A bill to be entitled

An act relating to plans, policies, contracts, and programs for the provision of health care services; amending s. 408.909, F.S.; revising eligibility requirements for participation in health flex plans; amending s. 627.4236, F.S.; redefining the term "bone marrow transplant" for purposes of required coverage for certain procedures to include nonablative therapy having life-prolonging intent; amending s. 627.642, F.S.; requiring an identification card containing specified information to be given to insureds who have health and accident insurance; requiring certain insurers to provide to certain service providers by an Internet website certain information relating to a covered person; providing criteria; specifying time requirements for such insurers to implement such requirements; amending s. 627.657, F.S.; requiring an identification card containing specified information to be given to insureds under group health insurance policies; requiring certain insurers to provide to certain service providers by an Internet website certain information relating to a covered person; providing criteria; specifying time requirements for such insurers to implement such requirements; amending s. 627.6699, F.S.; revising a provision relating to applicability and scope of the Employee Health Care Access Act; amending s. 636.204, F.S.; revising a license application provision for discount medical plan

organizations; amending s. 636.206, F.S.; revising examination and investigative authority; amending s. 636.210, F.S.; providing an exception to prohibited activities; amending s. 636.216, F.S.; providing exception to review of certain charges to members of the plan; amending s. 636.218, F.S.; removing certain information from the annual report; amending s. 636.220, F.S.; revising certain minimum capital requirements of discount medical plan organizations; revising commission rulemaking authority; amending s. 636.230, F.S.; providing requirements with respect to the bundling of discount medical plans with insurance products; amending s. 641.31, F.S.; requiring an identification card to be given to persons having health care services through a health maintenance contract; requiring certain health maintenance organizations to provide to certain service providers by an Internet website certain information relating to a covered person; providing criteria; specifying time requirements for such health maintenance organizations to implement such requirements; amending s. 641.316, F.S.; redefining the term "fiscal intermediary services organization"; revising registration requirements for fiscal intermediary services organizations; amending ss. 383.145, 641.185, 641.2018, 641.3107, 641.3922, and 641.513, F.S.; conforming cross-references to changes made by the act; providing application; reenacting and amending s. 409.9102, F.S.; directing the Agency for Health Care

Administration, in consultation with the Office of Insurance Regulation and the Department of Children and Family Services, to amend the Medicaid state plan that established the Florida Long-Term Care Partnership Program for purposes of compliance with provisions of the Social Security Act; establishing a qualified state Long-Term Care Insurance Partnership Program in Florida; providing duties of the program; requiring consultation with the Office of Insurance Regulation and the Department of Children and Family Services for the creation of standards for certain information; providing rulemaking authority to the agency for implementation of s. 409.9102, F.S.; providing rulemaking authority to the department regarding determination of eligibility for certain services; creating s. 627.94075, F.S.; providing rulemaking authority to the Financial Services Commission for the implementation of a qualified state Long-Term Care Insurance Partnership Program in Florida; repealing ss. 1 and 2 of ch. 2005-252, Laws of Florida, to delete conflicting provisions relating to the determination of eligibility for nursing and rehabilitative services and the establishment of the Florida Long-Term Care Partnership Program that were contingent upon amendment to the Social Security Act; amending s. 4 of ch. 2005-252, Laws of Florida, to delete a contingency in an effective date; requiring the Office of Program Policy Analysis and Government Accountability to submit a report on the

implementation of a qualified state Long-Term Care Insurance Partnership Program in Florida to the Governor and Legislature; providing an effective date.

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

Section 1. Subsection (5) of section 408.909, Florida Statutes, is amended to read:

408.909 Health flex plans.--

(5) ELIGIBILITY.--Eligibility to enroll in an approved health flex plan is limited to residents of this state who:

(a)1. Are 64 years of age or younger;

2.~~(b)~~ Have a family income equal to or less than 250 ~~200~~ percent of the federal poverty level;

3.~~(c)~~ Are eligible under a federally approved Medicaid demonstration waiver and reside in Palm Beach County or Miami-Dade County;

4.~~(d)~~ Are not covered by a private insurance policy and are not eligible for coverage through a public health insurance program, such as Medicare or Medicaid, unless specifically authorized under subparagraph 3. ~~paragraph (c)~~, or another public health care program, such as KidCare, and have not been covered at any time during the past 6 months; and

5.~~(e)~~ Have applied for health care coverage through an approved health flex plan and have agreed to make any payments required for participation, including periodic payments or payments due at the time health care services are provided; or

(b) Are part of an employer group where at least 75 percent of the employees have a family income equal to or less than 250 percent of the federal poverty level and the employee group is not covered by a private health insurance policy and has not been covered at any time during the past 6 months. If the health flex plan entity is a health insurer, health plan, or health maintenance organization properly licensed under Florida law, only 50 percent of the employees must meet the income requirements for the purposes of this paragraph.

