By the Committee on Health, Aging, and Long-Term Care; and Senator Peaden

317-2321-04

1 A bill to be entitled
2 An act relating to health care; creating the
3 Florida Health Insurance Plan to provide health
4 insurance for certain residents; providing for
5 a board to supervise and control the plan;
6 providing for a plan of operation to establish
7 operating procedures; providing powers of the
8 plan and of the board; providing for reports;
9 providing liability of the plan; providing for
10 audits; prescribing eligibility requirements;
11 prohibiting unfair referrals to the plan;
12 providing for a plan administrator and its term
13 limits and duties; providing for funding the
14 plan; prescribing benefits; providing annual
15 and cumulative maximum benefits; providing for
16 tax exemption; creating the Small Employers
17 Access Program; prescribing eligibility
18 requirements; providing for administration of
19 the program; providing qualifications and
20 duties of insurers; providing for reports;
21 prescribing benefits; providing that a benefit
22 plan approved by the Office of Insurance
23 Regulation may be issued to small employers
24 with up to 25 employees by specified persons;
25 providing for an advisory council; creating a
26 Statewide Electronic Medical Records Task Force
27 and providing its powers and duties; amending
28 s. 381.026, F.S.; requiring disclosure of
29 certain financial information to patients by
30 health care facilities or providers; amending
31 s. 395.301, F.S.; requiring disclosure of

1 certain financial information to patients of
2 licensed hospitals and similar facilities;
3 amending s. 408.909, F.S.; redefining the term
4 "health flex plan entity"; revising guidelines
5 for review of health flex plan applications;
6 amending s. 627.410, F.S.; revising
7 applicability of provisions relating to health
8 insurance policy and annuity contract forms;
9 amending s. 627.6487, F.S.; redefining the term
10 "eligible individual" for purposes of
11 guaranteed availability of coverage; amending
12 s. 636.003, F.S.; redefining the term "prepaid
13 limited health service organization"; providing
14 effective dates.
15
16 WHEREAS, the Legislature finds that 2.8 million
17 Floridians do not have access to health insurance coverage,
18 and
19 WHEREAS, often this lack of health insurance coverage
20 is because premiums are not affordable, and
21 WHEREAS, the Legislature finds that many small
22 employers are unable to provide health insurance to their
23 employees because of rising health care premiums, and
24 WHEREAS, it is the intent of the Legislature to
25 stabilize Florida's health insurance markets and make them
26 more competitive, and
27 WHEREAS, it is the intent of the Legislature to provide
28 access to health coverage for more of Florida's small
29 employers, and
30 WHEREAS, it is the intent of the Legislature to provide
31 access to health coverage to Florida's uninsurables, and

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1 WHEREAS, it is the intent of the Legislature to make
2 health insurance affordable by bringing about reductions in
3 costs to all of Florida's insureds, NOW, THEREFORE,
4
5 Be It Enacted by the Legislature of the State of Florida:
6
7 Section 1. There is created the Florida Health
8 Insurance Plan.
9 (1) DEFINITIONS.--As used in this section, the term:
10 (a) "Board" means the board of directors of the plan.
11 (b) "Governor" means the Governor of the State of
12 Florida.
13 (c) "Office" means the Office of Insurance Regulation
14 of the Financial Services Commission.
15 (d) "Dependent" means a resident spouse or resident
16 unmarried child under the age of 19 years, a child who is a
17 student under the age of 25 years and who is financially
18 dependent upon the parent, or a child of any age who is
19 disabled and dependent upon the parent.
20 (e) "Director" means the Director of the Office of
21 Insurance Regulation.
22 (f) "Health insurance" means any hospital or medical
23 expense incurred policy, health maintenance organization
24 subscriber contract pursuant to chapter 641, Florida Statutes,
25 or any other health care plan or arrangement that pays for or
26 furnishes medical or health care services whether by insurance
27 or otherwise. The term does not include short term, accident,
28 dental-only, vision-only, fixed indemnity, limited benefit, or
29 credit insurance; disability income insurance; coverage for
30 onsite medical clinics; insurance coverage specified in
31 federal regulations issued pursuant to Pub. L. No. 104-191,

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1 under which benefits for medical care are secondary or
2 incidental to other insurance benefits; benefits for long-term
3 care, nursing home care, home health care, community-based
4 care, or any combination thereof, or other similar, limited
5 benefits specified in federal regulations issued pursuant to
6 Pub. L. No. 104-191; benefits provided under a separate
7 policy, certificate, or contract of insurance, where there is
8 no coordination between the provision of the benefits and any
9 exclusion of benefits under any group health plan maintained
10 by the same plan sponsor, and the benefits are paid with
11 respect to an event without regard to whether benefits are
12 provided with respect to such an event under any group health
13 plan maintained by the same plan sponsor, such as for coverage
14 only for a specified disease or illness; hospital indemnity or
15 other fixed indemnity insurance; coverage offered as a
16 separate policy, certificate, or contract of insurance, such
17 as Medicare supplemental health insurance as defined under s.
18 1882(g)(1) of the Social Security Act; coverage supplemental
19 to the coverage provided under Chapter 55 of Title 10, United
20 States Code (Civilian Health and Medical Program of the
21 Uniformed Services (CHAMPUS); similar supplemental coverage
22 provided to coverage under a group health plan; coverage
23 issued as a supplement to liability insurance; insurance
24 arising out of a workers' compensation or similar law;
25 automobile medical-payment insurance; or insurance under which
26 benefits are payable with or without regard to fault and which
27 is statutorily required to be contained in any liability
28 insurance policy or equivalent self-insurance.
29 (g) "Insurer" means any entity that provides health
30 insurance in this state. For purposes of this act, the term
31 includes an insurance company with a valid certificate in

