each approved health flex plan is required to maintain records of enrollment, finances, and claims experience to enable the Agency and the Office to monitor the plan (s. 408.909(6), F.S.). The statute authorizing the health flex pilot program was amended during the 2003 Session to extend the expiration date of the program from July 1, 2004 to July 1, 2008.

The Agency reports that, to date, three health flex plans have been approved. American Care, Inc., has created a plan in Dade County that covers outpatient services only, including many outpatient surgery components with substantial co-payments and limitations; the program had 130 enrollees as of November 2003. Preferred Medical Plan, Inc., which has operated as an HMO for a number of years in Florida, was approved to offer a health flex plan in Dade County that offers a primary care and outpatient benefit plan with limited drug coverage, along with preventive services such as immunizations and mammograms. On December 1, 2003, JaxCare (a public/private sector partnership) became the most recent health flex plan to be approved. The plan links community groups and providers with private sector providers to create a network across Duval County. The JaxCare plan was developed through the "Communities In Charge" grant initiative of The Robert Wood Johnson Foundation and the technological infrastructure for the plan was developed through grants from the Department of Health and Human Services. In addition to the already approved plans, local government in Miami-Dade County is currently developing a health flex plan to offer to uninsured workers.

Electronic Medical Records

An electronic medical record is a patient's medical record in a digital format that a physician could transmit electronically to a hospital, to another physician, or to the patient. While most business and governmental record-keeping has been stored and transmitted electronically for many years, medical records are still largely paper records.

In recent years, private and public sector policy leaders have called for electronic medical records in a standard format that could be transmitted among medical professionals. The Institute of Medicine (IOM) issued a report in November 2003,[3] calling for the development of a national health information infrastructure with targeted support from the federal government for its development. Such a federal initiative has been compared to the Hill-Burton Act that provided funds for the construction of community hospitals. The proposal could also be compared with the federal legislation that established the e-rate for schools and libraries to permit nationwide access to the Internet.

The Healthy Florida Foundation,[4] a group of diverse Florida organizations representing health care providers, insurers, organized labor, state government and community initiatives recommends encouraging development of electronic medical records through financial

[3] Institute of Medicine, Aspden, Philip, Corrigan, Janet M., Wolcott, Julie, and Erickson, Shari M., Eds. Patient Safety: Achieving a New Standard. The National Academies Press 2004. Readable at: http://books.nap.edu/catalog/10863.html
[4] http://www.healthyfloridafoundation.org/

incentives and the establishment of a universal electronic medical record system in Florida within 5 years that would permit caregivers and patients to share medical records and access clinical information.

The Governor's Task Force on Access to Affordable Health Insurance recommended that the state encourage the development of electronic medical records by providing financial incentives and promoting the use of digital technology and information systems, involving Florida's medical schools in that effort.

In July 2003, the U.S. Secretary of Health and Human Services (HHS) announced that the department had taken two steps in building a national health information infrastructure by arranging for: (1) the establishment of a standardized medical vocabulary system and (2) the design of a standardized model of an electronic health record.[5] Through an agreement with the College of American Pathologists, HHS will license the College's standardized medical vocabulary system and make it available at no cost. HHS also commissioned IOM to design a standardized model of an electronic health record. After the standardized model record is evaluated, HHS will make it available at no cost.

Patient Safety Authority

As the 2003 Legislature addressed Florida's medical malpractice insurance crisis, the reduction of medical errors received renewed attention as one method of lowering the number of malpractice claims. A review of professional liability closed-claims data for the period 1990 – 2002 revealed that, in each of those years, more than 60 percent of indemnity claims paid in Florida were for injuries that occurred in the hospital setting.

In 1999, the Institute of Medicine reported that at least 44,000, and perhaps as many as 98,000, American hospital patients die each year as a result of medical error. The Governor's Select Task Force on Healthcare Professional Liability Insurance made 12 recommendations to improve health care quality in its January 2003 report, including the following two recommendations:

1. The Legislature should establish a Patient Safety Authority, or an entity similar in concept, as both a short-term and long-term strategy to improve patient safety. There are two options that should be considered. The first option, which is recommended by the Institute of Medicine (IOM) is to have two systems, one for the mandatory reporting of adverse events and another system for the voluntary reporting of near misses. The second option is similar to the Patient Safety Authority established and existing in Pennsylvania, which analyzes all adverse events and near misses in that state. Experts employed by both systems would analyze data received and make recommendations about how to reduce these adverse events and near misses. Information would not be subject to discovery in lawsuits.

2. The Legislature should timely develop or adopt statewide electronic medical records and protocols for a physician medication ordering system. The system should be developed collaboratively with hospitals, physicians, and other health care providers.

[5] http://www.os.dhhs.gov/news/press/2003pres/20030701.html

> The physician medication ordering system should be implemented first. The system could be implemented initially with a web-based data exchange platform which establishes interconnectivity among providers. Another possibility is to begin with business functions, which provide an early return on investment, and then include clinical functions.

The Governor's Task Force also recommended that the Legislature consider creating a statutory public-private non-profit entity that would administer the Patient Safety Authority.

During the 2003 Legislative Session and several subsequent special sessions, the Legislature addressed the issue of medical malpractice insurance and called for initiatives to improve patient safety as an essential part of reducing incidents of medical malpractice. In SB 2-D, the Legislature required AHCA, in consultation with DOH and existing patient safety centers in the state universities, to study the implementation requirements of establishing a statewide Patient Safety Authority. The authority would be responsible for performing activities and functions designed to improve patient safety and the quality of care delivered by health care facilities and health care practitioners. In undertaking the study, the agency was directed to examine and evaluate a Patient Safety Authority that would, either directly, by contract, or through a consortium of university-based patient safety centers collect, analyze and evaluate patient safety data, foster the development of a statewide electronic infrastructure, inventory hospitals regarding use of computerized physician order entry systems, identify best practices, provide continuing education, and other specified tasks to improve health care quality.