Section 2. Subsection (1) of section 627.4236, Florida Statutes, is amended to read:

627.4236 Coverage for bone marrow transplant procedures.--

(1) As used in this section, the term "bone marrow transplant" means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative or nonablative therapy with curative or life-prolonging intent. Human blood precursor cells may be obtained from the patient in an autologous transplant or from a medically acceptable related or unrelated donor, and may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "bone marrow transplant" includes both the transplantation and the chemotherapy.

Section 3. Subsections (3) and (4) are added to section 627.642, Florida Statutes, to read:

627.642 Outline of coverage.--

(3) In addition to the outline of coverage, a policy as specified in s. 627.6699(3)(k) must be accompanied by an identification card that contains, at a minimum:

(a) The name of the organization issuing the policy or name of the organization administering the policy, whichever applies.

(b) The name of the contract holder.

(c) The type of plan only if the health plan is filed with the state, an indication that the plan is self-funded, or the name of the network.

(d) The member identification number, contract number, and policy or group number, if applicable.

(e) A contact phone number or electronic address for authorizations.

(f) A phone number or electronic address whereby the covered person or hospital, physician, or other person rendering services covered by the policy may determine if the plan is insured and may obtain a benefits verification in order to estimate patient financial responsibility, in compliance with privacy rules under the Health Insurance Portability and Accountability Act.

(g) The national plan identifier, in accordance with the compliance date set forth by the federal Department of Health and Human Services.

The identification card must present the information in a readily identifiable manner or, alternatively, the information

may be embedded on the card and available through magnetic stripe or smart card. The information may also be provided through other electronic technology.

(4)(a) An insurer that issues a health insurance policy shall provide a hospital, physician, or other person rendering services covered by the policy electronic access to the covered person's eligibility and benefits information through a secure Internet website. The eligibility and benefits information shall comply with the transaction standards specified in ANSI ASC X12N 270 for health care claim eligibility inquiries and ANSI ASC X12N 271 for health care claim eligibility responses, or successor transaction standards, pursuant to the Health Insurance Portability and Accountability Act.

(b) An insurer shall develop an implementation plan to comply with paragraph (a) no later than March 31, 2007, and shall make the eligibility and benefits information described in this subsection available through a secure Internet website no later than July 1, 2007.

Section 4. Present subsection (2) of section 627.657, Florida Statutes, is renumbered as subsection (4), and new subsections (2) and (3) are added to that section, to read:

627.657 Provisions of group health insurance policies.--

(2) The medical policy as specified in s. 627.6699(3)(k) must be accompanied by an identification card that contains, at a minimum:

(a) The name of the organization issuing the policy or name of the organization administering the policy, whichever applies.

(b) The name of the certificateholder.

(c) The type of plan only if the health plan is filed with the state, an indication that the plan is self-funded, or the name of the network.

(d) The member identification number, contract number, and policy or group number, if applicable.

(e) A contact phone number or electronic address for authorizations.

(f) A phone number or electronic address whereby the covered person or hospital, physician, or other person rendering services covered by the policy may determine if the plan is insured and may obtain a benefits verification in order to estimate patient financial responsibility, in compliance with privacy rules under the Health Insurance Portability and Accountability Act.

(g) The national plan identifier, in accordance with the compliance date set forth by the federal Department of Health and Human Services.

The identification card must present the information in a readily identifiable manner or, alternatively, the information may be embedded on the card and available through magnetic stripe or smart card. The information may also be provided through other electronic technology.

(3)(a) An insurer that issues a group health insurance policy shall provide a hospital, physician, or other person rendering services covered by the policy electronic access to the covered person's eligibility and benefits information through a secure Internet website. The eligibility and benefits information shall comply with the transaction standards specified in ANSI ASC X12N 270 for health care claim eligibility inquiries and ANSI ASC X12N 271 for health care claim eligibility responses, or successor transaction standards, pursuant to the Health Insurance Portability and Accountability Act.

(b) An insurer shall develop an implementation plan to comply with paragraph (a) no later than March 31, 2007, and shall make the eligibility and benefits information described in this subsection available through a secure Internet website no later than July 1, 2007.