1 accordance with chapter 624, Florida Statutes, or a health
2 maintenance organization with a valid certificate of authority
3 in accordance with parts I and III of chapter 641, Florida
4 Statutes; prepaid health clinic authorized to transact
5 business in this state pursuant to part II of chapter 641,
6 Florida Statutes; multiple employer welfare arrangement
7 authorized to transact business in this state pursuant to
8 sections 624.436-624.45, Florida Statutes; or fraternal
9 benefit society providing health benefits to its members as
10 authorized pursuant to chapter 632, Florida Statutes.
11 (h) "Medicare" means coverage under both Parts A and B
12 of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et
13 seq., as amended.
14 (i) "Medicaid" means coverage under Titles XIX and XXI
15 of the Social Security Act.
16 (j) "Participating insurer" means any insurer
17 providing health insurance to residents of this state.
18 (k) "Provider" means any physician, hospital, or other
19 institution, organization, or person that furnishes health
20 care services and is licensed or otherwise authorized to
21 practice in this state.
22 (l) "Plan" means the Florida Health Insurance Plan as
23 created in this section.
24 (m) "Plan of operation" means the articles, bylaws,
25 and operating rules and procedures adopted by the board
26 pursuant to this act.
27 (n) "Resident" means an individual who has been
28 legally domiciled in this state for a period of at least 30
29 days.
30 (2) OPERATION OF THE PLAN.--
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1 (a) The plan shall be managed during full
2 implementation of this act by a three-member team appointed by
3 the Governor. The director shall head the team.
4 (b) Following full implementation, the plan shall
5 operate subject to the supervision and control of the board.
6 The board shall consist of the director or his or her
7 designated representative, who shall serve as a member of the
8 board and shall be its chairperson, and an additional eight
9 members appointed by the Governor. A majority of the board
10 must be composed of individuals who are not representatives of
11 insurers or health care providers.
12 (c) The initial board members shall be appointed as
13 follows: one-third of the members to serve a term of 2 years
14 each; one-third of the members to serve a term of 3 years
15 each; and one-third of the members to serve a term of 4 years
16 each. Subsequent board members shall serve for a term of 3
17 years. A board member's term shall continue until his or her
18 successor is appointed.
19 (d) Vacancies in the board shall be filled by the
20 Governor. Board members may be removed by the Governor for
21 cause.
22 (e) Members shall not be compensated in their capacity
23 as board members but shall be reimbursed for reasonable
24 expenses incurred in the necessary performance of their duties
25 in accordance with section 112.061, Florida Statutes.
26 (f) The board shall submit to the Governor a plan of
27 operation for the plan and any amendments thereto necessary or
28 suitable to assure the fair, reasonable, and equitable
29 administration of the plan. The plan of operation shall ensure
30 that the plan qualifies to apply for any available funding
31 from the Federal Government which adds to the financial

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1 viability of the plan. The plan of operation shall become
2 effective upon approval in writing by the Governor consistent
3 with the date on which the coverage under this act must be
4 made available. If the board fails to submit a suitable plan
5 of operation within 180 days after the appointment of the
6 board of directors, or at any time thereafter fails to submit
7 suitable amendments to the plan of operation, the office shall
8 adopt and promulgate such rules as are necessary or advisable
9 to effectuate this section. Such rules shall continue in force
10 until modified by the office or superseded by a plan of
11 operation submitted by the board and approved by the Governor.
12 (3) PLAN OF OPERATION.--The plan of operation shall:
13 (a) Establish procedures for operation of the plan.
14 (b) Establish procedures for selecting an
15 administrator in accordance with subsection (13).
16 (c) Establish procedures to create a fund, under
17 management of the board, for administrative expenses.
18 (d) Establish procedures for the handling, accounting,
19 and auditing of assets, moneys, and claims of the plan and the
20 plan administrator.
21 (e) Develop and implement a program to publicize the
22 existence of the plan, the eligibility requirements, and
23 procedures for enrollment and to maintain public awareness of
24 the plan.
25 (f) Establish procedures under which applicants and
26 participants may have grievances reviewed by a grievance
27 committee appointed by the board. The grievances shall be
28 reported to the board after completion of the review, with the
29 committee's recommendation for grievance resolution. The board
30 shall retain all written grievances regarding the plan for at
31 least 3 years.

