By the Committees on Appropriations; Banking and Insurance; Health, Aging, and Long-Term Care; and Senator Peaden

309-2683-04

1 A bill to be entitled
2 An act relating to affordable health care;
3 providing a popular name; providing purpose;
4 amending s. 381.026, F.S.; requiring certain
5 licensed facilities to provide public Internet
6 access to certain financial information;
7 amending s. 381.734, F.S.; including
8 participation by health care providers, small
9 businesses, and health insurers in the Healthy
10 Communities, Healthy People Program; requiring
11 the Department of Health to provide public
12 Internet access to certain public health
13 programs; requiring the department to monitor
14 and assess the effectiveness of such programs;
15 requiring a report; requiring the Office of
16 Program Policy and Government Accountability to
17 evaluate the effectiveness of such programs;
18 requiring a report; amending s. 395.003, F.S.;
19 prohibiting the Agency for Health Care
20 Administration from issuing licenses for
21 certain emergency departments located off the
22 primary premises of a hospital before July 1,
23 2005; requiring a study and report to the
24 Legislature; amending s. 395.1041, F.S.;
25 authorizing hospitals to develop certain
26 emergency room diversion programs; amending s.
27 395.301, F.S.; requiring certain licensed
28 facilities to provide prospective patients
29 certain estimates of charges for services;
30 requiring such facilities to provide patients
31 with certain bill verification information;

1 providing for a fine for failure to provide
2 such information; providing charge limitations;
3 requiring such facilities to establish a
4 patient question review and response
5 methodology; providing requirements; requiring
6 certain licensed facilities to provide public
7 Internet access to certain financial
8 information; providing an exception for
9 specified rural hospitals; amending s. 408.061,
10 F.S.; requiring the Agency for Health Care
11 Administration to require health care
12 facilities, health care providers, and health
13 insurers to submit certain information;
14 providing requirements; requiring the agency to
15 adopt certain risk and severity adjustment
16 methodologies; requiring the agency to adopt
17 certain rules; requiring certain information to
18 be certified; amending s. 408.062, F.S.;
19 requiring the agency to conduct certain health
20 care costs and access research, analyses, and
21 studies; expanding the scope of such studies to
22 include collection of pharmacy retail price
23 data, use of emergency departments, physician
24 information, and Internet patient charge
25 information availability; requiring publication
26 of information collected on the Internet;
27 requiring a report; requiring the agency to
28 conduct additional data-based studies and make
29 recommendations to the Legislature; requiring
30 the agency to develop and implement a strategy
31 to adopt and use electronic health records;

1 authorizing the agency to develop rules to
2 protect electronic records confidentiality;
3 requiring a report to the Governor and
4 Legislature; amending s. 408.05, F.S.;
5 requiring the agency to develop a plan to make
6 performance outcome and financial data
7 available to consumers for health care services
8 comparison purposes; requiring submittal of the
9 plan to the Governor and Legislature; requiring
10 the agency to update the plan; requiring the
11 agency to make the plan available
12 electronically; providing plan requirements;
13 amending s. 409.9066, F.S.; requiring the
14 agency to provide certain information relating
15 to the Medicare prescription discount program;
16 creating s. 465.0244, F.S.; requiring each
17 pharmacy to make available on its Internet
18 website a link to certain performance outcome
19 and financial data of the Agency for Health
20 Care Administration and a notice of the
21 availability of such information; amending s.
22 627.6499, F.S.; requiring each health insurer
23 to make available on its Internet website a
24 link to certain performance outcome and
25 financial data of the Agency for Health Care
26 Administration and a notice in policies of the
27 availability of such information; amending s.
28 641.54, F.S.; requiring health maintenance
29 organizations to make certain insurance
30 financial information available to subscribers;
31 requiring health maintenance organizations to

1 make available on its Internet website a link
2 to certain performance outcome and financial
3 data of the Agency for Health Care
4 Administration and a notice in policies of the
5 availability of such information; amending s.
6 408.7056, F.S.; renaming the Statewide Provider
7 and Subscriber Assistance Program as the
8 Subscriber Assistance Program; revising
9 provisions to conform; expanding certain
10 records availability provisions; revising
11 membership provisions relating to a subscriber
12 grievance hearing panel; providing hearing
13 procedures; amending s. 641.3154, F.S., to
14 conform to the renaming of the Subscriber
15 Assistance Program; amending s. 641.511, F.S.,
16 to conform to the renaming of the Subscriber
17 Assistance Program; adopting and incorporating
18 by reference the Employee Retirement Income
19 Security Act of 1974, as implemented by federal
20 regulations; amending s. 641.58, F.S., to
21 conform to the renaming of the Subscriber
22 Assistance Program; amending s. 408.909, F.S.;
23 expanding a definition of "health flex plan
24 entity" to include public-private partnerships;
25 making a pilot health flex plan program apply
26 permanently statewide; providing additional
27 program requirements; creating s. 381.0271,
28 F.S.; providing definitions; creating the
29 Florida Patient Safety Corporation, which shall
30 be registered, incorporated, organized, and
31 operated in compliance with ch. 617, F.S.;

1 authorizing the corporation to create
2 not-for-profit subsidiaries; specifying that
3 the corporation is not an agency within the
4 meaning of s. 20.03(11), F.S.; requiring the
5 corporation to be subject to public meetings
6 and records requirements; specifying that the
7 corporation is not subject to the provisions of
8 ch. 297, F.S., relating to procurement of
9 personal property and services; providing a
10 purpose for the corporation; establishing the
11 membership of the board of directors of the
12 corporation; requiring the formation of certain
13 advisory committees for the corporation;
14 requiring the Agency for Health Care
15 Administration to provide assistance in
16 establishing the corporation; specifying the
17 powers and duties of the corporation; requiring
18 annual reports; requiring the Office of Program
19 Policy Analysis and Government Accountability,
20 in consultation with the Agency for Health Care
21 Administration and the Department of Health, to
22 develop performance measures for the
23 corporation; requiring a performance audit;
24 requiring a report to the Governor and the
25 Legislature; requiring the Patient Safety
26 Center at the Florida State University College
27 of Medicine to study the return on investment
28 by hospitals from implementing computerized
29 physician order entry and other information
30 technologies related to patient safety;
31 providing requirements for the study; requiring

1 a report to the Governor and the Legislature;
2 amending s. 395.1012, F.S.; providing
3 additional duties of the patient safety
4 committee at hospitals and other licensed
5 facilities; requiring such facilities to adopt
6 a plan to reduce medication errors and adverse
7 drug events, including the use of computerized
8 physician order entry and other information
9 technologies; amending s. 409.91255, F.S.;
10 expanding assistance to certain health centers
11 to include community emergency room diversion
12 programs and urgent care services; amending s.
13 627.410, F.S.; requiring insurers to file
14 certain rates with the Office of Insurance
15 Regulation; creating s. 627.6405, F.S.; making
16 legislative findings related to inappropriate
17 utilization of emergency room care; requiring
18 health insurers to take certain actions and
19 authorizing higher copayments for certain uses
20 of emergency departments; creating s.
21 627.64872, F.S.; providing legislative intent;
22 creating the Florida Health Insurance Plan for
23 certain purposes; providing definitions;
24 providing requirements for operation of the
25 plan; providing for a board of directors;
26 providing for appointment of members; providing
27 for terms; specifying service without
28 compensation; providing for travel and per diem
29 expenses; requiring a plan of operation;
30 providing requirements; providing for powers of
31 the plan; requiring reports to the Governor and

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1 Legislature; providing certain immunity from
2 liability for plan obligations; authorizing the
3 board to provide for indemnification of certain
4 costs; requiring an annually audited financial
5 statement; providing for eligibility for
6 coverage under the plan; providing criteria;
7 requirements, and limitations; specifying
8 certain activity as an unfair trade practice;
9 providing for a plan administrator; providing
10 criteria; providing requirements; providing
11 term limits for the plan administrator;
12 providing duties; providing for paying the
13 administrator; providing for funding mechanisms
14 of the plan; providing for premium rates for
15 plan coverage; providing rate limitations;
16 specifying benefits under the plan; providing
17 criteria, requirements, and limitations;
18 providing for nonduplication of benefits;
19 providing for annual and maximum lifetime
20 benefits; providing for tax exempt status;
21 providing for abolition of the Florida
22 Comprehensive Health Association upon
23 implementation of the plan; providing for
24 enrollment in the plan of persons enrolled in
25 the association; requiring insurers to pay
26 certain assessments to the board for certain
27 purposes; providing criteria, requirements, and
28 limitations for such assessments; repealing ss.
29 627.6488, 627.6489, 627.649, 627.6492,
30 627.6494, 627.6496, and 627.6498, F.S.,
31 relating to the Florida Comprehensive Health

1 Association, upon implementation of the plan;
2 amending s. 627.662, F.S.; providing for
3 application of certain claim payment
4 methodologies and actions related to
5 inappropriate use of emergency care to certain
6 types of insurance; amending s. 627.6699, F.S.;
7 revising provisions requiring small employer
8 carriers to offer certain health benefit plans;
9 preserving a right to open enrollment for
10 certain small groups; requiring small employer
11 carriers to file and provide coverage under
12 certain high deductible plans; including high
13 deductible plans under certain required plan
14 provisions; providing a delayed effective date
15 for certain filing requirements; creating the
16 Small Employers Access Program; providing
17 legislative intent; providing definitions;
18 providing participation eligibility
19 requirements and criteria; requiring the Office
20 of Insurance Regulation to administer the
21 program by selecting an insurer through
22 competitive bidding; providing requirements;
23 specifying insurer qualifications; providing
24 duties of the insurer; providing a contract
25 term; providing insurer reporting requirements;
26 providing application requirements; providing
27 for benefits under the program; requiring the
28 office to annually report to the Governor and
29 Legislature; providing for decreases in
30 inappropriate use of emergency care; providing
31 legislative intent; requiring health insurers

1 to provide certain information electronically
2 and develop community emergency department
3 diversion programs; amending s. 627.9175, F.S.;
4 requiring certain health insurers to annually
5 report certain coverage information to the
6 office; providing requirements; deleting
7 certain reporting requirements; creating part I
8 of ch. 636, F.S., relating to prepaid limited
9 health services organization; amending s.
10 636.002, F.S.; providing a short title;
11 amending s. 636.003, F.S.; revising the
12 definition of the term "prepaid limited health
13 services organization"; creating part II of ch.
14 636, F.S., relating to discount medical plan
15 organization; providing a short title;
16 providing definitions; requiring that a person
17 be licensed before conducting business in this
18 state as a discount medical plan organizations;
19 providing for an application to receive a
20 license; providing for the contents of the
21 application; requiring each discount medical
22 plan organization to create an Internet
23 website; authorizing the Office of Insurance
24 Regulation to investigate or examine a discount
25 medical plan organization under certain
26 conditions; specifying the permitted and
27 prohibited activities of a discount medical
28 plan organization; directing each discount
29 medical plan organization to disclose certain
30 specified information to members and
31 prospective members; providing for contracts

1 and agreements with providers and networks of
2 providers; detailing the required contents of
3 the contract or agreement; requiring each
4 discount medical plan organization to file its
5 proposed rates with the office; directing each
6 discount medical plan organization to file an
7 annual report with the office; specifying the
8 contents of the report; providing for fines
9 when a discount medical plan organization is
10 delinquent in filing the annual report;
11 requiring minimum capitalization; providing the
12 circumstances and procedures when the office
13 proposes to suspend or revoke the license of a
14 discount medical plan organization; directing
15 each discount medical plan organization to
16 maintain an up-to-date list of the names and
17 addresses of the providers with whom it has a
18 contract to deliver medical services; directing
19 that the list be posted on the organization's
20 website; providing for marketing plans;
21 authorizing the office to adopt rules;
22 providing for service of process; providing for
23 a security deposit by each discount medical
24 plan organization; providing criminal penalties
25 for violations of the act; authorizing the
26 office to seek temporary and permanent
27 injunctive relief against a discount medical
28 plan organization under certain conditions;
29 providing civil remedies for any person injured
30 by another acting in violation of the act;
31 providing venue for a civil action; creating

1 ss. 627.65626 and 627.6402, F.S.; providing for
2 insurance rebates for healthy lifestyles;
3 providing for rebate of certain premiums for
4 participation in health wellness, maintenance,
5 or improvement programs under certain
6 circumstances; providing requirements; amending
7 s. 641.31, F.S.; authorizing health maintenance
8 organizations offering certain point-of-service
9 riders to offer such riders to certain
10 employers for certain employees; providing
11 requirements and limitations; providing for
12 application of certain claim payment
13 methodologies to certain types of insurance;
14 providing for rebate of certain premiums for
15 participation in health wellness, maintenance,
16 or improvement programs under certain
17 circumstances; providing requirements;
18 preserving certain rights to enrollment in
19 certain health benefit coverage for certain
20 groups under certain circumstances; repealing
21 s. 408.02, F.S., relating to the development,
22 endorsement, implementation, and evaluation of
23 patient management practice parameters by the
24 Agency for Health Care Administration; amending
25 s. 766.309, F.S.; granting the administrative
26 law judge exclusive jurisdiction to make
27 factual determinations regarding certain notice
28 requirements in medical negligence proceedings;
29 authorizing the Agency for Health Care
30 Administration to adopt rules; providing
31 legislative intent; requiring the Auditor

1 General to conduct a study of nursing home
2 finances; specifying the issues to be studied;
3 directing the Auditor General to report its
4 findings to the Governor, the President of the
5 Senate, and the Speaker of the House of
6 Representatives by a specified date; requiring
7 the Agency for Health Care Administration to
8 conduct a survey of all nursing home operators;
9 detailing the contents of the data survey;
10 directing the agency to report its findings to
11 the Governor, the President of the Senate, and
12 the Speaker of the House of Representatives by
13 a specified date; providing appropriations;
14 providing effective dates.
15
16 WHEREAS, according to the Kaiser Family Foundation,
17 eight out of ten uninsured Americans are workers or dependents
18 of workers and nearly eight out of ten uninsured Americans
19 have family incomes above the poverty level, and
20 WHEREAS, fifty-five percent of those who do not have
21 insurance state that the reason they do not have insurance is
22 lack of affordability, and
23 WHEREAS, average health insurance premium increases for
24 the last 2 years have been in the range of 10 to 20 percent
25 for Florida's employers, and
26 WHEREAS, an increasing number of employers are opting
27 to cease providing insurance coverage to their employees due
28 to the high cost, and
29 WHEREAS, an increasing number of employers who continue
30 providing coverage are forced to shift more premium cost to
31

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1 their employees, thus diminishing the value of employee wage
2 increases, and
3 WHEREAS, according to studies, the rate of avoidable
4 hospitalization is 50 to 70 percent lower for the insured
5 versus the uninsured, and
6 WHEREAS, according to Florida Cancer Registry data, the
7 uninsured have a 70 percent greater chance of a late
8 diagnosis, thus decreasing the chances of a positive health
9 outcome, and
10 WHEREAS, according to the Agency for Health Care
11 Administration's 2002 financial data, uncompensated care in
12 Florida's hospitals is growing at the rate of 12 to 13 percent
13 per year, and, at $4.3 billion in 2001, this cost, when
14 shifted to Floridians who remain insured, is not sustainable,
15 and
16 WHEREAS, the Florida Legislature, through the creation
17 of Health Flex, has already identified the need for lower cost
18 alternatives, and
19 WHEREAS, it is of vital importance and in the best
20 interests of the people of this state that the issue of
21 available, affordable health care insurance be addressed in a
22 cohesive and meaningful manner, and
23 WHEREAS, there is general recognition that the issues
24 surrounding the problem of access to affordable health
25 insurance are complicated and multifaceted, NOW, THEREFORE,
26
27 Be It Enacted by the Legislature of the State of Florida:
28
29 Section 1. This act may be referred to by the popular
30 name "The 2004 Affordable Health Care for Floridians Act."
31

1 Section 2. <u>The purpose of this act is to address the</u>
2 <u>underlying cause of the double-digit increases in health</u>
3 <u>insurance premiums by mitigating the overall growth in health</u>
4 <u>care costs.</u>
5 Section 3. Paragraph (c) of subsection (4) of section
6 381.026, Florida Statutes, is amended to read:
7 381.026 Florida Patient's Bill of Rights and
8 Responsibilities.--
9 (4) RIGHTS OF PATIENTS.--Each health care facility or
10 provider shall observe the following standards:
11 (c) Financial information and disclosure.--
12 1. A patient has the right to be given, upon request,
13 by the responsible provider, his or her designee, or a
14 representative of the health care facility full information
15 and necessary counseling on the availability of known
16 financial resources for the patient's health care.
17 2. A health care provider or a health care facility
18 shall, upon request, disclose to each patient who is eligible
19 for Medicare, in advance of treatment, whether the health care
20 provider or the health care facility in which the patient is
21 receiving medical services accepts assignment under Medicare
22 reimbursement as payment in full for medical services and
23 treatment rendered in the health care provider's office or
24 health care facility.
25 3. A health care provider or a health care facility
26 shall, upon request, furnish a patient, prior to provision of
27 medical services, a reasonable estimate of charges for such
28 services. Such reasonable estimate shall not preclude the
29 health care provider or health care facility from exceeding
30 the estimate or making additional charges based on changes in
31 the patient's condition or treatment needs.

1 4. Each licensed facility not operated by the state
2 shall make available to the public on its Internet website or
3 by other electronic means a description of and a link to the
4 performance outcome and financial data that is published by
5 the agency pursuant to s. 408.05(3)(l). The facility shall
6 place a notice in the reception areas that such information is
7 available electronically and the website address. The licensed
8 facility may indicate that the pricing information is based on
9 a compilation of charges for the average patient and that each
10 patient's bill may vary from the average depending upon the
11 severity of illness and individual resources consumed. The
12 licensed facility may also indicate that the price of service
13 is negotiable for eligible patients based upon the patient's
14 ability to pay.
15 5.~~4.~~ A patient has the right to receive a copy of an
16 itemized bill upon request. A patient has a right to be given
17 an explanation of charges upon request.
18 Section 4. Subsection (1) and paragraph (g) of
19 subsection (3) of section 381.734, Florida Statutes, are
20 amended, and subsections (4), (5), and (6) are added to that
21 section, to read:
22 381.734 Healthy Communities, Healthy People Program.--
23 (1) The department shall develop and implement the
24 Healthy Communities, Healthy People Program, a comprehensive
25 and community-based health promotion and wellness program. The
26 program shall be designed to reduce major behavioral risk
27 factors associated with chronic diseases, including those
28 chronic diseases identified in chapter 385, by enhancing the
29 knowledge, skills, motivation, and opportunities for
30 individuals, organizations, health care providers, small
31

1 businesses, health insurers, and communities to develop and
2 maintain healthy lifestyles.
3 (3) The program shall include:
4 (g) The establishment of a comprehensive program to
5 inform the public, health care professionals, health insurers,
6 and communities about the prevalence of chronic diseases in
7 the state; known and potential risks, including social and
8 behavioral risks; and behavior changes that would reduce
9 risks.
10 (4) The department shall make available on its
11 Internet website, no later than October 1, 2004, and in a
12 hard-copy format upon request, a listing of age-specific,
13 disease-specific, and community-specific health promotion,
14 preventive care, and wellness programs offered and established
15 under the Healthy Communities, Healthy People Program. The
16 website shall also provide residents with information to
17 identify behavior risk factors that lead to diseases that are
18 preventable by maintaining a healthy lifestyle. The website
19 shall allow consumers to select by county or region
20 disease-specific statistical information.
21 (5) The department shall monitor and assess the
22 effectiveness of such programs. The department shall submit a
23 status report based on this monitoring and assessment to the
24 Governor, the President of the Senate, the Speaker of the
25 House of Representatives, and the substantive committees of
26 each house of the Legislature, with the first annual report
27 due January 31, 2005.
28 (6) The Office of Program Policy and Government
29 Accountability shall evaluate and report to the Governor, the
30 President of the Senate, and the Speaker of the House of
31 Representatives, by March 1, 2005, on the effectiveness of the