Section 5. Paragraph (a) of subsection (4) of section 627.6699, Florida Statutes, is amended to read:

627.6699 Employee Health Care Access Act.--

(4) APPLICABILITY AND SCOPE.--

(a)1. This section applies to a health benefit plan that provides coverage to employees of a small employer in this state, unless the coverage is marketed directly to the individual employee, and the employer does not contribute directly or indirectly to the premiums or facilitate the administration of the coverage in any manner. For the purposes of this subparagraph, an employer is not deemed to be

contributing to the premiums or facilitating the administration of coverage if the employer:

a. Does not contribute to the premium and merely collects the premiums for coverage from an employee's wages or salary through payroll deduction and submits payment for the premiums of one or more employees in a lump sum to a carrier; or

b. Directly or indirectly establishes or administers a health reimbursement account plan for its employees.

2. A carrier authorized to issue group or individual health benefit plans under this chapter or chapter 641 may offer coverage as described in this paragraph to individual employees without being subject to this section if the employer has not had a group health benefit plan in place in the prior 6 months. A carrier authorized to issue group or individual health benefit plans under this chapter or chapter 641 may offer coverage as described in this subparagraph to employees that are not eligible employees as defined in this section, whether or not the small employer has a group health benefit plan in place. A carrier that offers coverage as described in this subparagraph must provide a cancellation notice to the primary insured at least 10 days prior to canceling the coverage for nonpayment of premium.

Section 6. Paragraph (i) of subsection (2) of section 636.204, Florida Statutes, is amended to read:

636.204 License required.--

(2) An application for a license to operate as a discount medical plan organization must be filed with the office on a

form prescribed by the commission. Such application must be sworn to by an officer or authorized representative of the applicant and be accompanied by the following, if applicable:

(i) A copy of the applicant's most recent financial statements audited by an independent certified public accountant. An applicant that is a subsidiary of a parent entity that is publicly traded and that prepares audited financial statements reflecting the consolidated operations of the parent entity and the subsidiary may submit ~~petition the office to accept~~, in lieu of the audited financial statement of the applicant, the audited financial statement of the parent entity and a written guaranty by the parent entity that the minimum capital requirements of the applicant required by this part will be met by the parent entity.

Section 7. Subsection (1) of section 636.206, Florida Statutes, is amended to read:

636.206 Examinations and investigations.--

(1) The office may examine or investigate the business and affairs of any discount medical plan organization if the commissioner has reason to believe that the discount medical plan organization is not complying with the requirements of this act. The office may order any discount medical plan organization or applicant to produce any records, books, files, advertising and solicitation materials, or other information and may take statements under oath to determine whether the discount medical plan organization or applicant is in violation of the law or is acting contrary to the public interest. The expenses incurred in

conducting any examination or investigation must be paid by the discount medical plan organization or applicant. Examinations and investigations must be conducted as provided in chapter 624.

Section 8. Subsection (1) of section 636.210, Florida Statutes, is amended to read:

636.210 Prohibited activities of a discount medical plan organization.--

(1) A discount medical plan organization may not:

(a) Use in its advertisements, marketing material, brochures, and discount cards the term "insurance" except as otherwise provided in this part or as a disclaimer of any relationship between discount medical plan organization benefits and insurance;

(b) Use in its advertisements, marketing material, brochures, and discount cards the terms "health plan," "coverage," "copay," "copayments," "preexisting conditions," "guaranteed issue," "premium," "PPO," "preferred provider organization," or other terms in a manner that could reasonably mislead a person into believing the discount medical plan was health insurance;

(c) Have restrictions on free access to plan providers, except for hospital services, including, but not limited to, waiting periods and notification periods; or

(d) Pay providers any fees for medical services.

Section 9. Subsection (1) of section 636.216, Florida Statutes, is amended to read:

636.216 Charge or form filings.--

(1) All charges to members must be filed with the office. ~~and~~ Any charge to members greater than $30 per month or $360 per year for access to healthcare services, other than those provided by physicians licensed under chapter 458 or chapter 459 or by hospitals licensed under chapter 395, must be approved by the office before the charges can be used. Any charge to members greater than $60 dollars per month or $720 per year for healthcare services that include services provided by physicians licensed under chapters 458 and 459 or by hospitals licensed under chapter 395 must be approved by the office before the charges can be used. The discount medical plan organization has the burden of proof that the charges bear a reasonable relation to the benefits received by the member.