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1 (g) Provide for other matters as are necessary and
2 proper for the execution of the board's powers, duties, and
3 obligations under this act.
4 (4) POWERS OF THE PLAN.--The plan shall have the
5 general powers and authority granted under the laws of this
6 state to health insurers and, in addition thereto, the
7 specific authority to:
8 (a) Enter into such contracts as are necessary or
9 proper to carry out the provisions and purposes of this act,
10 including the authority, with the approval of the Governor, to
11 enter into contracts with similar plans of other states for
12 the joint performance of common administrative functions, or
13 with persons or other organizations for the performance of
14 administrative functions;
15 (b) Take any legal actions necessary or proper to
16 recover or collect assessments due the plan;
17 (c) Take such legal action as is necessary:
18 1. To avoid payment of improper claims against the
19 plan or the coverage provided by or through the plan;
20 2. To recover any amounts erroneously or improperly
21 paid by the plan;
22 3. To recover any amounts paid by the plan as a result
23 of mistake of fact or law; or
24 4. To recover other amounts due the plan.
25 (d) Establish and modify as appropriate, rates, rate
26 schedules, rate adjustments, expense allowances, agents'
27 referral fees, claim reserve formulas, and any other actuarial
28 functions appropriate to the operation of the plan. Rates and
29 rate schedules may be adjusted for appropriate factors such as
30 age, sex, and geographic variation in claim cost and shall
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1 take into consideration appropriate factors in accordance with
2 established actuarial and underwriting practices;
3 (e) Issue policies of insurance in accordance with the
4 requirements of this act;
5 (f) Appoint appropriate legal, actuarial, investment,
6 and other committees as necessary to provide technical
7 assistance in the operation of the plan, develop and educate
8 its policyholders regarding health savings accounts (HSAs),
9 policy and contract design, and any other function within the
10 authority of the plan;
11 (g) Borrow money to effect the purposes of the plan.
12 Any notes or other evidence of indebtedness of the plan not in
13 default shall be legal investments for insurers and may be
14 carried as admitted assets;
15 (h) Employ and fix the compensation of employees;
16 (i) Prepare and distribute certificate of eligibility
17 forms and enrollment instruction forms to insurance producers
18 and to the general public;
19 (j) Provide for reinsurance of risks incurred by the
20 plan;
21 (k) Provide for and employ cost containment measures
22 and requirements, including, but not limited to, preadmission
23 screening, second surgical opinion, concurrent utilization
24 review, and individual case management for the purpose of
25 making the plan more cost effective;
26 (l) Design, use, contract, or otherwise arrange for
27 the delivery of cost effective health care services, including
28 establishing or contracting with preferred provider
29 organizations, health maintenance organizations, and other
30 limited network provider arrangements; and
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1 (m) Adopt such bylaws, policies, and procedures as are
2 necessary or convenient for the implementation of this act and
3 the operation of the plan.
4 (5) INTERIM REPORT.--No later than December 1, 2004,
5 the Transition Team shall submit a report to the Governor, the
6 President of the Senate, and the Speaker of the House of
7 Representatives, which includes an independent actuarial study
8 to determine, including, but not be limited to, the following
9 issues:
10 1. The impact the creation of this plan will have on
11 the small group insurance market on premiums paid by insureds.
12 This shall include an estimate of the total anticipated
13 aggregate savings for all small employers in the state.
14 2. How many people the pool could reasonably cover at
15 various funding levels and specifically how many people the
16 pool could cover at each of those funding levels.
17 3. A recommendation as to the best source of funding
18 for the anticipated deficits of the pool.
19 (6) ANNUAL REPORT.--The board shall make an annual
20 report to the Governor, the President of the Senate, and the
21 Speaker of the House of Representatives. The report shall
22 summarize the activities of the plan in the preceding calendar
23 year, including the net written and earned premiums, plan
24 enrollment, the expense of administration, and the paid and
25 incurred losses.
26 (7) EVALUATION REPORT.--The board shall report to the
27 Governor, the President of the Senate, and the Speaker of the
28 House of Representatives 3 years after commencement of
29 operations of the plan whether or nor the plan has met the
30 intent of this act.
31

1 (8) LIABILITY OF THE PLAN.--Neither the board nor its
2 employees shall be liable for any obligations of the plan. No
3 member or employee of the board is liable, and no cause of
4 action of any nature may arise against them, for any act or
5 omission related to the performance of their powers and duties
6 under this act, unless such act or omission constitutes
7 willful or wanton misconduct. The board may provide in its
8 bylaws or rules for indemnification of, and legal
9 representation for, its members and employees.
10 (9) AUDITED FINANCIAL STATEMENT.--No later than June 1
11 following the close of each calendar year the plan shall
12 submit to the Governor an audited financial statement,
13 prepared in accordance with Statutory Accounting Principles as
14 adopted by the National Association of Insurance
15 Commissioners.
16 (10) ADDITIONAL POWERS OF THE BOARD.--The board is
17 authorized to open up the plan to all eligible individual
18 persons as defined in subsection (11) for whom the estimated
19 loss ratio is 100 percent or less. The Governor may establish
20 additional powers and duties of the board to implement this
21 act.
22 (11) ELIGIBILITY.--
23 (a) Any individual person who is and continues to be a
24 resident of this state is eligible for plan coverage if
25 evidence is provided of:
26 1. A notice of rejection or refusal to issue
27 substantially similar insurance for health reasons by one
28 insurer;
29 2. A refusal by an insurer to issue insurance except
30 at a rate exceeding the plan rate. A rejection or refusal by
31 an insurer offering only stoploss, excess of loss, or

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1 reinsurance coverage with respect to the applicant is not
2 sufficient evidence under this paragraph; or
3 3. That person's eligibility for individual coverage
4 in accordance with the Health Insurance Accountability and
5 Portability Act (HIPAA).
6 (b) The board may promulgate a list of medical or
7 health conditions for which a person shall be eligible for
8 plan coverage without applying for health insurance pursuant
9 to paragraph (a). Persons who can demonstrate the existence or
10 history of any medical or health conditions on the list
11 promulgated by the board shall not be required to provide the
12 evidence specified in paragraph (a). The list shall be
13 effective on the first day of the operation of the plan and
14 may be amended as appropriate.
15 (c) Each resident dependent of a person who is
16 eligible for plan coverage is also eligible for plan coverage.
17 (d) A person is not eligible for coverage under the
18 plan if:
19 1. The person has or obtains health insurance coverage
20 substantially similar to or more comprehensive than a plan
21 policy, or would be eligible to obtain coverage, unless a
22 person may maintain other coverage for the period of time the
23 person is satisfying any preexisting condition waiting period
24 under a plan policy, and may maintain plan coverage for the
25 period of time the person is satisfying a preexisting
26 condition waiting period under another health insurance policy
27 intended to replace the plan policy;
28 2. The person is determined to be eligible for health
29 care benefits under Medicaid or any other federal, state, or
30 local government program that provides health benefits;
31

