



Journal of the Senate

Number 19

Thursday, April 14, 1994

CALL TO ORDER

The Senate was called to order by the President at 10:30 a.m. A quorum present—40:

Mr. President	Dantzler	Hargrett	Meadows
Bankhead	Diaz-Balart	Holzendorf	Myers
Beard	Dudley	Jenne	Scott
Boczar	Dyer	Jennings	Siegel
Brown-Waite	Foley	Johnson	Silver
Burt	Forman	Jones	Sullivan
Casas	Grant	Kirkpatrick	Turner
Childers	Grogan	Kiser	Weinstein
Crenshaw	Gutman	Kurth	Wexler
Crist	Harden	McKay	Williams

Excused: Senator Brown-Waite at 5:30 p.m.

PRAYER

The following prayer was offered by Joe Brown, Secretary of the Senate:

God of wisdom, share with us. God of courage, share with us. God of all, grant us thy peace and grace. Amen.

PLEDGE

The President led the Senate in the pledge of allegiance to the flag of the United States of America.

CONSIDERATION OF RESOLUTIONS

MOTION

On motion by Senator Childers, by two-thirds vote, the following resolution was considered outside the extended call:

On motion by Senator Childers, by two-thirds vote **SR 2834** was withdrawn from the Committee on Rules and Calendar.

On motion by Senator Childers—

SR 2834—A resolution honoring Escambia County's athletes who have made good.

WHEREAS, Emmitt Smith is an alumnus of Escambia High School, Escambia County; was the USA Today national high school player of the year in 1987; was drafted 17th overall by the Dallas Cowboys in the 1990 National Football League draft after an outstanding career at the University of Florida; has led the National Football League in rushing in 1991, 1992, and 1993 seasons; has been elected to the Pro Bowl four times; and was the National Football League's Most Valuable Player in 1993 and the Most Valuable Player in Super Bowl XXVIII, and

WHEREAS, Travis Fryman is an alumnus of J.M. Tate High School, Escambia County; was selected a High School All American in 1987 and the outstanding athlete in the North Florida area for that year; was drafted third by the Detroit Tigers in the 1987 baseball draft; and has been selected to the 1992 and 1993 American League All-Star teams as a shortstop and third baseman for the Detroit Tigers, and

WHEREAS, Jay Bell is an alumnus of J.M. Tate High School, Escambia County; was selected to the state all-star baseball team in 1984; was drafted eighth overall by the Minnesota Twins in the 1984 baseball draft; and has, as shortstop with the Pittsburgh Pirates, been elected to the 1993 National League All-Star Team and received the Golden Glove Award in that same year, and

WHEREAS, Mark Whiten is an alumnus of Pensacola High School and Pensacola Junior College, Escambia County, and, as an outfielder with the St. Louis Cardinals, tied a Major League Baseball record by hitting 4 home runs, with 12 runs batted in, in a single game on September 7, 1993, and

WHEREAS, Roy Jones, Jr., is an alumnus of Booker T. Washington High School and Pensacola Junior College, Escambia County; was a silver medalist in boxing in the 1988 Olympics and was awarded the Val Barker Trophy as the outstanding boxer in that Olympics; and is currently the undefeated IBF Middleweight World Champion, with a record of 24-0, including 21 knockouts, NOW, THEREFORE,

Be It Resolved by the Senate of the State of Florida:

That the Senate salutes these Floridians, in recognition of their demonstrated excellence in their chosen fields of athletic competition.

BE IT FURTHER RESOLVED that copies of this resolution, with the Seal of the Senate affixed, be presented to Emmitt Smith, Travis Fryman, Jay Bell, Mark Whiten, and Roy Jones, Jr., as a tangible token of the sentiments of the Senate and of the best wishes of the Senate for the recipients' continued success.

—was taken up out of order by unanimous consent, read the second time in full and adopted.

MOTIONS RELATING TO COMMITTEE REFERENCE

On motions by Senator Jenne, by two-thirds vote **CS for SB 2066**, and **CS for HB 2665** were withdrawn from the Committee on Appropriations.

MOTIONS

On motion by Senator Kirkpatrick, the rules were waived and the Special Order Subcommittee was granted permission to meet Friday, April 15 at 8:30 a.m.

SPECIAL AND CONTINUING ORDER

MOTION

On motion by Senator Kirkpatrick, the rules were waived to allow consideration of amendments to **CS for CS for SB 3060** notwithstanding the deadline for filing.

CS for CS for SB 3060—A bill to be entitled An act relating to health care; amending s. 20.42, F.S.; requiring Senate confirmation of the Director of Health Care Administration; deleting hospital budget review from duties of the Division of Health Policy and Cost Control and Health Care Board; amending s. 216.136, F.S.; providing additional duties of the Social Services Estimating Conference with respect to estimates and forecasts for Florida Health Security; creating s. 255.0516, F.S.; requiring contractors to comply with certain statutory provisions; amending s. 287.088, F.S.; requiring certain state agency contractors, including construction contractors, to ensure employee access to group health benefit plans; creating a task force to study health insurance requirements for state contractors; amending s. 400.602, F.S.; providing for issuance of additional hospice licenses; amending s. 408.02, F.S.; providing for practice guidelines for specified medical services; amending s. 408.40, F.S.; deleting reference to budget review proceedings of the Public Counsel; creating s. 408.7043, F.S.; providing certain limitations on the commingling of claims experience, rates, and charges for members of Florida Health Security by an accountable health partnership, a community health partnership, or a contract administrator; creating s. 408.7054, F.S.;

providing for antitrust law exemptions for certain health care provider networks meeting specified criteria; amending s. 408.706, F.S.; providing additional requirements for accountable health partnerships that participate in Florida Health Security; providing that an insurer or a health maintenance organization is not required to participate in Florida Health Security or the Medicaid program; amending s. 408.902, F.S.; delaying the effective date and providing a contingency for creating the MedAccess program; creating s. 409.810, F.S.; creating the Florida Health Security Act; creating s. 409.811, F.S.; providing legislative findings and intent; creating s. 409.812, F.S.; providing definitions; creating s. 409.813, F.S.; establishing Florida Health Security, subject to approval of financing by the Federal Government; requiring the Director of the Agency for Health Care Administration to appoint a director of Florida Health Security; creating s. 409.814, F.S.; providing eligibility criteria for membership in Florida Health Security; providing application requirements for individuals; providing application requirements for employers who apply on behalf of employees; requiring the agency to verify a member's continued eligibility; providing circumstances under which a member may be disenrolled; providing penalties for a member or employer who provides erroneous information or who fails to provide certain information; providing for an open enrollment period during which coverage is offered on a guarantee-issue basis; creating s. 409.815, F.S.; providing for certain exclusions for preexisting conditions and benefits available under workers' compensation insurance; providing for coverage under Florida Health Security to be provided by accountable health partnerships or community health partnerships; providing for a county, political subdivision, or tax district to establish a community health partnership; providing for the provision of emergency services; requiring that members be offered at least one benefit plan with a premium equal to or less than a benchmark premium established by the agency; providing certain limitations on changing accountable health partnerships; providing certain limitations on membership eligibility following termination of coverage; creating s. 409.816, F.S.; providing contribution requirements for premiums; providing a benchmark premium; providing for a member's premium subsidy to be based on gross family income; limiting the annual expenditures for Florida Health Security based on the General Appropriations Act; creating s. 409.817, F.S.; providing duties of the agency in administering Florida Health Security; creating s. 409.818, F.S.; providing duties of the agency for contract operations under Florida Health Security; creating s. 409.819, F.S.; authorizing a county, political subdivision, or tax district to create a community health partnership; providing enrollment criteria; providing requirements for qualification as a community health partnership; providing duties of a community health partnership; requiring that a community health partnership have adequate sources of revenue; providing disclosure requirements; providing requirements for coverage of a newborn or adopted child; providing for certain limitations on benefits; providing for liability for certain fees; providing for application of the Florida Insurance Code to certain services provided by a community health partnership; requiring actuarial certification of a community health partnership; providing requirements for a community health partnership that terminates its participation in Florida Health Security; providing for subcontracts for health care services with accountable health partnerships; requiring the Department of Health and Rehabilitative Services to establish pilot programs; requiring a report; creating s. 409.820, F.S.; providing that members may not be enrolled in Florida Health Security until there is sufficient funding; requiring the agency to make certain reports to the Social Services Estimating Conference; requiring the Social Services Estimating Conference to establish the enrollment ceiling for Florida Health Security; amending s. 409.901, F.S.; providing definitions; amending s. 409.908, F.S., relating to reimbursement of Medicaid providers; requiring legislative consultation and ratification for calculating reimbursement under Medicaid prepaid contracts; requiring certain consultation with and ratification by the Legislature before Medicaid recipients are enrolled in community health purchasing alliances; amending s. 409.9122, F.S.; providing for the enrollment of certain Medicaid recipients in a managed care plan or MediPass by a specified date; authorizing the Agency for Health Care Administration to establish a Medicaid mental health and substance abuse program pursuant to a federal waiver; requiring the agency to appoint an advisory panel; amending s. 409.915, F.S.; providing that services provided under Florida Health Security are not subject to certain requirements for matching funds from the counties; creating s. 627.4239, F.S.; providing for insurer coverage of certain drugs used in cancer treatment; creating s. 627.6045, F.S.; specifying policy requirements with respect to preexisting conditions; amending s. 627.6472, F.S.; prescribing responsibilities of exclusive provider organizations with respect to outpatient treatment by providers