The bill required that AHCA, in evaluating the operation of a Patient Safety Authority, must determine the costs of implementing and administering an authority and suggest funding sources and mechanisms. The report was produced by AHCA through a contract with the University of Miami Center for Patient Safety. The report contained the following recommendations:

- The Florida state legislature should establish and endow "A Learning Institute" to advise and foster improvements in patient safety, to be called the Florida Patient Safety Authority (PSA).
- The PSA should be a public-private partnership organized as a nonprofit corporation registered, incorporated, organized, and operated in compliance with ch. 617, F.S., and shall have all powers necessary to carry out the purposes of this section, including, but not limited to, the power to receive and accept from any source contributions of money, property, labor, or any other thing of value.
- The PSA should be given access to closed claims data from all insurance companies, self-insurance companies, professional liability carriers, as well as similar information from the trial bar. It should also be given the ability to seek to obtain access to expert witness reports, post litigation, as well as public and secured private records in the possession of regulators in order to allow full and effective usage of all adverse patient data collected in the state of Florida.
- The Florida state legislature should create a Patient Safety Advisory Board which will include representatives of all Florida academic medical centers, insurers (both indemnity plans such as Blue Cross, and HMOs), and consumer representatives in order to assure the Patient Safety Authority remains adherent to the highest standards of "evidence based" practice and emerging science. The report recommended 11 members.

- The PSA should collect patient safety data submitted voluntarily by a health care practitioner or health care facility, as well as data submitted to the state regulatory agencies, for learning purposes.
- The PSA should analyze the data and determine changes in practices and procedures that may be implemented for the purpose of improving patient safety and preventing patient harm events.
- The PSA should maintain and share a clearinghouse of "best practices" in the areas of quality improvement and patient safety and provide technical assistance to hospitals and other health care providers in the areas of health care quality improvement and patient safety.
- The PSA should disseminate all knowledge acquired via website, newsletter and email blasts.
- The PSA mandate will include procedures that ensure privacy and confidentiality of data in full accordance with the Health Insurance Portability and Accountability Act and consistent with other state and federal laws.
- The PSA should receive state funding and coordinate contracts with providers to increase access to various simulation resources for use by hospitals, universities and other providers.
- The PSA will hold an annual Patient Safety Conference, as an opportunity for stakeholders to share lessons learned on patient safety issues.

Computerized Physician Order Entry Systems

Computerized physician order entry systems are a tool that can be used to reduce medical errors and improve patient care by permitting the direct entry into a computer of orders for diagnostic tests, medications, patient care and referrals by physicians. The basic CPOE system is a computer application that accepts physician orders electronically, replacing hand-written orders on an order sheet or prescription pad. Most CPOE systems communicate the orders entered into the system electronically to the hospital departments and personnel responsible for their execution. The departments or personnel can send back notification of the status of the order or the results, such as laboratory or x-ray results.

The Leapfrog Group, comprised of 145 public and private organizations that provide health care benefits, is a leader in establishing a national emphasis on patient safety. The group identifies problems and proposes to hospitals solutions that have the potential to save lives. The Leapfrog Group has recently focused on three practices that likely would improve patient safety, computerized physician order entry (CPOE) for filling prescriptions, evidenced-based hospital referral, and intensive care unit physician staffing. The Leapfrog Group recommends using CPOE for medication orders because a computerized prescription system "can reduce serious medication mistakes by up to 86 percent."[6]

The Patient Safety Center at the Florida State University College of Medicine is conducting a study of the Information Technology (IT) capabilities of Florida Hospitals. Preliminary results have been obtained from a survey conducted during the summer and fall of 2003, with 40

[6] Leapfrog Group. "Survey Results". http://www.leapfroggroup.org/consumer_intro2.htm

percent of hospitals responding. See the Senate Staff analysis to CS/CS/SB 1474 for the results of this survey and additional information on Computerized physician order entry,

The 2003 Legislature created s. 395.1012, F.S., to require each licensed hospital, ambulatory surgical center, and mobile surgical facility to adopt a patient safety plan and appoint a patient safety officer and a patient safety committee. The purpose of the patient safety officer and the patient safety committee is to promote the health and safety of patients, review and evaluate the quality of patient safety measures used by the facility, and assist in the implementation of the facility's patient safety plan.

Patient Safety Data

Section 766.1016, F.S., which was created as section 10 of CS/SB 2-D (2003), provides that patient safety data, as defined in this section, shall not be subject to discovery or introduction into evidence in any civil or administrative action. However, information, documents, or records otherwise available from original sources are not immune from discovery or use in any civil or administrative action merely because they were also collected, analyzed, or presented to a patient safety organization.

Patient safety data is defined to mean reports made to patient safety organizations, including all health care data, interviews, memoranda, analyses, root cause analyses, products of quality assurance or quality improvement processes, corrective action plans information collected or created by a health care facility licensed under ch. 395, F.S., or a health care practitioner as defined in s. 456.001(4), F.S., as a result of an occurrence related to the provision of health care services which exacerbates an existing medical condition or could result in injury, illness, or death.

Patient safety organization is defined to mean any organization, group, or other entity that collects and analyzes patient safety data for the purpose of improving patient safety and health care outcomes and that is independent and not under the control of the entity that reports patient safety data.

Section 766.1016(3), F.S., requires that, unless otherwise provided by law, a patient safety organization must promptly remove all patient-identifying information after receipt of a complete patient safety data report unless such organization is otherwise permitted by state or federal law to maintain such information. Patient safety organizations must maintain the confidentiality of all patient-identifying information and may not disseminate such information, except as permitted by stat or federal law.

Centers for Patient Safety
Florida has three university-based patient safety centers, all created in the past two years:

- In 2001, the Suncoast Developmental Center for Patient Safety Evaluation and Research, a national patient safety center, was created at the University of South Florida with funding from the Federal Agency for Healthcare Research and Quality. The Suncoast center works in partnership with the Veteran's Administration Patient Safety Center of Inquiry at James A. Haley V.A. Hospital, with other local and regional health care

providers, with the patient safety centers at Florida State University and the University of Miami and with the college of Pharmacy at Florida Agricultural and Mechanical University.

- In 2002, the Florida State University College of Medicine established the Center on Patient Safety to promote and conduct research and education designed to reduce medical errors and increase healthcare quality. In 2003, the center conducted a survey of the information technology capabilities of Florida's hospitals relating to patient safety.
- In 2003, the Center for Patient Safety was established at the University of Miami. As the recipient of a grant from the Agency for Health Care Administration to conduct patient safety studies mandated by the 2003 Legislature in CS/SB 2-D, the center provided reports to the Legislature in February 2004, on the establishment of a statewide patient safety authority and on the most feasible information to provide to consumers comparing in-patient quality indicators for state licensed hospitals.