1 department's monitoring and assessment of the program's
2 effectiveness.
3 Section 5. Subsection (1) of section 395.003, Florida
4 Statutes, is amended to read:
5 395.003 Licensure; issuance, renewal, denial,
6 modification, suspension, and revocation.--
7 (1)(a) No person shall establish, conduct, or maintain
8 a hospital, ambulatory surgical center, or mobile surgical
9 facility in this state without first obtaining a license under
10 this part.
11 (b)1. It is unlawful for any person to use or
12 advertise to the public, in any way or by any medium
13 whatsoever, any facility as a "hospital," "ambulatory surgical
14 center," or "mobile surgical facility" unless such facility
15 has first secured a license under the provisions of this part.
16 2. Nothing in this part applies to veterinary
17 hospitals or to commercial business establishments using the
18 word "hospital," "ambulatory surgical center," or "mobile
19 surgical facility" as a part of a trade name if no treatment
20 of human beings is performed on the premises of such
21 establishments.
22 3. The agency may not issue any license for an
23 emergency department for a medical facility located away from
24 the primary premises of a licensed hospital before July 1,
25 2005. The agency shall conduct a study of existing facilities
26 licensed as offsite emergency departments in this state and
27 other states, which includes a review of issues related to
28 access to care and quality of care. The study shall be
29 submitted to the Governor and the Legislature by February 1,
30 2005.
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1 Section 6. Subsection (7) is added to section
2 395.1041, Florida Statutes, to read:
3 395.1041 Access to emergency services and care.--
4 (7) EMERGENCY ROOM DIVERSION PROGRAMS.--Hospitals may
5 develop emergency room diversion programs, including, but not
6 limited to, an "Emergency Hotline" which allows patients to
7 help determine if emergency department services are
8 appropriate or if other health care settings may be more
9 appropriate for care, and a "Fast Track" program allowing
10 nonemergency patients to be treated at an alternative site.
11 Alternative sites may include health care programs funded with
12 local tax revenue and federally funded community health
13 centers, county health departments, or other nonhospital
14 providers of health care services. The program may include
15 provisions for followup care and case management.
16 Section 7. Subsections (1), (2), and (3) of section
17 395.301, Florida Statutes, are amended, and subsections (7),
18 (8), (9), (10), and (11) are added to that section, to read:
19 395.301 Itemized patient bill; form and content
20 prescribed by the agency.--
21 (1) A licensed facility not operated by the state
22 shall notify each patient during admission and at discharge of
23 his or her right to receive an itemized bill upon request.
24 Within 7 days following the patient's discharge or release
25 from a licensed facility not operated by the state, ~~or within~~
26 ~~7 days after the earliest date at which the loss or expense~~
27 ~~from the service may be determined,~~ the licensed facility
28 providing the service shall, upon request, submit to the
29 patient, or to the patient's survivor or legal guardian as may
30 be appropriate, an itemized statement detailing in language
31 comprehensible to an ordinary layperson the specific nature of

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1 charges or expenses incurred by the patient, which in the
2 initial billing shall contain a statement of specific services
3 received and expenses incurred for such items of service,
4 enumerating in detail the constituent components of the
5 services received within each department of the licensed
6 facility and including unit price data on rates charged by the
7 licensed facility, as prescribed by the agency.
8 (2)(a) Each such statement submitted pursuant to this
9 section:
10 1.~~(a)~~ May not include charges of hospital-based
11 physicians if billed separately.
12 2.~~(b)~~ May not include any generalized category of
13 expenses such as "other" or "miscellaneous" or similar
14 categories.
15 3.~~(c)~~ Shall list drugs by brand or generic name and
16 not refer to drug code numbers when referring to drugs of any
17 sort.
18 4.~~(d)~~ Shall specifically identify therapy treatment as
19 to the date, type, and length of treatment when therapy
20 treatment is a part of the statement.
21 (b) Any person receiving a statement pursuant to this
22 section shall be fully and accurately informed as to each
23 charge and service provided by the institution preparing the
24 statement.
25 (3) On each ~~such~~ itemized statement submitted pursuant
26 to subsection (1) there shall appear the words "A FOR-PROFIT
27 (or NOT-FOR-PROFIT or PUBLIC) HOSPITAL (or AMBULATORY SURGICAL
28 CENTER) LICENSED BY THE STATE OF FLORIDA" or substantially
29 similar words sufficient to identify clearly and plainly the
30 ownership status of the licensed facility. Each itemized
31 statement must prominently display the phone number of the

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1 medical facility's patient liaison who is responsible for
2 expediting the resolution of any billing dispute between the
3 patient, or his or her representative, and the billing
4 department.
5 (7) Each licensed facility not operated by the state
6 shall provide, prior to provision of any nonemergency medical
7 services, a written good faith estimate of reasonably
8 anticipated charges for the facility to treat the patient's
9 condition upon written request of a prospective patient. The
10 estimate shall be provided to the prospective patient within 7
11 business days of the receipt of the request. The estimate may
12 be the average charges for that diagnosis related group or the
13 average charges for that procedure. Upon request, the facility
14 shall notify the patient of any revision to the good faith
15 estimate. Such estimate shall not preclude the actual charges
16 from exceeding the estimate. The facility shall place a notice
17 in reception areas that such information is available. Failure
18 to provide the estimate within the provisions established
19 pursuant to this section shall result in a fine of $500 for
20 each instance of the facility's failure to provide the
21 requested information.
22 (8) A licensed facility shall make available to a
23 patient all records necessary for verification of the accuracy
24 of the patient's bill within 30 business days after the
25 request for such records. The verification information must be
26 made available in the facility's offices. Such records shall
27 be available to the patient prior to and after payment of the
28 bill or claim. The facility may not charge the patient for
29 making such verification records available; however, the
30 facility may charge its usual fee for providing copies of
31 records as specified in s. 395.3025.

1 (9) Each facility shall establish a method for
2 reviewing and responding to questions from patients concerning
3 the patient's itemized bill. Such response shall be provided
4 within 30 days after the date a question is received. If the
5 patient is not satisfied with the response, the facility must
6 provide the patient with the address of the agency to which
7 the issue may be sent for review.
8 (10) Each licensed facility shall make available on
9 its Internet website a link to the performance outcome and
10 financial data that is published by the Agency for Health Care
11 Administration pursuant to s. 408.05(3)(l). The facility shall
12 place a notice in the reception area that the information is
13 availability electronically and the website address.
14 (11) Each rural hospital as defined in s. 395.602
15 which has fewer than 50 beds is exempt from subsection (10).
16 The agency shall evaluate the most cost-efficient method for
17 collecting and reporting data for these qualifying rural
18 hospitals and shall, by December 1, 2005, submit a report to
19 the Governor, the President of the Senate, and the Speaker of
20 the House of Representatives.
21 Section 8. Subsection (1) of section 408.061, Florida
22 Statutes, is amended to read:
23 408.061 Data collection; uniform systems of financial
24 reporting; information relating to physician charges;
25 confidential information; immunity.--
26 (1) The agency shall ~~may~~ require the submission by
27 health care facilities, health care providers, and health
28 insurers of data necessary to carry out the agency's duties.
29 Specifications for data to be collected under this section
30 shall be developed by the agency with the assistance of
31 technical advisory panels including representatives of

1 affected entities, consumers, purchasers, and such other
2 interested parties as may be determined by the agency.
3 (a) Data ~~to be~~ submitted by health care facilities,
4 including the facilities as defined in chapter 395, shall ~~may~~
5 include, but are not limited to: case-mix data, patient
6 admission and ~~or~~ discharge data, hospital emergency department
7 data shall include the number of patients treated in the
8 emergency department of a licensed hospital reported by
9 patient acuity level, data on hospital-acquired infections as
10 specified by rule, data on complications as specified by rule,
11 data on readmissions as specified by rule, with patient and
12 provider-specific identifiers included, actual charge data by
13 diagnostic groups, financial data, accounting data, operating
14 expenses, expenses incurred for rendering services to patients
15 who cannot or do not pay, interest charges, depreciation
16 expenses based on the expected useful life of the property and
17 equipment involved, and demographic data. The agency shall
18 adopt nationally recognized risk adjustment methodologies or
19 software consistent with the standards of the Agency for
20 Healthcare Research and Quality for all data submitted as
21 required by this section. Data may be obtained from documents
22 such as, but not limited to: leases, contracts, debt
23 instruments, itemized patient bills, medical record abstracts,
24 and related diagnostic information. Reported data elements
25 shall be reported electronically in accordance with Rule
26 59E-7.012, Florida Administrative Code. Data submitted shall
27 be certified by the chief executive officer or an appropriate
28 and duly authorized representative or employee of the licensed
29 facility that the information is true and accurate.
30 (b) Data to be submitted by health care providers may
31 include, but are not limited to: Medicare and Medicaid

1 participation, types of services offered to patients, amount
2 of revenue and expenses of the health care provider, and such
3 other data which are reasonably necessary to study utilization
4 patterns. Data submitted shall be certified as true and
5 accurate by the health care provider or by an appropriate and
6 duly authorized representative or employee of the health care
7 provider.
8 (c) Data to be submitted by health insurers may
9 include, but are not limited to: claims, premium,
10 administration, and financial information. Data submitted
11 shall be certified by the appropriate and duly authorized
12 representative, or employee of the insurer that the
13 information submitted is true and accurate.
14 (d) Data required to be submitted by health care
15 facilities, health care providers, or health insurers shall
16 not include specific provider contract reimbursement
17 information. However, such specific provider reimbursement
18 data shall be reasonably available for onsite inspection by
19 the agency as is necessary to carry out the agency's
20 regulatory duties. Any such data obtained by the agency as a
21 result of onsite inspections may not be used by the state for
22 purposes of direct provider contracting and are confidential
23 and exempt from the provisions of s. 119.07(1) and s. 24(a),
24 Art. I of the State Constitution.
25 (e) A requirement to submit data shall be adopted by
26 rule if the submission of data is being required of all
27 members of any type of health care facility, health care
28 provider, or health insurer. Rules are not required, however,
29 for the submission of data for a special study mandated by the
30 Legislature or when information is being requested for a
31

single health care facility, health care provider, or health insurer.

Section 9. Subsections (1) and (4) of section 408.062, Florida Statutes, are amended, and subsection (5) is added to that section, to read:

408.062 Research, analyses, studies, and reports.--

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

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

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

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

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

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

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

(g) The development of physician <u>information</u> ~~payment~~ systems which are capable of <u>providing data for health care consumers</u> taking into account the amount of resources consumed<u>, including at licensed facilities as defined in</u>

1 chapter 395, and the outcomes produced in the delivery of
2 care.
3 (h) The collection of a statistically valid sample of
4 data on the retail prices charged by pharmacies for the 50
5 most frequently prescribed medicines from any pharmacy
6 licensed by this state as a special study authorized by the
7 Legislature to be performed by the agency quarterly. If the
8 drug is available generically, price data shall be reported
9 for the generic drug and price data of a brand-named drug for
10 which the generic drug is the equivalent shall be reported.
11 The agency shall make available on its Internet website for
12 each pharmacy, no later than October 1, 2005, drug prices for
13 a 30-day supply at a standard dose. The data collected shall
14 be reported for each drug by pharmacy and by metropolitan
15 statistical area or region and updated quarterly. ~~The impact~~
16 ~~of subacute admissions on hospital revenues and expenses for~~
17 ~~purposes of calculating adjusted admissions as defined in s.~~
18 ~~408.07.~~
19 (i) The use of emergency department services by
20 patient acuity level and the implication of increasing
21 hospital cost by providing nonurgent care in emergency
22 departments. The agency shall submit an annual report based on
23 this monitoring and assessment to the Governor, the President
24 of the Senate, and the Speaker of the House of
25 Representatives, and the substantive legislative committees
26 with the first report due January 1, 2006.
27 (j) Making available on its Internet website no later
28 than October 1, 2004, and in a hard-copy format upon request,
29 patient charge, volumes, length of stay, and performance
30 outcome indicators collected from health care facilities
31 pursuant to s. 408.061(1)(a) for not less than 50 inpatient

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1 and 50 outpatient procedures provided in inpatient and
2 outpatient facilities as determined by the agency. In making
3 the determination of specific medical conditions, surgeries,
4 and procedures to include, the agency shall consider such
5 factors as volume, severity of the illness, urgency of
6 admission, individual and societal costs, and whether the
7 condition is acute or chronic. Performance outcome indicators
8 shall re risk adjusted or severity adjusted, as applicable,
9 using nationally recognized risk adjustment methodologies or
10 software consistent with the standards of the Agency for
11 Healthcare Research and Quality and as selected by the agency.
12 The website shall also provide an interactive search that
13 allows consumers to view and compare the information for
14 specific facilities, a map that allows consumers to select a
15 county or region, definitions of all of the data, descriptions
16 of each procedure, and an explanation about why the data may
17 differ from facility to facility. Such public data shall be
18 updated quarterly. The agency shall submit an annual status
19 report on the collection of data and publication of
20 performance outcome indicators to the Governor, the Speaker of
21 the House of Representatives, the President of the Senate, and
22 the substantive legislative committees with the first status
23 report due January 1, 2005.
24 (4)(a) The agency shall ~~may~~ conduct data-based studies
25 and evaluations and make recommendations to the Legislature
26 and the Governor concerning exemptions, the effectiveness of
27 limitations of referrals, restrictions on investment interests
28 and compensation arrangements, and the effectiveness of public
29 disclosure. Such analysis shall ~~may~~ include, but need not be
30 limited to, utilization of services, cost of care, quality of
31 care, and access to care. The agency may require the

1 submission of data necessary to carry out this duty, which may
2 include, but need not be limited to, data concerning
3 ownership, Medicare and Medicaid, charity care, types of
4 services offered to patients, revenues and expenses,
5 patient-encounter data, and other data reasonably necessary to
6 study utilization patterns and the impact of health care
7 provider ownership interests in health-care-related entities
8 on the cost, quality, and accessibility of health care.
9 (b) The agency may collect such data from any health
10 facility or licensed health care provider as a special study.
11 (5) The agency shall develop and implement a strategy
12 for the adoption and use of electronic health records. The
13 agency may develop rules to facilitate the functionality and
14 protect the confidentiality of electronic health records. The
15 agency shall report to the Governor, the President of the
16 Senate, and the Speaker of the House of Representatives on
17 legislative recommendations to protect the confidentiality of
18 electronic health records.
19 Section 10. Paragraph (l) is added to subsection (3)
20 of section 408.05, Florida Statutes, and paragraph (a) of
21 subsection (8) of that section is amended, to read:
22 408.05 State Center for Health Statistics.--
23 (3) COMPREHENSIVE HEALTH INFORMATION SYSTEM.--In order
24 to produce comparable and uniform health information and
25 statistics, the agency shall perform the following functions:
26 (l) Develop, in conjunction with the State
27 Comprehensive Health Information System Advisory Council, and
28 implement a long-range plan for making available performance
29 outcome and financial data that will allow consumers to
30 compare health care services. The performance outcomes and
31 financial data the agency must make available shall include,

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1 but is not limited to, pharmaceuticals, physicians, health
2 care facilities, and health plans and managed care entities.
3 The agency shall submit the initial plan to the Governor, the
4 President of the Senate, and the Speaker of the House of
5 Representatives by March 1, 2005, and shall update the plan
6 and report on the status of its implementation annually
7 thereafter. The agency shall also make the plan and status
8 report available to the public on its Internet website. As
9 part of the plan, the agency shall identify the process and
10 timeframes for implementation, any barriers to implementation,
11 and recommendations of changes in the law that may be enacted
12 by the Legislature to eliminate the barriers. As preliminary
13 elements of the plan, the agency shall:
14 1. Make available performance outcome and patient
15 charge data collected from health care facilities pursuant to
16 s. 408.061(1)(a) and (2). The agency shall determine which
17 conditions and procedures, performance outcomes, and patient
18 charge data to disclose based upon input from the council.
19 When determining which conditions and procedures are to be
20 disclosed, the council and the agency shall consider variation
21 in costs, variation in outcomes, and magnitude of variations
22 and other relevant information. When determining which
23 performance outcomes to disclose, the agency:
24 a. Shall consider such factors as volume of cases;
25 average patient charges; average length of stay; complication
26 rates; mortality rates; and infection rates, among others,
27 which shall he adjusted for case mix and severity, if
28 applicable.
29 b. May consider such additional measures that are
30 adopted by the Centers for Medicare and Medicaid Studies,
31 National Quality Forum, the Joint Commission on Accreditation

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1 of Healthcare Organizations, the Agency for Healthcare
2 Research and Quality, or a similar national entity that
3 establishes standards to measure the performance of health
4 care providers, or by other states.
5
6 When determining which patient charge data to disclose, the
7 agency shall consider such measures as average charge, average
8 net revenue per adjusted patient day, average cost per
9 adjusted patient day, and average cost per admission, among
10 others.
11 2. Make available performance measures, benefit
12 design, and premium cost data from health plans licensed
13 pursuant to chapter 627 or chapter 641. The agency shall
14 determine which performance outcome and member and subscriber
15 cost data to disclose, based upon input from the council. When
16 determining which data to disclose, the agency shall consider
17 information that may be required by either individual or group
18 purchasers to assess the value of the product, which may
19 include membership satisfaction, quality of care, current
20 enrollment or membership, coverage areas, accreditation
21 status, premium costs, plan costs, premium increases, range of
22 benefits, copayments and deductibles, accuracy and speed of
23 claims payment, credentials of physicians, number of
24 providers, names of network providers, and hospitals in the
25 network. Health plans shall make available to the agency any
26 such data or information that is not currently reported to the
27 agency or the office.
28 3. Determine the method and format for public
29 disclosure of data reported pursuant to this paragraph. The
30 agency shall make its determination based upon input from the
31 Comprehensive Health Information System Advisory Council. At a

1 minimum, the data shall be made available on the agency's
2 Internet website in a manner that allows consumers to conduct
3 an interactive search that allows them to view and compare the
4 information for specific providers. The website must include
5 such additional information as is determined necessary to
6 ensure that the website enhances informed decision-making
7 among consumers and health care purchasers, which shall
8 include, at a minimum, appropriate guidance on how to use the
9 data and an explanation of why the data may vary from provider
10 to provider. The data specified in subparagraph 1. shall be
11 released no later than March 1, 2005. The data specified in
12 subparagraph 2. shall be released no later than March 1, 2006.
13 (8) STATE COMPREHENSIVE HEALTH INFORMATION SYSTEM
14 ADVISORY COUNCIL.--
15 (a) There is established in the agency the State
16 Comprehensive Health Information System Advisory Council to
17 assist the center in reviewing the comprehensive health
18 information system and to recommend improvements for such
19 system. The council shall consist of the following members:
20 1. An employee of the Executive Office of the
21 Governor, to be appointed by the Governor.
22 2. An employee of the Office of Insurance Regulation
23 ~~Department of Financial Services~~, to be appointed by the
24 Chief Financial Officer.
25 3. An employee of the Department of Education, to be
26 appointed by the Commissioner of Education.
27 4. Ten persons, to be appointed by the Secretary of
28 Health Care Administration, representing other state and local
29 agencies, state universities, the Florida Association of
30 Business/Health Coalitions, local health councils,
31

professional health-care-related associations, consumers, and purchasers.

Section 11. Subsection (3) of section 409.9066, Florida Statutes, is amended to read:

409.9066 Medicare prescription discount program.--

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

Section 12. Section 465.0244, Florida Statutes, is created to read:

465.0244 Information disclosure.--Every pharmacy shall make available on its Internet website a link to the financial data that is published by the Agency for Health Care Administration pursuant to ss. 408.05(3)(l) and 409.9066 and shall place in the area where customers receive filled prescriptions notice that such information is available electronically and the address of its Internet website.