1 3. The person has previously terminated plan coverage
2 unless 12 months have lapsed since such termination;
3 4. The plan has paid out $1 million in benefits on
4 behalf of the person;
5 5. The person is an inmate or resident of a public
6 institution; or
7 6. The person's premiums are paid for or reimbursed
8 under any government-sponsored program or by any government
9 agency or health care provider, except as an otherwise
10 qualifying full-time employee, or dependent thereof, of a
11 government agency or health care provider.
12 (e) Coverage shall cease:
13 1. On the date a person is no longer a resident of
14 this state;
15 2. On the date a person requests coverage to end;
16 3. Upon the death of the covered person;
17 4. On the date state law requires cancellation of the
18 policy; or
19 5. At the option of the plan, 30 days after the plan
20 makes any inquiry concerning the person's eligibility or place
21 of residence to which the person does not reply.
22 (f) Except under the circumstances described in this
23 subsection, a person who ceases to meet the eligibility
24 requirements of this section may be terminated at the end of
25 the policy period for which the necessary premiums have been
26 paid.
27 (12) UNFAIR REFERRAL TO PLAN.--It shall constitute an
28 unfair trade practice for the purposes of part IX of chapter
29 626, Florida Statutes, or section 641.3901, Florida Statutes,
30 for an insurer, health maintenance organization, insurance
31 agent, insurance broker, or third-party administrator to refer

1 an individual employee to the plan, or arrange for an
2 individual employee to apply to the plan, for the purpose of
3 separating that employee from group health insurance coverage
4 provided in connection with the employee's employment.
5 (13) PLAN ADMINISTRATOR.--The board shall select
6 through a competitive bidding process a plan administrator to
7 administer the plan. The board shall evaluate bids submitted
8 based on criteria established by the board, which shall
9 include:
10 (a) The plan administrator's proven ability to handle
11 health insurance coverage to individuals;
12 (b) The efficiency and timeliness of the plan
13 administrator's claim-processing procedures;
14 (c) An estimate of total charges for administering the
15 plan;
16 (d) The plan administrator's ability to apply
17 effective cost containment programs and procedures and to
18 administer the plan in a cost efficient manner; and
19 (e) The financial condition and stability of the plan
20 administrator.
21
22 The administrator shall be either an insurer, a health
23 maintenance organization or a third-party administrator, or
24 another organization duly authorized pursuant to the Florida
25 Insurance Code.
26 (14) ADMINISTRATOR TERM LIMITS.--The plan
27 administrator shall serve for a period specified in the
28 contract between the plan and the plan administrator, subject
29 to removal for cause and subject to any terms, conditions, and
30 limitations of the contract between the plan and the plan
31 administrator. At least 1 year before the expiration of each

1 period of service by a plan administrator, the board shall
2 invite eligible entities, including the current plan
3 administrator, to submit bids to serve as the plan
4 administrator. Selection of the plan administrator for each
5 succeeding period shall be made at least 6 months before the
6 end of the current period.
7 (15) DUTIES OF THE PLAN ADMINISTRATOR.--The plan
8 administrator shall perform such functions relating to the
9 plan as are assigned to it, including, but not limited to:
10 (a) Determination of eligibility;
11 (b) Payment of claims;
12 (c) Establishment of a premium billing procedure for
13 collection of premiums from persons covered under the plan;
14 and
15 (d) Other necessary functions to assure timely payment
16 of benefits to covered persons under the plan.
17
18 The plan administer shall submit regular reports to the board
19 regarding the operation of the plan. The frequency, content,
20 and form of the reports shall be specified in the contract
21 between the board and the plan administrator. On March 1
22 following the close of each calendar year, the plan
23 administrator shall determine net written and earned premiums,
24 the expense of administration, and the paid and incurred
25 losses for the year and report this information to the board
26 and the Governor on a form prescribed by the Governor.
27 (16) PAYMENT OF THE PLAN ADMINISTRATOR.--The plan
28 administrator shall be paid as provided in the contract
29 between the plan and the plan administrator.
30 (17) FUNDING OF THE PLAN.--
31 (a) Premiums.--

1. The plan shall establish premium rates for plan coverage as provided in subparagraph 2. Separate schedules of premium rates based on age, sex, and geographical location may apply for individual risks. Premium rates and schedules shall be submitted to the office for approval before use.

2. The plan, in conjunction with the office, shall determine a standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Initial rates for plan coverage shall not be less than 200 percent of rates established as applicable for individual standard risks. The plan shall also develop a sliding scale premium surcharge based upon the insured's income. Subject to the limits provided in this paragraph, subsequent rates shall be established to provide fully for the expected costs of claims, including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein.

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

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1 estimate the number of new policies it believes the plan has
2 the financial capacity to insure during that year so that
3 costs do not exceed income. The board shall take steps
4 necessary to assure that plan enrollment does not exceed the
5 number of residents it has estimated it has the financial
6 capacity to insure.
7 (18) BENEFITS.--
8 (a) The benefits provided shall be the same as the
9 standard and basic plans for small employers as outlined in
10 section 627.6699, Florida Statutes. The board may also
11 establish an option of alternative coverage such as
12 catastrophic coverage that includes a minimum level of primary
13 care coverage.
14 (b) In establishing the plan coverage, the board shall
15 take into consideration the levels of health insurance
16 provided in the state and such medical economic factors as are
17 deemed appropriate and adopt benefit levels, deductibles,
18 co-payments, coinsurance factors, exclusions and limitations
19 determined to be generally reflective of and commensurate with
20 health insurance provided through a representative number of
21 large employers in the state.
22 (c) The board may adjust any deductibles and
23 coinsurance factors annually according to the Medical
24 Component of the Consumer Price Index.
25 (d)1. Plan coverage shall exclude charges or expenses
26 incurred during the first 6 months following the effective
27 date of coverage for any condition for which medical advice,
28 care, or treatment was recommended or received during the
29 6-month period immediately preceding the effective date of
30 coverage.
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1 2. Such preexisting condition exclusions shall be
2 waived to the extent that similar exclusions, if any, have
3 been satisfied under any prior health insurance coverage that
4 was involuntarily terminated, provided that application for
5 pool coverage is made not later than 63 days following such
6 involuntary termination; and, in such case, coverage in the
7 plan shall be effective from the date on which such prior
8 coverage was terminated and the applicant is not eligible for
9 continuation or conversion rights that would provide coverage
10 substantially similar to plan coverage.
11 (19) NONDUPLICATION OF BENEFITS.--
12 (a) The plan shall be payer of last resort of benefits
13 whenever any other benefit or source of third-party payment is
14 available. Benefits otherwise payable under plan coverage
15 shall be reduced by all amounts paid or payable through any
16 other health insurance and by all hospital and medical expense
17 benefits paid or payable under any workers' compensation
18 coverage, automobile medical payment or liability insurance
19 whether provided on the basis of fault or nonfault, and by any
20 hospital or medical benefits paid or payable under or provided
21 pursuant to any state or federal law or program.
22 (b) The plan shall have a cause of action against an
23 eligible person for the recovery of the amount of benefits
24 paid that are not for covered expenses. Benefits due from the
25 plan may be reduced or refused as a set-off against any amount
26 recoverable under this paragraph.
27 (20) ANNUAL AND MAXIMUM BENEFITS.--Maximum benefits
28 shall be limited to $75,000 annually and $1 million per
29 lifetime.
30
31