of specified medical services; creating s. 627.6691, F.S.; providing for continuation of coverage under group health benefit plans; providing definitions; providing for notice; amending s. 627.6691, F.S.; providing applicability of the Employee Health Care Access Act with respect to plans under Florida Health Security; amending s. 641.31, F.S.; prescribing responsibilities of health maintenance organizations with respect to outpatient treatment by providers of specified medical services; providing legislative findings and intent; prohibiting Medicaid recipients from being included in coverage by community health purchasing alliances unless certain conditions are met; requiring the Agency for Health Care Administration to study the impact of transferring medically needy recipients from Medicaid to Florida Health Security and Medicaid reimbursements to prepaid health plans and to report the findings of both studies to the Legislature; repealing s. 407.61, F.S., relating to Health Care Cost Containment Board studies; repealing s. 408.072, F.S., relating to reviews of hospital budgets; repealing s. 408.08(2)-(13), F.S., relating to duties of the board with respect to hospital inspections and audits; repealing s. 408.085, F.S., relating to comprehensive inpatient rehabilitation hospitals; repealing s. 455.25(2), F.S., relating to disclosure of financial interests to patients; repealing s. 455.2555, F.S., relating to imposition of a fee schedule on providers of designated health services; providing effective dates.

—was read the second time by title.

Senators Forman, Scott and Gutman offered the following amendment which was moved by Senator Forman:

Amendment 1 (with Title Amendment)—Strike everything after the enacting clause and insert:

Section 1. Subsection (1), paragraphs (b) and (d) of subsection (2), and subsection (6) of section 20.42, Florida Statutes, are amended to read:

20.42 Agency for Health Care Administration.—There is created the Agency for Health Care Administration within the Department of Professional Regulation. The agency shall be a separate budget entity, and the director of the agency shall be the agency head for all purposes. The agency shall not be subject to control, supervision, or direction by the Department of Professional Regulation in any manner, including, but not limited to, personnel, purchasing, transactions involving real or personal property, and budgetary matters.

(1) DIRECTOR OF HEALTH CARE ADMINISTRATION.—The head of the agency is the Director of Health Care Administration, who shall be appointed by the Governor, *subject to confirmation by the Senate*. The director shall serve at the pleasure of and report to the Governor.

(2) ORGANIZATION OF THE AGENCY.—The agency shall be organized as follows:

(b) The Division of Health Policy and Cost Control, which shall be responsible for health policy, the State Center for Health Statistics, the development of The Florida Health Plan, certificate of need, ~~hospital budget review~~, state and local health planning under s. 408.033, and research and analysis.

(d) The Health Care Board, which shall be responsible for ~~hospital budget review~~, nursing home financial analysis, and special studies as assigned by the secretary or the Legislature.

(6) HEALTH CARE BOARD.—The Health Care Board shall be composed of 11 members appointed by the Governor, subject to confirmation by the Senate. The members of the board shall biennially elect a chairperson and a vice chairperson from its membership. The board shall be responsible for ~~hospital budget review~~, nursing home financial review and analysis, and special studies requested by the Governor, the Legislature, or the director.

Section 2. Section 61.12, Florida Statutes, is amended to read:

61.12 Attachment or garnishment of amounts due for alimony or child support.—

(1) So much as the court orders of the money or other things due to any person or public officer, state or county, whether the head of a family residing in this state or not, when the money or other thing is due for the personal labor or service of the person or otherwise, is subject to attachment or garnishment to enforce and satisfy the orders and judgments of

the court of this state for alimony, suit money, or child support, or payment of health insurance premiums for a dependent child, or other orders in proceedings for dissolution, alimony, or child support; when the money or other thing sought to be attached or garnished is the salary of a public officer, state or county, the writ of attachment or garnishment shall be served on the public officer whose duty it is to pay the salary, who shall obey the writ as provided by law in other cases. It is the duty of the officer to notify the public officer whose duty it is to audit or issue a warrant for the salary sought to be attached immediately upon service of the writ. A warrant for as much of the salary as is ordered held under the writ shall not issue except pursuant to court order unless the writ is dissolved. No more of the salary shall be retained by virtue of the writ than is provided for in the order.

(2) The provisions of chapter 77 or any other provision of law to the contrary notwithstanding, the court may issue a continuing writ of garnishment to an employer to enforce the order of the court for periodic payment of alimony or child support or health insurance premiums for a dependent child, or periodic payments for all these purposes both. The writ may provide that the salary of any person having a duty of support pursuant to such order be garnished on a periodic and continuing basis for so long as the court may determine or until otherwise ordered by the court or a court of competent jurisdiction in a further proceeding. Any disciplinary action against the employee by an employer to whom a writ is issued pursuant to this section solely because such writ is in effect constitutes a contempt of court, and the court may enter such order as it deems just and proper.

Section 3. Subsection (6) of section 216.136, Florida Statutes, is amended to read:

216.136 Consensus estimating conferences; duties and principals.—

(6) SOCIAL SERVICES ESTIMATING CONFERENCE.—

(a) Duties.—

1. The Social Services Estimating Conference shall develop such official information relating to the social services system of the state, including forecasts of social services caseloads, as the conference determines is needed for the state planning and budgeting system. Such official information shall include, but not be limited to, subsidized child care caseloads mandated by the Family Support Act of 1988.

2. In addition, the Social Services Estimating Conference shall develop estimates and forecasts of the unduplicated count of children eligible for subsidized child care as defined in s. 402.3015(1). These estimates and forecasts shall not include children enrolled in the prekindergarten early intervention program established in s. 230.2305.

3. The Department of Health and Rehabilitative Services and the Department of Education shall provide information on caseloads and waiting lists for the subsidized child care and prekindergarten early intervention programs requested by the Social Services Estimating Conference or individual conference principals, in a timely manner.

4. For the purpose of estimating the savings in the Medicaid program because of the implementation of the Florida Health Security Act, the Social Services Estimating Conference shall provide baseline estimates through a forecast period ending June 30, 1999, of the cost of the Medicaid program as if the Florida Health Security Act had not become law. Specifically, the Social Services Estimating Conference shall provide an estimate of the savings on a per-unit-of-service basis from implementation of the managed care plan for Medicaid recipients. The conference shall make these estimates as needed until such time as all Medicaid recipients are enrolled in a managed care program. These estimates of savings shall be used to determine the maximum number of individuals who may be enrolled in the Florida Health Security program to ensure that expenditures for the Florida Health Security program do not exceed the savings in the Medicaid program.