Section 13. Section 627.6499, Florida Statutes, is amended to read:

627.6499 Reporting by insurers and third-party administrators.--

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

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1 (2) Each health insurance issuer shall make available
2 on its Internet website a link to the performance outcome and
3 financial data that is published by the Agency for Health Care
4 Administration pursuant to s. 408.05(3)(l) and shall include
5 in every policy delivered or issued for delivery to any person
6 in the state or any materials provided as required by s.
7 627.64725 notice that such information is available
8 electronically and the address of its Internet website.
9 Section 14. Subsections (6) and (7) are added to
10 section 641.54, Florida Statutes, to read:
11 641.54 Information disclosure.--
12 (6) Each health maintenance organization shall make
13 available to its subscribers the estimated co-pay, coinsurance
14 percentage, or deductible, whichever is applicable, for any
15 covered services, the status of the subscriber's maximum
16 annual out-of-pocket payments for a covered individual or
17 family, and the status of the subscriber's maximum lifetime
18 benefit. Such estimate shall not preclude the actual co-pay,
19 coinsurance percentage, or deductible, whichever is
20 applicable, from exceeding the estimate.
21 (7) Each health maintenance organization shall make
22 available on its Internet website a link to the performance
23 outcome and financial data that is published by the Agency for
24 Health Care Administration pursuant to s. 408.05(3)(l) and
25 shall include in every policy delivered or issued for delivery
26 to any person in the state or any materials provided as
27 required by s. 627.64725 notice that such information is
28 available electronically and the address of its Internet
29 website.
30 Section 15. Section 408.7056, Florida Statutes, is
31 amended to read:

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1 408.7056 ~~Statewide Provider and~~ Subscriber Assistance
2 Program.--
3 (1) As used in this section, the term:
4 (a) "Agency" means the Agency for Health Care
5 Administration.
6 (b) "Department" means the Department of Financial
7 Services.
8 (c) "Grievance procedure" means an established set of
9 rules that specify a process for appeal of an organizational
10 decision.
11 (d) "Health care provider" or "provider" means a
12 state-licensed or state-authorized facility, a facility
13 principally supported by a local government or by funds from a
14 charitable organization that holds a current exemption from
15 federal income tax under s. 501(c)(3) of the Internal Revenue
16 Code, a licensed practitioner, a county health department
17 established under part I of chapter 154, a prescribed
18 pediatric extended care center defined in s. 400.902, a
19 federally supported primary care program such as a migrant
20 health center or a community health center authorized under s.
21 329 or s. 330 of the United States Public Health Services Act
22 that delivers health care services to individuals, or a
23 community facility that receives funds from the state under
24 the Community Alcohol, Drug Abuse, and Mental Health Services
25 Act and provides mental health services to individuals.
26 (e) "Managed care entity" means a health maintenance
27 organization or a prepaid health clinic certified under
28 chapter 641, a prepaid health plan authorized under s.
29 409.912, or an exclusive provider organization certified under
30 s. 627.6472.
31

1 (f) "Office" means the Office of Insurance Regulation
2 of the Financial Services Commission.
3 (g) "Panel" means a ~~statewide provider and~~ subscriber
4 assistance panel selected as provided in subsection (11).
5 (2) The agency shall adopt and implement a program to
6 provide assistance to subscribers ~~and providers~~, including
7 those whose grievances are not resolved by the managed care
8 entity to the satisfaction of the subscriber ~~or provider~~. The
9 program shall consist of one or more panels that meet as often
10 as necessary to timely review, consider, and hear grievances
11 and recommend to the agency or the office any actions that
12 should be taken concerning individual cases heard by the
13 panel. The panel shall hear every grievance filed by
14 subscribers ~~and providers~~ on behalf of subscribers, unless the
15 grievance:
16 (a) Relates to a managed care entity's refusal to
17 accept a provider into its network of providers;
18 (b) Is part of an internal grievance in a Medicare
19 managed care entity or a reconsideration appeal through the
20 Medicare appeals process which does not involve a quality of
21 care issue;
22 (c) Is related to a health plan not regulated by the
23 state such as an administrative services organization,
24 third-party administrator, or federal employee health benefit
25 program;
26 (d) Is related to appeals by in-plan suppliers and
27 providers, unless related to quality of care provided by the
28 plan;
29 (e) Is part of a Medicaid fair hearing pursued under
30 42 C.F.R. ss. 431.220 et seq.;
31

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1 (f) Is the basis for an action pending in state or
2 federal court;
3 (g) Is related to an appeal by nonparticipating
4 providers, unless related to the quality of care provided to a
5 subscriber by the managed care entity and the provider is
6 involved in the care provided to the subscriber;
7 (h) Was filed before the subscriber ~~or provider~~
8 completed the entire internal grievance procedure of the
9 managed care entity, the managed care entity has complied with
10 its timeframes for completing the internal grievance
11 procedure, and the circumstances described in subsection (6)
12 do not apply;
13 (i) Has been resolved to the satisfaction of the
14 subscriber ~~or provider~~ who filed the grievance, unless the
15 managed care entity's initial action is egregious or may be
16 indicative of a pattern of inappropriate behavior;
17 (j) Is limited to seeking damages for pain and
18 suffering, lost wages, or other incidental expenses, including
19 accrued interest on unpaid balances, court costs, and
20 transportation costs associated with a grievance procedure;
21 (k) Is limited to issues involving conduct of a health
22 care provider or facility, staff member, or employee of a
23 managed care entity which constitute grounds for disciplinary
24 action by the appropriate professional licensing board and is
25 not indicative of a pattern of inappropriate behavior, and the
26 agency, office, or department has reported these grievances to
27 the appropriate professional licensing board or to the health
28 facility regulation section of the agency for possible
29 investigation; or
30
31

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1 (l) Is withdrawn by the subscriber ~~or provider~~.
2 Failure of the subscriber ~~or the provider~~ to attend the
3 hearing shall be considered a withdrawal of the grievance.
4 (3) The agency shall review all grievances within 60
5 days after receipt and make a determination whether the
6 grievance shall be heard. Once the agency notifies the panel,
7 the subscriber ~~or provider~~, and the managed care entity that a
8 grievance will be heard by the panel, the panel shall hear the
9 grievance either in the network area or by teleconference no
10 later than 120 days after the date the grievance was filed.
11 The agency shall notify the parties, in writing, by facsimile
12 transmission, or by phone, of the time and place of the
13 hearing. The panel may take testimony under oath, request
14 certified copies of documents, and take similar actions to
15 collect information and documentation that will assist the
16 panel in making findings of fact and a recommendation. The
17 panel shall issue a written recommendation, supported by
18 findings of fact, to the ~~provider or~~ subscriber, to the
19 managed care entity, and to the agency or the office no later
20 than 15 working days after hearing the grievance. If at the
21 hearing the panel requests additional documentation or
22 additional records, the time for issuing a recommendation is
23 tolled until the information or documentation requested has
24 been provided to the panel. The proceedings of the panel are
25 not subject to chapter 120.
26 (4) If, upon receiving a proper patient authorization
27 along with a properly filed grievance, the agency requests
28 ~~medical~~ records from a health care provider or managed care
29 entity, the health care provider or managed care entity that
30 has custody of the records has 10 days to provide the records
31 to the agency. <u>Records include medical records, communication</u>

1 <u>logs associated with the grievance both to and from the</u>
2 <u>subscriber, contracts, and any other contents of the internal</u>
3 <u>grievance file associated with the complaint filed with the</u>
4 <u>Subscriber Assistance Program.</u> Failure to provide requested
5 ~~medical~~ records may result in the imposition of a fine of up
6 to $500. Each day that records are not produced is considered
7 a separate violation.
8 (5) Grievances that the agency determines pose an
9 immediate and serious threat to a subscriber's health must be
10 given priority over other grievances. The panel may meet at
11 the call of the chair to hear the grievances as quickly as
12 possible but no later than 45 days after the date the
13 grievance is filed, unless the panel receives a waiver of the
14 time requirement from the subscriber. The panel shall issue a
15 written recommendation, supported by findings of fact, to the
16 office or the agency within 10 days after hearing the
17 expedited grievance.
18 (6) When the agency determines that the life of a
19 subscriber is in imminent and emergent jeopardy, the chair of
20 the panel may convene an emergency hearing, within 24 hours
21 after notification to the managed care entity and to the
22 subscriber, to hear the grievance. The grievance must be heard
23 notwithstanding that the subscriber has not completed the
24 internal grievance procedure of the managed care entity. The
25 panel shall, upon hearing the grievance, issue a written
26 emergency recommendation, supported by findings of fact, to
27 the managed care entity, to the subscriber, and to the agency
28 or the office for the purpose of deferring the imminent and
29 emergent jeopardy to the subscriber's life. Within 24 hours
30 after receipt of the panel's emergency recommendation, the
31

1 agency or office may issue an emergency order to the managed
2 care entity. An emergency order remains in force until:
3 (a) The grievance has been resolved by the managed
4 care entity;
5 (b) Medical intervention is no longer necessary; or
6 (c) The panel has conducted a full hearing under
7 subsection (3) and issued a recommendation to the agency or
8 the office, and the agency or office has issued a final order.
9 (7) After hearing a grievance, the panel shall make a
10 recommendation to the agency or the office which may include
11 specific actions the managed care entity must take to comply
12 with state laws or rules regulating managed care entities.
13 (8) A managed care entity, subscriber, or provider
14 that is affected by a panel recommendation may within 10 days
15 after receipt of the panel's recommendation, or 72 hours after
16 receipt of a recommendation in an expedited grievance, furnish
17 to the agency or office written evidence in opposition to the
18 recommendation or findings of fact of the panel.
19 (9) No later than 30 days after the issuance of the
20 panel's recommendation and, for an expedited grievance, no
21 later than 10 days after the issuance of the panel's
22 recommendation, the agency or the office may adopt the panel's
23 recommendation or findings of fact in a proposed order or an
24 emergency order, as provided in chapter 120, which it shall
25 issue to the managed care entity. The agency or office may
26 issue a proposed order or an emergency order, as provided in
27 chapter 120, imposing fines or sanctions, including those
28 contained in ss. 641.25 and 641.52. The agency or the office
29 may reject all or part of the panel's recommendation. All
30 fines collected under this subsection must be deposited into
31 the Health Care Trust Fund.

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1 (10) In determining any fine or sanction to be
2 imposed, the agency and the office may consider the following
3 factors:
4 (a) The severity of the noncompliance, including the
5 probability that death or serious harm to the health or safety
6 of the subscriber will result or has resulted, the severity of
7 the actual or potential harm, and the extent to which
8 provisions of chapter 641 were violated.
9 (b) Actions taken by the managed care entity to
10 resolve or remedy any quality-of-care grievance.
11 (c) Any previous incidents of noncompliance by the
12 managed care entity.
13 (d) Any other relevant factors the agency or office
14 considers appropriate in a particular grievance.
15 (11)(a) The panel shall consist of the Insurance
16 Consumer Advocate, or designee thereof, established by s.
17 627.0613; at least two members employed by the agency and at
18 least two members employed by the department, chosen by their
19 respective agencies; a consumer appointed by the Governor; a
20 physician appointed by the Governor, as a standing member;
21 and, if necessary, physicians who have expertise relevant to
22 the case to be heard, on a rotating basis. The agency may
23 contract with a medical director, and a primary care
24 physician, or both, who shall provide additional technical
25 expertise to the panel but shall not be voting members of the
26 panel. The medical director shall be selected from a health
27 maintenance organization with a current certificate of
28 authority to operate in Florida.
29 (b) A majority of those panel members required under
30 paragraph (a) shall constitute a quorum for any meeting or
31 hearing of the panel. A grievance may not be heard or voted

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1 upon at any panel meeting or hearing unless a quorum is
2 present, except that a minority of the panel may adjourn a
3 meeting or hearing until a quorum is present. A panel convened
4 for the purpose of hearing a subscriber's grievance in
5 accordance with subsections (2) and (3) shall not consist of
6 more than 11 members.
7 (12) Every managed care entity shall submit a
8 quarterly report to the agency, the office, and the department
9 listing the number and the nature of all subscribers' and
10 providers' grievances which have not been resolved to the
11 satisfaction of the subscriber or provider after the
12 subscriber or provider follows the entire internal grievance
13 procedure of the managed care entity. The agency shall notify
14 all subscribers and providers included in the quarterly
15 reports of their right to file an unresolved grievance with
16 the panel.
17 (13) A proposed order issued by the agency or office
18 which only requires the managed care entity to take a specific
19 action under subsection (7) is subject to a summary hearing in
20 accordance with s. 120.574, unless all of the parties agree
21 otherwise. If the managed care entity does not prevail at the
22 hearing, the managed care entity must pay reasonable costs and
23 attorney's fees of the agency or the office incurred in that
24 proceeding.
25 (14)(a) Any information that identifies a subscriber
26 which is held by the panel, agency, or department pursuant to
27 this section is confidential and exempt from the provisions of
28 s. 119.07(1) and s. 24(a), Art. I of the State Constitution.
29 However, at the request of a subscriber or managed care entity
30 involved in a grievance procedure, the panel, agency, or
31 department shall release information identifying the

1 subscriber involved in the grievance procedure to the
2 requesting subscriber or managed care entity.
3 (b) Meetings of the panel shall be open to the public
4 unless the provider or subscriber whose grievance will be
5 heard requests a closed meeting or the agency or the
6 department determines that information which discloses the
7 subscriber's medical treatment or history or information
8 relating to internal risk management programs as defined in s.
9 641.55(5)(c), (6), and (8) may be revealed at the panel
10 meeting, in which case that portion of the meeting during
11 which a subscriber's medical treatment or history or internal
12 risk management program information is discussed shall be
13 exempt from the provisions of s. 286.011 and s. 24(b), Art. I
14 of the State Constitution. All closed meetings shall be
15 recorded by a certified court reporter.
16 Section 16. Paragraph (c) of subsection (4) of section
17 641.3154, Florida Statutes, is amended to read:
18 641.3154 Organization liability; provider billing
19 prohibited.--
20 (4) A provider or any representative of a provider,
21 regardless of whether the provider is under contract with the
22 health maintenance organization, may not collect or attempt to
23 collect money from, maintain any action at law against, or
24 report to a credit agency a subscriber of an organization for
25 payment of services for which the organization is liable, if
26 the provider in good faith knows or should know that the
27 organization is liable. This prohibition applies during the
28 pendency of any claim for payment made by the provider to the
29 organization for payment of the services and any legal
30 proceedings or dispute resolution process to determine whether
31 the organization is liable for the services if the provider is

1 informed that such proceedings are taking place. It is
2 presumed that a provider does not know and should not know
3 that an organization is liable unless:
4 (c) The office or agency makes a final determination
5 that the organization is required to pay for such services
6 subsequent to a recommendation made by the ~~Statewide Provider~~
7 ~~and~~ Subscriber Assistance Panel pursuant to s. 408.7056; or
8 Section 17. Subsection (1), paragraphs (b) and (e) of
9 subsection (3), paragraph (d) of subsection (4), subsection
10 (5), paragraph (g) of subsection (6), and subsections (9),
11 (10), and (11) of section 641.511, Florida Statutes, are
12 amended to read:
13 641.511 Subscriber grievance reporting and resolution
14 requirements.--
15 (1) Every organization must have a grievance procedure
16 available to its subscribers for the purpose of addressing
17 complaints and grievances. Every organization must notify its
18 subscribers that a subscriber must submit a grievance within 1
19 year after the date of occurrence of the action that initiated
20 the grievance, and may submit the grievance for review to the
21 ~~Statewide Provider and~~ Subscriber Assistance Program panel as
22 provided in s. 408.7056 after receiving a final disposition of
23 the grievance through the organization's grievance process. An
24 organization shall maintain records of all grievances and
25 shall report annually to the agency the total number of
26 grievances handled, a categorization of the cases underlying
27 the grievances, and the final disposition of the grievances.
28 (3) Each organization's grievance procedure, as
29 required under subsection (1), must include, at a minimum:
30 (b) The names of the appropriate employees or a list
31 of grievance departments that are responsible for implementing

1 the organization's grievance procedure. The list must include
2 the address and the toll-free telephone number of each
3 grievance department, the address of the agency and its
4 toll-free telephone hotline number, and the address of the
5 ~~Statewide Provider and~~ Subscriber Assistance Program and its
6 toll-free telephone number.
7 (e) A notice that a subscriber may voluntarily pursue
8 binding arbitration in accordance with the terms of the
9 contract if offered by the organization, after completing the
10 organization's grievance procedure and as an alternative to
11 the ~~Statewide Provider and~~ Subscriber Assistance Program. Such
12 notice shall include an explanation that the subscriber may
13 incur some costs if the subscriber pursues binding
14 arbitration, depending upon the terms of the subscriber's
15 contract.
16 (4)
17 (d) In any case when the review process does not
18 resolve a difference of opinion between the organization and
19 the subscriber or the provider acting on behalf of the
20 subscriber, the subscriber or the provider acting on behalf of
21 the subscriber may submit a written grievance to the ~~Statewide~~
22 ~~Provider and~~ Subscriber Assistance Program.
23 (5) Except as provided in subsection (6), the
24 organization shall resolve a grievance within 60 days after
25 receipt of the grievance, or within a maximum of 90 days if
26 the grievance involves the collection of information outside
27 the service area. These time limitations are tolled if the
28 organization has notified the subscriber, in writing, that
29 additional information is required for proper review of the
30 grievance and that such time limitations are tolled until such
31 information is provided. After the organization receives the

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1 requested information, the time allowed for completion of the
2 grievance process resumes. The Employee Retirement Income
3 Security Act of 1974, as implemented by 29 C.F.R. 2560.503-1,
4 is adopted and incorporated by reference as applicable to all
5 organizations that administer small and large group health
6 plans that are subject to 29 C.F.R. 2560.503-1. The claims
7 procedures of the regulations of the Employee Retirement
8 Income Security Act of 1974 as implemented by 29 C.F.R.
9 2560.503-1 shall be the minimum standards for grievance
10 processes for claims for benefits for small and large group
11 health plans that are subject to 29 C.F.R. 2560.503-1.
12 (6)
13 (g) In any case when the expedited review process does
14 not resolve a difference of opinion between the organization
15 and the subscriber or the provider acting on behalf of the
16 subscriber, the subscriber or the provider acting on behalf of
17 the subscriber may submit a written grievance to the ~~Statewide~~
18 ~~Provider and~~ Subscriber Assistance Program.
19 (9)(a) The agency shall advise subscribers with
20 grievances to follow their organization's formal grievance
21 process for resolution prior to review by the ~~Statewide~~
22 ~~Provider and~~ Subscriber Assistance Program. The subscriber
23 may, however, submit a copy of the grievance to the agency at
24 any time during the process.
25 (b) Requiring completion of the organization's
26 grievance process before the ~~Statewide Provider and~~ Subscriber
27 Assistance Program panel's review does not preclude the agency
28 from investigating any complaint or grievance before the
29 organization makes its final determination.
30 (10) Each organization must notify the subscriber in a
31 final decision letter that the subscriber may request review

1 of the organization's decision concerning the grievance by the
2 ~~Statewide Provider and~~ Subscriber Assistance Program, as
3 provided in s. 408.7056, if the grievance is not resolved to
4 the satisfaction of the subscriber. The final decision letter
5 must inform the subscriber that the request for review must be
6 made within 365 days after receipt of the final decision
7 letter, must explain how to initiate such a review, and must
8 include the addresses and toll-free telephone numbers of the
9 agency and the ~~Statewide Provider and~~ Subscriber Assistance
10 Program.
11 (11) Each organization, as part of its contract with
12 any provider, must require the provider to post a consumer
13 assistance notice prominently displayed in the reception area
14 of the provider and clearly noticeable by all patients. The
15 consumer assistance notice must state the addresses and
16 toll-free telephone numbers of the Agency for Health Care
17 Administration, the ~~Statewide Provider and~~ Subscriber
18 Assistance Program, and the Department of Financial Services.
19 The consumer assistance notice must also clearly state that
20 the address and toll-free telephone number of the
21 organization's grievance department shall be provided upon
22 request. The agency may adopt rules to implement this section.
23 Section 18. Subsection (4) of section 641.58, Florida
24 Statutes, is amended to read:
25 641.58 Regulatory assessment; levy and amount; use of
26 funds; tax returns; penalty for failure to pay.--
27 (4) The moneys received and deposited into the Health
28 Care Trust Fund shall be used to defray the expenses of the
29 agency in the discharge of its administrative and regulatory
30 powers and duties under this part, including conducting an
31 annual survey of the satisfaction of members of health

1 maintenance organizations; contracting with physician
2 consultants for the ~~Statewide Provider and~~ Subscriber
3 Assistance Panel; maintaining offices and necessary supplies,
4 essential equipment, and other materials, salaries and
5 expenses of required personnel; and discharging the
6 administrative and regulatory powers and duties imposed under
7 this part.
8 Section 19. Paragraph (f) of subsection (2) and
9 subsections (3) and (9) of section 408.909, Florida Statutes,
10 are amended to read:
11 408.909 Health flex plans.--
12 (2) DEFINITIONS.--As used in this section, the term:
13 (f) "Health flex plan entity" means a health insurer,
14 health maintenance organization,
15 health-care-provider-sponsored organization, local government,
16 health care district, ~~or~~ other public or private
17 community-based organization, or public-private partnership
18 that develops and implements an approved health flex plan and
19 is responsible for administering the health flex plan and
20 paying all claims for health flex plan coverage by enrollees
21 of the health flex plan.
22 (3) ~~PILOT~~ PROGRAM.--The agency and the office shall
23 each approve or disapprove health flex plans that provide
24 health care coverage for eligible participants ~~who reside in~~
25 ~~the three areas of the state that have the highest number of~~
26 ~~uninsured persons, as identified in the Florida Health~~
27 ~~Insurance Study conducted by the agency and in Indian River~~
28 ~~County~~ . A health flex plan may limit or exclude benefits
29 otherwise required by law for insurers offering coverage in
30 this state, may cap the total amount of claims paid per year
31 per enrollee, may limit the number of enrollees, or may take

1 any combination of those actions. A health flex plan offering
2 may include the option of a catastrophic plan supplementing
3 the health flex plan.
4 (a) The agency shall develop guidelines for the review
5 of applications for health flex plans and shall disapprove or
6 withdraw approval of plans that do not meet or no longer meet
7 minimum standards for quality of care and access to care. The
8 agency shall ensure that the health flex plans follow
9 standardized grievance procedures similar to those required of
10 health maintenance organizations.
11 (b) The office shall develop guidelines for the review
12 of health flex plan applications and provide regulatory
13 oversight of health flex plan advertisement and marketing
14 procedures. The office shall disapprove or shall withdraw
15 approval of plans that:
16 1. Contain any ambiguous, inconsistent, or misleading
17 provisions or any exceptions or conditions that deceptively
18 affect or limit the benefits purported to be assumed in the
19 general coverage provided by the health flex plan;
20 2. Provide benefits that are unreasonable in relation
21 to the premium charged or contain provisions that are unfair
22 or inequitable or contrary to the public policy of this state,
23 that encourage misrepresentation, or that result in unfair
24 discrimination in sales practices; or
25 3. Cannot demonstrate that the health flex plan is
26 financially sound and that the applicant is able to underwrite
27 or finance the health care coverage provided.
28 (c) The agency and the Financial Services Commission
29 may adopt rules as needed to administer this section.
30 (9) PROGRAM EVALUATION.--The agency and the office
31 shall evaluate the pilot program and its effect on the

1 entities that seek approval as health flex plans, on the
2 number of enrollees, and on the scope of the health care
3 coverage offered under a health flex plan; shall provide an
4 assessment of the health flex plans and their potential
5 applicability in other settings; shall use health flex plans
6 to gather more information to evaluate low-income consumer
7 driven benefit packages; and shall, by January 1, 2005 ~~2004~~,
8 jointly submit a report to the Governor, the President of the
9 Senate, and the Speaker of the House of Representatives.
10 Section 20. Effective upon this act becoming a law,
11 section 381.0271, Florida Statutes, is created to read:
12 381.0271 Florida Patient Safety Corporation.--
13 (1) DEFINITIONS.--As used in this section, the term:
14 (a) "Adverse incident" has the same meanings as
15 provided in ss. 395.0197, 458.351, and 459.026.
16 (b) "Corporation" means the Florida Patient Safety
17 Corporation created in this section.
18 (c) "Patient safety data" has the same meaning as
19 provided in s. 766.1016.
20 (2) CREATION.--
21 (a) There is created a not-for-profit corporation to
22 be known as the Florida Patient Safety Corporation, which
23 shall be registered, incorporated, organized, and operated in
24 compliance with chapter 617. Upon the prior approval of the
25 board of directors, the corporation may create not-for-profit
26 corporate subsidiaries, organized under the provisions of
27 chapter 617, as necessary to fulfill the mission of the
28 corporation.
29 (b) The corporation or any authorized and approved
30 subsidiary is not an agency within the meaning of s.
31 20.03(11).