1 (21) TAXATION.--The plan established pursuant to this
2 act shall be exempt from any and all taxes. The plan shall
3 apply for federal tax exemption.
4 Section 2. There is created the Small Employers Access
5 Program.
6 (1) DEFINITIONS.--As used in this section, the term:
7 (a) "Office" means the Office of Insurance Regulation
8 of the Department of Financial Services.
9 (b) "Insurer" means any entity that provides health
10 insurance in this state. For purposes of this section, the
11 term includes an insurance company holding a certificate of
12 authority pursuant to chapter 624, Florida Statutes, or a
13 health maintenance organization holding a certificate of
14 authority pursuant to chapter 641, Florida Statutes, which
15 qualifies to provide coverage to small employer groups
16 pursuant to section 627.6699, Florida Statutes.
17 (c) "Participating insurer" means any insurer
18 providing health insurance to small employers which has been
19 selected by the office in accordance with this section for its
20 designated region.
21 (d) "Program" means the Small Employer Access Program
22 created by this section.
23 (e) "Fair commission" means a commission structure
24 determined by the office and the insurers, which will carry
25 out the intent of this section.
26 (2) ELIGIBILITY.--
27 (a) Any small employer group up to 25 employees may
28 participate.
29 (b) Each dependent of a person eligible for coverage
30 is also eligible.
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1 (c) Any municipality, county, school district, or
2 hospital located in a rural community as defined in section
3 288.0656(2)(b), Florida Statutes.
4 (d) Nursing home employees may participate.
5 (e) A small employer group that ceases to meet the
6 eligibility requirements of this section may be terminated at
7 the end of the policy period for which the necessary premiums
8 have been paid.
9 (3) ADMINISTRATION.--The office shall by competitive
10 bid, in accordance with current state law, select an insurer
11 to provide coverage to small employers within established
12 geographical areas of this state. The office may develop
13 exclusive regions for the program similar to those used by the
14 Healthy Kids Corporation. However, the office is not precluded
15 from developing, in conjunction with insurers, regions
16 different from those used by the Healthy Kids Corporation if
17 the office deems that such a region will carry out the
18 intentions of this act. The office shall evaluate bids
19 submitted based upon criteria established by the office, which
20 shall include, but are not limited to:
21 (a) The insurer's proven ability to provide health
22 insurance coverage to small employer groups;
23 (b) The efficiency and timeliness of the insurer's
24 claim-processing procedures;
25 (c) The insurer's ability to apply effective cost
26 containment programs and procedures and to administer the
27 program in a cost-efficient manner; and
28 (d) The financial condition and stability of the
29 insurer. The office may use any financial information
30 available to it through its regulatory duties to make this
31 evaluation.

1 (4) INSURER QUALIFICATIONS.--The insurer shall be a
2 duly authorized insurer or health maintenance organization.
3 (5) DUTIES OF THE INSURER.--The insurer shall develop
4 and implement a program to publicize the existence of the
5 program, the eligibility requirements, procedures for
6 enrollment, and:
7 (a) Maintain employer awareness of the program.
8 (b) Demonstrate the ability to use delivery of cost
9 effective health care services.
10 (c) Encourage, educate, advise, and administer the
11 effective use of health savings accounts (HSAs) by covered
12 employees and dependents.
13 (d) Serve for a period specified in the contract
14 between the office and the insurer subject to removal for
15 cause and subject to any terms, conditions, and limitations of
16 the contract between the office and the insurer as are
17 specified in the request for proposal.
18 (6) CONTRACT TERM.--The contract term shall not exceed
19 3 years. At least 6 months before the expiration of each
20 contract period, the office shall invite eligible entities,
21 including the current insurer, to submit bids to serve as the
22 insurer for a designated geographic area. Selection of the
23 insurer for the succeeding period must be made at least 3
24 months before the end of the current period.
25 (7) INSURER REPORTING REQUIREMENTS.--On March 1,
26 following the close of each calendar year, the insurer shall
27 determine net written and earned premiums, the expense of
28 administration, and the paid and incurred losses for the year
29 and report this information to the office on a form prescribed
30 by the office.
31