(b) Principals.—The Executive Office of the Governor, the director of the Division of Economic and Demographic Research of the Joint Legislative Management Committee, and professional staff, who have forecasting expertise, from the Department of Health and Rehabilitative Services, the Agency for Health Care Administration, the Senate, and the House of Representatives, or their designees, are the principals of the Social Services Estimating Conference. The principal representing the Executive Office of the Governor shall preside over sessions of the conference.

Section 4. Section 255.0516, Florida Statutes, is created to read:

255.0516 Construction contracts; access to health care.—In any state agency contract for the construction, renovation, or repair of a building or public work, which contract is valued in excess of \$250,000, the contractor shall comply with the provisions of s. 287.088.

Section 5. Section 287.088, Florida Statutes, is amended to read:

287.088 Employees of state contractors; access to hospitalization and medical insurance benefits.—

(1) As used in this section:

(a) "Access" means the availability of a group health benefit plan approved for issuance in this state which provides benefits similar to or exceeding the benefits provided under the basic health benefit plan established pursuant to s. 627.6699(12).

(b)(a) "Agency" means any state officer, department, division, board, bureau, commission, and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any state agency.

(c)(b) "Contractor" means any person or entity that enters into a contract with an agency to sell commodities or contractual services or for the construction, renovation, or repair of any building or public work, which contract exceeds the amount of \$250,000 provide services or to furnish materials of any kind, but does not include a person or entity that enters into a provider agreement with the Agency for Health Care Administration Department of Health and Rehabilitative Services to provide services under the Medicaid program.

(d) "Eligible employee" means an employee who works fulltime, having a normal workweek of 25 or more hours, and who has met any applicable waiting period requirements or other eligibility requirements of the contractor's group health benefit plan. "Eligible employee" does not include a part-time, temporary, or substitute employee or an individual covered under a subminimum wage sheltered workshop certificate issued by the United States Department of Labor.

(e) "Subcontractor" means any person or entity who is in privity with a contractor to provide services or to furnish materials of any kind, either to the contractor or to the agency.

(2) Effective January 1, 1995 July 1, 1994, every contractor, and each subcontractor of every contractor, shall ensure that each eligible employee of the contractor who works on a competitively bid state agency contract valued in excess of \$250,000 \$100,000 shall have access to a group health benefit plan hospitalization and medical insurance benefits during his employment on such agency contracts. The contractor's and subcontractor's obligation to ensure employee access to hospitalization and medical insurance benefits shall be fulfilled through the employer's payment of wages or contributions to employee hospitalization and medical insurance benefit plans, or any combination thereof. The monetary value of the hospitalization and medical insurance benefits provided to the employee by the employer shall be based on hospitalization and medical insurance coverage for the employee, the employee's spouse, and legally dependent children.

(3) A contractor shall be deemed in compliance with this section if the contractor fails to qualify for a group health benefit plan solely because of an insufficient level of employee participation, unless such health benefit plan requires an employee participation level of 70 percent or more.

(4)(3) Before signing the contract as described in subsection (2), the contractor shall certify to provide the agency with sufficient written documentation to demonstrate that the provisions of this section have been satisfied by the contractor and the subcontractors, if any. The agency shall examine the written documentation to ascertain that each employee who will work on the contract has access to hospitalization and medical insurance benefits. If the agency finds that the contractor or any subcontractor under the contractor has not certified its compliance with this section ensured employees access to hospitalization and medical insurance benefits, the agency shall notify the contractor in writing that the provisions of this section have not been met and shall provide sufficient detail, including information on community health purchasing alliances, to enable the contractor to take remedial action.

(5) If at any time during the course of the contract, the agency finds that the contractor has not ensured its employees access to a group health insurance plan, the agency shall notify the contractor in writing that the provisions of this section have not been met and shall provide sufficient detail to enable the contractor to take remedial action. The agency shall include with the notification information on community health purchasing alliances.

(6) A contractor or any subcontractor who has been notified by an agency pursuant to subsections (4) and (5) that the provisions of this section have not been met has 30 15 days from the date the agency provided written notice to provide ensure access to a group health benefit plan hospitalization and medical insurance benefits for each eligible employee who will work on the contract and to provide written documentation of the remedial action to the agency or to provide a certification evidencing the contractor's compliance with this section. No later than 10 days after receiving written documentation from the contractor, the agency shall examine the written documentation pertaining to the contractor's remedial action to determine if the provisions of this section have been met. If the agency finds that the contractor still has not provided ensured access to a group health benefit plan hospitalization and medical insurance benefits for each eligible employee who will work on the contract or has failed to provide the required certification, the following provisions apply: the agency shall award the contract to another contractor who has complied with the provisions of this section.

(a) In cases where the agency and the contractor have not signed the contract, the agency shall award the contract to another contractor who has complied with the provisions of this section.

(b) In cases where the agency and the contractor have signed the contract, the agency may terminate the contract and award the contract to another contractor who has complied with the provisions of this section. Before terminating a contract pursuant to this paragraph, the agency shall consider:

1. The nature of the contractor's noncompliance.
2. The expenditure of funds to date on contract activities.
3. The effect termination of the contract may have upon the agency's operations.
4. The disruption or delay that termination of the contract may have upon the completion of the project under contract.
5. The effects which termination may have on the life, safety, and welfare of Florida citizens.

(c) If the agency determines not to terminate the contract pursuant to paragraph (b), the agency shall prohibit the contractor from bidding or otherwise contracting on any future contract with that agency until the contractor provides documentation which shows compliance with provisions of this section. Any contractor penalized in accordance with this paragraph shall be reported to the Department of Management Services within 5 days of notice to the contractor.

(7) After receipt of notification pursuant to paragraph (6)(c), the Department of Management Services shall take all action necessary to prohibit the contractor from bidding on, participating in, or receiving the award of any state agency contract.

(8)(4) Each agency contract governed by this section shall provide mandate that the contractor to whom the contract is awarded, and any subcontractor under him:

(a) May not pay hospitalization and medical insurance benefits contributions in lieu of the employee's regular wages for the type of work he will perform under the state contract.

(b) Shall pay to the state \$200 as liquidated damages for each employee of the contractor, or of any subcontractor under him, who performs any portion of the contract work for each calendar day, or portion thereof, if such employee's hospitalization and medical insurance benefit contributions have not been paid by the employer. These liquidated damages shall be deposited in the Public Medical Assistance Trust Fund.

(a)(e) Shall post, in a conspicuous place on the site where such contract work is performed:

1. A statement of the employee's right to access to a group health benefit plan hospitalization and medical insurance benefits.

~~2. The amount of liquidated damages for any failure to pay such benefits.~~

2.3. The name and address of the responsible state official or agency to whom complaints should be given.

(b)(4) May not terminate an employee performing work on the contract because of the employee's filing a complaint regarding the contractor's failure to provide access to a group health benefit plan. Nothing in this paragraph is intended to limit a contractor's right to terminate an employee for other reasons or to give an employee a cause of action that is not otherwise provided by s. 112.3187. An agency may terminate the contract of a contractor that violates the provisions of this paragraph pursuant to paragraph (6)(b). This paragraph does not apply with respect to a complaint that is made with knowledge that the complaint is false or to a complaint that is made with reckless disregard of the truth or falsity of the complaint payment of hospitalization and medical insurance benefits contributions.

(9)(5) Any contractor and the principal owners thereof Should it be determined by an agency to have violated that a contractor or any subcontractor under him has substantially or repeatedly failed to comply with the provisions of this section on three separate occasions, the non-complying contractor or subcontractor, and the principal owners thereof, shall be prohibited from bidding on or otherwise participating in state contracts for a period of 2 3 years.