1 (c) The corporation and its authorized and approved
2 subsidiaries are subject to the public meetings and records
3 requirements of s. 24, Art I of the State Constitution,
4 chapter 119, and s. 286.011.
5 (d) The corporation and its authorized and approved
6 subsidiaries are not subject to the provisions of chapter 287.
7 (e) The corporation is a patient safety organization
8 for purposes of s. 766.1016.
9 (3) PURPOSE.--
10 (a) The purpose of the Florida Patient Safety
11 Corporation is to serve as a learning organization dedicated
12 to assisting health care providers in the state to improve the
13 quality and safety of health care rendered and to reduce harm
14 to patients. The corporation shall promote the development of
15 a culture of patient safety in the health care system in the
16 state. The corporation may not regulate health care providers
17 in this state.
18 (b) In the fulfillment of its purpose, the corporation
19 shall work with a consortium of patient safety centers and
20 other patient safety programs within the universities in this
21 state.
22 (4) BOARD OF DIRECTORS; MEMBERSHIP.--The corporation
23 shall be governed by a board of directors. The board of
24 directors shall consist of:
25 (a) The chairperson of the Council of Medical School
26 Deans.
27 (b) The person responsible for patient safety issues
28 for the authorized health insurer with the largest market
29 share as measured by premiums written in the state for the
30 most recent calendar year, appointed by such insurer.
31

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1 (c) A representative of the authorized medical
2 malpractice insurer with the largest market share as measured
3 by premiums written in the state for the most recent calendar
4 year, appointed by such insurer.
5 (d) The president of the Florida Health Care
6 Coalition.
7 (e) A representative of a hospital in the state that
8 is implementing innovative patient safety initiatives,
9 appointed by the Florida Hospital Association.
10 (f) A physician with expertise in patient safety,
11 appointed by the Florida Medical Association.
12 (g) A physician with expertise in patient safety,
13 appointed by the Florida Osteopathic Medical Association.
14 (h) A nurse with expertise in patient safety,
15 appointed by the Florida Nurses Association.
16 (i) An institutional pharmacist, appointed by the
17 Florida Society of Health System Pharmacists, Inc.
18 (j) A representative of Florida AARP, appointed by the
19 state director of the Florida AARP.
20 (k) An independent consultant on health care
21 information systems, appointed jointly by the Central Florida
22 Chapter and the South Florida Chapter of the Healthcare
23 Information and Management Systems Society.
24 (l) A physician with expertise in patient safety,
25 appointed by the Florida Podiatric Medical Association.
26 (m) A physician with expertise in patient safety,
27 appointed by the Florida Chiropractic Association.
28 (n) A dentist with expertise in patient safety,
29 appointed bt the Florida Dental Association.
30
31

1 (5) ADVISORY COMMITTEES.--In addition to any
2 committees that the corporation may establish, the corporation
3 shall establish the following advisory committees:
4 (a) A scientific research advisory committee that
5 includes, at a minimum, a representative from each patient
6 safety center or other patient safety program in the
7 universities of this state who is a physician licensed under
8 chapter 458 or chapter 459, with experience in patient safety
9 and evidence-based medicine. The duties of the scientific
10 research advisory committee shall include, but not be limited
11 to, the analysis of existing data and research to improve
12 patient safety and encourage evidence-based medicine.
13 (b) A technology advisory committee that includes, at
14 a minimum, a representative of a hospital that has implemented
15 a computerized physician order entry system and a health care
16 provider that has implemented an electronic medical records
17 system. The duties of the technology advisory committee shall
18 include, but not be limited to, fostering development and use
19 of new patient safety technologies, including electronic
20 medical records.
21 (c) A health care provider advisory committee that
22 includes, at a minimum, representatives of hospitals,
23 ambulatory surgical centers, physicians, nurses, and
24 pharmacists licensed in this state and a representative of the
25 Veterans Integrated Service Network 8 VA Patient Safety
26 Center. The duties of the health care provider advisory
27 committee shall include, but not be limited to, promotion of a
28 culture of patient safety that reduces errors.
29 (d) A health care consumer advisory committee that
30 includes, at a minimum, representatives of businesses that
31 provide health insurance coverage to their employees, consumer

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1 advocacy groups, and representatives of patient organizations.
2 The duties of the health care consumer advisory committee
3 shall include, but not be limited to, identification of
4 incentives to encourage patient safety and the efficiency and
5 quality of care.
6 (e) A state agency advisory committee that includes,
7 at a minimum, a representative from each state agency that has
8 regulatory responsibilities related to patient safety. The
9 duties of the state agency advisory committee shall include,
10 but not be limited to, fostering coordination of patient
11 safety activities among state agencies.
12 (f) A litigation alternatives advisory committee that
13 includes, at a minimum, representatives of attorneys who
14 represent plaintiffs and defendants in medical malpractice
15 cases, a representative of each law school in the state,
16 physicians, and health care facilities. The duties of the
17 litigation alternatives advisory committee shall include, but
18 not be limited to, identification of alternative systems to
19 compensate for injuries.
20 (g) An education advisory committee that includes, at
21 a minimum, the associate dean for education, or the equivalent
22 position, as a representative from each school of medicine,
23 nursing, public health, or allied health to provide advice on
24 the development, implementation, and measurement of core
25 competencies for patient safety to be considered for
26 incorporation in the educational programs of the universities
27 and colleges of this state.
28 (6) ORGANIZATION; MEETINGS.--
29 (a) The Agency for Health Care Administration shall
30 assist the corporation in its organizational activities
31 required under chapter 617, including, but not limited to:

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1. Eliciting appointments for the initial board of directors.
2. Convening the first meeting of the board of directors and assisting with other meetings of the board of directors, upon the request of the board of directors, during the first year of operation of the corporation.
3. Drafting articles of incorporation for the board of directors and, upon the request of the board of directors, delivering articles of incorporation to the Department of State for filing.
4. Drafting proposed bylaws for the corporation.
5. Paying fees related to incorporation.
6. Providing office space and administrative support, at the request of the board of directors, but not beyond July 1, 2005.

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

(7) POWERS AND DUTIES.--In addition to the powers and duties prescribed in chapter 617 and the articles and bylaws adopted under that chapter, the corporation shall directly or through contract:

(a) Secure staff necessary to properly administer the corporation.

(b) Collect, analyze, and evaluate patient safety data, quality and patient safety indicators, medical malpractice closed claims, and adverse incidents reported to the Agency for Health Care Administration and the Department of Health for the purpose of recommending changes in practices and procedures which may be implemented by health care

1 practitioners and health care facilities to improve the
2 quality of health care and to prevent future adverse
3 incidents. Notwithstanding any other law, the Agency for
4 Health Care Administration and the Department of Health shall
5 make available to the corporation any adverse incident report
6 submitted under s. 395.0197, s. 458.351, or s. 459.026. To the
7 extent that adverse incident reports submitted under s.
8 395.0197 are confidential and exempt from disclosure, the
9 confidential and exempt status of such reports must be
10 maintained by the corporation.
11 (c) Maintain an active library of best practices
12 relating to patient safety and patient safety literature,
13 along with the emerging evidence supporting the retention or
14 modification of such practices, and make this information
15 available to health care practitioners, health care
16 facilities, and the public.
17 (d) Assess the patient safety culture at volunteering
18 hospitals and recommend methods to improve the working
19 environment related to patient safety at these hospitals.
20 (e) Inventory the information technology capabilities
21 related to patient safety of health care facilities and health
22 care practitioners and recommend a plan for expediting
23 implementation of safety technologies statewide.
24 (f) Facilitate the development of core competencies
25 relevant to patient safety which can be made available to be
26 considered for incorporation into the undergraduate and
27 graduate curriculums in schools of medicine, nursing, and
28 allied health in this state.
29 (g) Facilitate continuing professional education
30 regarding patient safety for practicing health care
31 practitioners.

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1 (h) Study and facilitate the testing of alternative
2 systems of encouraging the implementation of effective risk
3 management strategies and clinical best practices, and of
4 compensating injured patients as a means of reducing and
5 preventing medical errors and promoting patient safety.
6 (i) Develop programs to educate the public about the
7 role of health care consumers in promoting patient safety.
8 (j) Provide interagency coordination of patient safety
9 efforts in this state.
10 (k) Conduct other activities identified by the board
11 of directors to promote patient safety in this state.
12 (8) ANNUAL REPORT.--By December 1, 2004, the
13 corporation shall prepare a report on the start-up activities
14 of the corporation and any proposals for legislative action
15 needed to enable the corporation to fulfill its purposes under
16 this section. By December 1 of each year thereafter, the
17 corporation shall prepare a report for the preceding fiscal
18 year. The report, at a minimum, must include:
19 (a) A description of the activities of the corporation
20 under this section.
21 (b) Progress made in improving patient safety and
22 reducing medical errors.
23 (c) A compliance and financial audit of the accounts
24 and records of the corporation at the end of the preceding
25 fiscal year conducted by an independent certified public
26 accountant.
27 (d) An assessment of the ability of the corporation to
28 fulfill the duties specified in subsection (7) and the
29 appropriateness of those duties for the corporation.
30 (e) Recommendations for legislative action needed to
31 improve patient safety in this state.

1
2 The corporation shall submit the report to the Governor, the
3 President of the Senate, and the Speaker of the House of
4 Representatives.
5 (9) PERFORMANCE EXPECTATIONS.--The Office of Program
6 Policy Analysis and Government Accountability, in consultation
7 with the Agency for Health Care Administration, the Department
8 of Health, and the corporation, shall develop performance
9 standards by which to measure the success of the corporation
10 in organizing to fulfill and beginning to implement the
11 purposes and duties established in this section. The Office of
12 Program Policy Analysis and Government Accountability shall
13 conduct a performance audit of the corporation during 2006,
14 using the performance standards, and shall submit a report to
15 the Governor, the President of the Senate, and the Speaker of
16 the House of Representatives by January 1, 2007.
17 Section 21. The Patient Safety Center at the Florida
18 State University College of Medicine, in collaboration with
19 researchers at other state universities, shall conduct a study
20 to analyze the return on investment that hospitals in this
21 state could realize from implementing computerized physician
22 order entry and other information technologies related to
23 patient safety. For the purposes of this analysis, the return
24 on investment shall include both financial results and
25 benefits relating to quality of care and patient safety. The
26 study must include a representative sample of large and small
27 hospitals, located in urban and rural areas, in the north,
28 central, and southern regions of the state. By February 1,
29 2005, the Patient Safety Center at the Florida State
30 University College of Medicine must submit a report to the
31

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1 Governor, the President of the Senate, and the Speaker of the
2 House of Representatives concerning the results of the study.
3 Section 22. Section 395.1012, Florida Statutes, is
4 amended to read:
5 395.1012 Patient safety.--
6 (1) Each licensed facility must adopt a patient safety
7 plan. A plan adopted to implement the requirements of 42
8 C.F.R. part 482.21 shall be deemed to comply with this
9 requirement.
10 (2) Each licensed facility shall appoint a patient
11 safety officer and a patient safety committee, which shall
12 include at least one person who is neither employed by nor
13 practicing in the facility, for the purpose of promoting the
14 health and safety of patients, reviewing and evaluating the
15 quality of patient safety measures used by the facility,
16 recommending improvements in the patient safety measures used
17 by the facility, and assisting in the implementation of the
18 facility patient safety plan.
19 (3) Each licensed facility shall adopt a plan to
20 reduce medication errors and adverse drug events, which must
21 consider the use of computerized physician order entry and
22 other information technologies related to patient safety.
23 Section 23. Subsection (3) of section 409.91255,
24 Florida Statutes, is amended to read:
25 409.91255 Federally qualified health center access
26 program.--
27 (3) ASSISTANCE TO FEDERALLY QUALIFIED HEALTH
28 CENTERS.--The Department of Health shall develop a program for
29 the expansion of federally qualified health centers for the
30 purpose of providing comprehensive primary and preventive
31 health care and urgent care services~~, including services~~ that

1 may reduce the morbidity, mortality, and cost of care among
2 the uninsured population of the state. The program shall
3 provide for distribution of financial assistance to federally
4 qualified health centers that apply and demonstrate a need for
5 such assistance in order to sustain or expand the delivery of
6 primary and preventive health care services. In selecting
7 centers to receive this financial assistance, the program:
8 (a) Shall give preference to communities that have few
9 or no community-based primary care services or in which the
10 current services are unable to meet the community's needs.
11 (b) Shall require that primary care services be
12 provided to the medically indigent using a sliding fee
13 schedule based on income.
14 (c) Shall allow innovative and creative uses of
15 federal, state, and local health care resources.
16 (d) Shall require that the funds provided be used to
17 pay for operating costs of a projected expansion in patient
18 caseloads or services or for capital improvement projects.
19 Capital improvement projects may include renovations to
20 existing facilities or construction of new facilities,
21 provided that an expansion in patient caseloads or services to
22 a new patient population will occur as a result of the capital
23 expenditures. The department shall include in its standard
24 contract document a requirement that any state funds provided
25 for the purchase of or improvements to real property are
26 contingent upon the contractor granting to the state a
27 security interest in the property at least to the amount of
28 the state funds provided for at least 5 years from the date of
29 purchase or the completion of the improvements or as further
30 required by law. The contract must include a provision that,
31 as a condition of receipt of state funding for this purpose,

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1 the contractor agrees that, if it disposes of the property
2 before the department's interest is vacated, the contractor
3 will refund the proportionate share of the state's initial
4 investment, as adjusted by depreciation.
5 (e) May require in-kind support from other sources.
6 (f) May encourage coordination among federally
7 qualified health centers, other private-sector providers, and
8 publicly supported programs.
9 <u>(g) Shall allow the development of community emergency</u>
10 <u>room diversion programs in conjunction with local resources,</u>
11 <u>providing extended hours of operation to urgent care patients.</u>
12 <u>Diversion programs shall include case management for emergency</u>
13 <u>room followup care.</u>
14 Section 24. Paragraph (a) of subsection (6) of section
15 627.410, Florida Statutes, is amended to read:
16 627.410 Filing, approval of forms.--
17 (6)(a) An insurer shall not deliver or issue for
18 delivery or renew in this state any health insurance policy
19 form until it has filed with the office a copy of every
20 applicable rating manual, rating schedule, change in rating
21 manual, and change in rating schedule; if rating manuals and
22 rating schedules are not applicable, the insurer must file
23 with the <u>office</u> ~~order~~ applicable premium rates and any change
24 in applicable premium rates. This paragraph does not apply to
25 group health insurance policies, effectuated and delivered in
26 this state, insuring groups of 51 or more persons, except for
27 Medicare supplement insurance, long-term care insurance, and
28 any coverage under which the increase in claim costs over the
29 lifetime of the contract due to advancing age or duration is
30 prefunded in the premium.
31

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1 Section 25. Section 627.6405, Florida Statutes, is
2 created to read:
3 627.6405 Decrease in inappropriate utilization of
4 emergency care.--
5 (1) The Legislature finds and declares it to be of
6 vital importance that emergency services and care be provided
7 by hospitals and physicians to every person in need of such
8 care, but with the double-digit increases in health insurance
9 premiums, health care providers and insurers should encourage
10 patients and the insured to assume responsibility for their
11 treatment, including emergency care. The Legislature finds
12 that inappropriate utilization of emergency department
13 services increases the overall cost of providing health care
14 and these costs are ultimately borne by the hospital, the
15 insured patients, and, many times, by the taxpayers of this
16 state. Finally, the Legislature declares that the providers
17 and insurers must share the responsibility of providing
18 alternative treatment options to urgent care patients outside
19 of the emergency department. Therefore, it is the intent of
20 the Legislature to place the obligation for educating
21 consumers and creating mechanisms for delivery of care that
22 will decrease the overutilization of emergency service on
23 health insurers and providers.
24 (2) Health insurers shall provide on their websites
25 information regarding appropriate utilization of emergency
26 care services which shall include, but not be limited to, a
27 list of alternative urgent care contracted providers, the
28 types of services offered by these providers, and what to do
29 in the event of a true emergency.
30 (3) Health insurers shall develop community emergency
31 department diversion programs. Such programs may include, at

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1 the discretion of the insurer, but are not limited to,
2 enlisting providers to be on call to insurers after hours,
3 coordinating care through local community resources, and
4 incentives to providers for case management.
5 (4) As a disincentive for insureds to inappropriately
6 use emergency department services, health insurers may require
7 higher copayments for nonemergency use of emergency
8 departments and higher copayments for use of out-of-network
9 emergency departments. For the purposes of this section, the
10 term "emergency care" has the same meaning as provided in s.
11 395.002, and shall include services provided to rule out an
12 emergency medical condition.
13 Section 26. Effective upon this act becoming a law,
14 section 627.64872, Florida Statutes, is created to read:
15 627.64872 Florida Health Insurance Plan.--
16 (1) LEGISLATIVE INTENT; FLORIDA HEALTH INSURANCE
17 PLAN.--
18 (a) The Legislature recognizes that to secure a more
19 stable and orderly health insurance market, the establishment
20 of a plan to assume risks deemed uninsurable by the private
21 marketplace is required.
22 (b) The Florida Health Insurance Plan is created to
23 make coverage available to individuals who have no other
24 option for similar coverage, at a premium that is commensurate
25 with the risk and benefits provided, and with benefit designs
26 that are reasonable in relation to the general market. While
27 plan operations may include supplementary funding, the plan
28 shall fundamentally operate on sound actuarial principles,
29 using basic insurance management techniques to ensure that the
30 plan is run in an economical, cost-efficient, and sound
31

1 manner, conserving plan resources to serve the maximum number
2 of people possible in a sustainable fashion.
3 (2) DEFINITIONS.--As used in this section:
4 (a) "Board" means the board of directors of the plan.
5 (b) "Commission" means the Financial Services
6 Commission.
7 (c) "Dependent" means a resident spouse or resident
8 unmarried child under the age of 19 years, a child who is a
9 student under the age of 25 years and who is financially
10 dependent upon the parent, or a child of any age who is
11 disabled and dependent upon the parent.
12 (d) "Director" means the director of the Office of
13 Insurance Regulation.
14 (e) "Health insurance" means any hospital or medical
15 expense incurred policy pursuant to this chapter or health
16 maintenance organization subscriber contract pursuant to
17 chapter 641. The term does not include short term, accident,
18 dental-only, vision-only, fixed indemnity, limited benefit,
19 credit, or disability income insurance; coverage for onsite
20 medical clinics; insurance coverage specified in federal
21 regulations issued pursuant to Pub. L. No. 104-191, under
22 which benefits for medical care are secondary or incidental to
23 other insurance benefits; benefits for long-term care, nursing
24 home care, home health care, community-based care, or any
25 combination thereof, or other similar, limited benefits
26 specified in federal regulations issued pursuant to Pub. L.
27 No. 104-191; benefits provided under a separate policy,
28 certificate, or contract of insurance where there is no
29 coordination between the provision of the benefits and any
30 exclusion of benefits under any group health plan maintained
31 by the same plan sponsor, and the benefits are paid with

1 respect to an event without regard to whether benefits are
2 provided with respect to such an event under any group health
3 plan maintained by the same plan sponsor, such as for coverage
4 only for a specified disease or illness; hospital indemnity or
5 other fixed indemnity insurance; coverage offered as a
6 separate policy, certificate, or contract of insurance, such
7 as Medicare supplemental health insurance as defined under s.
8 1882(g)(1) of the Social Security Act; coverage supplemental
9 to the coverage provided under Chapter 55 of Title 10, United
10 States Code (Civilian Health and Medical Program of the
11 Uniformed Services (CHAMPUS)); similar supplemental coverage
12 provided to coverage under a group health plan; coverage
13 issued as a supplement to liability insurance; insurance
14 arising out of a workers' compensation or similar law;
15 automobile medical-payment insurance; or insurance under which
16 benefits are payable with or without regard to fault and which
17 is statutorily required to be contained in any liability
18 insurance policy or equivalent self-insurance.
19 (f) "Implementation" means the effective date after
20 the first meeting of the board when legal authority and
21 administrative ability exist for the board to subsume the
22 transfer of all statutory powers, duties, functions, assets,
23 records, personnel, and property of the Florida Comprehensive
24 Health Association as specified in s. 627.6488.
25 (g) "Insurer" means any entity that provides health
26 insurance in this state. For purposes of this section, insurer
27 includes an insurance company with a valid certificate in
28 accordance with chapter 624, a health maintenance organization
29 with a valid certificate of authority in accordance with part
30 I or part III of chapter 641, a prepaid health clinic
31 authorized to transact business in this state pursuant to part

1 II of chapter 641, multiple employer welfare arrangements
2 authorized to transact business in this state pursuant to ss.
3 624.436-624.45, or a fraternal benefit society providing
4 health benefits to its members as authorized pursuant to
5 chapter 632.
6 (h) "Medicare" means coverage under both Parts A and B
7 of Title XVIII of the Social Security Act, 42 USC 1395 et
8 seq., as amended.
9 (i) "Medicaid" means coverage under Title XIX of the
10 Social Security Act.
11 (j) "Office" means the Office of Insurance Regulation
12 of the Financial Services Commission.
13 (k) "Participating insurer" means any insurer
14 providing health insurance to citizens of this state.
15 (l) "Provider" means any physician, hospital, or other
16 institution, organization, or person that furnishes health
17 care services and is licensed or otherwise authorized to
18 practice in the state.
19 (m) "Plan" means the Florida Health Insurance Plan
20 created in subsection (1).
21 (n) "Plan of operation" means the articles, bylaws,
22 and operating rules and procedures adopted by the board
23 pursuant to this section.
24 (o) "Resident" means an individual who has been
25 legally domiciled in this state for a period of at least 6
26 months.
27 (3) BOARD OF DIRECTORS.--
28 (a) The plan shall operate subject to the supervision
29 and control of the board. The board shall consist of the
30 director or his or her designated representative, who shall
31 serve as a member of the board and shall be its chair, and an

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1 additional eight members, five of whom shall be appointed by
2 the Governor, at least three of whom shall be individuals not
3 representative of insurers or health care providers, one of
4 whom shall be appointed by the Chief Financial Officer, one of
5 whom shall be appointed by the President of the Senate, and
6 one of whom shall be appointed by the Speaker of the House of
7 Representatives.
8 (b) The Director of the Office of Insurance
9 Regulation's term on the board shall be determined by
10 continued employment in the position. The remaining initial
11 board members shall serve for a period of time as follows: two
12 members appointed by the Governor and the members appointed by
13 the President of the Senate and the Speaker of the House of
14 Representatives shall serve 2-year terms; and three members
15 appointed by the Governor and the state's Chief Financial
16 Officer shall serve 4-year terms. Subsequent board members
17 shall serve for 3-year terms. A board member's term shall
18 continue until his or her successor is appointed.
19 (c) Vacancies on the board shall be filled by the
20 appointing authority, the authority being the Governor, the
21 President of the Senate, the Speaker of the House of
22 Representatives, or the Chief Financial Officer. Board members
23 may be removed by the appointing authority for cause.
24 (d) The director, or his or her representative, is
25 responsible for any organizational requirements necessary for
26 the initial meeting of the board which shall take place no
27 later than September 1, 2004.
28 (e) Members shall not be compensated in their capacity
29 as board members but shall be reimbursed for reasonable
30 expenses incurred in the necessary performance of their duties
31 in accordance with s. 112.061.