Senate Interim Project Report 2004-143

Senate Interim Project 2004-143 analyzed the use of CPOE systems in hospitals as a tool for reducing medical errors. The report concluded that:

- The history of the use of information technology in clinical practice by physicians and hospitals does not indicate that progress can be mandated.
- The implementation of CPOE has been successful where administrators and practitioners supported the change.
- The best way to bring about further use of CPOE in Florida would be for the Legislature to encourage the state's existing patient safety centers at universities to work with hospitals to improve their use of information technology to improve patient safety.
- Florida's university-based patient safety centers should analyze the return on investment that could be realized from implementing CPOE in large and small hospitals in both urban and rural settings.

Each hospital's patient safety officer, required under s. 395.1012, F.S., should identify ways that inpatient care processes that affect physicians, pharmacists, nurses, and ancillary personnel could be redesigned for implementation of CPOE.

Former Community Health Purchasing Alliances and Current Small Employer Health Alliances

In 1993, the Florida Legislature established Community Health Purchasing Alliances (CHPAs) as state chartered, nonprofit private organizations, intended to pool purchasers of health care together in organizations that broker health plans.[7] The number of persons insured through CHPAs steadily decreased from about 94,000 at the end of 1998 to about 35,000 in February 2000. Only seven insurance carriers were currently actively participating in CHPAs in 2000, as compared to 25 carriers that participated in 1998. CHPAs made health insurance plans available to small employers with1 to 50 employees, including sole proprietors and self-employed individuals. The Agency for Health Care Administration (AHCA) was responsible for

[7] Chapter 93-129, Laws of Florida, codified as ss. 408.70-408.706, F.S. (1993)

implementation and oversight of the statewide system of CHPAs, including technical and legal assistance, liaison functions, and designation of "accountable health partnerships" (AHPs), which were authorized insurers and HMOs that offered health plans through CHPAs.

The law created eleven CHPAs, which was eventually reduced to seven due to merger of certain districts. Each CHPA operated under the direction of an appointed 17 member board of directors and employed an executive director and from one to three full time staff. All but one contracted with a third party administrator. CHPAs acted as clearing houses for health insurance plans that qualified as AHPs, and choosing AHPs via requests for proposals. The CHPAs offered several benefit plans from which small employers and employees could select, which were sold through authorized insurance agents.

The legislative Office of Program Policy Analysis and Government Accountability (OPPAGA) issued its report, The Follow Up Report on the Status of Community Health Purchasing Alliances in Florida, Report No. 98 14, October 1998. The report stated that the CHPAs continued to have a small impact in reducing the number of uninsured Floridians. Limitations cited in the report included:

- The CHPAs inability to negotiate or select health plans that offer the most competitive products and prices; and
- The CHPAs dependence on agents designated by health plans to sell CHPA products, and to further improve access to affordable health care coverage.

The OPPAGA report recommended that the Legislature should consider the following policy options, including:

- Allow CHPAs to negotiate with competing health plans and select those that offer the most competitive products and prices.
- Reduce AHCA's responsibilities to minimal oversight and coordination among CHPAs.
- Enable CHPAs to appoint their agents.

In 2000, the Legislature repealed the laws that established the CHPAs (ch. 2000-296, L.O.F.). In its place, the act amended s. 627.654, F.S., to authorize a health insurer to issue a group policy to a small employer health alliance organized as a not-for-profit corporation under ch. 617, F.S. This included former CHPAs that continued to operate as a not-for-profit corporation, or any other alliance so organized. The alliance may be formed for purposes of obtaining insurance. The group policy issued to the alliance may insure a small employer with 1 to 50 employees, including sole proprietors and self-employed individuals, and may cover dependents. The 2000 law amended s. 627.6699, F.S., to: (1) allow rates for a policy issued to an alliance or association to reflect a premium credit for expense savings attributable to administrative activities being performed by the group association; and (2) allow an insurer to 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. According to the Office of Insurance Regulation, there was one small employer health alliance established, but that it never generated any significant enrollment and has been discontinued.

Statewide Provider and Subscriber Assistance Program

Section 408.7056, F.S., requires the Agency for Health Care Administration (AHCA) to implement the Statewide Provider and Subscriber Assistance Program to assist subscribers of managed care entities with grievances that have not been satisfactorily resolved through the managed care entity's internal grievance process. The program can hear grievances of subscribers of health maintenance organizations, prepaid health clinics and exclusive provider organizations. According to AHCA, the program title, "The Statewide Provider and Subscriber Assistance Program," is misleading and causes confusion to a large number of contracted and non-contracted managed health care providers who believe, incorrectly, that the panel can resolve their billing problems. Section 408.7057, F.S., establishes the Statewide Provider and Health Plan Claim Dispute Resolution Program in AHCA for the purpose of resolving billing problems.

Currently, managed health care entities and health care providers are required to submit medical records to the program upon request when the program is investigating a grievance between a subscriber and a managed care entity. Failure to provide medical records within 10 days of the request may subject the entity or provider to fines. It may not be clear whether the "medical records" that must be submitted include records associated with the grievance, such as telephone logs and internal communications, but such records are often requested by ACHA. In FY 2002-2003, 46 percent of all submissions of records other than medical records to the program were in excess of the 10 days permitted for the filing of medical records. According to representatives with AHCA, this significantly slows down the review process.

State and Federal Claims Procedures

State and federal claims procedures for health maintenance organizations (HMOs) differ significantly, and the federal procedures may preempt the current state statutes that are less restrictive. Under current Florida law, s. 641.511(5), F.S., HMOs must resolve subscriber grievances within 60 days after receipt of the grievance, or within a maximum of 90 days if the grievance involves the collection of information outside the service area.

The federal regulations, 29 C.F.R. 2560.503-1, effective to all ERISA-covered HMOs by January 1, 2002, are more restrictive and break down grievance procedures into two distinct categories, pre-service and post-service claims. Pre-service claims must be processed and a decision provided by the health plan within 15 days of receipt, plus a 15-day extension when a plan member receives a bona fide reason for extension. Post-service claims must be processed within 30 days with an additional 15-day authorized extension when the health plan has justified the extension in writing and notified the member.