(10)(6) The Agency for Health Care Administration State agencies shall adopt, in consultation with the Department of Management Services and other state agencies, promulgate the necessary rules to administer the provisions of this section and shall establish uniform administrative procedures for the resolution of written complaints pertaining to the contractor's failure to provide access to a group health benefit plan for each eligible employee working on the awarded state agency contract underpayment of hospitalization and medical insurance benefits. The Agency for Health Care Administration, in adopting rules to administer the provisions of this section, shall not mandate all or any portion of an employer's contribution to an employee's group health benefit plan.

(11)(7) This section shall not apply to:

(a) Any contract that is in effect on January 1, 1995 July 1, 1994. This section shall not apply to any contract for which bids have been advertised or proposals have been requested prior to January 1, 1995 July 1, 1994.

(b) Blanket contracts designed to consolidate an indeterminate number of smaller contracts which may be needed over a fixed period of time, provided the overall contract ceiling does not exceed \$1,000,000 \$500,000, and further provided that no individual work order issued under such contract shall exceed \$100,000 \$25,000.

(c) State agency contracts which are subject to the provisions of the Davis-Bacon Act.

(d) Contractors or subcontractors who are subject to the provisions of a collective bargaining agreement which provides access to hospitalization and medical insurance benefits.

(e) Contractors who provide an employee a health benefit plan under the Employee Retirement Income Security Act of 1974.

(12)(a) The State Contractor Health Insurance Access Task Force is hereby created to study health insurance requirements for state contractors. The task force shall consist of 12 members to be appointed in the following manner:

1. One representative, appointed by the Governor, from each of the following state agencies:
 - a. The Department of Management Services.
 - b. The Department of Commerce.
 - c. The Agency for Health Care Administration.
2. The Insurance Commissioner or his designee.
3. Two private sector representatives, appointed by the President of the Senate, one of whom shall be a contractor subject to the requirements of this section.

4. Two private sector representatives, appointed by the Speaker of the House of Representatives, one of whom shall be a minority small employer subject to the requirements of this section.

5. Four representatives of employee organizations that represent employees working on state contracts subject to this section, two of whom shall be appointed by the President of the Senate, and two of whom shall be appointed by the Speaker of the House of Representatives.

(b) The task force shall prepare a report on health insurance requirements for state contractors, which shall include, but need not be limited to, findings and recommendations regarding the following:

1. The effects of this section on public contracts and public contractors.
2. The number and types of businesses affected by this section.
3. The specific effect on small employers and minority firms.
4. The effect of increasing access to health insurance for employees of contractors affected by this section.
5. The effect this section will have on the ability of contractors to increase employment with respect to future state contracts.
6. The effects this section will have on the ability of contractors to compete.
7. The effect of lowering the contract threshold to varying amounts.
8. The impact of providing access to health insurance for employees of subcontractors of contractors subject to this section.

(c) The report shall be presented to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than January 1, 1995.

(d) The Department of Management Services and the Agency for Health Care Administration shall jointly provide the administrative and staff support necessary for the task force to carry out its duties under this subsection.

Section 6. Effective October 1, 1994, subsection (81) is added to section 316.003, Florida Statutes, to read:

316.003 Definitions.—The following words and phrases, when used in this chapter, shall have the meanings respectively ascribed to them in this section, except where the context otherwise requires:

(81) **NONEMERGENCY, NONMEDICAL TRANSPORTATION SERVICE VEHICLES.**—A nonemergency, nonmedical transportation service vehicle is any motor vehicle used solely to transport ambulatory passengers to or from any medical place of business including, but not limited to: a hospital, a health maintenance organization, a clinic, a doctor's office, a nursing home, or an outpatient therapy center. Such vehicle must have the capacity to transport nine or more passengers, but may not transport any passengers in a stretcher or any passenger whose handicap, illness, injury, or other incapacities make transport by regular commercial carriers, such as a bus or taxicab, impracticable, or anyone in need, or expected to be in need, of medical attention during transport.

Section 7. Effective October 1, 1994, section 316.6151, Florida Statutes, is created to read:

316.6151 Licensure; inspection of nonemergency, nonmedical transportation service vehicles.--

(1)(a) Any person, corporation, or business that operates, advertises, engages in, or proposes to engage in the business of operating a nonemergency, nonmedical transportation service vehicle must first obtain a license from the department for each such vehicle.

(b) The application for the license must be in such form as prescribed by rule of the department. Each application must be accompanied by an annual license fee, to be deposited in the Highway Safety Operating Trust Fund, not to exceed \$250 per vehicle.

(2) Each nonemergency, nonmedical transportation service vehicle operated in this state must be inspected each year by the department.

(3)(a) Each nonemergency, nonmedical transportation service vehicle must be equipped with the following:

1. A nonleaking exhaust system;
2. A first aid kit;
3. A fire extinguisher;
4. Unbroken safety glass and unbroken windows;
5. An inside rearview mirror capable of giving the driver clear view of motor vehicles approaching from the rear; and
6. Seats that are securely anchored to the vehicle's floor.

(b) Each vehicle must be covered by liability insurance to protect the passengers being transported.

(c) Each vehicle must not transport more passengers than it is equipped to seat.

(4) Except as provided in chapter 401, the department shall be the sole regulator of nonemergency, nonmedical transportation service vehicles. All such vehicles licensed by the department may be operated throughout the state.

(5) Nothing in this section requires licenses or permits for nonemergency, nonmedical transportation vehicles owned and operated by a physician's office or medical care facility for the exclusive use of the patient's visiting the physician or facility for treatment, provided such patient is not in need of emergency medical care or medical services during transport.

(6) The department may collect a civil fine, in an amount not to exceed \$1,000 per violation, against any person, corporation, or business that has violated any provision of this section. The department may apply to a circuit court for an injunction to restrain any person, corporation, or business from operating any nonemergency, nonmedical transportation service vehicle that is not properly licensed under this section. Actions that the department is authorized to take under this subsection are cumulative to all other actions available to it by law.

Section 8. Section 381.0407, Florida Statutes, is created to read:

381.0407 Urban community-based primary care networks.—

(1) Legislative findings and intent.—

(a) The Legislature finds that urban community-based primary care centers provide access to health care services for low-income persons without regard to a person's ability to pay and provide a safety net for the uninsured. The centers provide preventive and primary care in urban, low-income communities and serve also as coordinators in the provision of a continuum of care to medically needy individuals and families.

(b) It is the intent of the Legislature that support be offered to urban community-based primary care centers so that they can continue to provide high quality health care services to low-income persons in a managed competition and managed care environment. In order to achieve this goal, the centers should be provided the opportunity to modernize their infrastructure through financial assistance grants.

(2) Subject to a specific appropriation being provided by law to implement this section, the Agency for Health Care Administration is authorized to establish, in consultation with the State Health Officer, financial assistance grants to model urban community-based primary care networks. In order to be eligible to receive a grant, a primary care network must be located in an urban area as designated by the agency. Urban community-based primary care networks may include any combination of the following:

- (a) Nonprofit legal entities consisting of urban health care providers.
 - (b) Publicly funded community health centers.
 - (c) Urban migrant centers.
 - (d) County public health units.
 - (e) Organizations supported with charitable or local government funds.
- (3) Financial assistance grants shall be awarded to selected urban community-based primary care networks to develop:

- (a) Integrated information systems.
- (b) Quality assurance and utilization management programs.
- (c) Risk management programs.
- (d) Common clinical protocols and medical systems to be used by network members.
- (e) Other infrastructure requirements needed to deliver health care services in a competitive, capitated managed care environment.

(4) The Director of the Agency for Health Care Administration, in consultation with the State Health Officer, shall publicize the availability of funds, targeting those urban areas that have a high incidence of medically underserved persons.