1 (f) The board shall submit to the commission a plan of
2 operation for the plan and any amendments thereto necessary or
3 suitable to ensure the fair, reasonable, and equitable
4 administration of the plan. The plan of operation shall ensure
5 that the plan qualifies to apply for any available funding
6 from the Federal Government that adds to the financial
7 viability of the plan. The plan of operation shall become
8 effective upon approval in writing by the commission
9 consistent with the date on which the coverage under this
10 section must be made available. If the board fails to submit a
11 suitable plan of operation within 1 year after the appointment
12 of the board of directors, or at any time thereafter fails to
13 submit suitable amendments to the plan of operation, the
14 commission shall adopt such rules as are necessary or
15 advisable to effectuate the provisions of this section. Such
16 rules shall continue in force until modified by the office or
17 superseded by a plan of operation submitted by the board and
18 approved by the commission.
19 (g) The board shall take no action to implement the
20 plan, other than the administration of coverage of individuals
21 enrolled in the Florida Comprehensive Health Association, as
22 specified in subsection (20) and the completion of the
23 actuarial study authorized in subsection (6), until funds are
24 appropriated for start-up costs and any projected deficits.
25 (4) PLAN OF OPERATION.--The plan of operation shall:
26 (a) Establish procedures for operation of the plan.
27 (b) Establish procedures for selecting an
28 administrator in accordance with subsection (11).
29 (c) Establish procedures to create a fund, under
30 management of the board, for administrative expenses.
31

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1 (d) Establish procedures for the handling, accounting,
2 and auditing of assets, moneys, and claims of the plan and the
3 plan administrator.
4 (e) Develop and implement a program to publicize the
5 existence of the plan, plan eligibility requirements, and
6 procedures for enrollment and maintain public awareness of the
7 plan.
8 (f) Establish procedures under which applicants and
9 participants may have grievances reviewed by a grievance
10 committee appointed by the board. The grievances shall be
11 reported to the board after completion of the review, with the
12 committee's recommendation for grievance resolution. The board
13 shall retain all written grievances regarding the plan for at
14 least 3 years.
15 (g) Provide for other matters as may be necessary and
16 proper for the execution of the board's powers, duties, and
17 obligations under this section.
18 (5) POWERS OF THE PLAN.--The plan shall have the
19 general powers and authority granted under the laws of this
20 state to health insurers and, in addition thereto, the
21 specific authority to:
22 (a) Enter into such contracts as are necessary or
23 proper to carry out the provisions and purposes of this
24 section, including the authority, with the approval of the
25 commission, to enter into contracts with similar plans of
26 other states for the joint performance of common
27 administrative functions, or with persons or other
28 organizations for the performance of administrative functions.
29 (b) Take any legal actions necessary or proper to
30 recover or collect assessments due the plan.
31 (c) Take such legal action as is necessary to:

1 1. Avoid payment of improper claims against the plan
2 or the coverage provided by or through the plan;
3 2. Recover any amounts erroneously or improperly paid
4 by the plan;
5 3. Recover any amounts paid by the plan as a result of
6 mistake of fact or law; or
7 4. Recover other amounts due the plan.
8 (d) Establish, and modify as appropriate, rates, rate
9 schedules, rate adjustments, expense allowances, agents'
10 commissions, claims reserve formulas, and any other actuarial
11 functions appropriate to the operation of the plan. Rates and
12 rate schedules may be adjusted for appropriate factors such as
13 age, sex, and geographic variation in claim cost and shall
14 take into consideration appropriate factors in accordance with
15 established actuarial and underwriting practices. For purposes
16 of this paragraph, usual and customary agent's commissions
17 shall be paid for the initial placement of coverage with the
18 plan and for one renewal only.
19 (e) Issue policies of insurance in accordance with the
20 requirements of this section.
21 (f) Appoint appropriate legal, actuarial, investment,
22 and other committees as necessary to provide technical
23 assistance in the operation of the plan and develop and
24 educate its policyholders regarding health savings accounts,
25 policy and contract design, and any other function within the
26 authority of the plan.
27 (g) Borrow money to effectuate the purposes of the
28 plan. Any notes or other evidence of indebtedness of the plan
29 not in default shall be legal investments for insurers and may
30 be carried as admitted assets.
31 (h) Employ and fix the compensation of employees.

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1 (i) Prepare and distribute certificate of eligibility
2 forms and enrollment instruction forms to insurance producers
3 and to the general public.
4 (j) Provide for reinsurance of risks incurred by the
5 plan.
6 (k) Provide for and employ cost-containment measures
7 and requirements, including, but not limited to, preadmission
8 screening, second surgical opinion, concurrent utilization
9 review, and individual case management for the purpose of
10 making the plan more cost-effective.
11 (l) Design, use, contract, or otherwise arrange for
12 the delivery of cost-effective health care services,
13 including, but not limited to, establishing or contracting
14 with preferred provider organizations, health maintenance
15 organizations, and other limited network provider
16 arrangements.
17 (m) Adopt such bylaws, policies, and procedures as may
18 be necessary or convenient for the implementation of this
19 section and the operation of the plan.
20 (n) Subsume the transfer of statutory powers, duties,
21 functions, assets, records, personnel, and property of the
22 Florida Comprehensive Health Association as specified in ss.
23 627.6488, 627.6489, 627.649, 627.6492, 627.6496, 627.6498, and
24 627.6499, unless otherwise specified by law.
25 (6)(a) Interim report.--No later than December 1,
26 2004, the board shall submit to the Governor, the President of
27 the Senate, and the Speaker of the House of Representatives an
28 actuarial study to determine, including, but not limited to:
29 1. The impact the creation of this plan will have on
30 the small group insurance market, specifically on the premiums
31 paid by insureds. This shall include an estimate of the total

1 anticipated aggregate savings for all small employers in the
2 state.
3 2. The number of individuals the pool could reasonably
4 cover at various funding levels.
5 3. A recommendation as to the best source of funding
6 for the anticipated deficits of the pool.
7 4. The effect on the individual and small group market
8 by including in the Florida Health Insurance Plan persons
9 eligible for coverage under s. 627.6487, as well as the cost
10 of including these individuals.
11 (b) Annual report.--No later than December 1, 2005,
12 and annually thereafter, the board shall submit to the
13 Governor, the President of the Senate, the Speaker of the
14 House of Representatives, and the substantive legislative
15 committees of the Legislature a report which includes an
16 independent actuarial study to determine, including, but not
17 be limited to:
18 1. The impact the creation of the plan has on the
19 small group and individual insurance market, specifically on
20 the premiums paid by insureds. This shall include an estimate
21 of the total anticipated aggregate savings for all small
22 employers in the state.
23 2. The actual number of individuals covered at the
24 current funding and benefit level, the projected number of
25 individuals that may seek coverage in the forthcoming fiscal
26 year, and the projected funding needed to cover anticipated
27 increase or decrease in plan participation.
28 3. A recommendation as to the best source of funding
29 for the anticipated deficits of the pool.
30 4. A summarization of the activities of the plan in
31 the preceding calendar year, including the net written and

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1 earned premiums, plan enrollment, the expense of
2 administration, and the paid and incurred losses.
3 5. A review of the operation of the plan as to whether
4 the plan has met the intent of this section.
5 (7) LIABILITY OF THE PLAN.--Neither the board nor its
6 employees shall be liable for any obligations of the plan. No
7 member or employee of the board shall be liable, and no cause
8 of action of any nature may arise against a member or employee
9 of the board, for any act or omission related to the
10 performance of any powers and duties under this section,
11 unless such act or omission constitutes willful or wanton
12 misconduct. The board may provide in its bylaws or rules for
13 indemnification of, and legal representation for, its members
14 and employees.
15 (8) AUDITED FINANCIAL STATEMENT.--No later than June 1
16 following the close of each calendar year, the plan shall
17 submit to the Governor an audited financial statement prepared
18 in accordance with statutory accounting principles as adopted
19 by the National Association of Insurance Commissioners.
20 (9) ELIGIBILITY.--
21 (a) Any individual person who is and continues to be a
22 resident of this state shall be eligible for coverage under
23 the plan if:
24 1. Evidence is provided that the person received
25 notices of rejection or refusal to issue substantially similar
26 insurance for health reasons from two or more health insurers.
27 A rejection or refusal by an insurer offering only stoploss,
28 excess of loss, or reinsurance coverage with respect to the
29 applicant shall not be sufficient evidence under this
30 paragraph; or
31

1 2. The person is enrolled in the Florida Comprehensive
2 Health Association as of the date the plan is implemented.
3 (b) Each resident dependent of a person who is
4 eligible for coverage under the plan shall also be eligible
5 for such coverage.
6 (c) A person shall not be eligible for coverage under
7 the plan if:
8 1. The person has or obtains health insurance coverage
9 substantially similar to or more comprehensive than a plan
10 policy, or would be eligible to obtain such coverage, unless a
11 person may maintain other coverage for the period of time the
12 person is satisfying any preexisting condition waiting period
13 under a plan policy or may main tain plan coverage for the
14 period of time the person is satisfying a preexisting
15 condition waiting period under another health insurance policy
16 intended to replace the plan policy;
17 2. The person is determined to be eligible for health
18 care benefits under Medicaid, Medicare, the state's children's
19 health insurance program, or any other federal, state, or
20 local government program that provides health benefits;
21 3. The person voluntarily terminated plan coverage
22 unless 12 months have elapsed since such termination;
23 4. The person is an inmate or resident of a public
24 institution; or
25 5. The person's premiums are paid for or reimbursed
26 under any government-sponsored program or by any government
27 agency or health care provider.
28 (d) Coverage shall cease:
29 1. On the date a person is no longer a resident of
30 this state;
31 2. On the date a person requests coverage to end;

1 3. Upon the death of the covered person;
2 4. On the date state law requires cancellation or
3 nonrenewal of the policy;
4 5. At the option of the plan, 30 days after the plan
5 makes any inquiry concerning the person's eligibility or place
6 of residence to which the person does not reply; or
7 6. Upon failure of the insured to pay for continued
8 coverage.
9 (e) Except under the circumstances described in this
10 subsection, coverage of a person who ceased to meet the
11 eligibility requirements of this subsection shall be
12 terminated at the end of the policy period for which the
13 necessary premiums have been paid.
14 (10) UNFAIR REFERRAL TO PLAN.--It is an unfair trade
15 practice for the purposes of part IX of chapter 626 or s.
16 641.3901 for an insurer, health maintenance organization
17 insurance agent, insurance broker, or third-party
18 administrator to refer an individual employee to the plan, or
19 arrange for an individual employee to apply to the plan, for
20 the purpose of separating that employee from group health
21 insurance coverage provided in connection with the employee's
22 employment.
23 (11) PLAN ADMINISTRATOR.--The board shall select
24 through a competitive bidding process a plan administrator to
25 administer the plan. The board shall evaluate bids submitted
26 based on criteria established by the board, which shall
27 include:
28 (a) The plan administrator's proven ability to handle
29 health insurance coverage to individuals.
30 (b) The efficiency and timeliness of the plan
31 administrator's claim processing procedures.

1 (c) An estimate of total charges for administering the
2 plan.
3 (d) The plan administrator's ability to apply
4 effective cost-containment programs and procedures and to
5 administer the plan in a cost-efficient manner.
6 (e) The financial condition and stability of the plan
7 administrator.
8
9 The administrator shall be an insurer, a health maintenance
10 organization, or a third-party administrator, or another
11 organization duly authorized to provide insurance pursuant to
12 the Florida Insurance Code.
13 (12) ADMINISTRATOR TERM LIMITS.--The plan
14 administrator shall serve for a period specified in the
15 contract between the plan and the plan administrator subject
16 to removal for cause and subject to any terms, conditions, and
17 limitations of the contract between the plan and the plan
18 administrator. At least 1 year prior to the expiration of each
19 period of service by a plan administrator, the board shall
20 invite eligible entities, including the current plan
21 administrator, to submit bids to serve as the plan
22 administrator. Selection of the plan administrator for each
23 succeeding period shall be made at least 6 months prior to the
24 end of the current period.
25 (13) DUTIES OF THE PLAN ADMINISTRATOR.--
26 (a) The plan administrator shall perform such
27 functions relating to the plan as may be assigned to it,
28 including, but not limited to:
29 1. Determination of eligibility.
30 2. Payment of claims.
31

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1 3. Establishment of a premium billing procedure for
2 collection of premiums from persons covered under the plan.
3 4. Other necessary functions to ensure timely payment
4 of benefits to covered persons under the plan.
5 (b) The plan administrator shall submit regular
6 reports to the board regarding the operation of the plan. The
7 frequency, content, and form of the reports shall be specified
8 in the contract between the board and the plan administrator.
9 (c) On March 1 following the close of each calendar
10 year, the plan administrator shall determine net written and
11 earned premiums, the expense of administration, and the paid
12 and incurred losses for the year and report this information
13 to the board and the Governor on a form prescribed by the
14 Governor.
15 (14) PAYMENT OF THE PLAN ADMINISTRATOR.--The plan
16 administrator shall be paid as provided in the contract
17 between the plan and the plan administrator.
18 (15) FUNDING OF THE PLAN.--
19 (a) Premiums.--
20 1. The plan shall establish premium rates for plan
21 coverage as provided in this section. Separate schedules of
22 premium rates based on age, sex, and geographical location may
23 apply for individual risks. Premium rates and schedules shall
24 be submitted to the office for approval prior to use.
25 2. Initial rates for plan coverage shall be limited to
26 200 percent of rates established as applicable for individual
27 standard risks as specified in s. 627.6675(3)(c). Subject to
28 the limits provided in this paragraph, subsequent rates shall
29 be established to provide fully for the expected costs of
30 claims, including recovery of prior losses, expenses of
31 operation, investment income of claim reserves, and any other

1 cost factors subject to the limitations described herein, but
2 in no event shall premiums exceed the 200-percent rate
3 limitation provided in this section. Notwithstanding the
4 200-percent rate limitation, sliding scale premium surcharges
5 based upon the insured's income may apply to all enrollees,
6 provided that such premiums do not exceed 300 percent of the
7 standard risk rate.
8 (b) Sources of additional revenue.--Any deficit
9 incurred by the plan shall be primarily funded through amounts
10 appropriated by the Legislature from general revenue sources,
11 including, but not limited to, a portion of the annual growth
12 in existing net insurance premium taxes. The board shall
13 operate the plan in such a manner that the estimated cost of
14 providing health insurance during any fiscal year will not
15 exceed total income the plan expects to receive from policy
16 premiums and funds appropriated by the Legislature, including
17 any interest on investments. After determining the amount of
18 funds appropriated to the board for a fiscal year, the board
19 shall estimate the number of new policies it believes the plan
20 has the financial capacity to insure during that year so that
21 costs do not exceed income. The board shall take steps
22 necessary to ensure that plan enrollment does not exceed the
23 number of residents it has estimated it has the financial
24 capacity to insure.
25 (16) BENEFITS.--
26 (a) The benefits provided shall be the same as the
27 standard and basic plans for small employers as outlined in s.
28 627.6699. The board shall also establish an option of
29 alternative coverage such as catastrophic coverage that
30 includes a minimum level of primary care coverage and a high
31

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1 deductible plan that meets the federal requirements of a
2 health savings account.
3 (b) In establishing the plan coverage, the board shall
4 take into consideration the levels of health insurance
5 provided in the state and such medical economic factors as may
6 be deemed appropriate and adopt benefit levels, deductibles,
7 copayments, coinsurance factors, exclusions, and limitations
8 determined to be generally reflective of and commensurate with
9 health insurance provided through a representative number of
10 large employers in the state.
11 (c) The board may adjust any deductibles and
12 coinsurance factors annually according to the medical
13 component of the Consumer Price Index.
14 (d)1. Plan coverage shall exclude charges or expenses
15 incurred during the first 6 months following the effective
16 date of coverage for any condition for which medical advice,
17 care, or treatment was recommended or received for such
18 condition during the 6-month period immediately preceding the
19 effective date of coverage.
20 2. Such preexisting condition exclusions shall be
21 waived to the extent that similar exclusions, if any, have
22 been satisfied under any prior health insurance coverage which
23 was involuntarily terminated, provided application for pool
24 coverage is made not later than 63 days following such
25 involuntary termination. In such case, coverage under the plan
26 shall be effective from the date on which such prior coverage
27 was terminated and the applicant is not eligible for
28 continuation or conversion rights that would provide coverage
29 substantially similar to plan coverage.
30 (17) NONDUPLICATION OF BENEFITS.--
31

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1 (a) The plan shall be payor of last resort of benefits
2 whenever any other benefit or source of third-party payment is
3 available. Benefits otherwise payable under plan coverage
4 shall be reduced by all amounts paid or payable through any
5 other health insurance, by all hospital and medical expense
6 benefits paid or payable under any workers' compensation
7 coverage, automobile medical payment, or liability insurance,
8 whether provided on the basis of fault or nonfault, and by any
9 hospital or medical benefits paid or payable under or provided
10 pursuant to any state or federal law or program.
11 (b) The plan shall have a cause of action against an
12 eligible person for the recovery of the amount of benefits
13 paid that are not for covered expenses. Benefits due from the
14 plan may be reduced or refused as a setoff against any amount
15 recoverable under this paragraph.
16 (18) ANNUAL AND MAXIMUM BENEFITS.--Maximum benefits
17 under the plan shall be determined by the board.
18 (19) TAXATION.--The plan is exempt from any tax
19 imposed by this state. The plan shall apply for federal tax
20 exemption status.
21 (20) COMBINING MEMBERSHIP OF THE FLORIDA COMPREHENSIVE
22 HEALTH ASSOCIATION.--
23 (a)1. Upon implementation of the Florida Health
24 Insurance Plan, the Florida Comprehensive Health Association,
25 as specified in s. 627.6488 is abolished as a separate
26 nonprofit entity and shall be subsumed under the Board of
27 Directors of the Florida Health Insurance Plan. All
28 individuals actively enrolled in the Florida Comprehensive
29 Health Association shall be enrolled in th plan subject to its
30 rules and requirements, except as otherwise specified in this
31 section. Maximum lifetime benefits paid to an individual in

1 the plan may not exceed the amount established under
2 subsection (16), and benefits previously paid for any
3 individual by the Florida Comprehensive Health Association
4 shall be used in the determination of the total lifetime
5 benefits paid under the plan.
6 2. All persons enrolled in the Florida Comprehensive
7 Health Association upon implementation of the Florida Health
8 Insurance Plan are eligible only for the benefits authorized
9 under subsection (16). Persons identified by this section
10 shall convert to the benefits authorized under subsection (16)
11 no later than January 1, 2005.
12 3. Except as otherwise provided in this section, the
13 Florida Comprehensive Health Association shall operate under
14 the existing plan of operation without modification until the
15 adoption of the new plan of operation for the Florida Health
16 Insurance Plan.
17 (b)1. As a condition of doing business in this state,
18 an insurer shall pay an assessment to the board in the amount
19 prescribed by this paragraph. For operating losses incurred on
20 or after July 1, 2004, by persons previously enrolled in the
21 Florida Comprehensive Health Association, each insurer shall
22 annually be assessed by the board in the following calendar
23 year a portion of such incurred operating losses of the plan.
24 Such portion shall be determined by multiplying such operating
25 losses by a fraction, the numerator of which equals the
26 insurer's earned premium pertaining to direct writings of
27 health insurance in the state during the calendar year
28 proceeding that for which the assessment is levied, and the
29 denominator of which equals the total of all such premiums
30 earned by participating insurers in the state during such
31 calendar year.