A United States Department of Labor interpretive guideline addresses the "federal preemption" language of the final federal regulation and says, "States may impose non-conflicting standards for internal processes." (Paragraph 29, C.F.R. 2560.503-1(k)(1)). Under this interpretive guideline, states having less restrictive claims/grievance procedures for small and large group health plans may be in conflict with the federal standards and thereby preempted by federal law. Florida's grievance resolution time lines are less restrictive than the federal regulation and may be preempted.

III. Effect of Proposed Changes:

The bill makes Legislative findings ("Whereas" clauses) that identify statistics of the number of persons who are uninsured, reasons for persons not having insurance, average premium increases for the last two years, employers shifting premium costs to employees, increased health costs and health problems for the uninsured, the cost of uncompensated care to hospitals, the need for lower cost alternatives, and that the issue of available, affordable health care insurance be addressed in a meaningful manner.

Section 1 provides that the act may be referred to as "The 2004 Affordable Health Care for Floridians Act,"

Section 2 states the purpose of the act is to address the underlying cause of the double-digit increases in health insurance premiums by mitigating the overall growth in health care costs.

Section 3 amends s. 381.026, F.S., requires each licensed facility[8] (hospitals, ambulatory surgical centers and mobile surgical facilities) not operated by the state, to publish on its website the average cost of the top 50 inpatient and top 50 outpatient services provided. This must be the "package price" for all facility-related charges for all services typically associated with a procedure or diagnosis-related group. The facility must place a notice in the reception areas that such information is available on its website.

The section being amended currently requires health care providers and facilities to provide a patient an estimate of charges upon request; to disclose whether the provider or facility accepts Medicare assignment as payment in full; and to provide a patient an itemized bill and explanation of charges. However, this chapter (Public Health; General Provisions) does not contain any clear penalty or enforcement authority. The bill provides that failure to provide data upon request as required by this paragraph shall result in a fine of $500 for each instance of the facility's failure to provide the requested information. Presumably, this fine would be imposed by the Agency for Health Care Administration, which licenses facilities under ch. 395, F.S.

Section 4 amend s. 381.734, F.S., to require the Department of Health to provide on its website and a copy upon request a listing of the wellness programs that it offers and provide information to identify behavior risk factors that lead to preventable diseases. The department must monitor and assess the effectiveness of such programs and submit a status report to the Legislature, and the Office of Program Policy and Government Accountability must evaluate and report on the effectiveness of the Department's assessment.

Section 5 amends s. 395.1041, F.S., to allow hospitals to develop emergency room diversion programs, including an "Emergency Hotline" to help patients determine if emergency services are appropriate or if other health care settings may be more appropriate and a "Fast Track" program allowing nonemergency patients to be treated at an alternative site.

[8] Section 381.026(2)(b), F.S., defines *health care facility* as a facility licensed under chapter 395, F.S., which includes hospitals, ambulatory surgical centers, and mobile surgical facilities.

Section 6 amends s. 395.301, F.S., to require hospitals and other licensed facilities to provide an estimate of charges for the proposed service upon request of a prospective patient who does not have insurance or whose insurer or HMO does not have a contract with the hospital and an emergency medical condition does not exist or the service is not a covered service. The estimate may be the average charges for the procedure or diagnosis-related group. The actual charge may exceed the estimate.

This section also requires each licensed facility to make available on its website a link to the performance outcome and financial data that is published by AHCA.

Section 7 amends s. 408.061, F.S., to require AHCA to require health care facilities, health care providers, and health insurers to submit certain information. Health care facilities must report data on the number of patients treated in the emergency department by acuity level, hospital-acquired infections, complications of diagnosis, and readmissions. ACHA must adopt a specified methodology (3M All Patient Refined DRG software) for reporting date regarding risk and severity adjustment.

Health insurers must report percentage of claims denied, percentage of claims meeting prompt pay requirements, and medical and administrative loss ratios.

Section 8 amends s. 408.062, F.S., requires AHCA to:

- collect and report a statistically valid sample of data on retail prices charged by pharmacies for the 50 most frequently prescribed medicines for licensed pharmacies to provide comparative information;
- research and report on the use of emergency services by patient acuity level;
- make available on its website information regarding patient charges, volumes, length of stay, and performance outcome data collected from heath care facilities for specified medical conditions and procedures;
- develop and implement a strategy for the adoption and use of electronic health records (for which the bill appropriates $2 million).

Section 9 amends s. 408.05, F.S., to require AHCA to develop, in conjunction with the State Comprehensive Health Information System Advisory Council, and implement a plan to make performance outcome and financial data available to consumers for health care services comparison purposes, including information on pharmaceuticals, physicians, health care facilities, and health plans. The plan must be submitted to the Governor and Legislature and updated annually.

Section 10 amends s. 409.9066, F.S., to require AHCA to provide retail price information by geographic area relating to the Medicare prescription discount program.

Section 11 amend s. 408.7056, F.S., to rename the Statewide Provider and Subscriber Assistance Program as the Subscriber Assistance Program, and limits the program to hearing grievances filed by subscribers of managed care plans, deleting references to hearing grievances filed by providers (for which a separate dispute resolution program exists).

The bill specifies that when AHCA is investigating a grievance, the managed care entity or health care provider must submit records associated with the grievance, as well as the medical records that are currently required. Officials of AHCA state that this will help speed up the review process.

The bill provides greater flexibility in the composition of the Subscriber Assistance Panel by permitting *at least* two members employed by AHCA, *at least* two members employed by the Department of Financial Services, a consumer and a physician appointed by the Governor, and *if necessary*, physicians who have expertise relevant to the case to be heard. The current authorization for the panel to contract with a medical director and a primary care physician to provide additional medical expertise is modified to authorize *a medical director, a primary care physician, or both*, and the bill specifies that they must not be voting members of the panel. The bill defines a quorum as a majority of the required membership and requires the presence of a quorum before the panel can hear a grievance. The maximum size of the panel will be 11 members.