(5)(a) The agency shall issue requests for proposals to select the urban community-based primary care networks to receive the financial assistance grants.

(b) In determining which urban community-based primary care networks should receive financial assistance grants, the agency shall consider how well the proposal will improve a network's infrastructure and the extent to which the network's ability to operate in a competitive, managed care environment will be enhanced.

(6) The agency shall conduct an evaluation of the urban community-based primary care networks that are funded pursuant to this section to assess the effectiveness of the funded programs in integrating managed care strategies into urban community-based primary care networks. An evaluation report shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 1996.

Section 9. Effective upon becoming a law, subsections (3), (4), and (5) of section 395.1055, Florida Statutes, are renumbered as subsections (4), (5), and (6), respectively, and a new subsection (3) is added to that section, to read:

395.1055 Rules and enforcement.—

(3) *The agency shall adopt rules with respect to the care and treatment of patients residing in distinct part nursing units of hospitals which are certified for participation in the Title XVIII (Medicare) and Title XIX (Medicaid) skilled nursing facility program. Such rules shall take into account the types of patients treated in hospital skilled nursing units, including typical patient acuity levels, the average length of stay in such units, and shall be limited to the appropriate portions of the Omnibus Budget Reconciliation Act of 1987 (Pub. L. No. 100-203) (December 22, 1987) Title IV (Medicare, Medicaid and Other Related Health Programs), Subtitle C (Nursing Home Reform), as amended.*

Section 10. Effective upon becoming a law, paragraph (b) of subsection (1) of section 400.051, Florida Statutes, is amended to read:

400.051 Homes or institutions exempt from the provisions of this part.—

(1) The following shall be exempt from the provisions of this part:

(b) ~~Any hospital, as defined by s. 395.002(10), that institution which offers its services primarily for medical treatment or surgery and is licensed under chapter 395.~~

Section 11. Subsection (6) is added to section 400.602, Florida Statutes, to read:

400.602 Licensure required; prohibited acts; exemptions; display, transferability of license.—

(6) *Notwithstanding s. 400.061(2), at any time after July 1, 1994, any entity entitled to licensure under subsection (5) may obtain a license for up to two additional hospices in accordance with s. 400.606(4) and other requirements of this part.*

Section 12. Present subsections (5), (6), (7), (8), (9), and (10) of section 408.02, Florida Statutes, are redesignated as subsections (6), (7), (8), (9), (10), and (11), respectively, a new number (5) is added to that section, and subsection (6) of that section is amended, to read:

408.02 Practice parameters.—

(5) *The agency, in conjunction with the State Health Office, the Florida Obstetric and Gynecologic Society, the Florida Pediatric Society and the Florida Society of Neonatal Perinatologists, shall develop and may adopt by rule by December 31, 1994, state practice parameters for the detection and treatment of group B streptococcal infection in pregnancy.*

(6) The agency, in conjunction with the appropriate health professional associations, shall develop and may adopt by rule practice parameters for outpatient services provided by ~~dermatologists, ophthalmologists, and optometrists diagnostic imaging centers, radiation therapy services, clinical laboratory services, physical therapy services, and comprehensive rehabilitative services.~~ *The practice parameters must applicable to diagnostic imaging services shall be developed by December 31, 1994 1993. The parameters developed for dermatologists must be guidelines relevant to the appropriate use of Mohs micrographic surgery, phototherapy, and cutaneous flaps and grafts.*

Section 13. Section 408.033, Florida Statutes, is amended to read:

408.033 Local and state health planning.—

(1) *LEGISLATIVE FINDINGS AND INTENT.—The Legislature finds that while health insurance coverage is being provided to increasing numbers of state residents as a result of recent health care reform initiatives, some population groups will continue to lack adequate health care coverage. The Legislature further finds that community planning, system analysis, program facilitation, and coordination efforts are needed to complement public and private efforts to increase health care coverage at the local level. The Legislature further finds that effective health care reform requires substantial input at the local level from providers, consumers, and governmental officials in order to accommodate the needs of special population groups and geographical areas. Therefore, it is the intent of the Legislature that such input be obtained through the operation of community health planning agencies that will serve as an entry point for state and local policy makers.*

(2)(4) LOCAL HEALTH COUNCILS.—

(a) Local health councils are hereby established as public or private nonprofit agencies serving the counties of a health service planning district of the department. The members of each council shall be appointed in an equitable manner by the county commissions having jurisdiction in the respective district. Each council shall be composed of a number of persons equal to 1½ times the number of counties that which compose the district or 12 members, whichever is greater. Each county in a district is shall be entitled to at least one member on the council. The balance of the membership of the council shall be allocated among the counties of the district on the basis of population rounded to the nearest whole number; except that in a district composed of only two counties, a no county may not shall have fewer than four members. The appointees must shall be representatives of health care providers, health care purchasers, the business community, and nongovernmental health care consumers, but not excluding elected government officials. The members who are representatives of consumers must of the consumer group shall include at least one a representative number of persons over 60 years of age. A majority of council members shall consist of health care purchasers and health care consumers. The local health council shall provide each county commission a schedule for appointing council members to ensure that council membership complies with the requirements of this paragraph. The members of the local health council shall elect a chairman. Members shall be appointed to serve for terms of 2 years and are may be eligible for reappointment.

(b) Each local health council shall:

1. Develop a district health plan that is consistent with the objectives and strategies of the Florida Health Plan and in the state health plan, but that permits shall permit each local health council to develop strategies and set priorities for the expansion of access to health care beyond target populations identified by the department implementation based on its unique local health needs. The district health plan must contain preferences for the development of health services and facilities, which must be considered by the department in its review of certificate of need applications. The district health plan shall be submitted to the department and updated periodically. The district health plans must shall use a uniform format and be submitted to the department according to a schedule and format developed by the department in conjunction with the Statewide Health Council and the local health councils. The schedule must provide for coordination between the development of the state

health plan and the district health plans and for the development of district health plans by major sections over a multiyear period. ~~The elements of a district plan which are necessary to the review of certificate of need applications for proposed projects within the district shall be adopted by the department as a part of its rules.~~

2. Advise the Department of Elderly Affairs, the department, and other appropriate state agencies on the regulation of health care services, health care issues, and resource allocations.

3. Promote public awareness and understanding of community health needs, emphasizing health promotion and cost-effective health service selection. To avoid duplication of planning efforts, state and local governmental units are encouraged to contract with local health councils for professional services pertaining to health-related issues and service needs. The contracts must not require a competitive request for proposal or a formal bid process.

4. Collect data and conduct analyses and studies related to health care needs of the district, including the needs of medically indigent persons, and assist the department and other state agencies in carrying out data collection activities that relate to the functions in this subsection.

a. Local health councils shall establish a database from area providers of primary care services for the purpose of assisting the state in the implementation of the Florida Health Plan.

b. Local health councils shall collect such data as are necessary to assist in making a determination as to any new population groups who are identified as underserved following the implementation of health care reform legislation. The councils shall document any new obstacles to access that they identify through their data-collection activities.

5. Monitor the onsite construction progress, if any, of certificate-of-need approved projects and report council findings to the department on forms provided by the department.

6. Advise and assist any regional planning councils within each district in developing ~~that have elected to address health issues in their strategic regional policy plans with the development of the health element of the Comprehensive Regional Policy plans to address the health goals and policies in the State Comprehensive Plan.~~

7. Advise and assist local governments within each district in developing ~~on the development of an optional health plan element of the comprehensive plan provided in chapter 163, to assure compatibility with the health goals and policies in the State Comprehensive Plan and district health plan. To facilitate the implementation of this section,~~ The local health council shall annually provide the local governments in its service area, upon request, with:

- a. A copy and appropriate updates of the district health plan;
- b. A report of hospital and nursing home utilization statistics for facilities within the local government jurisdiction; and
- c. Applicable department rules and calculated need methodologies for health facilities and services regulated under s. 408.304 ~~§ 381.704~~ for the district served by the local health council.