Section 10. Subsection (2) of section 636.218, Florida Statutes, is amended to read:

636.218 Annual reports.--

(2) Such reports must be on forms prescribed by the commission and must include:

~~(a) Audited financial statements prepared in accordance with generally accepted accounting principles certified by an independent certified public accountant, including the organization's balance sheet, income statement, and statement of changes in cash flow for the preceding year. An organization that is a subsidiary of a parent entity that is publicly traded and that prepares audited financial statements reflecting the consolidated operations of the parent entity and the organization may petition the office to accept, in lieu of the~~

~~audited financial statement of the organization, the audited financial statement of the parent entity and a written guaranty by the parent entity that the minimum capital requirements of the organization required by this part will be met by the parent entity.~~

(a) ~~(b)~~ If different from the initial application or the last annual report, a list of the names and residence addresses of all persons responsible for the conduct of the organization's affairs, together with a disclosure of the extent and nature of any contracts or arrangements between such persons and the discount medical plan organization, including any possible conflicts of interest.

(b) ~~(c)~~ The number of discount medical plan members in the state.

(c) ~~(d)~~ Such other information relating to the performance of the discount medical plan organization as is reasonably required by the commission or office.

Section 11. Subsection (1) of section 636.220, Florida Statutes, is amended to read:

636.220 Minimum capital requirements.--

(1) Each discount medical plan organization must at all times maintain a net worth of at least $150,000 and each discount medical plan organization shall certify in writing under oath at licensure and annually that the minimum capitalization requirements of this part are satisfied.

Section 12. Section 636.230, Florida Statutes, is amended to read:

636.230 Bundling discount medical plans with insurance ~~other~~ products.--When a marketer or discount medical plan organization sells a discount medical plan together with any insurance ~~other~~ product, the fees for the discount medical plan must be provided in writing to the member if the fees exceed $30 per month for access to healthcare services other than those provided by physicians licensed under chapter 458 or chapter 459 or by hospitals licensed under chapter 395 or $60 dollars per month for healthcare services which include services provided by physicians licensed under chapter 458 or chapter 459 or by hospitals licensed under chapter 395.

Section 13. Present subsections (5) through (40) of section 641.31, Florida Statutes, are renumbered as subsections (7) through (42), respectively, and new subsections (5) and (6) are added to that section, to read:

641.31 Health maintenance contracts.--

(5) The contract, certificate, or member handbook must be accompanied by an identification card that contains, at a minimum:

(a) The name of the organization offering the contract or name of the organization administering the contract, whichever applies.

(b) The name of the subscriber.

(c) A statement that the health plan is a health maintenance organization. Only a health plan with a certificate of authority issued under this chapter may be identified as a health maintenance organization.

(d) The member identification number, contract number, and group number, if applicable.

(e) A contact phone number or electronic address for authorizations.

(f) A phone number or electronic address whereby the covered person or hospital, physician, or other person rendering services covered by the contract may determine if the plan is insured and may obtain a benefits verification in order to estimate patient financial responsibility, in compliance with privacy rules under the Health Insurance Portability and Accountability Act.

(g) The national plan identifier, in accordance with the compliance date set forth by the federal Department of Health and Human Services.

The identification card must present the information in a readily identifiable manner or, alternatively, the information may be embedded on the card and available through magnetic stripe or smart card. The information may also be provided through other electronic technology.

(6)(a) A health maintenance organization shall provide a hospital, physician, or other person rendering services covered by the policy electronic access to the covered person's eligibility and benefits information through a secure Internet website. The eligibility and benefits information shall comply with the transaction standards specified in ANSI ASC X12N 270 for health care claim eligibility inquiries and ANSI ASC X12N

271 for health care claim eligibility responses, or successor transaction standards, pursuant to the Health Insurance Portability and Accountability Act.

(b) A health maintenance organization shall develop an implementation plan to comply with paragraph (a) no later than March 31, 2007, and shall make the eligibility and benefits information described in this subsection available through a secure Internet website no later than July 1, 2007.

Section 14. Paragraph (j) of subsection (3) of section 383.145, Florida Statutes, is amended to read:

383.145 Newborn and infant hearing screening.--

(3) REQUIREMENTS FOR SCREENING OF NEWBORNS; INSURANCE COVERAGE; REFERRAL FOR ONGOING SERVICES.--

(j) The initial procedure for screening the hearing of the newborn or infant and any medically necessary followup reevaluations leading to diagnosis shall be a covered benefit, reimbursable under Medicaid as an expense compensated supplemental to the per diem rate for Medicaid patients enrolled in MediPass or Medicaid patients covered by a fee for service program. For Medicaid patients enrolled in HMOs, providers shall be reimbursed directly by the Medicaid Program Office at the Medicaid rate. This service may not be considered a covered service for the purposes of establishing the payment rate for Medicaid HMOs. All health insurance policies and health maintenance organizations as provided under ss. 627.6416, 627.6579, and 641.31(32) ~~(30)~~, except for supplemental policies that only provide coverage for specific diseases, hospital

indemnity, or Medicare supplement, or to the supplemental polices, shall compensate providers for the covered benefit at the contracted rate. Nonhospital-based providers shall be eligible to bill Medicaid for the professional and technical component of each procedure code.