Section 12 amends s 641.3154, F.S., to conform the renaming of the Statewide Provider and Subscriber Assistance Program as the Subscriber Assistance Program.

Section 13 amends s. 641.511, F.S., to adopt federal claims procedures established under the Employee Retirement Income Security Act as the minimum standards for grievance procedures (described in Present Situation, above) for certain organizations that administer group health plans. Incorporating the federal standards in this statute would give the state regulatory agencies, AHCA and the Department of Financial Services, the authority to enforce such federal standards.

Section 14 amends s 641.58, F.S., to conform the renaming of the Statewide Provider and Subscriber Assistance Program as the Subscriber Assistance Program.

Section 15 amends s. 408.909, F.S., related to Health Flex Plans, to:

- allow Health Flex Plans to be established statewide (as approved by AHCA and the Office of Insurance Regulation), rather than being limited to the three geographic areas of this state with the highest number of uninsured;
- deletes a reference to the program as a "pilot" program (but does not change the July 1, 2008 expiration of the statute);
- requires AHCA to ensure that health flex plans follow standardized grievance procedures similar to those required of HMOs;
- requires OIR to provide regulatory oversight of health flex plan advertising and marketing procedures;
- requires AHCA and OIR to use health flex plans to gather information to evaluate low-income, consumer driven benefit packages and submit a report that includes this information;
- includes public-private partnerships within the definition of a "health flex plan entity";
- allows the offering of a catastrophic plan option supplementing the health flex plan.

Section 16 creates s. 381.0271, F.S., to create the Florida Patient Safety Corporation to assist health care providers to improve the quality and safety of health care rendered and to reduce harm to patients.

The bill requires the Florida Patient Safety Corporation to be registered, incorporated, organized and operated as a non-profit corporation in compliance with ch. 617, F.S. The corporation may create not-for-profit subsidiaries. The corporation is subject to public meetings and records requirements; is not an agency within the meaning of s. 20.03(11), F.S.; and is not subject to the provisions of ch. 297, F.S., relating to procurement of personal property and services. The bill establishes the membership of the board of directors of the corporation; requires certain advisory committees for the corporation; and requires AHCA to provide assistance in getting the corporation established. The bill specifies the powers and duties of the corporation; requires an annual report; and requires the Office of Program Policy Analysis and Government Accountability in consultation with AHCA and the Department of Health, to develop performance measures for the corporation. The bill requires a performance audit of the corporation during 2006.

The bill requires the corporation to collect, analyze, and evaluate patient safety data and related information; requires the corporation to establish a pilot project to identify and report near misses relating to patient safety; provides for an active library of evidence-based medicine and patient safety practices; requires the corporation to develop and recommend core competencies in patient safety and public education programs; and authorizes the corporation to seek funding and apply for grants.

Section 17 requires the Patient Safety Center at the Florida State University College of Medicine, in collaboration with researchers at other state universities, to conduct a study t to analyze the return on investment that hospitals could realize from implementing computerized physician order entry and other information technologies related to patient safety. The analysis must include both financial results and benefits relating to quality of care and patient safety. The study must include a representative sample of large and small hospitals, in urban and rural settings, in the north, central and southern regions of the state. By February 1, 2005, the Patient Safety Center at the Florida State University College of Medicine must submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives concerning the results of the study.

Section 18 amends s. 395.1012, F.S., to require each patient safety officer and patient safety committee at a licensed hospital, ambulatory surgical facility, or mobile surgical facility to recommend improvements in the patient safety measures used by the facility. Each licensed facility must adopt a plan to reduce medication errors and adverse drug events that must consider the use of computerized physician order entry and other information technologies related to patient safety.

Section 19 amends s. 409.91255, F.S., to expand the requirements of federally quality health centers to include community emergency room diversion programs and urgent care services.

Section 20 amends s. 627.410, F.S., to exempt from rate filing and approval requirements group health insurance policies insuring groups of 26 or more persons. This expands the current

exemption from rate regulation for group policies insuring 51 or more persons. This provision is tied to the bill's amendment to s. 627.6699, F.S., below, which limits the application of the modified community rating requirements to small employer polices covering 2 to 25 employees, rather than 2 to 50 employees.

The bill also corrects technical error in current law (to change *order* to *office* to clarify that insurers must file certain rates with the Office of Insurance Regulation.

Section 21 amends s. 624.6405, F.S., to require health insurers selling individual health insurance policies to provide on their websites information regarding appropriate utilization of emergency care services which shall include a list of alternative urgent care contracted providers. It requires health insurers to develop community emergency department diversion programs, by enlisting providers to be on call after hours, and allows health insurers to require higher copayments for nonemergency use of emergency departments and for use of out-of-network emergency departments.

Section 22 amends s. 627.6487, F.S., to revise eligibility for guaranteed issuance of individual coverage to provide that an individual who is otherwise eligible (generally, those persons who lose eligibility for group coverage after being covered for at least 18 months) are not entitled to guaranteed issuance of an individual health insurance policy if that person is eligible for coverage under the Florida Health Insurance Plan and such plan is accepting new enrollment. This is the new high-risk pool created by Section 23, below.

This provision may not conform to federal HIPAA requirements. (See discussion of HIPAA in Present Situation.) For one reason, the eligibility criteria for the Florida Health Insurance Plan in Section 23, below, do not expressly include persons who are eligible individuals under s. 627.6487. To be eligible for the Florida Health Insurance Plan, an individual must document at least two notices of rejection or refusal to issue substantially similar insurance for health reasons.

Section 23 creates s. 627.64872, F.S., to create the Florida Health Insurance Plan as a plan to assume risks deemed uninsurable by the private market and to make coverage available to individuals who have no other option for similar coverage. The plan is intended to operate on sound actuarial principles but may include supplementary funding.

This section takes effect upon becoming law, which allows for the board to be appointed as soon as feasible. The board must submit to the Financial Services Commission a plan of operation that becomes effective upon approval in writing, consistent with the date on which the coverage must be made available. However, the bill also provides that the board shall take no action to implement the plan, other than completion of an actuarial study, until funds are appropriated for start-up costs and any projected deficits.