8. Assist the Statewide Health Council in monitoring and evaluating ~~Monitor and evaluate the adequacy, appropriateness, and effectiveness, within the district, of health care reforms upon the health status of residents within the district and their access to health care, and upon publicly financed health services local, state, federal, and private funds distributed to meet the needs of the medically indigent and other underserved population groups.~~

9. In conjunction with the Department of Health and Rehabilitative Services and Statewide Health Council, plan for services at the local level for persons who have special health care needs ~~infected with the human immunodeficiency virus.~~

10. Advise the Statewide Health Council and other appropriate agencies on issues that affect access to health care services and the delivery of health care services for residents of this state.

11. Assist in the development of local responses to improve access and service delivery by facilitating community responses to need, including the development of regional trauma systems and agencies, rural health networks, community health partnerships, rural comprehensive primary care programs, and community primary-care facilities and programs.

12.10. Provide technical assistance to encourage and support activities by providers, purchasers, consumers, and local, regional, and state agencies in meeting the health care goals, objectives, and policies adopted by the local health council.

13.11. Provide the department with data required by rule for reviewing ~~the review of~~ certificate-of-need applications and projecting the ~~projection of~~ need for health services and facilities in the district.

14. Assist in other activities identified by the Statewide Health Council.

(c) Local health councils may conduct public hearings pursuant to s. 408.039(3)(b), and may assist the Statewide Health Council and state and local agencies in holding public hearings and educational forums that are designed to encourage public input and public participation in developing health care goals, objectives, and policies ~~§ 381.709(3)(b).~~

(d) Each local health council shall enter into a memorandum of agreement with each regional planning council in its district that elects to address health issues in its strategic regional policy plan. In addition, each local health council shall enter into a memorandum of agreement with each local government that includes an optional health element in its comprehensive plan. Each memorandum of agreement must specify the manner in which each local government, regional planning council, and local health council will coordinate its activities to ensure a unified approach to health planning and implementation efforts.

(e) Local health councils may employ and compensate personnel or contract for staffing services with persons who ~~to carry out the councils' purposes. Such personnel shall possess appropriate qualifications and be compensated in a manner commensurate with comparable positions in the Career Service System. However, Such employed personnel are shall not be deemed to be state employees. Contracts for these staffing services do not require a competitive request for proposal or a formal bid process.~~

(f) Personnel of the local health councils shall provide an annual orientation to council members about council member responsibilities. ~~The orientation shall include presentations and participation by department staff.~~

(g) Each local health council ~~may is authorized to~~ accept and receive, in furtherance of its health planning functions, funds, grants, and services from governmental agencies and from private or civic sources and to perform studies related to local health planning in exchange for such funds, grants, or services. Each local health council shall, no later than January 30 of each year, render an accounting of the receipt and disbursement of such funds received by it to the department. The department shall consolidate all such reports and submit ~~the such~~ consolidated report to the Legislature no later than March 1 of each year. Funds received by a local health council pursuant to this paragraph ~~may shall not be substituted deemed to be a substitute for, or used to an offset against,~~ any funding provided under ~~pursuant to~~ subsection (3).

(3)(2) STATEWIDE HEALTH COUNCIL.—The Statewide Health Council is hereby established as a state-level comprehensive health planning and policy advisory board. For administrative purposes, the council shall be located within the ~~department agency.~~ The Statewide Health Council shall be composed of: the State Health Officer; the Deputy Director for Health Policy and Cost Control and the Deputy Director for Health Quality Assurance of the department; the director of the Health Care Board; the Insurance Commissioner or his designee; the Vice Chancellor for Health Affairs of the Board of Regents; three chairmen of regional planning councils, selected by the regional planning councils; five chairmen of local health councils, selected by the local health councils; four members appointed by the Governor, one of whom is a consumer over 60 years of age, one of whom is a representative of organized labor, one of whom is a physician, and one of whom represents the nursing home industry; five members appointed by the President of the Senate, one of whom is a representative of the insurance industry in this state, one of whom is the chief executive officer of a business with more than 300 employees in this state, one of whom represents the hospital industry, one of whom is a primary care physician, and one of whom is a nurse, and five members appointed by the Speaker of the House of Representatives, one of whom is a consumer who represents a minority group in this state, one of whom represents the home health care industry in this state, one of whom is an allied health care professional, one of whom is the chief executive officer of a business with fewer than 25 employees in this state, and one of whom represents a county social services program

that provides health care services to the indigent. Appointed members of the council shall serve for 2-year terms commencing October 1 of each even-numbered year. The council shall elect a president from among the members who are not state employees. The Statewide Health Council shall:

(a) Advise the Governor, the Legislature, and the department on state health policy issues, state and local health planning activities, and state health regulation programs;

(b) Prepare a state health plan that specifies subgoals, quantifiable objectives, strategies, and resource requirements to implement the goals and policies of the health element of the State Comprehensive Plan. The plan must assess the health status of residents of this state; evaluate the adequacy, accessibility, and affordability of health services and facilities; assess government-financed programs and private health care insurance coverages; and address other topical local and state health care issues. Within 2 years after the health element of the State Comprehensive Plan is amended, and by July 1 of every 3rd year, if it is not amended, the Statewide Health Council shall submit the state health plan to the Executive Office of the Governor, the secretary of the department, the President of the Senate, and the Speaker of the House of Representatives;

(c) Promote public awareness of state health care issues and, in conjunction with the local health councils, conduct public forums throughout the state to solicit the comments and advice of the public on the adequacy, accessibility, and affordability of health care services in this state and other health care issues;

(d) Consult with local health councils, the Health Care Cost Containment Board, the Department of Insurance, the Department of Health and Rehabilitative Services, and other appropriate public and private entities, including health care industry representatives regarding the development of health policies;

(e) Serve as a forum for the discussion of local health planning issues of concern to the local health councils and regional planning councils;

(f) Review district health plans for consistency with the State Comprehensive Plan and the state health plan;

(g) Review the health components of agency functional plans for consistency with the health element of the State Comprehensive Plan, advise the Executive Office of the Governor regarding inconsistencies, and recommend revisions to agency functional plans to make them consistent with the State Comprehensive Plan;

(h) Review any strategic regional plans that address health issues for consistency with the health element of the State Comprehensive Plan, advise the Executive Office of the Governor regarding inconsistencies, and recommend revisions to strategic regional policy plans to make them consistent with the State Comprehensive Plan;

(i) Assist the Department of Community Affairs in the review of local government comprehensive plans to ensure consistency with policy developed in the district health plans;

(j) With the assistance of the local health councils, conduct public forums and use other means to determine the opinions of health care consumers, providers, payers, and insurers regarding the state's health care goals and policies and develop suggested revisions to the health element of the State Comprehensive Plan. The council shall submit the proposed revisions to the health element of the State Comprehensive Plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives by February 1, 1993, and shall widely circulate the proposed revisions to affected parties. The council shall periodically assess the progress made in achieving the goals and policies contained in the health element of the State Comprehensive Plan and report to the department, the Governor, the President of the Senate, and the Speaker of the House of Representatives; and

(4)(3) FUNDING.—

(a) *The Legislature recognizes that in developing policy for reforming the health care system, community input and involvement is essential in order to ensure access to health care services and maintain the quality of health care in a system of managed competition. Furthermore, the Legislature recognizes that an effective program of health care planning and policy development requires maintaining a system of local health councils.*

(b)(a) The Legislature intends that the cost of local health councils and the Statewide Health Council be borne by application fees for certificates of need and by assessments on selected health care facilities subject to facility licensure by the ~~department Agency for Health Care Administration~~, including abortion clinics, adult congregate living facilities, ambulatory surgical centers, birthing centers, clinical laboratories except community nonprofit blood banks, home health agencies, hospices, hospitals, intermediate care facilities for the developmentally disabled, nursing homes, and multiphasic testing centers, and by assessments on organizations subject to certification by the agency pursuant to chapter 641, part III, including health maintenance organizations and prepaid health clinics.