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1 (8) APPLICATION REQUIREMENTS.--The insurer shall
2 permit or allow any licensed and duly appointed health
3 insurance agent residing in the designated region to submit
4 applications for coverage, and such agent shall be paid a fair
5 commission if coverage is written. The agency must be
6 appointed to at least one insurer.
7 (9) BENEFITS.--The benefits provided shall be the same
8 as the standard and basic plans for small employers as
9 outlined in section 627.6699, Florida Statutes, except that
10 the insurer, with the approval of the office, may also
11 establish an option of alternative coverage such as
12 catastrophic coverage that includes a minimum level of primary
13 care coverage or other such benefit plan, which will carry out
14 the intent of this act.
15 (10) ALTERNATIVE COVERAGE.--Any benefit plan approved
16 by the office may be issued to small employer groups with up
17 to 25 employees by any insurer licensed under chapter 627,
18 Florida Statutes, or health maintenance organization licensed
19 under chapter 641, Florida Statutes.
20 (11) ANNUAL REPORTING.--The office shall make an
21 annual report to the Governor, the President of the Senate,
22 and the Speaker of the House of Representatives. The report
23 shall summarize the activities of the program in the preceding
24 calendar year, including the net written and earned premiums,
25 program enrollment, the expense of administration, and the
26 paid and incurred losses. The report shall be submitted no
27 later than March 15 following the close of the prior calendar
28 year.
29 (12) ADVISORY COUNCIL.--The office, in conjunction
30 with representatives of each of the regional insurers,
31 provider groups, and small employer representatives, and a

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1 person designated by the Governor shall meet at least annually
2 to review the operations of the program, suggest improvements,
3 and recommend incentives to the Governor and the Legislature
4 which will encourage employer participation in the program.
5 Section 3. There is created a Statewide Electronic
6 Medical Records Task Force to serve as a body of experts to
7 guide the Agency for Health Care Administration in the
8 development of policy related to electronic medical records
9 and the technology required for sharing clinical information
10 among caregivers.
11 (1) The agency shall provide staff support to the task
12 force and may enter into contracts as are necessary or proper
13 to carry out the provisions and purposes of this act,
14 assisting the task force in the creation of the Electronic
15 Medical Records System.
16 (2) The task force shall be appointed by the Governor.
17 (3) The task force shall meet at least quarterly and
18 advise the Governor, the Legislature, and the agency
19 regarding:
20 (a) Public and private sector initiatives related to
21 electronic medical records and communication systems for the
22 sharing of clinical information among caregivers;
23 (b) Regulatory barriers that interfere with the
24 sharing of clinical information among caregivers;
25 (c) Investment incentives to promote the use of
26 recommended technologies by health care providers;
27 (d) Educational strategies to promote the use of
28 recommended technologies by health care providers; and
29 (e) Standards for public access to facilitate
30 transparency in pricing, costs, and quality.
31

1 (4) By November 30, 2004, and annually thereafter, the
2 task force shall provide to the Office of the Governor, the
3 President of the Senate, and the Speaker of the House of
4 Representatives, a status report to include any
5 recommendations and an implementation plan to include, but not
6 limited to, estimated costs, capital investment requirements,
7 recommended investment incentives, initial committed provider
8 participation by region, standards of functionality and
9 features, marketing plan, and implementation schedules for key
10 components.
11 (5) Members of the task force shall serve without
12 compensation but shall be entitled to receive reimbursement
13 for per diem and travel expenses as provided in section
14 112.061, Florida Statutes.
15 (6) The sum of $2 million is appropriated from the
16 General Revenue Fund to the Agency for Health Care
17 Administration for funding activities relative to the
18 Statewide Electronic Medical Records Task Force.
19 (7) Unless otherwise reenacted by the Legislature, the
20 task force is abolished effective July 1, 2007.
21 Section 4. Paragraph (c) of subsection (4) and
22 subsection (6) of section 381.026, Florida Statutes, are
23 amended to read:
24 381.026 Florida Patient's Bill of Rights and
25 Responsibilities.--
26 (4) RIGHTS OF PATIENTS.--Each health care facility or
27 provider shall observe the following standards:
28 (c) Financial information and disclosure.--
29 1. A patient has the right to be given, upon request,
30 by the responsible provider, his or her designee, or a
31 representative of the health care facility full information

1 and necessary counseling on the availability of known
2 financial resources for the patient's health care.
3 2. A health care provider or a health care facility
4 shall, upon request, disclose to each patient who is eligible
5 for Medicare, in advance of treatment, whether the health care
6 provider or the health care facility in which the patient is
7 receiving medical services accepts assignment under Medicare
8 reimbursement as payment in full for medical services and
9 treatment rendered in the health care provider's office or
10 health care facility.
11 3. A health care provider or a health care facility
12 shall, upon request, furnish a patient, prior to provision of
13 medical services, a reasonable estimate of charges for such
14 services. Such reasonable estimate shall not preclude the
15 health care provider or health care facility from exceeding
16 the estimate or making additional charges based on changes in
17 the patient's condition or treatment needs.
18 4. Each licensed facility not operated by the state
19 shall make available to the public on its Internet website or
20 by other electronic means package prices for each of the top
21 50 most used elective inpatient and outpatient procedures. The
22 package pricing shall include all hospital-related services
23 and shall include separate estimates of costs for professional
24 fees charged by independent contractor physicians or physician
25 groups. The licensed facility shall also make available to the
26 public on its Internet website or by other electronic means
27 each of the top 50 most used inpatient and outpatient
28 procedures. Such list shall be updated quarterly. The facility
29 shall place a notice in the reception areas that such
30 information is available electronically and the website
31 address. The licensed facility may indicate that the package

pricing is based on a compilation of charges for the average patient and that each patient's bill may vary from the average depending upon the severity of illness and individual resources consumed. The licensed facility may also indicate that the package pricing is negotiable based upon the patient's health plan and the ability to pay. The agency shall develop rules for implementation of a uniform mechanism for reporting this information on the facility's website.