Board of Governors: A 9-member Board of Directors will supervise the plan, chaired by the Director of OIR, plus five members appointed by the Governor, one member appointed by the Chief Financial Officer, one member by the Senate President, and one by the Speaker of the House of Representatives. The initial meeting of the board must occur no later than September 1, 2004. At least 3 of the Governor's 5 appointees may not be individuals who are representatives of insurers or health care providers. The bill provides for staggered terms and specifies that board

members will not be compensated, except for reimbursement for reasonable expenses in accordance with s. 112.061, F.S.

Plan of Operation: The board must submit a plan of operation to the Financial Services Commission, effective upon approval of the commission. By December 1, 2004, the board must submit an actuarial study to determine the impact the creation of the plan will have on the small group market, the number of individuals the pool could reasonably cover at various funding levels, and a recommendation as to the best source o funding for anticipated deficits. The plan of operation must ensure that the plan qualifies for any available federal funding. If the board fails to submit a suitable plan of operation within 180 days after the appointment of the board, the Commission must adopt rules to implement the Florida Health Insurance Plan.

Eligibility for coverage: Individuals who are a resident of Florida for at least 6 months are eligible for coverage if evidence is provided that:

- the person received "at least two notices of rejection or refusal to issue substantially similar insurance for health reasons by one insurer" or
- the person is enrolled in the Florida Comprehensive Health Association as of the date the plan is implemented.

It appears that the language in the first bullet, above, incorrectly refers to "one insurer" and should have referred to two different insurers. Also, the 6-month residency requirement does not apply to a resident deemed eligible under federal HIPAA (but the bill does not otherwise expressly authorize HIPAA-eligible individuals to be eligible for coverage under the plan, without obtaining the two rejections of coverage).

Persons are not eligible for the plan if they are eligible for health insurance coverage that is substantially similar or more comprehensive, or eligible for Medicaid, Medicare, the state's children's health insurance program, or any other federal, state, or local government program that provides health benefits.

Benefits: The plan must offer the standard and basic benefit plans required to be offered to small employers and an option of alternative coverage such as catastrophic coverage with a minimum level of primary care coverage and a high deductible plan that meets the federal requirements of a health savings account. The board would establish the maximum benefits under the plan. Benefits previously paid to persons by the Florida Comprehensive Health Association must be used in determining the total lifetime benefits paid under the plan.

Funding: Funding of the high risk pool is provided premiums capped at 200% of standard risk rate, subject to a sliding scale surcharge based on the insured's income, but not to exceed 300 percent of the standard risk rate. Additional revenue for any deficit shall be primarily funded through amounts appropriated by the Legislature from general revenue sources, including a portion of the annual growth in premium taxes. The board must operate the plan so that the estimated cost will not exceed total income and to limit plan enrollment accordingly.

Upon the implementation of the FHIP, all high-risk individuals actively enrolled in the Florida Comprehensive Health Association shall be enrolled in the FHIP. For such individuals, for

operating losses incurred on or after July 1, 2004, each insurer shall be annually assessed up to 1 percent of premiums.

Powers of the plan: The plan will have the general powers and authority granted to health insurers under state law, and in addition thereto, the specific authority to enter into contracts; take legal actions for specified purposes; establish and modify rates, agents' referral fees, claim reserve formulas, and any other actuarial functions appropriate to the operation of the plan; issue policies of insurance; appoint legal, actuarial, investment, and other committees; develop and educate its policyholders regarding health savings accounts (HSAs), policy and contract design, and any other function within the authority of the plan; borrow money to effect the purposes of the plan; employ and fix the compensation of employees; prepare and distribute certificate of eligibility forms and enrollment instruction forms to insurance producers and to the general public; provide for reinsurance of risks incurred by the plan; provide for and employ cost containment measures and requirements, including, but not limited to, preadmission screening, second surgical opinion, concurrent utilization review, and individual case management for the purpose of making the plan more cost effective; and arrange for the delivery of cost effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations, and other limited network provider arrangements.

The board must select, through a competitive bidding process, a plan administrator to administer the plan. The bill establishes criteria for the board to consider in evaluating bids. The administrator shall be either an insurer, a health maintenance organization or a third-party administrator, or another organization duly authorized under the Florida Insurance Code.

The board must make an annual report to the Governor and Legislative presiding officers that summarizes the activities of the plan in the preceding calendar year, including the net written and earned premiums, plan enrollment, the expense of administration, and the paid and incurred losses. The board must submit an evaluation report three years after commencement of the operation of the plan.

The board and its employees are not liable for any obligations of the plan. A member or employee of the board is not liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under the act, unless such act or omission constitutes willful or wanton misconduct.

Section 24 repeals the statutes establishing the Florida Comprehensive Health Association upon implementation of the Florida Health Insurance Plan.

Section 25 amends s. 627.662, F.S., to require group health insurance policies to be subject to the laws that apply to individual health insurance policies related to the use of specific methodology for payment of claims (current law) and inappropriate utilization of emergency care (as created by Section 21).

Section 26 amends s. 627.6699, F.S., related to the Employee Health Care Access Act, to revise the requirements for small employer policies to:

- Provides that the modified community rating requirements would no longer apply to policies issued to employers with 26 to 50 employees. This is related to the bill's amendment to s. 627.410, F.S., which provides that rates for such policies would not be subject to filing and approval by the Office of Insurance Regulation. The modified community rating would apply only to small employer policies covering 2 to 25 employees (with separate pooling for one-life groups, as currently allowed).
- Deletes the requirement that small group carriers guaranty-issue policies to one-life groups (sole proprietors and self-employed individuals) if there is enrollment availability in the Florida Health Insurance Plan.
- Requires small group carriers to offer a high deductible plan that meets the federal requirements of a health savings account plan..
- Reduces from 5% to 4% the maximum aggregate increased premiums charged to all policyholders, over a 6-month period, due to the application of health-related rating factors (which allows rates to be adjusted by plus or minus 15% for a single employer.)

This section also creates the Small Employers Access Program to provide health insurance to small employers (25 employees). The Office of Insurance Regulation is required to administer the program by selecting an insurer, through competitive bidding, to provide coverage to small employers within established geographical areas of the state. The bill provides criteria for OIR to consider in evaluating bids. Establishes eligibility for the program, including any small employer group up to 25 employees; any municipality, county, school district, or hospital located in a rural community; any nursing home employee; and dependents of eligible persons.