(c)(b)1. A hospital licensed under chapter 395, a nursing home licensed under chapter 400, and an adult congregate living facility licensed under chapter 400 shall be assessed an annual fee based on number of beds.

2. All other facilities and organizations listed in paragraph (a) shall each be assessed an annual fee of \$150.

3. Facilities operated by the Department of Health and Rehabilitative Services or the Department of Corrections and any hospital which meets the definition of rural hospital pursuant to s. 395.602 are exempt from the assessment required in this subsection.

(d)(e)1. The ~~department agency~~ shall, by rule, establish fees for hospitals and nursing homes based on an assessment of \$2 per bed. However, no such facility shall be assessed more than a total of \$500 under this subsection.

2. The ~~department agency~~ shall, by rule, establish fees for adult congregate living facilities based on an assessment of \$1 per bed. However, no such facility shall be assessed more than a total of \$150 under this subsection.

3. The ~~department agency~~ shall, by rule, establish an annual fee of \$150 for all other facilities and organizations listed in paragraph (a).

(e)(d) The ~~department agency~~ shall, by rule, establish a facility billing and collection process for the billing and collection of the health facility fees authorized by this subsection.

(f)(e) A health facility ~~that which~~ is assessed a fee under this subsection is subject to a fine of \$100 per day for each day in which the facility is late in submitting its annual fee, ~~but the fine may not exceed up to~~ ~~maximum~~ of the annual fee owed by the facility. A facility ~~that which~~ refuses to pay the fee or fine is subject to the forfeiture of its license.

(g)(f) The ~~department agency~~ shall deposit in the Health Care Trust Fund all health care facility assessments that are assessed under this subsection and proceeds from the certificate-of-need application fees which ~~are to be used to support the operation of sufficient to maintain the aggregate funding level for the local health councils and the Statewide Health Council as specified in the general appropriations act. The remaining certificate of need application fees shall be used only for the purpose of administering the Health Facility and Services Development Act.~~

(5)(4) DUTIES AND RESPONSIBILITIES OF THE DEPARTMENT.—

(a) The department, in conjunction with the Statewide Health Council and the local health councils, is responsible for the planning of all health care services in the state and for assisting the Statewide Health Council in the preparation of the state health plan.

(b) ~~The State Center for Health Statistics shall provide the Statewide Health Council with the data required by the council to perform its functions. The department shall develop and maintain a comprehensive health care data base for the purpose of health planning and for certificate of need determinations. The department or its contractor, may be authorized to require the submission of information from health facilities, health service providers, and licensed health professionals which is determined by the department, through rule, to be necessary for meeting the department's responsibilities as established in this section.~~

(c) The department shall assist personnel of the local health councils in providing an annual orientation to council members about council member responsibilities.

(d) The department shall contract with the local health councils for the services specified in subsection (1). ~~All contract funds shall be distributed according to an allocation plan developed by the department that provides for a minimum and equal funding base for each local health council. Any remaining funds shall be distributed based on adjustments for workload. The department may also make grants to or reimburse local health councils from federal funds provided to the state for activities related to those functions set forth in this section. The department may withhold funds from a local health council or cancel its contract with a local health council which does not meet performance standards agreed upon by the department and local health councils.~~

Section 14. Section 408.301, Florida Statutes, is amended to read:

408.301 Legislative findings.—

(1) The Legislature has found that access to quality, affordable, health care for all Floridians is an important goal for the state. The Legislature has charged the Agency for Health Care Administration with the responsibility of developing the Florida Health Plan for assuring access to health care for all Floridians. At the same time, the Legislature recognizes that there are Floridians with special health care and social needs which require particular attention. The people served by the Department of Health and Rehabilitative Services are examples of citizens with special needs. The Legislature further recognizes that the Medicaid program is an intricate part of the service delivery system for the special needs citizens served by or through the Department of Health and Rehabilitative Services. The Agency for Health Care Administration is not a service provider and does not develop or direct programs for the special needs citizens served by or through the Department of Health and Rehabilitative Services. Therefore, it is the intent of the Legislature that the Agency for Health Care Administration work closely with the Department of Health and Rehabilitative Services in developing plans for assuring access to all Floridians in order to assure that the needs of special citizens are met.

(2) *The Legislature finds that chronically ill children have disabling or potentially disabling physical conditions that require, on a permanent or intermittent basis, specialized or technically advanced care. There is a need to provide this care through programs or centers that meet standards and maintain a sufficient volume of technology and specialty services to promote cost-effectiveness and quality care. The Legislature also finds that chronically ill children require a comprehensive and coordinated system of health care that links community-based health care with multidisciplinary regional programs and tertiary medical centers. Furthermore, there is a need for the system to be coordinated with other services, such as education and social support, to promote the growth and development of the child and to support the family's management of the child in the home and community.*

(3) *The Legislature finds that persons with mental illnesses, including substance abuse disorders, have conditions that require, on a permanent or intermittent basis, specialized care. There is a need to provide this care through programs or centers that meet standards and maintain a high quality of care. The Legislature also finds that these persons require a comprehensive and coordinated system of care that promotes community-based care.*

Section 15. Section 408.40, Florida Statutes, is amended to read:

408.40 ~~Budget review proceedings~~; Duty of Public Counsel.—

(1) Notwithstanding any other provisions of this chapter, it shall be the duty of the Public Counsel to represent the general public of the state in any proceeding before the agency or its advisory panels in any administrative hearing conducted pursuant to the provisions of chapter 120 or before any other state and federal agencies and courts in any issue before the agency, any court, or any agency. With respect to any such proceeding, the Public Counsel is subject to the provisions of and may utilize the powers granted to him by ss. 350.061-350.0614.

(2) The Public Counsel shall:

(a) Recommend to the agency, by petition, the commencement of any proceeding or action or to appear, in the name of the state or its citizens, in any proceeding or action before the agency and urge therein any position which he deems to be in the public interest, whether consistent or inconsistent with positions previously adopted by the agency, and utilize therein all forms of discovery available to attorneys in civil actions generally, subject to protective orders of the agency which shall be reviewable by summary procedure in the circuit courts of this state.

(b) Have access to and use of all files, records, and data of the agency available to any other attorney representing parties in a proceeding before the agency.

(c) In any proceeding in which he has participated as a party, seek review of any determination, finding, or order of the agency, or of any hearing examiner designated by the agency, in the name of the state or its citizens.

(d) Prepare and issue reports, recommendations, and proposed orders to the agency, the Governor, and the Legislature on any matter or subject within the jurisdiction of the agency, and to make such recommendations as he deems appropriate for legislation relative to agency procedures, rules, jurisdiction, personnel, and functions.

(e) Appear before other state agencies, federal agencies, and state and federal courts in connection with matters under the jurisdiction of the agency, in the name of the state or its citizens.

Section 16. Paragraph (e) of subsection (6) of section 408.702, Florida Statutes, is amended to read:

408.702 Community health purchasing alliance; establishment.—

(6) Each community health purchasing alliance has the following powers, duties, and responsibilities:

(e) Requesting proposals from all accountable health partnerships and limited accountable health partnerships in the district for specialized benefits approved by the alliance board based on input from alliance members, determining if the proposals submitted by the accountable health partnerships and limited accountable health partnerships meet the requirements of the request for proposals, and offering them as options through riders to standard plans and basic plans. This paragraph does not limit an accountable health partnership's ability to offer other specialized benefits to alliance members.