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

(6) SUMMARY OF RIGHTS AND RESPONSIBILITIES.--Any health care provider who treats a patient in an office or any health care facility licensed under chapter 395 that provides emergency services and care or outpatient services and care to a patient, or admits and treats a patient, shall adopt and make available to the patient, in writing, a statement of the rights and responsibilities of patients, including the following:

SUMMARY OF THE FLORIDA PATIENT'S BILL
OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

A patient has the right to a prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his or her care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

A patient has the right to know what rules and regulations apply to his or her conduct.

A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

<u>A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for the proposed service.</u>

1 A patient has the right to receive a copy of a
2 reasonably clear and understandable, itemized bill and, upon
3 request, to have the charges explained.
4 A patient has the right to impartial access to medical
5 treatment or accommodations, regardless of race, national
6 origin, religion, handicap, or source of payment.
7 A patient has the right to treatment for any emergency
8 medical condition that will deteriorate from failure to
9 provide treatment.
10 A patient has the right to know if medical treatment is
11 for purposes of experimental research and to give his or her
12 consent or refusal to participate in such experimental
13 research.
14 A patient has the right to express grievances regarding
15 any violation of his or her rights, as stated in Florida law,
16 through the grievance procedure of the health care provider or
17 health care facility which served him or her and to the
18 appropriate state licensing agency.
19 A patient is responsible for providing to the health
20 care provider, to the best of his or her knowledge, accurate
21 and complete information about present complaints, past
22 illnesses, hospitalizations, medications, and other matters
23 relating to his or her health.
24 A patient is responsible for reporting unexpected
25 changes in his or her condition to the health care provider.
26 A patient is responsible for reporting to the health
27 care provider whether he or she comprehends a contemplated
28 course of action and what is expected of him or her.
29 A patient is responsible for following the treatment
30 plan recommended by the health care provider.
31

1 A patient is responsible for keeping appointments and,
2 when he or she is unable to do so for any reason, for
3 notifying the health care provider or health care facility.
4 A patient is responsible for his or her actions if he
5 or she refuses treatment or does not follow the health care
6 provider's instructions.
7 A patient is responsible for assuring that the
8 financial obligations of his or her health care are fulfilled
9 as promptly as possible.
10 A patient is responsible for following health care
11 facility rules and regulations affecting patient care and
12 conduct.
13 Section 5. Subsections (7) and (8) are added to
14 section 395.301, Florida Statutes, to read:
15 395.301 Itemized patient bill; form and content
16 prescribed by the agency.--
17 (7) Each licensed facility not operated by the state
18 shall make available to the public on its Internet website or
19 by other electronic means package prices for each of the top
20 50 most used elective inpatient and outpatient procedures. The
21 package pricing shall include all hospital-related services
22 and shall include separate estimates of costs for professional
23 fees charged by independent contractor physicians or physician
24 groups. The licensed facility shall also make available to the
25 public on its Internet website or by other electronic means
26 the top 50 most used procedures in both the inpatient and
27 outpatient settings. The list shall be updated quarterly. The
28 facility shall place a notice in the reception areas that such
29 information is available electronically and the website
30 address. The licensed facility may indicate that the package
31 pricing is based on a compilation of charges for the average

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1 patient and that each patient's bill may vary from the average
2 depending upon the severity of illness and individual
3 resources consumed. The licensed facility may also indicate
4 that the package pricing is negotiable based upon the
5 patient's health plan and the ability to pay. The agency shall
6 develop rules for implementation of a uniform mechanism for
7 reporting this information on the facility's website.
8 (8) Each licensed facility not operated by the state
9 shall, upon request of a prospective patient prior to the
10 provision of medical services, provide a reasonable estimate
11 of charges for the proposed service. Such estimate shall not
12 preclude the actual charges from exceeding the estimate based
13 on changes in the patient's medical condition or the treatment
14 needs of the patient as determined by the attending and
15 consulting physicians.
16 Section 6. Paragraph (f) of subsection (2) and
17 subsections (3) and (9) of section 408.909, Florida Statutes,
18 are amended to read:
19 408.909 Health flex plans.--
20 (2) DEFINITIONS.--As used in this section, the term:
21 (f) "Health flex plan entity" means a health insurer,
22 health maintenance organization,
23 health-care-provider-sponsored organization, local government,
24 health care district, ~~or~~ other public or private
25 community-based organization, or public-private partnership
26 that develops and implements an approved health flex plan and
27 is responsible for administering the health flex plan and
28 paying all claims for health flex plan coverage by enrollees
29 of the health flex plan.
30 (3) PILOT PROGRAM.--The agency and the office shall
31 each approve or disapprove health flex plans that provide

health care coverage for eligible participants ~~who reside in the three areas of the state that have the highest number of uninsured persons, as identified in the Florida Health Insurance Study conducted by the agency and in Indian River County~~. A health flex plan may limit or exclude benefits otherwise required by law for insurers offering coverage in this state, may cap the total amount of claims paid per year per enrollee, may limit the number of enrollees, or may take any combination of those actions.

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

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

1. Contain any ambiguous, inconsistent, or misleading provisions or any exceptions or conditions that deceptively affect or limit the benefits purported to be assumed in the general coverage provided by the health flex plan;

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

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1 3. Cannot demonstrate that the health flex plan is
2 financially sound and that the applicant is able to underwrite
3 or finance the health care coverage provided.
4 (c) The agency and the Financial Services Commission
5 may adopt rules as needed to administer this section.
6 (9) PROGRAM EVALUATION.--The agency and the office
7 shall evaluate the pilot program and its effect on the
8 entities that seek approval as health flex plans, on the
9 number of enrollees, and on the scope of the health care
10 coverage offered under a health flex plan; shall provide an
11 assessment of the health flex plans and their potential
12 applicability in other settings; shall use health flex plans
13 to gather more information to evaluate low-income consumer
14 driven benefit packages;and shall, by January 1, 2004,
15 jointly submit a report to the Governor, the President of the
16 Senate, and the Speaker of the House of Representatives.
17 Section 7. Paragraph (a) of subsection (6) of section
18 627.410, Florida Statutes, is amended to read:
19 627.410 Filing, approval of forms.--
20 (6)(a) An insurer shall not deliver or issue for
21 delivery or renew in this state any health insurance policy
22 form until it has filed with the office a copy of every
23 applicable rating manual, rating schedule, change in rating
24 manual, and change in rating schedule; if rating manuals and
25 rating schedules are not applicable, the insurer must file
26 with the order applicable premium rates and any change in
27 applicable premium rates. This paragraph does not apply to
28 group health insurance policies, effectuated and delivered in
29 this state, insuring groups of 26 ~~51~~ or more persons, except
30 for Medicare supplement insurance, long-term care insurance,
31 and any coverage under which the increase in claim costs over