The bill specifies that insurers must be duly authorized insurers or health maintenance organizations. Such insurers must meet certain other criteria. The bill provides that the contract term shall not exceed 3 years. At least 6 months before the expiration of each contract period, OIR must invite eligible entities to submit bids to serve as the insurer for a designated geographic area. Selection of the insurer for the succeeding period must be made at least 3 months before the end of the current period. The bill establishes requirements for health insurance agents to submit applications for coverage. The agent must be paid a fair commission if coverage is written. "Fair commission" is defined as a commission structure determined by the insurers and reflected in the insurers' rate filing. The benefits must be the same as the standard and basic plans for small employers as outlined in s. 627.6699, F.S. The insurer, with the approval of OIR, may also establish an option of alternative coverage

Section 27 amends s. 627.9175, F.S., to require health insurers to annually report certain coverage information to OIR, including premiums, losses, number of policies, number of certificates, covered lives, number or percentage of claims denied and claims meeting prompt pay requirements, and the average number of days to pay claims. Deletes certain reporting requirements.

Section 28 renames chapter 636, F.S., as "Prepaid Limited Health Service Organizations and Discount Medical Plan Organizations." This chapter is presently related only to prepaid limited health service organizations (PLHSO). Under this bill, the chapter will be divided into two parts. Part 1 will be for the PLHSO; Part 2 will be for Discount Medical Plan Organizations (DMPO).

Section 29 designates existing ch. 636, F.S., as part I of the chapter.

Section 30 amends s. 626.003, F.S., which defines prepaid limited health service organizations. The definition presently has an exemption for a person who provides access to a limited health service provider without assuming responsibility for payment, which has been generally interpreted as an exemption for discount plans. This exemption is changed in the bill to limit it to licensed discount plans (under part II, below).

Section 31 creates a new part II of ch. 636, F.S., titled Discount Medical Plan Organizations. The bill establishes a comprehensive regulatory scheme for discount medical plan organizations. It creates a new license for this purpose, forms and rate filings and approval, procedures for examinations and investigations by OIR, prohibited activities, required disclosures to plan members, better tracking of providers, annual report filing, minimum capital requirements, a process for suspension and revocation of licenses, sale by licensed agents only, service of process through the Department of Financial Services, security deposits, criminal penalties, injunctive relief by OIR, civil remedies, and unlicensed activities by the plans.

The following statutory sections are created by the bill:

Section 636.202 Creates definitions. *Medical discount plan* is the arrangement by which a *member* receives access to a *provider* from whom the member receives *medical services* at a discount. *Medical services* does not include pharmacy benefits. The *medical discount plan organization* is the company that runs one or more *medical discount plans*; it is the organization that will become the licensee. A *marketer* sells the plan to the members. A *provider network* is a group of providers; the medical discount plan organization has a contract with the provider network under which the individual providers provide the medical services at a discount.

Section 636.204 This section requires a medical discount plan organization to be a corporation and to be licensed by OIR. The licensing process is similar to that of specialty insurers. The OIR will create, by rule, an application packet which will require the corporate documents (articles and bylaws), backgrounds and biographical statements, fingerprint cards, audited financials, and explanation of how the business will be run. An exemption is provided for individual providers who offer discounts to their own patients; such providers will not need to have a license.

Section 636.206 This section gives the OIR the authority to examine and investigate discount medical plan organizations. The exams and investigations are conducted in accordance with ch. 624, F.S., and the cost of exams is to be paid by the licensee.

Section 636.208 A discount medical plan organization is allowed to charge a monthly fee; if it charges a fee for a time period exceeding one month, it must, in case of cancellation by either party, make a pro rata refund to the member.

Section 636.210 This section sets out prohibited activities of a discount medical plan organization. It prohibits the use of words which could lead a person into thinking the discount medical plan was health insurance. It prohibits a discount medical plan organization from having restrictions of free access to the providers with whom the discount medical plan organization has contracted. It prohibits the discount medical plan organization from making payments to its providers. It prohibits a discount medical plan organization from collecting fees for services from

the members, in effect acting as an administrator for the providers, unless the discount medical plan organization has a TPA license.

Section 636.212 The discount medical plan organization is required to make four disclosures to prospective and actual members. These disclosures must be on all advertising and brochures.

The four disclosures are:

- the plan is not insurance;
- the plan does not make payments to providers;
- the member is responsible for the full amount of the discounted fee; and
- the corporate name and location of the discount medical plan organization.

Section 636.214 The discount medical plan organization must have a written provider agreement with every individual provider who offers discounts under its discount medical plans. The agreements must set forth the services and the discounts being offered, and must include an agreement by the provider that the provider will not charge members in excess of the discount. Provider networks must have written agreements with each of their providers which include these same provisions. Provider networks must provide the discount medical plan organization every month with an up-to-date list of providers in the network.

Section 636.216 Every discount medical plan organization must file and have approved all of its forms and rates.

Section 636.218 Every year each discount medical plan organization must file an annual report, containing audited financials on a GAPP basis, an updated list of principals, number of members, and other information as set forth in rules to be promulgated. Failure to timely file the report will result in specified fines.

Section 636.220 Establishes minimum capital requirements, which are a net worth of at least $150,000.

Section 636.222 Authorizes OIR to suspend or revoke the license of a discount medical plan organization when it violates the law, or when its continuing business would be harmful to the public, and other specified grounds.

Section 636.224 Each discount medical plan organization must give the OIR at least 30 days notice before changing its name or address.

Section 636.226 Each discount medical plan organization must have a web page on which it keeps an up to date list of all its providers. The address of the web page must be on all its marketing materials as well as on its discount cards.

Section 636.228 All advertisements used in marketing a discount medical plan must be approved by the discount medical plan organization. Persons marketing the plan must have an insurance agent license, must be appointed by the discount medical plan organization, and must have a written agreement with the discount medical plan organization.

Section 636.230 If a discount medical plan is sold in conjunction with any other product (for example, travel insurance) the fees for each product must be separately itemized.

Section 636.232 The Financial Services Commission has rulemaking authority regarding discount medical plan organizations.

Section 636.234 A licensed discount medical plan organization can be served in the same manner as an authorized insurer, through the Service of Process section of the Department of Financial Services.