Section 15. Paragraphs (b) and (i) of subsection (1) of section 641.185, Florida Statutes, are amended to read:

641.185 Health maintenance organization subscriber protections.--

(1) With respect to the provisions of this part and part III, the principles expressed in the following statements shall serve as standards to be followed by the commission, the office, the department, and the Agency for Health Care Administration in exercising their powers and duties, in exercising administrative discretion, in administrative interpretations of the law, in enforcing its provisions, and in adopting rules:

(b) A health maintenance organization subscriber should receive quality health care from a broad panel of providers, including referrals, preventive care pursuant to s. 641.402(1), emergency screening and services pursuant to ss. 641.31(14) ~~(12)~~ and 641.513, and second opinions pursuant to s. 641.51.

(i) A health maintenance organization subscriber should receive timely and, if necessary, urgent grievances and appeals within the health maintenance organization pursuant to ss. 641.228, 641.31(7) ~~(5)~~, 641.47, and 641.511.

Section 16. Subsection (1) of section 641.2018, Florida Statutes, is amended to read:

641.2018 Limited coverage for home health care authorized.--

(1) Notwithstanding other provisions of this chapter, a health maintenance organization may issue a contract that limits coverage to home health care services only. The organization and the contract shall be subject to all of the requirements of this part that do not require or otherwise apply to specific benefits other than home care services. To this extent, all of the requirements of this part apply to any organization or contract that limits coverage to home care services, except the requirements for providing comprehensive health care services as provided in ss. 641.19(4), (11), and (12), and 641.31(1), except ss. 641.31(11) ~~(9)~~, (14) ~~(12), (17)~~, (18), (19), (20), (21), (23), and (26) ~~(24)~~ and 641.31095.

Section 17. Section 641.3107, Florida Statutes, is amended to read:

641.3107 Delivery of contract.--Unless delivered upon execution or issuance, a health maintenance contract, certificate of coverage, or member handbook shall be mailed or delivered to the subscriber or, in the case of a group health maintenance contract, to the employer or other person who will hold the contract on behalf of the subscriber group within 10 working days from approval of the enrollment form by the health maintenance organization or by the effective date of coverage, whichever occurs first. However, if the employer or other person who will hold the contract on behalf of the subscriber group requires retroactive enrollment of a subscriber, the

organization shall deliver the contract, certificate, or member handbook to the subscriber within 10 days after receiving notice from the employer of the retroactive enrollment. This section does not apply to the delivery of those contracts specified in s. 641.31(15) ~~(13)~~.

Section 18. Paragraph (a) of subsection (7) of section 641.3922, Florida Statutes, is amended to read:

641.3922 Conversion contracts; conditions.--Issuance of a converted contract shall be subject to the following conditions:

(7) REASONS FOR CANCELLATION; TERMINATION.--The converted health maintenance contract must contain a cancellation or nonrenewability clause providing that the health maintenance organization may refuse to renew the contract of any person covered thereunder, but cancellation or nonrenewal must be limited to one or more of the following reasons:

(a) Fraud or intentional misrepresentation, subject to the limitations of s. 641.31(25) ~~(23)~~, in applying for any benefits under the converted health maintenance contract.~~;~~

Section 19. Subsection (4) of section 641.513, Florida Statutes, is amended to read:

641.513 Requirements for providing emergency services and care.--

(4) A subscriber may be charged a reasonable copayment, as provided in s. 641.31(14) ~~(12)~~, for the use of an emergency room.

Section 20. Paragraph (b) of subsection (2) and subsection (6) of section 641.316, Florida Statutes, are amended to read:

641.316 Fiscal intermediary services.--

(2)

(b) The term "fiscal intermediary services organization" means a person or entity that ~~which~~ performs fiduciary or fiscal intermediary services to health care professionals who contract with health maintenance organizations other than ~~a fiscal intermediary services organization owned, operated, or controlled by~~ a hospital licensed under chapter 395, an insurer licensed under chapter 624, a third-party administrator licensed under chapter 626, a prepaid limited health service organization licensed under chapter 636, a health maintenance organization licensed under this chapter, or physician group practices as defined in s. 456.053(3)(h) and providing services under the scope of licenses of the members of the group practice.