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1 the lifetime of the contract due to advancing age or duration
2 is prefunded in the premium.
3 Section 8. Subsection (3) of section 627.6487, Florida
4 Statutes, is amended to read:
5 627.6487 Guaranteed availability of individual health
6 insurance coverage to eligible individuals.--
7 (3) For the purposes of this section, the term
8 "eligible individual" means an individual:
9 (a)1. For whom, as of the date on which the individual
10 seeks coverage under this section, the aggregate of the
11 periods of creditable coverage, as defined in s. 627.6561(5)
12 and (6), is 18 or more months; and
13 2.a. Whose most recent prior creditable coverage was
14 under a group health plan, governmental plan, or church plan,
15 or health insurance coverage offered in connection with any
16 such plan; or
17 b. Whose most recent prior creditable coverage was
18 under an individual plan issued in this state by a health
19 insurer or health maintenance organization, which coverage is
20 terminated due to the insurer or health maintenance
21 organization becoming insolvent or discontinuing the offering
22 of all individual coverage in the State of Florida, or due to
23 the insured no longer living in the service area in the State
24 of Florida of the insurer or health maintenance organization
25 that provides coverage through a network plan in the State of
26 Florida;
27 (b) Who is not eligible for coverage under:
28 1. A group health plan, as defined in s. 2791 of the
29 Public Health Service Act;
30 2. A conversion policy or contract issued by an
31 authorized insurer or health maintenance organization under s.

627.6675 or s. 641.3921, respectively, offered to an individual who is no longer eligible for coverage under either an insured or self-insured employer plan;

3. Part A or part B of Title XVIII of the Social Security Act; ~~or~~

4. A state plan under Title XIX of such act, or any successor program, and does not have other health insurance coverage; or

5. The Florida Health Insurance Plan as specified in s. 627.64872 and such plan is accepting new enrollment;

(c) With respect to whom the most recent coverage within the coverage period described in paragraph (a) was not terminated based on a factor described in s. 627.6571(2)(a) or (b), relating to nonpayment of premiums or fraud, unless such nonpayment of premiums or fraud was due to acts of an employer or person other than the individual;

(d) Who, having been offered the option of continuation coverage under a COBRA continuation provision or under s. 627.6692, elected such coverage; and

(e) Who, if the individual elected such continuation provision, has exhausted such continuation coverage under such provision or program.

Section 9. Subsection (7) of section 636.003, Florida Statutes, is amended to read:

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

(7) "Prepaid limited health service organization" means any person, corporation, partnership, or any other entity which, in return for a prepayment, undertakes to provide or arrange for, or provide access to, the provision of a limited health service to enrollees through an exclusive panel of providers or undertakes to provide access to any

1 discounted medical services. Prepaid limited health service
2 organization does not include:
3 (a) An entity otherwise authorized pursuant to the
4 laws of this state to indemnify for any limited health
5 service;
6 (b) A provider or entity when providing limited health
7 services pursuant to a contract with a prepaid limited health
8 service organization, a health maintenance organization, a
9 health insurer, or a self-insurance plan; ~~or~~
10 (c) Any person who, in exchange for fees, dues,
11 charges or other consideration, provides access to a limited
12 health service provider without assuming any responsibility
13 for payment for the limited health service or any portion
14 thereof; or~~.~~
15 (d) Any plan or program of discounted medical services
16 for which fees, dues, charges, or other consideration paid to
17 the plan by consumers does not exceed $15 per month or $180
18 per year and which in its advertising and contracts:
19 1. Clearly indicates that the plan is not insurance,
20 that the plan is not obligated to pay any portion of the
21 discounted medical fees, and that the consumer is responsible
22 for paying the full amount of the discounted fees;
23 2. Does not use the term "affordable health care" or
24 "coverage," or any other term that misrepresents the nature of
25 the program; and
26 3. Requires a statement beside the provider network on
27 the discount card alerting the network providers and
28 facilities that the cardholder does not have insurance and is
29 merely entitled to the network discount rate for services
30 provided.
31

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1 Section 10. Except for this section and section 5,
2 which shall take effect July 1, 2004, and paragraph (17)(b) of
3 section 1, which shall take effect July 1, 2005, this act
4 shall take effect October 1, 2004.
5
6 STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR
7 Senate Bill 2910
8
9 The committee substitute differs from SB 2910 in the following ways:
10
The definition of health insurance for purposes of the Florida
11 Health Insurance Plan, is amended to specify numerous types of special insurance that are not insurance under the Plan.
12
Insurers are not required to offer optional coverage for
13 speech, language, hearing, and swallowing disorders.
14 Insurers and health maintenance organizations will not be required to offer basic and standard policies.
15
The bill does not alter provisions for rating adjustments in
16 the Employee Health Care Access Act.
17 The Statewide Electronic Medical Records Advisory Panel created by the bill is renamed the Statewide Electronic
18 Medical Records Task Force.
19 Any benefit plan approved by the Office of Insurance Regulation may be issued to small employer groups with up to
20 25 employees by any licensed insurer or health maintenance organization.
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