Section 636.236 A discount medical plan organization must make a deposit with the Department in the amount of $35,000. The deposit is protected from levy.

Section 636.238 Violation of any provision of this part is a second degree misdemeanor. Operating an unlicensed discount medical plan organization is punishable under s. 624.401 F.S., as if the unlicensed discount medical plan organization were an unlicensed insurer and the fees charged were premium. The penalties increase as the amount of fees collected rises.

Section 636.240 The OIR is authorized to seek injunctive relief against an unlicensed discount medical plan organization, or any person who has violated a provision of this part or a rule adopted pursuant to this part.

Section 636.242 A private citizen may file a civil action against a person for violations of this part. Attorneys' fees may be recoverable.

Section 636.244 Sections 626.901 through 626.912, F.S., relating to unauthorized insurers, applies to unlicensed discount medical plan organizations as if they were unauthorized insurers. This includes penalties for representing an unlicensed discount medical plan organization and the procedure for serving an unlicensed discount medical plan organization.

Sections 32 and 33 amend ss. 627.65626 and 627.6402, F.S., to require health insurers issuing individual policies and group policies, respectively, to provide for a rebate of premiums when the majority of members of a health plan have maintained participation in any wellness program offered by the employer, subject to certain conditions.

Section 34 amends s. 641.31, F.S., to authorize HMOs that offer point-of-service riders to offer such riders to employers for employees living and working outside the HMO's approved geographic service area, without having to obtain a health care provider certificate, as long as the master group contract is issued to an employer that maintains its primary place of business within the HMO service area. The bill also requires HMOs to provide a premium rebate for individuals enrolled in a health wellness program approved by the HMO, under certain conditions.

Section 35 preserves rights to open enrollment for one-life groups until the Florida Health Insurance Plan begins to accept new risks or members.

Section 36 amends s. 465.0244, F.S., to require each pharmacy to make available on its Internet website a link to certain performance outcome and financial data of the Agency for Health Care Administration and a notice of the availability of such information.

Section 37 amends s. 627.6499, F.S., to require each health insurer to make available on its Internet website a link to certain performance outcome and financial data of the Agency for Health Care Administration and a notice in policies of the availability of such information.

Section 38 amends s.641.54, F.S., to require HMOs to make certain insurance financial information available to subscribers; and requires HMOs to make available on its Internet website a link to certain performance outcome and financial data of the Agency for Health Care Administration and a notice in policies of the availability of such information.

Section 39 repeals s. 408.02, F.S., relating to the development of patient management practice parameters by the Agency for Health Care Administration.

Section 40 repeals s. 766.1016(3) F.S., which requires a patient safety organization to promptly remove all patient-identifying information after receipt of a complete patient safety data report, unless otherwise provided by law. The requirement for patient safety organizations to maintain the confidentiality of patient-identifying information and not disseminate such information, except as permitted by state or federal law, is also repealed.

Section 41 appropriates $250,000 from the Insurance Regulatory Trust Fund to the OIR to implement the provisions in this act relating to the Small Employer Access Program.

Section 42 appropriates $350,000 in nonrecurring general revenue funds to AHCA for the establishment of the Florida Patient Safety Corporation during the 2004-2005 fiscal year.

Section 43 appropriates $113,500 in nonrecurring general revenue funds to the Florida State University College of Medicine for the purpose of conducting the study required in section 15 on hospitals implementing computerized physician order entry, for the 2004-2005 fiscal year.

Section 44 appropriates $250,000 in nonrecurring general funds to the board of the Florida Health Insurance Plan to contract for an independent actuarial study for the interim report that the board is required to submit to the Financial Services Commission.

Section 45 appropriates $2 million in nonrecurring general revenue to AHCA to implement a strategy for the adoption and use of electronic health records, as required by the act.

Section 46. Except as otherwise provided, the act takes effect July 1, 2004.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Art. I, s. 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill provides that policies issued to small employers with 26 to 50 employees would no longer be subject to the community rating requirements of s. 627.6699, F.S., and would not be subject to filing with the OIR for approval. Such policies would no longer be pooled for rating purposes with policies issued to employers with 2 to 25 employees. It is likely that this will act to lower rates for employers with 26 to 50 employees and increase rates for employers with 2 to 25 employees, because it is likely that the loss experience of the larger size groups is more favorable than for smaller size groups.

If the Florida Health Insurance Plan is opened to new enrollment, eligible individuals would be provided access to health insurance at subsidized rates. However, the funding for deficits must be provided by state general revenue sources, but the bill does not appropriate any funds for this purpose.

Small businesses, rural hospitals, and local governments may find affordable coverage through the creation of the Small Employers Access Program. However, for small employers, it is not clear where the savings would be generated compared to small group policies that are otherwise offered. The bill does not provide any exception to the small group rating provisions of s. 626.6699, F.S., which requires small group carriers to establish a modified community rate for all of its small group policies. Such modified community rate would apparently still be required for coverage offered through the Small Employer Access Program. Carriers may generally vary rates by plus or minus 15 percent for factors related to health status and claims experience of a small employer.

Low-income persons may be provided access to affordable coverage due to the statewide expansion of the Health Flex program.

Consumers may benefit from increased knowledge, as well as increased competitive pressures, by providing transparency in pricing among health care providers.

C. Government Sector Impact:

Section 41 appropriates $250,000 from the Insurance Regulatory Trust Fund to OIR to implement the provisions in this act relating to the Small Employer Access Program.

Section 42 appropriates $350,000 in nonrecurring general revenue funds to AHCA for the establishment of the Florida Patient Safety Corporation during the 2004-2005 fiscal year.

Section 43 appropriates $113,500 in nonrecurring general revenue funds to the Florida State University College of Medicine for the purpose of conducting the study required in section 15 on hospitals implementing computerized physician order entry, for the 2004-2005 fiscal year.

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Section 45 appropriates $2 million in nonrecurring general revenue to AHCA to implement a strategy for the adoption and use of electronic health records, as required by the act.

The bill requires deficits in the Florida Health Insurance Plan to be funded through appropriated General Revenue sources including, but not limited to, a portion of the annual growth in existing net insurance premium taxes. But, the bill does not make any appropriation for this purpose.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.