(6) Any fiscal intermediary services organization, other than ~~a fiscal intermediary services organization owned, operated, or controlled by~~ a hospital licensed under chapter 395, an insurer licensed under chapter 624, a third-party administrator licensed under chapter 626, a prepaid limited health service organization licensed under chapter 636, a health maintenance organization licensed under this chapter, or physician group practices as defined in s. 456.053(3)(h), and providing services under the scope of licenses of the members of the group practice, must register with the office and meet the requirements of this section. In order to register as a fiscal intermediary services organization, the organization must comply with ss. 641.21(1)(c), ~~and~~ (d), and (j), ~~and~~ 641.22(6), and 641.27. The fiscal intermediary services organization must also

comply with the provisions of ss. 641.3155, 641.3156, and 641.51(4). Should the office determine that the fiscal intermediary services organization does not meet the requirements of this section, the registration shall be denied. In the event that the registrant fails to maintain compliance with the provisions of this section, the office may revoke or suspend the registration. In lieu of revocation or suspension of the registration, the office may levy an administrative penalty in accordance with s. 641.25.

Section 21. Section 409.9102, Florida Statutes, as created by section 2 of chapter 2005-252, Laws of Florida, is reenacted and amended to read:

(Substantial rewording of section. See s. 409.9102, F.S., for present text.)

409.9102 A qualified state Long-Term Care Insurance Partnership Program in Florida.--The Agency for Health Care Administration, in consultation with the Office of Insurance Regulation and the Department of Children and Family Services, is directed to establish a qualified state Long-Term Care Insurance Partnership Program in Florida, in compliance with the requirements of s. 1917(b) of the Social Security Act, as amended.

(1) The program shall:

(a) Provide incentives for an individual to obtain or maintain insurance to cover the cost of long-term care.

(b) Provide a mechanism to qualify for coverage of the costs of long-term care needs under Medicaid without first being

required to substantially exhaust his or her assets, including a provision for the disregard of any assets in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under the program.

(c) Alleviate the financial burden on the state's medical assistance program by encouraging the pursuit of private initiatives.

(2) The Agency for Health Care Administration, in consultation with the Office of Insurance Regulation and the Department of Children and Family Services, and in accordance with federal guidelines, shall create standards for long-term care partnership program information distributed to individuals through insurance companies offering approved long-term care partnership program policies.

(3) The Agency for Health Care Administration is authorized to amend the Medicaid state plan and adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section.

(4) The Department of Children and Family Services, when determining eligibility for Medicaid long-term care services for an individual who is the beneficiary of an approved long-term care partnership program policy, shall reduce the total countable assets of the individual by an amount equal to the insurance benefit payments that are made to or on behalf of the individual. The department is authorized to adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this subsection.

Section 22. Section 627.94075, Florida Statutes, is created to read:

627.94075 A qualified state Long-Term Care Insurance Partnership Program in Florida.--The commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement applicable provisions of a qualified state Long-Term Care Insurance Partnership Program in Florida in accordance with the requirements of s. 1917(b) of the Social Security Act, as amended, any applicable federal guidelines, and any rules necessary to ensure program compliance by insurers as provided in s. 409.9102.

Section 23. Sections 1 and 2 of chapter 2005-252, Laws of Florida, are repealed.

Section 24. Section 4 of chapter 2005-252, Laws of Florida, is amended to read:

Section 4. This act shall take effect upon becoming a law~~, except that the amendments to section 409.905, Florida Statutes, and the newly created section 409.9102, Florida Statutes, provided in this act shall take effect contingent upon amendment to section 1917(b)(1)(c) of the Social Security Act by the United States Congress to delete the "May 14, 1993," deadline for approval by states of long-term care partnership plans~~.

Section 25. The Office of Program Policy Analysis and Government Accountability is directed to prepare a report on the implementation of a qualified state Long-Term Care Insurance Partnership Program in Florida. The report shall include data on the number and value of policies sold and the geographic areas in which the policies were purchased, a demographic description of the policyholders, and other information necessary to

evaluate the program. The report shall be provided to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 31, 2009.

Section 26. This act shall take effect January 1, 2007, and shall apply to identification cards issued for policies or certificates issued or renewed on or after that date.