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1 2. The total of all assessments under this paragraph
2 upon a participating insurer shall not exceed 1 percent of
3 such insurer's health insurance premium earned in this state
4 during the calendar year preceding the year for which the
5 assessments were levied.
6 3. All rights, title, and interest in the assessment
7 funds collected under this paragraph shall vest in this state.
8 However, all of such funds and interest earned shall be used
9 by the plan to pay claims and administrative expenses.
10 (c) If assessments and other receipts by the plan,
11 board, or plan administrator exceed the actual losses and
12 administrative expenses of the plan, the excess shall be held
13 in interest and used by the board to offset future losses. As
14 used in this subsection, the term "future losses" includes
15 reserves for claims incurred but not reported.
16 (d) Each insurer's assessment shall be determined
17 annually by the board or plan administrator based on annual
18 statements and other reports deemed necessary by the board or
19 plan administrator and filed with the board or plan
20 administrator by the insurer. Any deficit incurred under the
21 plan by persons previously enrolled in the Florida
22 Comprehensive Health Association shall be recouped by the
23 assessments against participating insurers by the board or
24 plan administrator in the manner provided in paragraph (b),
25 and the insurers may recover the assessment in the normal
26 course of their respective businesses without time limitation.
27 (e) If a person enrolled in the Florida Comprehensive
28 Health Association as of July 1, 2004, loses eligibility for
29 participation in the plan, such person shall not be included
30 in the calculation of incurred operational losses as described
31

1 in paragraph (b) if the person later regains eligibility for
2 participation in the plan.
3 (f) After all persons enrolled in the Florida
4 Comprehensive Health Association as of July 1, 2004, are no
5 longer eligible for participation in the plan, the plan,
6 board, or plan administrator shall no longer be allowed to
7 assess insurers in this state for incurred losses as described
8 in paragraph (b).
9 Section 27. Upon implementation, as defined in section
10 627.64872(2), Florida Statutes, and provided in section
11 627.64872(20), Florida Statutes, of the Florida Health Benefit
12 Plan created under section 627.64872, Florida Statutes,
13 sections 627.6488, 627.6489, 627.649, 627.6492, 627.6494,
14 627.6496, and 627.6498, Florida Statutes, are repealed.
15 Section 28. Subsections (12) and (13) are added to
16 section 627.662, Florida Statutes, to read:
17 627.662 Other provisions applicable.--The following
18 provisions apply to group health insurance, blanket health
19 insurance, and franchise health insurance:
20 (12) Section 627.6044, relating to the use of specific
21 methodology for payment of claims.
22 (13) Section 627.6405, relating to inappropriate
23 utilization of emergency care.
24 Section 29. Paragraphs (c) and (d) of subsection (5),
25 subsection (6), and subsection (12) of section 627.6699,
26 Florida Statutes, are amended, subsections (15) and (16) of
27 that section are renumbered as subsections (16) and (17),
28 respectively, present subsection (15) of that section is
29 amended, and new subsections (15) and (18) are added to that
30 section, to read:
31 627.6699 Employee Health Care Access Act.--

1 (5) AVAILABILITY OF COVERAGE.--
2 (c) Every small employer carrier must, as a condition
3 of transacting business in this state:
4 1. Offer and issue all small employer health benefit
5 plans on a guaranteed-issue basis to every eligible small
6 employer, with 2 to 50 eligible employees, that elects to be
7 covered under such plan, agrees to make the required premium
8 payments, and satisfies the other provisions of the plan. A
9 rider for additional or increased benefits may be medically
10 underwritten and may only be added to the standard health
11 benefit plan. The increased rate charged for the additional or
12 increased benefit must be rated in accordance with this
13 section.
14 2. <u>In the absence of enrollment availability in the</u>
15 <u>Florida Health Insurance Plan,</u> offer and issue basic and
16 standard small employer health benefit plans on a
17 guaranteed-issue basis, during a 31-day open enrollment period
18 of August 1 through August 31 of each year, to every eligible
19 small employer, with fewer than two eligible employees, which
20 small employer is not formed primarily for the purpose of
21 buying health insurance and which elects to be covered under
22 such plan, agrees to make the required premium payments, and
23 satisfies the other provisions of the plan. Coverage provided
24 under this subparagraph shall begin on October 1 of the same
25 year as the date of enrollment, unless the small employer
26 carrier and the small employer agree to a different date. A
27 rider for additional or increased benefits may be medically
28 underwritten and may only be added to the standard health
29 benefit plan. The increased rate charged for the additional or
30 increased benefit must be rated in accordance with this
31 section. For purposes of this subparagraph, a person, his or

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1 her spouse, and his or her dependent children constitute a
2 single eligible employee if that person and spouse are
3 employed by the same small employer and either that person or
4 his or her spouse has a normal work week of less than 25
5 hours. Any right to an open enrollment of health benefit
6 coverage for groups of fewer than two employees, pursuant to
7 this section, shall remain in full force and effect in the
8 absence of the availability of new enrollment into the Florida
9 Health Insurance Plan.
10 3. This paragraph does not limit a carrier's ability
11 to offer other health benefit plans to small employers if the
12 standard and basic health benefit plans are offered and
13 rejected.
14 (d) A small employer carrier must file with the
15 office, in a format and manner prescribed by the committee, a
16 standard health care plan, a high deductible plan that meets
17 the federal requirements of a health savings account plan or a
18 health reimbursement arrangement, and a basic health care plan
19 to be used by the carrier. The provisions of this section
20 which require the filing of a high deductible plan shall take
21 effect September 1, 2004.
22 (6) RESTRICTIONS RELATING TO PREMIUM RATES.--
23 (a) The commission may, by rule, establish regulations
24 to administer this section and to assure that rating practices
25 used by small employer carriers are consistent with the
26 purpose of this section, including assuring that differences
27 in rates charged for health benefit plans by small employer
28 carriers are reasonable and reflect objective differences in
29 plan design, not including differences due to the nature of
30 the groups assumed to select particular health benefit plans.
31

1 (b) For all small employer health benefit plans that
2 are subject to this section and are issued by small employer
3 carriers on or after January 1, 1994, premium rates for health
4 benefit plans subject to this section are subject to the
5 following:
6 1. Small employer carriers must use a modified
7 community rating methodology in which the premium for each
8 small employer must be determined solely on the basis of the
9 eligible employee's and eligible dependent's gender, age,
10 family composition, tobacco use, or geographic area as
11 determined under paragraph (5)(j) and in which the premium may
12 be adjusted as permitted by this paragraph.
13 2. Rating factors related to age, gender, family
14 composition, tobacco use, or geographic location may be
15 developed by each carrier to reflect the carrier's experience.
16 The factors used by carriers are subject to office review and
17 approval.
18 3. Small employer carriers may not modify the rate for
19 a small employer for 12 months from the initial issue date or
20 renewal date, unless the composition of the group changes or
21 benefits are changed. However, a small employer carrier may
22 modify the rate one time prior to 12 months after the initial
23 issue date for a small employer who enrolls under a previously
24 issued group policy that has a common anniversary date for all
25 employers covered under the policy if:
26 a. The carrier discloses to the employer in a clear
27 and conspicuous manner the date of the first renewal and the
28 fact that the premium may increase on or after that date.
29 b. The insurer demonstrates to the office that
30 efficiencies in administration are achieved and reflected in
31 the rates charged to small employers covered under the policy.

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1 4. A carrier may issue a group health insurance policy
2 to a small employer health alliance or other group association
3 with rates that reflect a premium credit for expense savings
4 attributable to administrative activities being performed by
5 the alliance or group association if such expense savings are
6 specifically documented in the insurer's rate filing and are
7 approved by the office. Any such credit may not be based on
8 different morbidity assumptions or on any other factor related
9 to the health status or claims experience of any person
10 covered under the policy. Nothing in this subparagraph exempts
11 an alliance or group association from licensure for any
12 activities that require licensure under the insurance code. A
13 carrier issuing a group health insurance policy to a small
14 employer health alliance or other group association shall
15 allow any properly licensed and appointed agent of that
16 carrier to market and sell the small employer health alliance
17 or other group association policy. Such agent shall be paid
18 the usual and customary commission paid to any agent selling
19 the policy.
20 5. Any adjustments in rates for claims experience,
21 health status, or duration of coverage may not be charged to
22 individual employees or dependents. For a small employer's
23 policy, such adjustments may not result in a rate for the
24 small employer which deviates more than 15 percent from the
25 carrier's approved rate. Any such adjustment must be applied
26 uniformly to the rates charged for all employees and
27 dependents of the small employer. A small employer carrier may
28 make an adjustment to a small employer's renewal premium, not
29 to exceed 10 percent annually, due to the claims experience,
30 health status, or duration of coverage of the employees or
31 dependents of the small employer. Semiannually, small group

1 carriers shall report information on forms adopted by rule by
2 the commission, to enable the office to monitor the
3 relationship of aggregate adjusted premiums actually charged
4 policyholders by each carrier to the premiums that would have
5 been charged by application of the carrier's approved modified
6 community rates. If the aggregate resulting from the
7 application of such adjustment exceeds the premium that would
8 have been charged by application of the approved modified
9 community rate by <u>4</u> ~~5~~ percent for the current reporting
10 period, the carrier shall limit the application of such
11 adjustments only to minus adjustments beginning not more than
12 60 days after the report is sent to the office. For any
13 subsequent reporting period, if the total aggregate adjusted
14 premium actually charged does not exceed the premium that
15 would have been charged by application of the approved
16 modified community rate by <u>4</u> ~~5~~ percent, the carrier may apply
17 both plus and minus adjustments. A small employer carrier may
18 provide a credit to a small employer's premium based on
19 administrative and acquisition expense differences resulting
20 from the size of the group. Group size administrative and
21 acquisition expense factors may be developed by each carrier
22 to reflect the carrier's experience and are subject to office
23 review and approval.
24 6. A small employer carrier rating methodology may
25 include separate rating categories for one dependent child,
26 for two dependent children, and for three or more dependent
27 children for family coverage of employees having a spouse and
28 dependent children or employees having dependent children
29 only. A small employer carrier may have fewer, but not
30 greater, numbers of categories for dependent children than
31 those specified in this subparagraph.

1 7. Small employer carriers may not use a composite
2 rating methodology to rate a small employer with fewer than 10
3 employees. For the purposes of this subparagraph, a "composite
4 rating methodology" means a rating methodology that averages
5 the impact of the rating factors for age and gender in the
6 premiums charged to all of the employees of a small employer.
7 8.a. A carrier may separate the experience of small
8 employer groups with <u>fewer</u> ~~less~~ than 2 eligible employees from
9 the experience of small employer groups with 2-50 eligible
10 employees for purposes of determining an alternative modified
11 community rating.
12 b. If a carrier separates the experience of small
13 employer groups as provided in sub-subparagraph a., the rate
14 to be charged to small employer groups of <u>fewer</u> ~~less~~ than 2
15 eligible employees may not exceed 150 percent of the rate
16 determined for small employer groups of 2-50 eligible
17 employees. However, the carrier may charge excess losses of
18 the experience pool consisting of small employer groups with
19 <u>fewer</u> ~~less~~ than 2 eligible employees to the experience pool
20 consisting of small employer groups with 2-50 eligible
21 employees so that all losses are allocated and the 150-percent
22 rate limit on the experience pool consisting of small employer
23 groups with <u>fewer</u> ~~less~~ than 2 eligible employees is
24 maintained. Notwithstanding s. 627.411(1), the rate to be
25 charged to a small employer group of fewer than 2 eligible
26 employees, insured as of July 1, 2002, may be up to 125
27 percent of the rate determined for small employer groups of
28 2-50 eligible employees for the first annual renewal and 150
29 percent for subsequent annual renewals.
30 (c) For all small employer health benefit plans that
31 are subject to this section, that are issued by small employer

1 carriers before January 1, 1994, and that are renewed on or
2 after January 1, 1995, renewal rates must be based on the same
3 modified community rating standard applied to new business.
4 (d) Notwithstanding s. 627.401(2), this section and
5 ss. 627.410 and 627.411 apply to any health benefit plan
6 provided by a small employer carrier that is an insurer, and
7 this section and s. 641.31 apply to any health benefit
8 provided by a small employer carrier that is a health
9 maintenance organization, that provides coverage to one or
10 more employees of a small employer regardless of where the
11 policy, certificate, or contract is issued or delivered, if
12 the health benefit plan covers employees or their covered
13 dependents who are residents of this state.
14 (12) STANDARD, BASIC, <u>HIGH DEDUCTIBLE,</u> AND LIMITED
15 HEALTH BENEFIT PLANS.--
16 (a)1. The Chief Financial Officer shall appoint a
17 health benefit plan committee composed of four representatives
18 of carriers which shall include at least two representatives
19 of HMOs, at least one of which is a staff model HMO, two
20 representatives of agents, four representatives of small
21 employers, and one employee of a small employer. The carrier
22 members shall be selected from a list of individuals
23 recommended by the board. The Chief Financial Officer may
24 require the board to submit additional recommendations of
25 individuals for appointment.
26 2. The plans shall comply with all of the requirements
27 of this subsection.
28 3. The plans must be filed with and approved by the
29 office prior to issuance or delivery by any small employer
30 carrier.
31

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

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

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

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

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

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

a. A preferred provider arrangement or exclusive provider organization or any combination thereof, in which a small employer carrier enters into a written agreement with the provider to provide services at specified levels of reimbursement or to provide reimbursement to specified

1 providers. Any such written agreement between a provider and a
2 small employer carrier must contain a provision under which
3 the parties agree that the insured individual or covered
4 member has no obligation to make payment for any medical
5 service rendered by the provider which is determined not to be
6 medically necessary. A carrier may use preferred provider
7 arrangements or exclusive provider arrangements to the same
8 extent as allowed in group products that are not issued to
9 small employers.
10 b. A procedure for utilization review by the small
11 employer carrier or its designees.
12
13 This subparagraph does not prohibit a small employer carrier
14 from including in its policy or contract additional managed
15 care and cost containment provisions, subject to the approval
16 of the office, which have potential for controlling costs in a
17 manner that does not result in inequitable treatment of
18 insureds or subscribers. The carrier may use such provisions
19 to the same extent as authorized for group products that are
20 not issued to small employers.
21 4. The standard health benefit plan shall include:
22 a. Coverage for inpatient hospitalization;
23 b. Coverage for outpatient services;
24 c. Coverage for newborn children pursuant to s.
25 627.6575;
26 d. Coverage for child care supervision services
27 pursuant to s. 627.6579;
28 e. Coverage for adopted children upon placement in the
29 residence pursuant to s. 627.6578;
30 f. Coverage for mammograms pursuant to s. 627.6613;
31

1 g. Coverage for handicapped children pursuant to s.
2 627.6615;
3 h. Emergency or urgent care out of the geographic
4 service area; and
5 i. Coverage for services provided by a hospice
6 licensed under s. 400.602 in cases where such coverage would
7 be the most appropriate and the most cost-effective method for
8 treating a covered illness.
9 5. The standard health benefit plan and the basic
10 health benefit plan may include a schedule of benefit
11 limitations for specified services and procedures. If the
12 committee develops such a schedule of benefits limitation for
13 the standard health benefit plan or the basic health benefit
14 plan, a small employer carrier offering the plan must offer
15 the employer an option for increasing the benefit schedule
16 amounts by 4 percent annually.
17 6. The basic health benefit plan shall include all of
18 the benefits specified in subparagraph 4.; however, the basic
19 health benefit plan shall place additional restrictions on the
20 benefits and utilization and may also impose additional cost
21 containment measures.
22 7. Sections 627.419(2), (3), and (4), 627.6574,
23 627.6612, 627.66121, 627.66122, 627.6616, 627.6618, 627.668,
24 and 627.66911 apply to the standard health benefit plan and to
25 the basic health benefit plan. However, notwithstanding said
26 provisions, the plans may specify limits on the number of
27 authorized treatments, if such limits are reasonable and do
28 not discriminate against any type of provider.
29 8. The high deductible plan associated with a health
30 savings account or a health reimbursement arrangement shall
31 include all the benefits specified in subparagraph 4.

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

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

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

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

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

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

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

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1 2. Before a small employer carrier issues a standard
2 health benefit plan, a basic health benefit plan, or a limited
3 benefit policy or contract, it must obtain from the
4 prospective policyholder a signed written statement in which
5 the prospective policyholder:
6 a. Certifies as to eligibility for coverage under the
7 standard health benefit plan, basic health benefit plan, or
8 limited benefit policy or contract;
9 b. Acknowledges the limited nature of the coverage and
10 an understanding of the managed care and cost control features
11 of the policy or contract;
12 c. Acknowledges that if misrepresentations are made
13 regarding eligibility for coverage under a standard health
14 benefit plan, a basic health benefit plan, or a limited
15 benefit policy or contract, the person making such
16 misrepresentations forfeits coverage provided by the policy or
17 contract; and
18 d. If a limited plan is requested, acknowledges that
19 the prospective policyholder had been offered, at the time of
20 application for the insurance policy or contract, the
21 opportunity to purchase any health benefit plan offered by the
22 carrier and that the prospective policyholder had rejected
23 that coverage.
24
25 A copy of such written statement shall be provided to the
26 prospective policyholder no later than at the time of delivery
27 of the policy or contract, and the original of such written
28 statement shall be retained in the files of the small employer
29 carrier for the period of time that the policy or contract
30 remains in effect or for 5 years, whichever period is longer.
31

1 3. Any material statement made by an applicant for
2 coverage under a health benefit plan which falsely certifies
3 as to the applicant's eligibility for coverage serves as the
4 basis for terminating coverage under the policy or contract.
5 4. Each marketing communication that is intended to be
6 used in the marketing of a health benefit plan in this state
7 must be submitted for review by the office prior to use and
8 must contain the disclosures stated in this subsection.
9 (e) A small employer carrier may not use any policy,
10 contract, form, or rate under this section, including
11 applications, enrollment forms, policies, contracts,
12 certificates, evidences of coverage, riders, amendments,
13 endorsements, and disclosure forms, until the insurer has
14 filed it with the office and the office has approved it under
15 ss. 627.410 and 627.411 and this section.
16 (15) SMALL EMPLOYERS ACCESS PROGRAM.--
17 (a) Popular name.--This subsection may be referred to
18 by the popular name "The Small Employers Access Program."
19 (b) Intent.--The Legislature finds that increased
20 access to health care coverage for small employers with up to
21 25 employees could improve employees' health and reduce the
22 incidence and costs of illness and disabilities among
23 residents in this state. Many employers do not offer health
24 care benefits to their employees citing the increased cost of
25 this benefit. It is the intent of the Legislature to create
26 the Small Business Health Plan to provide small employers the
27 option and ability to provide health care benefits to their
28 employees at an affordable cost through the creation of
29 purchasing pools for employers with up to 25 employees, and
30 rural hospital employers and nursing home employers regardless
31 of the number of employees.

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1 (c) Definitions.--For purposes of this subsection, the
2 term:
3 1. "Fair commission" means a commission structure
4 determined by the insurers and reflected in the insurers' rate
5 filings made pursuant to this subsection.
6 2. "Insurer" means any entity that provides health
7 insurance in this state. For purposes of this subsection,
8 insurer includes an insurance company holding a certificate of
9 authority pursuant to chapter 624 or a health maintenance
10 organization holding a certificate of authority pursuant to
11 chapter 641, which qualifies to provide coverage to small
12 employer groups pursuant to this section.
13 3. "Mutually supported benefit plan" means an optional
14 alternative coverage plan developed within a defined
15 geographic region which may include, but is not limited to, a
16 minimum level of primary care coverage in which the percentage
17 of the premium is distributed among the employer, the
18 employee, and community-generated revenue either alone or in
19 conjunction with federal matching funds.
20 4. "Office" means the Office of Insurance Regulation
21 of the Department of Financial Services.
22 5. "Participating insurer" means any insurer providing
23 health insurance to small employers that has been selected by
24 the office in accordance with this subsection for its
25 designated region.
26 6. "Program" means the Small Employer Access Program
27 as created by this subsection.
28 (d) Eligibility.--
29 1. Any small employer group of up to 25 employees.
30
31

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1 2. Any municipality, county, school district, or
2 hospital located in a rural community as defined in s.
3 288.0636(2)(b).
4 3. Nursing home employers may participate.
5 4. Each dependent of a person eligible for coverage is
6 also eligible to participate.
7 5. Any small employer that is actively engaged in
8 business, has its principal place of business in this state,
9 employed up to 25 eligible employees on business days during
10 the preceding calendar year, and employs at least 2 employees
11 on the first day of the plan year may participate.
12
13 Coverage for a small employer group that ceases to meet the
14 eligibility requirements of this section may be terminated at
15 the end of the policy period for which the necessary premiums
16 have been paid.
17 (e) Administration.--
18 1. The office shall by competitive bid, in accordance
19 with current state law, select an insurer to provide coverage
20 through the program to eligible small employers within an
21 established geographical area of this state. The office may
22 develop exclusive regions for the program similar to those
23 used by the Healthy Kids Corporation. However the office is
24 not precluded from developing, in conjunction with insurers,
25 regions different from those used by the Healthy Kids
26 Corporation if the office deems that such a region will carry
27 out the intentions of this subsection.
28 2. The office shall evaluate bids submitted based upon
29 criteria established by the office, which shall include, but
30 not be limited to:
31

1 a. The insurer's proven ability to handle health
2 insurance coverage to small employer groups.
3 b. The efficiency and timeliness of the insurer's
4 claim processing procedures.
5 c. The insurer's ability to apply effective
6 cost-containment programs and procedures and to administer the
7 program in a cost-efficient manner.
8 d. The financial condition and stability of the
9 insurer.
10 e. The insurer's ability to develop an optional
11 mutually supported benefit plan.
12
13 The office may use any financial information available to it
14 through its regulatory duties to make this evaluation.
15 (f) Insurer qualifications.--The insurer shall be a
16 duly authorized insurer or health maintenance organization.
17 (g) Duties of the insurer.--The insurer shall:
18 1. Develop and implement a program to publicize the
19 existence of the program, program eligibility requirements,
20 and procedures for enrollment and maintain public awareness of
21 the program.
22 2. Maintain employer awareness of the program.
23 3. Demonstrate the ability to use delivery of
24 cost-effective health care services.
25 4. Encourage, educate, advise, and administer the
26 effective use of health savings accounts by covered employees
27 and dependents.
28 5. Serve for a period specified in the contract
29 between the office and the insurer, subject to removal for
30 cause and subject to any terms, conditions, and limitations of
31

1 the contract between the office and the insurer as may be
2 specified in the request for proposal.
3 (h) Contract term.--The contract term shall not exceed
4 3 years. At least 6 months prior to the expiration of each
5 contract period, the office shall invite eligible entities,
6 including the current insurer, to submit bids to serve as the
7 insurer for a designated geographic area. Selection of the
8 insurer for the succeeding period shall be made at least 3
9 months prior to the end of the current period. If a protest is
10 filed and not resolved by the end of the contract period, the
11 contract with the existing administrator may be extended for a
12 period not to exceed 6 months. During the contract extension
13 period, the administrator shall be paid at a rate to be
14 negotiated by the office.
15 (i) Insurer reporting requirements.--On March 1
16 following the close of each calendar year, the insurer shall
17 determine net written and earned premiums, the expense of
18 administration, and the paid and incurred losses for the year
19 and report this information to the office on a form prescribed
20 by the office.
21 (j) Application requirements.--The insurer shall
22 permit or allow any licensed and duly appointed health
23 insurance agent residing in the designated region to submit
24 applications for coverage, and such agent shall be paid a fair
25 commission if coverage is written. The agent must be appointed
26 to at least one insurer.
27 (k) Benefits.--The benefits provided by the plan shall
28 be the same as the coverage required for small employers under
29 subsection (12). Upon the approval of the office, the insurer
30 may also establish an optional mutually supported benefit plan
31 which is an alternative plan developed within a defined

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1 geographic region of this state or any other such alternative
2 plan which will carry out the intent of this subsection. Any
3 small employer carrier issuing new health benefit plans may
4 offer a benefit plan with coverages similar to, but not less
5 than, any alternative coverage plan developed pursuant to this
6 subsection.
7 (l) Annual reporting.--The office shall make an annual
8 report to the Governor, the President of the Senate, and the
9 Speaker of the House of Representatives. The report shall
10 summarize the activities of the program in the preceding
11 calendar year, including the net written and earned premiums,
12 program enrollment, the expense of administration, and the
13 paid and incurred losses. The report shall be submitted no
14 later than March 15 following the close of the prior calendar
15 year.
16 (16)~~(15)~~ APPLICABILITY OF OTHER STATE LAWS.--
17 (a) Except as expressly provided in this section, a
18 law requiring coverage for a specific health care service or
19 benefit, or a law requiring reimbursement, utilization, or
20 consideration of a specific category of licensed health care
21 practitioner, does not apply to a standard or basic health
22 benefit plan policy or contract or a limited benefit policy or
23 contract offered or delivered to a small employer unless that
24 law is made expressly applicable to such policies or
25 contracts. A law restricting or limiting deductibles,
26 coinsurance, copayments, or annual or lifetime maximum
27 payments does not apply to any health plan policy, including a
28 standard or basic health benefit plan policy or contract,
29 offered or delivered to a small employer unless such law is
30 made expressly applicable to such policy or contract. However,
31 every small employer carrier must offer to eligible small

1 employers the standard benefit plan and the basic benefit
2 plan, as required by subsection (5), as such plans have been
3 approved by the office pursuant to subsection (12).
4 (b) Except as provided in this section, a standard or
5 basic health benefit plan policy or contract or limited
6 benefit policy or contract offered to a small employer is not
7 subject to any provision of this code which:
8 1. Inhibits a small employer carrier from contracting
9 with providers or groups of providers with respect to health
10 care services or benefits;
11 2. Imposes any restriction on a small employer
12 carrier's ability to negotiate with providers regarding the
13 level or method of reimbursing care or services provided under
14 a health benefit plan; or
15 3. Requires a small employer carrier to either include
16 a specific provider or class of providers when contracting for
17 health care services or benefits or to exclude any class of
18 providers that is generally authorized by statute to provide
19 such care.
20 (c) Any second tier assessment paid by a carrier
21 pursuant to paragraph (11)(j) may be credited against
22 assessments levied against the carrier pursuant to s.
23 627.6494.
24 (d) Notwithstanding chapter 641, a health maintenance
25 organization is authorized to issue contracts providing
26 benefits equal to the standard health benefit plan, the basic
27 health benefit plan, and the limited benefit policy authorized
28 by this section.
29 (17)~~(16)~~ RULEMAKING AUTHORITY.--The commission may
30 adopt rules to administer this section, including rules
31

governing compliance by small employer carriers and small employers.

Section 30. Section 627.9175, Florida Statutes, is amended to read:

627.9175 Reports of information on health and accident insurance.--

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

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

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

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

~~1. The deductible amount;~~

~~2. The coinsurance percentage;~~

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

~~4. Outpatient~~ benefits;

~~5. Inpatient benefits; and~~

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

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

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

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

(2)(a) Every insurer transacting health insurance in this state shall report annually to the office, not later than April 1, information relating to any measure the insurer has implemented or proposes to implement during the next calendar year for the purpose of containing health insurance costs or cost increases. The reports shall identify each measure and the forms to which the measure is applied, shall provide an explanation as to how the measure is used, and shall provide an estimate of the cost effect of the measure.

(b) The commission shall promulgate forms to be used by insurers in reporting information pursuant to this subsection and shall utilize such forms to analyze the effects of health care cost containment programs used by health insurers in this state.

(c) The office shall analyze the data reported under this subsection and shall annually make available to the department which shall provide to the public a summary of its findings as to the types of cost containment measures reported and the estimated effect of these measures.

Section 31. (1) Effective January 1, 2005, chapter 636, Florida Statutes, is redesignated as "Prepaid Limited Health Service Organizations and Discount Medical Plan Organizations."

(2) Effective January 1, 2005, sections 636.002-636.067, Florida Statutes, are designated as part I of chapter 636, Florida Statutes, entitled "Prepaid Limited Health Service Organizations."

Section 32. Effective January 1, 2005, section 636.002, Florida Statutes, is amended to read:

636.002 Short title.--This part ~~Sections 1-57, chapter 93-148, Laws of Florida,~~ may be cited as the "Prepaid Limited Health Service Organization Act of Florida."

Section 33. Effective January 1, 2005, 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

1 panel of providers. 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 is licensed pursuant to part II of
11 this chapter as a discount medical plan organization~~, in~~
12 ~~exchange for fees, dues, charges or other consideration,~~
13 ~~provides access to a limited health service provider without~~
14 ~~assuming any responsibility for payment for the limited health~~
15 ~~service or any portion thereof~~.
16 Section 34. Effective January 1, 2005, part II of
17 chapter 636, Florida Statutes, consisting of sections 636.202,
18 636.204, 636.206, 636.208, 636.210, 636.212, 636.214, 636.216,
19 636.218, 636.220, 636.222, 636.224, 636.226, 636.228, 636.230,
20 636.232, 636.234, 636.236, 636.238, 636.240, 636.242, and
21 636.244, is created to read:
22 Part II
23 Discount Medical Plan Organizations
24 636.202 Definitions.--As used in this part, the term:
25 (1) "Commission" means the Financial Services
26 Commission.
27 (2) "Discount medical plan" means a business
28 arrangement or contract in which a person, in exchange for
29 fees, dues, charges, or other consideration, provides access
30 for plan members to providers of medical services and the
31 right to receive medical services from those providers at a

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1 discount. However, the term does not include any product
2 regulated under chapter 627, chapter 641, or part I of this
3 chapter.
4 (3) "Discount medical plan organization" means a
5 person who, in exchange for fees, dues, charges, or other
6 consideration, provides members a discount medical plan.
7 Discount medical plan organization does not include an entity
8 licensed under chapter 624, chapter 641, or part I of chapter
9 636.
10 (4) "Marketer" means a person that markets, promotes,
11 sells, or distributes a discount medical plan, including a
12 private label entity which places its name on and markets or
13 distributes a discount medical plan, but does not operate a
14 discount medical plan.
15 (5) "Medical services" means any care, service, or
16 treatment of an illness or a dysfunction of, or injury to, the
17 human body, including, but not limited to, physician care,
18 inpatient care, hospital surgical services, emergency
19 services, ambulance services, dental care services, vision
20 care services, mental health services, substance abuse
21 services, chiropractic services, podiatric care services,
22 laboratory services, medical equipment and supplies. The term
23 does not include pharmaceutical supplies or prescriptions.
24 (6) "Member" means any person who pays fees, dues,
25 charges, or other consideration for the right to receive the
26 benefits of a discount medical plan.
27 (7) "Office" means the Office of Insurance Regulation
28 of the Financial Services Commission.
29 (8) "Provider" means any person that contracts,
30 directly or indirectly, with a discount medical plan
31 organization to provide medical services to members.

1 (9) "Provider network" means an entity that negotiates
2 on behalf of more than one provider with a discount medical
3 plan organization to provide medical services to members.
4 636.204 License.--
5 (1) A person may not conduct business in this state as
6 a discount medical plan organization unless the person:
7 (a) Is a corporation, either incorporated under the
8 laws of this state, or, if a foreign corporation, is
9 authorized to transact business in this state; and
10 (b) Is licensed as a discount medical plan
11 organization by the office.
12 (2) An application for a license to operate as a
13 discount medical plan organization must be filed with the
14 office on a form prescribed by the commission. The application
15 must be sworn to by an officer or authorized representative of
16 the applicant and must be accompanied by the following:
17 (a) A copy of the applicant's articles of
18 incorporation, including all amendments.
19 (b) A copy of the corporate bylaws.
20 (c) A list of the names, addresses, official
21 positions, and biographical information of the individuals
22 responsible for conducting the applicant's affairs, including,
23 but not limited to, all members of the board of directors,
24 board of trustees, executive committee, or other governing
25 board or committee, the officers, contracted management
26 company personnel, and any person or entity owning or having
27 the right to acquire 10 percent or more of the voting
28 securities of the applicant. The list must fully disclose the
29 extent and nature of any contract or arrangement between any
30 individual who is responsible for conducting the applicant's
31

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1 affairs and the discount medical plan organization, including
2 any possible conflicts of interest.
3 (d) A complete biographical statement, on forms
4 prescribed by the commission, an independent investigation
5 report, and a set of fingerprints, as provided in chapter 624,
6 from each individual identified in subsection (c).
7 (e) A statement describing the applicant, its
8 facilities, and personnel and the medical services it proposes
9 to offer.
10 (f) A copy of any form contract used by the applicant
11 with any provider or provider network regarding the provision
12 of medical services to members.
13 (g) A copy of any form contract used by the applicant
14 with any person listed in subsection (c).
15 (h) A copy of any form contract used by the applicant
16 with any person, corporation, partnership, or other entity for
17 the performance on the applicant's behalf of any function,
18 including, but not limited to, marketing, administration,
19 enrollment, investment management, and subcontracting for the
20 provision of health services to members.
21 (i) A copy of the applicant's most recent financial
22 statements that have been audited by an independent certified
23 public accountant.
24 (j) A description of the applicant's proposed method
25 of marketing.
26 (k) A description of the member's complaint procedures
27 to be established and maintained by the applicant.
28 (l) The fee for issuance of a license.
29 (m) Such other information as the commission or office
30 may request from the applicant.
31

1 (3) The office shall issue a license that expires 1
2 year after the date of issuance, and each year on that date
3 thereafter. The office shall renew the license if the licensee
4 pays the annual license fee of $50 and if the licensee is in
5 compliance with this part.
6 (4) Before the office issues a license, each medical
7 discount plan organization must establish a website in order
8 to conform with the requirements of s. 636.226.
9 (5) The license fee under this section is $50 per
10 year, per licensee. All amounts collected shall be deposited
11 in the General Revenue Fund.
12 (6) This part does not require a provider who provides
13 discounts to his or her own patients to obtain and maintain a
14 license as a discount medical plan organization.
15 636.206 Examinations and investigations.--
16 (1) The office may examine or investigate any discount
17 medical plan organization. The office may order any discount
18 medical plan organization or applicant to produce any records,
19 books, files, advertising and solicitation materials, or other
20 information and may take statements under oath to determine
21 whether the discount medical plan organization or applicant is
22 in violation of the law or is acting contrary to the public
23 interest. The expenses incurred in conducting an examination
24 or investigation must be paid by the discount medical plan
25 organization or applicant. Examinations and investigations
26 must be conducted as provided in chapter 624 and a discount
27 medical plan organization is subject to all applicable
28 provisions of the Florida Insurance Code.
29 (2) Failure by a discount medical plan organization to
30 pay the costs incurred under this section is grounds for
31 denial or revocation of a license.

1 636.208 Fees.--A discount medical plan organization
2 may charge a reasonable one-time processing fee and a periodic
3 charge. If a discount medical plan charges a fee for a time
4 period exceeding 1 month, it must, in the event of
5 cancellation of the membership by either party, make a pro
6 rata reimbursement of the fee to the member.
7 636.210 Prohibited activities of a discount medical
8 plan.--
9 (1) A discount medical plan organization may not:
10 (a) Use in its advertisements, marketing material,
11 brochures, or discount cards the term "insurance" except as
12 otherwise authorized in this part;
13 (b) Use in its advertisements, marketing material,
14 brochures, or discount cards the terms "health plan,"
15 "coverage," "co-pay," "co-payments," "pre-existing
16 conditions," "guaranteed issue," "premium," "enrollment,"
17 "PPO," "preferred provider organization," or other terms that
18 could reasonably mislead a person into believing the discount
19 medical plan was health insurance;
20 (c) Have restrictions on free access to plan
21 providers, including, but not limited to, waiting periods and
22 notification periods; or
23 (d) Pay providers any fees for medical services.
24 (2) A discount medical plan organization is prohibited
25 from collecting or accepting money from a member for payment
26 to a provider for specific medical services furnished or to be
27 furnished to the member unless it has an active certificate of
28 authority from the office to act as an administrator.
29 636.212 Disclosures.--The following disclosures must
30 be made in writing to any prospective member, and must be on
31 the first page of any advertisements, marketing material, or

1 brochures relating to a discount medical plan. The disclosures
2 must be printed in not less than 12-point type or no smaller
3 than the largest type on the page if larger than 12-point
4 type, and must state:
5 (1) That the plan is not a health insurance policy;
6 (2) That the plan provides discounts at certain
7 healthcare providers for medical services;
8 (3) That the plan does not make payments directly to
9 providers of medical services;
10 (4) That the plan member is obligated to pay for all
11 health care services but will receive a discount from those
12 health care providers who have contracted with the discount
13 plan organization; and
14 (5) The corporate name and the locations of the
15 licensed discount medical plan organization.
16 636.214 Provider agreements.--
17 (1) A provider offering medical services to a member
18 under a discount medical plan must provide the service under a
19 written agreement with the organization. The agreement may be
20 entered into directly by the provider or by a provider network
21 to which the provider belongs.
22 (2) A provider agreement must contain the following:
23 (a) A list of the services and products to be
24 delivered at a discount;
25 (b) A statement specifying the amount of the discounts
26 offered or, alternatively, a fee schedule that reflects the
27 provider's discounted rates; and
28 (c) A statement that the provider will not charge
29 members more than the discounted rates.
30 (3) A provider agreement between a discount medical
31 plan organization and a provider network shall require the

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1 provider network to have written agreements with each
2 provider. An agreement must:
3 (a) Contain the elements described in subsection (2);
4 (b) Authorize the provider network to contract with
5 the medical discount medical plan organization on behalf of
6 the provider; and
7 (c) Require the provider network to maintain an
8 up-to-date list of the providers with whom it has a contract
9 and to deliver that list to the discount medical plan
10 organization each month.
11 (4) The discount medical plan organization shall
12 maintain a copy of each active provider agreement.
13 636.216 Form and fees filings.--
14 (1) All fees charged to members must be filed with the
15 office and any fee or charge to members greater than $30 per
16 month or $360 per year must be approved by the office before
17 they can be imposed on a member. The discount medical plan
18 organization has the burden of proof that the fees charged
19 bear a reasonable relation to the benefits received by the
20 member.
21 (2) There must be a written agreement between the
22 discount medical plan organization and the member specifying
23 the benefits under the discount medical plan and complying
24 with the disclosure requirements of this part.
25 (3) Any form used by the discount medical plan
26 organization, including the written agreement between the
27 organization and the member, must first be filed with and
28 approved by the office. Every form filed shall be identified
29 by a unique form number placed in the lower left corner of
30 each form.
31

1 (4) If the office disapproves any filing, the office
2 shall notify the discount medical plan organization in writing
3 and must specify the reasons why the office disapproved the
4 filing. The discount medical plan organization has 21 days
5 from the date it receives the disapproval notice to request a
6 hearing before the office under chapter 120.
7 636.218 Annual reports.--
8 (1) Each discount medical plan organization must file
9 with the office an annual report no later than 3 months after
10 the end of the organization's fiscal year.
11 (2) The report must be on a form and in a format
12 prescribed by the commission and must include:
13 (a) Audited financial statements prepared in
14 accordance with generally accepted accounting principles and
15 certified by an independent certified public accountant. The
16 financial statements shall include the organization's balance
17 sheet, income statement, and statement of changes in cash flow
18 for the preceding year.
19 (b) A list of the names and residence addresses of all
20 persons responsible for the conduct of its affairs, together
21 with a disclosure of the extent and nature of any contracts or
22 arrangements between these persons and the discount medical
23 plan organization, including any possible conflicts of
24 interest.
25 (c) The number of discount medical plan members.
26 (d) Such other information relating to the performance
27 of the discount medical plan organization that is required by
28 the commission or office.
29 (3) A discount medical plan organization that fails to
30 file an annual report in the form and within the time required
31 by this section shall forfeit up to $500 for each day for the

1 first 10 days during which the report is delinquent and shall
2 forfeit up to $1,000 for each day after the first 10 days
3 during which the report is delinquent. Upon notice by the
4 office, the organization may no longer enroll new members or
5 do business in this state until the organization complies with
6 this section. The office shall deposit all sums collected by
7 it under this section to the credit of the Insurance
8 Regulatory Trust Fund. The office may not collect more than
9 $50,000 for each delinquent report.
10 636.220 Minimum capital requirements.--
11 (1) Each discount medical plan organization must at
12 all times maintain a net worth of at least $150,000.
13 (2) The office may not issue a license unless the
14 medical discount medical plan organization has a net worth of
15 at least $150,000.
16 636.222 Suspension or revocation of license;
17 suspension of enrollment of new members; terms of
18 suspension.--
19 (1) The office may suspend the authority of a discount
20 medical plan organization to enroll new members, may revoke a
21 license issued to a discount medical plan organization, or may
22 order compliance if it finds that any of the following
23 conditions exist:
24 (a) The organization is not operating in compliance
25 with this part.
26 (b) The discount medical plan organization does not
27 have the minimum net worth as required by this part.
28 (c) The organization has advertised, merchandised, or
29 attempted to merchandise its services in a manner as to
30 misrepresent its services or capacity for service or has
31

1 engaged in deceptive, misleading, or unfair practices with
2 respect to advertising or merchandising.
3 (d) The discount medical plan organization is not
4 fulfilling its obligations as a discount medical plan
5 organization.
6 (e) The continued operation of the discount medical
7 plan organization would be hazardous to its members.
8 (2) If the office has cause to believe that grounds
9 for the suspension or revocation of a license exist, it shall
10 notify the discount medical plan organization in writing
11 specifically stating the grounds for suspension or revocation
12 and shall pursue a hearing on the matter in accordance with
13 chapter 120.
14 (3) If the license of a discount medical plan
15 organization is surrendered or revoked, the organization must
16 proceed, immediately following the effective date of the order
17 of revocation, to wind up its affairs transacted under the
18 license. It may not engage in any further advertising,
19 solicitation, collecting of fees, or renewal of contracts.
20 (4) The office shall, in its order suspending the
21 authority of a discount medical plan organization to enroll
22 new members, specify the period during which the suspension is
23 to be in effect and the conditions, if any, which must be met
24 by the discount medical plan organization before reinstatement
25 of its license to enroll new members. The order of suspension
26 is subject to rescission or modification by further order of
27 the office before expiration of the suspension period.
28 Reinstatement may not be made unless requested by the discount
29 medical plan organization. However, the office may not grant
30 reinstatement if it finds that the circumstances for which the
31 suspension occurred still exist or are likely to recur.

1 636.224 Notice of change of name or address of
2 discount medical plan organization.--Each discount medical
3 plan organization must notify the office at least 30 days in
4 advance of any change in the discount medical plan
5 organization's name, address, principal business address, or
6 mailing address.
7 636.226 Provider name listing.--
8 (1) Each discount medical plan organization must
9 maintain an up-to-date list of the names and addresses of the
10 providers with whom it has a contract to deliver medical
11 services. The list must be stored on its website, the Internet
12 address of which must be prominently displayed on all its
13 advertisements, marketing material, brochures, and discount
14 cards.
15 (2) This section applies to providers with whom the
16 discount medical plan organization has contracted directly and
17 to those who are members of a provider network with which the
18 discount medical plan organization has a contract to deliver
19 medical services.
20 636.228 Marketing of discount medical plans.--
21 (1) All advertisements, marketing material, brochures,
22 and discount cards used by marketers must be approved in
23 writing for use by the discount medical plan organization.
24 (2) The discount medical plan organization shall have
25 an executed written agreement with a marketer before the
26 marketer marketing, promoting, selling, or distributing the
27 discount medical plan and shall be responsible and financially
28 liable for any acts of its marketers which do not comply with
29 the provisions of this part.
30 636.230 Bundling discount medical plans with other
31 insurance products.--When a marketer or discount medical plan

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1 organization sells a discount medical plan along with any
2 other product, the fees for each product must be itemized
3 separately and provided to the members in writing.
4 636.232 Rules.--The commission may adopt rules to
5 administer this part, including rules for the licensing of
6 discount medical plan organizations; establishing standards
7 for evaluating forms, advertisements, marketing material,
8 brochures, and discount cards; the collection of data;
9 disclosures to plan members; and rules defining terms used in
10 this act.
11 636.234 Service of process on a discount medical plan
12 organization.--Sections 624.422 and 624.423 apply to a
13 discount medical plan organization as if a discount medical
14 plan organization were an insurer.
15 636.236 Security deposit.--
16 (1) A licensed discount medical plan organization must
17 deposit, and maintain deposited in trust with the department,
18 securities eligible for deposit under s. 625.52, in order that
19 the office might protect plan members. The securities must, at
20 all times, have a value of not less than $35,000.
21 (2) A judgment creditor or other claimant of a
22 discount medical plan organization, other than the office or
23 the Department of Financial Services, does not have the right
24 to levy upon any of the assets or securities held in this
25 state as a deposit under this section.
26 636.238 Penalties for violation of this part.--
27 (1) Except as provided in subsection (2), a person who
28 violates this part commits a misdemeanor of the second degree,
29 punishable as provided in s. 775.082 or s. 775.083.
30 (2) A person who operates as or aids and abets another
31 operating as a discount medical plan organization in violation

1 of s. 636.204(1) commits a felony punishable as provided for
2 in s. 624.401(4)(b), as if the unlicensed discount medical
3 plan organization were an unauthorized insurer, and the fees,
4 dues, charges, or other consideration collected from the
5 members by the unlicensed discount medical plan organization
6 or marketer were insurance premium.
7 (3) A person who collects fees for purported
8 membership in a discount medical plan but fails to provide the
9 promised benefits commits a theft punishable as provided in s.
10 812.014.
11 636.240 Injunction.--
12 (1) In addition to the penalties and other enforcement
13 provisions of this act, the office may commence an action for
14 temporary and permanent injunctive relief if:
15 (a) A discount medical plan is operated by a person
16 that is not licensed under this part.
17 (b) A person, entity, or discount medical plan
18 organization has engaged in any activity prohibited by this
19 act or any rule adopted under this act.
20 (2) Venue for any proceeding bought under this section
21 shall be in the Circuit Court for Leon County.
22 (3) The office's authority to seek injunctive relief
23 is not conditioned on having conducted any proceeding under
24 chapter 120.
25 636.242 Civil remedies.--Any person injured by a
26 person acting in violation of this part may bring a civil
27 action against the person committing the violation in the
28 circuit court of the county in which the alleged violator
29 resides or has a principal place of business or in the county
30 where the alleged violation occurred. If the defendant is
31 found to have injured the plaintiff, the defendant is liable

1 for damages and the court may also award the prevailing
2 plaintiff court costs and reasonable attorney's fees. If so
3 awarded, the court costs and attorney's fees must be included
4 in the judgment or decree rendered in the case. If it appears
5 to the court that the suit brought by the plaintiff is
6 frivolous or brought for purposes of harassment, the court may
7 award the defendant court costs and reasonable attorney's fees
8 and may apply sanctions against the plaintiff in accordance
9 with chapter 57.
10 636.244 Unlicensed discount medical plan
11 organizations.--Sections 626.901 through 626.912 apply to the
12 activities of an unlicensed discount medical plan organization
13 as if an unlicensed discount medical plan organization were an
14 unauthorized insurer.
15 Section 35. Section 627.65626, Florida Statutes, is
16 created to read:
17 627.65626 Insurance rebates for healthy lifestyles.--
18 (1) Any rate, rating schedule, or rating manual for a
19 health insurance policy filed with the office shall provide
20 for an appropriate rebate of premiums paid in the last
21 calendar year when the majority of members of a health plan
22 have enrolled and maintained participation in any health
23 wellness, maintenance, or improvement program offered by the
24 employer. The employer must provide evidence of demonstrative
25 maintenance or improvement of the enrollees' health status as
26 determined by assessments of agreed-upon health status
27 indicators between the employer and the health insurer,
28 including, but not limited to, reduction in weight, body mass
29 index, and smoking cessation. Any rebate provided by the
30 health insurer is presumed to be appropriate unless credible
31

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1 data demonstrates otherwise, but shall not exceed 10 percent
2 of paid premiums.
3 (2) The premium rebate authorized by this section
4 shall be effective for an insured on an annual basis, unless
5 the number of participating employees becomes less than the
6 majority of the employees eligible for participation in the
7 wellness program.
8 Section 36. Section 627.6402, Florida Statutes, is
9 created to read:
10 627.6402 Insurance rebates for healthy lifestyles.--
11 (1) Any rate, rating schedule, or rating manual for an
12 individual health insurance policy filed with the office shall
13 provide for an appropriate rebate of premiums paid in the last
14 calendar year when the individual covered by such plan is
15 enrolled in and maintains participation in any health
16 wellness, maintenance, or improvement program approved by the
17 health plan. The individual must provide evidence of
18 demonstrative maintenance or improvement of the individual's
19 health status as determined by assessments of agreed-upon
20 health status indicators between the individual and the health
21 insurer, including, but not limited to, reduction in weight,
22 body mass index, and smoking cessation. Any rebate provided by
23 the health insurer is presumed to be appropriate unless
24 credible data demonstrates otherwise, but shall not exceed 10
25 percent of paid premiums.
26 (2) The premium rebate authorized by this section
27 shall be effective for an insured on an annual basis, unless
28 the individual fails to maintain or improve his or her health
29 status while participating in an approved wellness program, or
30 credible evidence demonstrates that the individual is not
31 participating in the approved wellness program.

1 Section 37. Subsection (38) of section 641.31, Florida
2 Statutes, is amended, and subsection (40) is added to that
3 section, to read:
4 641.31 Health maintenance contracts.--
5 (38)(a) Notwithstanding any other provision of this
6 part, a health maintenance organization that meets the
7 requirements of paragraph (b) may, through a point-of-service
8 rider to its contract providing comprehensive health care
9 services, include a point-of-service benefit. Under such a
10 rider, a subscriber or other covered person of the health
11 maintenance organization may choose, at the time of covered
12 service, a provider with whom the health maintenance
13 organization does not have a health maintenance organization
14 provider contract. The rider may not require a referral from
15 the health maintenance organization for the point-of-service
16 benefits.
17 (b) A health maintenance organization offering a
18 point-of-service rider under this subsection must have a valid
19 certificate of authority issued under the provisions of the
20 chapter, must have been licensed under this chapter for a
21 minimum of 3 years, and must at all times that it has riders
22 in effect maintain a minimum surplus of $5 million. A health
23 maintenance organization offering a point-of-service rider to
24 its contract providing comprehensive health care services may
25 offer the rider to employers who have employees living and
26 working outside the health maintenance organization's approved
27 geographic service area without having to obtain a health care
28 provider certificate, as long as the master group contract is
29 issued to an employer that maintains its primary place of
30 business within the health maintenance organization's approved
31 service area. Any member or subscriber that lives and works

1 outside the health maintenance organization's service area and
2 elects coverage under the health maintenance organization's
3 point-of-service rider must provide a statement to the health
4 maintenance organization which indicates that the member or
5 subscriber understands the limitations of his or her policy
6 and that only those benefits under the point-of-service rider
7 will be covered when services are provided outside the service
8 area.
9 (c) Premiums paid in for the point-of-service riders
10 may not exceed 15 percent of total premiums for all health
11 plan products sold by the health maintenance organization
12 offering the rider. If the premiums paid for point-of-service
13 riders exceed 15 percent, the health maintenance organization
14 must notify the office and, once this fact is known, must
15 immediately cease offering such a rider until it is in
16 compliance with the rider premium cap.
17 (d) Notwithstanding the limitations of deductibles and
18 copayment provisions in this part, a point-of-service rider
19 may require the subscriber to pay a reasonable copayment for
20 each visit for services provided by a noncontracted provider
21 chosen at the time of the service. The copayment by the
22 subscriber may either be a specific dollar amount or a
23 percentage of the reimbursable provider charges covered by the
24 contract and must be paid by the subscriber to the
25 noncontracted provider upon receipt of covered services. The
26 point-of-service rider may require that a reasonable annual
27 deductible for the expenses associated with the
28 point-of-service rider be met and may include a lifetime
29 maximum benefit amount. The rider must include the language
30 required by s. 627.6044 and must comply with copayment limits
31

1 described in s. 627.6471. Section 641.3154 does not apply to a
2 point-of-service rider authorized under this subsection.
3 (e) The point-of-service rider must contain provisions
4 that comply with s. 627.6044.
5 (f)~~(e)~~ The term "point of service" may not be used by
6 a health maintenance organization except with riders permitted
7 under this section or with forms approved by the office in
8 which a point-of-service product is offered with an indemnity
9 carrier.
10 (g)~~(f)~~ A point-of-service rider must be filed and
11 approved under ss. 627.410 and 627.411.
12 (40)(a) Any rate, rating schedule, or rating manual
13 for a health maintenance organization policy filed with the
14 office shall provide for an appropriate rebate of premiums
15 paid in the last calendar year when the individual covered by
16 such plan is enrolled in and maintains participation in any
17 health wellness, maintenance, or improvement program approved
18 by the health plan. The individual must provide evidence of
19 demonstrative maintenance or improvement of his or her health
20 status as determined by assessments of agreed-upon health
21 status indicators between the individual and the health
22 insurer, including, but not limited to, reduction in weight,
23 body mass index, and smoking cessation. Any rebate provided by
24 the health insurer is presumed to be appropriate unless
25 credible data demonstrates otherwise, but shall not exceed 10
26 percent of paid premiums.
27 (b) The premium rebate authorized by this section
28 shall be effective for an insured on an annual basis, unless
29 the individual fails to maintain or improve his or her health
30 status while participating in an approved wellness program, or
31

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1 credible evidence demonstrates that the individual is not
2 participating in the approved wellness program.
3 Section 38. Notwithstanding the amendment to section
4 627.6699(5)(c), Florida Statutes, by this act, any right to an
5 open enrollment offer of health benefit coverage for groups of
6 fewer than two employees, pursuant to section 627.6699(5)(c),
7 Florida Statutes, as it existed immediately before the
8 effective date of this act, shall remain in full force and
9 effect until the enactment of section 627.64872, Florida
10 Statutes, and the subsequent date upon which such plan begins
11 to accept new risks or members.
12 Section 39. Section 408.02, Florida Statutes, is
13 repealed.
14 Section 40. Subsection (1) of section 766.309, Florida
15 Statutes, is amended to read:
16 766.309 Determination of claims; presumption; findings
17 of administrative law judge binding on participants.--
18 (1) The administrative law judge shall make the
19 following determinations based upon all available evidence:
20 (a) Whether the injury claimed is a birth-related
21 neurological injury. If the claimant has demonstrated, to the
22 satisfaction of the administrative law judge, that the infant
23 has sustained a brain or spinal cord injury caused by oxygen
24 deprivation or mechanical injury and that the infant was
25 thereby rendered permanently and substantially mentally and
26 physically impaired, a rebuttable presumption shall arise that
27 the injury is a birth-related neurological injury as defined
28 in s. 766.302(2).
29 (b) Whether obstetrical services were delivered by a
30 participating physician in the course of labor, delivery, or
31 resuscitation in the immediate postdelivery period in a

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1 hospital; or by a certified nurse midwife in a teaching
2 hospital supervised by a participating physician in the course
3 of labor, delivery, or resuscitation in the immediate
4 postdelivery period in a hospital.
5 (c) How much compensation, if any, is awardable
6 pursuant to s. 766.31.
7 (d) Whether, if raised by the claimant or other party,
8 the factual determinations regarding the notice requirements
9 in s. 766.316 are satisfied. The administrative law judge has
10 the exclusive jurisdiction to make these factual
11 determinations.
12 Section 41. The Agency for Health Care Administration
13 shall adopt all rules necessary to implement this act no later
14 than January 1, 2005.
15 Section 42. The amendment to section 766.309, Florida
16 Statutes, contained in this act, is intended to clarify that
17 the administrative law judge has always had the exclusive
18 jurisdiction to make factual determinations as to whether the
19 notice requirements in section 766.316, Florida Statutes, are
20 satisfied.
21 Section 43. The Auditor General shall conduct a study
22 of nursing home finances which shall examine the following:
23 (1) Profits of nursing home licensees, nursing home
24 management companies, related-party businesses, and owners of
25 real estate that is leased to nursing home operators in this
26 state;
27 (2) Salaries of nonfacility-based nursing home
28 executives, nursing home operators, management companies, and
29 real estate entities; and
30
31

1 (3) Home office costs and related party costs that are
2 reported to the Agency for Health Care Administration by a
3 nursing home.
4
5 The Auditor General shall report the overall profits of all
6 nursing home licensees and associated business entities,
7 including home office operators, management companies, real
8 estate entities, and related party organizations. The Auditor
9 General shall report on the retained earnings for nonprofit
10 facilities and any home office, management, real estate
11 entities, and related party organizations. The Auditor General
12 shall report the total amount of executive salaries, home
13 office costs, and related party costs for the most recently
14 completed cost-reporting period. The Auditor General shall
15 report its findings to the Governor, the President of the
16 Senate, and the Speaker of the House of Representatives by
17 December 15, 2004.
18 Section 44. The Agency for Health Care Administration
19 shall conduct a survey of all nursing home operators to
20 determine:
21 (1) The number of nursing home operators offering
22 health insurance to their employees, and the requirements for
23 this coverage;
24 (2) The number of nursing home employees not meeting
25 the employer's requirements for health insurance coverage;
26 (3) The number of nursing home employees enrolled in
27 employer-sponsored health insurance plans and the actual
28 number of employees not enrolled in an employer-sponsored
29 health insurance plan;
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1 (4) The number of nursing home employees who have
2 employee-only coverage and the actual number of employees who
3 have dependent coverage; and
4 (5) The number of nursing home employees whose
5 dependents are enrollees in KidCare, Healthy Kids, and
6 Medicaid.
7
8 The agency shall report its findings to the Governor, the
9 President of the Senate, and the Speaker of the House of
10 Representatives by December 15, 2004.
11 Section 45. The sum of $250,000 is appropriated from
12 the Insurance Regulatory Trust Fund in the Department of
13 Financial Services to the Office of Insurance Regulation for
14 the purpose of implementing the provisions in this act
15 relating to the Small Employers Access Program.
16 Section 46. The sum of $350,000 in nonrecurring
17 general revenue funds is appropriated to the Agency for Health
18 Care Administration to support the establishment of and to
19 contract with the Florida Patient Safety Corporation to
20 implement the provisions of section 16 of this act during the
21 2004-2005 fiscal year.
22 Section 47. The sum of $113,500 in nonrecurring
23 general revenue funds is appropriated to the Florida State
24 University College of Medicine for the purpose of conducting
25 the study required in section 17 of this act during the
26 2004-2005 fiscal year.
27 Section 48. The sum of $250,000 is appropriated from
28 the Insurance Regulatory Trust Fund in the Department of
29 Financial Services to the Office of Insurance Regulation for
30 the board of the Florida Health Insurance Plan to contract for
31 an independent actuarial study for the interim report that the

1 board is required to submit pursuant to section 627.64872,
2 Florida Statutes, as created by this act. In addition, the
3 board shall include in that study an analysis of exempting
4 health insurance rates for employers with 26 to 50 employees
5 from the requirements of modified community rating, as
6 provided in section 672.6699, Florida Statutes, and the
7 potential impact that such an exemption would have on the
8 accessibility and affordability of health insurance coverage
9 in the small employer market.
10 Section 49. The sum of $169,069 is appropriated from
11 the Insurance Regulatory Trust Fund in the Department of
12 Financial Services to the Office of Insurance Regulation for
13 the purpose of implementing the provisions in this act
14 relating to the regulation of discount medical plan
15 organizations.
16 Section 50. The sum of $2 million in nonrecurring
17 general revenue funds is appropriated to the Agency for Health
18 Care Administration for its activities during the 2004-2005
19 fiscal year which relate to developing and implementing a
20 strategy for the adoption and use of electronic health
21 records.
22 Section 51. Except as otherwise expressly provided in
23 this act, and except for this section, which shall take effect
24 upon becoming a law, this act shall take effect July 1, 2004.
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STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR
CS for CS for SB 2910

Revises the transparency provisions to: 1) require licensed facilities to have a website link to the Agency for Health Care Administration's patient charge and performance outcome data, and deletes the exemption for rural hospitals with fewer than 50 beds; 2) requires a $500 fine for facilities that fail to provide this information or an estimate of charges; 3) require facilities to provide an itemized bill within 7 days after discharge; and 4) requires licensed facilities to make available to a patient, all records necessary for verification of the patient's bill.

Makes the section that creates the Florida Patient Safety Corporation take effect upon the bill becoming a law.

Adds a podiatrist, chiropractor and dentist to the board of directors of the Florida Patient Safety Corporation.

Specifies minimum duties of the advisory committees of the Florida Patient Safety Corporation and adds physicians and health care facility representatives to the litigation alternatives advisory committee.

Clarifies that the insurers have the discretion to determine the specific features of the emergency department diversion program that health insurers must develop.

Changes the definition of "implementation" of the Florida Health Insurance Plan (FHIP) to mean the date when legal authority and administrative ability exists for the board to subsume the powers of the Florida Comprehensive Health Association (FCHA).

Deletes from the definition of "resident" for purposes of the FHIP, the provisions that HIPAA-eligible individuals do not have to meet the six month residency requirement because the bill no longer makes HIPAA-eligible individuals automatically eligible for the plan.

Specifies the initial terms of office of each of the board members of the FHIP and makes the Director of the Office of Insurance Regulation responsible for any organizational requirements for the initial board meeting.

Clarifies that the board of the FHIP may take action to administer coverage of individuals enrolled in the FCHA, prior to funds being appropriated.

Clarifies that the board of the FHIP subsumes the statutory powers of the FCHA.

Requires the actuarial study done for the FHIP to determine the effect on the individual and small group market by including HIPAA-eligible individual in the FHIP.

Requires the Auditor General to conduct a study of nursing home finances.

Deletes a reference to HIPAA-eligible individuals in the premium limits for the FHIP since the bill no longer makes HIPAA-eligible individuals automatically eligible for the plan.

Clarifies that upon implementation of the FHIP, the FCHA is abolished and all individuals actively enrolled in the FCHA shall be enrolled in the FHIP, and will convert to the plan benefits by January 1, 2005.

Requires small employer carriers to offer a high deductible plan that meets the federal requirements of a health reimbursement arrangement, as well as a health savings account plan.

Requires the high deductible plan offered by small group carriers for health reimbursement arraignments, as well as health savings accounts, to meet the minimum benefits of this section.

Deletes the requirement that the date submitted by health maintenance organizations (HMOs) to the Agency for Health Care Administration include percentage of claims denied, percentage of claims meeting prompt pay requirements, and medical and administrative loss ratios.

Provides that a discount medical plan does not include any health insurance policy or HMO contract regulated under the insurance code.

Specifies that a discount medical plan organization does not include a licensed insurance company, HMO, or prepaid limited health service organization.

Adds terms that would be prohibited in the marketing material for discount medical plans and clarifies language relating to plan charges.

Limits prior approval of rates by the Office of Insurance Regulation for discount medical plans to those plans with fees of more than $30 a month or $360 a year.

Deletes the requirement that marketers of discount medical plans be licensed and appointed insurance agents, but requires plans to be responsible and financially liable for actions not complying with their contract or the provisions of law.

Requires the actuarial study done for the FHIP to analyze exempting rates for employers with 26 to 50 employees from the requirements of modified community rating.

Requires the Auditor General to conduct a study of nursing home finances.

Provides for the development and implementation of a strategy for the adoption and use of electronic health records.

Provides a $2 million nonrecurring general revenue appropriation to the Agency for Health Care Administration during the 2004-05 fiscal year to develop and implement a strategy for the adoption and use of electronic health records.