Section 17. Section 408.703, Florida Statutes, is amended to read:

408.703 Small employer members of community health purchasing alliances; eligibility requirements.—

(1) The agency shall establish conditions of participation for small employers, as defined in s. 627.6699, which must include, but need not be limited to:

(a) Assurance that the group is a valid small employer and is not formed for the purpose of securing health benefit coverage. This assurance must include requirements for sole proprietors and self-employed individuals which must be based on a specified requirement for the time that the sole proprietor or self-employed individual has been in business, required filings to verify employment status, and other requirements to ensure that the individual is working.

(b) Assurance that the individuals in the small employer group are employees and have not been added for the purpose of securing health benefit coverage.

(2) The agency may not require a small employer to pay any portion of premiums as a condition of participation in an alliance.

(3) The agency may require a small employer seeking membership to agree to participate in the alliance for a specified minimum period of time, not to exceed 1 year.

~~(4) If a member small employer offers more than one accountable health partnership or health plan and the employer contributes to coverage of employees or dependents of the employee, the alliance shall require that the employer contribute the same dollar amount for each employee, regardless of the accountable health partnership or benefit plan chosen by the employee.~~

(4)(5) An employer that employs 30 or fewer employees must offer at least two (2) accountable health partnerships or health benefit plans to its employees, and an employer that employs 31 or more employees must offer three (3) or more accountable health partnerships or health benefit plans to its employees.

(5) An employer that offers employees a health benefit plan issued by a health maintenance organization shall also provide each employee with the option of obtaining a point of service plan from the health maintenance organization, as required to be made available by the health maintenance organization pursuant to s. 641.351. The employer

may require the employee to pay for any additional premium for the point of service plan that is in excess of the premium for the health maintenance organization plan and any additional administrative costs.

Section 18. Subsection (5) of section 408.704, Florida Statutes, is amended to read:

408.704 Agency duties and responsibilities related to community health purchasing alliances.—The agency shall assist in developing a statewide system of community health purchasing alliances. To this end, the agency is responsible for:

(5) Establishing the sole a data system for accountable health partnership reporting ~~partnerships~~. The agency shall distribute these data to the alliances in printed and electronic format for the alliance's use in disseminating the information to alliance members. The agency shall adjust hospital patient outcome data collected under this chapter using a severity adjustment method based on the Uniform Hospital Discharge Data Set information. If the data for specific high-volume, high-charge diagnoses or procedures exhibit wide variations in outcomes, the Uniform Hospital Discharge Data Set may be supplemented with focused studies. The agency shall consider the costs of implementation and collection in the selection of any severity adjustment method.

Section 19. Section 408.7043, Florida Statutes, is created to read:

408.7043 Providing health care for Florida Health Security members.—

(1) An accountable health partnership shall ensure that the claims experience, rates, and charges for Florida Health Security members are not commingled with those of other alliance members.

(2) When providing health care services for Florida Health Security members, a community health partnership shall ensure that the claims experience for Florida Health Security members is not commingled with those of other programs administered by the county, political subdivision, or tax district.

(3) A contract administrator shall ensure that all administrative costs associated with Florida Health Security members are accounted for separately and are not commingled or charged to others.

Section 20. Section 408.7056, Florida Statutes, is amended to read:

408.7056 Statewide provider and subscriber assistance program.—

(1) The agency ~~Agency for Health Care Administration~~ shall ~~adopt and implement~~ a program to provide assistance to subscribers and providers, including those whose grievances are not satisfactorily resolved by ~~an the~~ accountable health partnership or health maintenance organization. ~~The panel shall not consider grievances which relate to an accountable health partnership's or health maintenance organization's refusal to accept a provider into its network of providers.~~ The program ~~must shall~~ include the following:

(a) A review panel ~~to which may~~ periodically review, consider, and recommend to the agency any actions the agency or the ~~department Department of Insurance~~ should take concerning individual cases heard by the panel as well as the types of grievances which have not been satisfactorily resolved after subscribers or providers have followed the full grievance procedures of the accountable health partnership or health maintenance ~~organization organizations~~. The proceedings of the grievance panel ~~are shall~~ not be subject to the provisions of chapter 120. The review panel shall consist of members employed by the agency and members employed by the ~~department Department of Insurance~~, chosen by their respective ~~employers agencies~~. The agency may contract with a medical director and a primary care physician ~~to who shall~~ provide additional technical expertise to the review panel. The medical director ~~must shall~~ be selected from a health maintenance organization with a current certificate of authority to operate in ~~this state Florida~~.

(b) A plan to disseminate information concerning the program to the general public as widely as possible.

(2)(a) Every accountable health partnership or health maintenance organization ~~must shall~~ submit a quarterly report to the agency and the ~~department Department of Insurance~~ listing the number and the nature of all subscribers' grievances ~~that which~~ have not been resolved to the satisfaction of the subscriber after the subscriber follows the full grievance procedure of the ~~accountable health partnership or health maintenance organization~~.

(b) The Division of Insurance Consumer Services of the Department of Insurance shall establish a data base of complaint and grievance information that is specific to accountable health partnerships, health maintenance organizations, and prepaid health plans. The data base may compile information from any credible source, but must compile information received through the agency's managed care hotline, from the quarterly reports required under paragraph (a), or directly from providers, subscribers, or enrollees of accountable health partnerships, health maintenance organizations, or prepaid health plans, as provided under s. 641.495(8)(d).

(c) The Statewide Provider and Subscriber Assistance Program shall provide for systematic review of the data base and shall analyze the complaint and grievance data to compare the complaint and grievance levels within and among accountable health partnerships, health maintenance organizations, and prepaid health plans and to evaluate changes over time as part of an early warning system for identifying problematic accountable health partnerships, health maintenance organizations, and prepaid health plans.

(3)(a) ~~The agency Agency for Health Care Administration~~ may impose an administrative fine, after a formal investigation has been conducted on ~~an the~~ accountable health partnership's or health maintenance organization's failure to comply with quality of health services standards set forth in statute or rule. ~~The agency Agency for Health Care Administration~~ may initiate such an investigation based on the recommendations related to the quality of health services received from the Statewide Provider and Subscriber Assistance Panel pursuant to paragraph (1)(a). The fine ~~may shall~~ not exceed \$2,500 per violation, ~~nor may the and in no event shall such~~ fine exceed an aggregate amount of \$10,000 for noncompliance arising out of the same action.

(b) In determining the amount of a fine to be levied for noncompliance under paragraph (a), the following factors ~~must shall~~ be considered:

1. The severity of the noncompliance, including the probability that death or serious harm to the health or safety of the subscriber will result or has resulted, the severity of actual or potential harm, and the extent to which provisions of this part were violated.

2. Actions taken by the accountable health partnership or health maintenance organization to resolve or remedy any quality of care grievance.

3. Any previous incidences of noncompliance by the accountable health partnership or health maintenance organization.

(c) All amounts collected pursuant to this subsection shall be deposited into the Health Maintenance Organization Quality Care Trust Fund.

(4)(a) The agency and the Department of Insurance shall assist the Statewide Provider and Subscriber Assistance Program in developing and operating a comprehensive program throughout the state. At a minimum, the program must address consumer dissatisfaction with accountable health partnerships, health maintenance organizations, prepaid health plans, and other types of managed care services.

(b) Existing community resources, when available, must be used to support the program. The program must seek funding for its services and activities, especially for those addressing fraud and abuse, from federal and state financial assistance programs that presently exist or that may be created hereafter. The program may accept gifts and grants.

(c) Volunteers shall be used to the maximum extent possible in carrying out the program. The agency shall contract for the necessary insurance coverage to protect volunteers from personal liability while they are acting within the scope of their volunteer assignments under the program.

(5) The provisions of this section are cumulative to rights under the general civil and common law, and neither the agency nor the Department of Insurance may abrogate such rights to damages or to other relief in any court.

Section 21. Subsections (14), (15), (16), and (17) are added to section 408.706, Florida Statutes, to read:

408.706 Community health purchasing alliances; accountable health partnerships.—

(14) An accountable health partnership that elects to participate in Florida Health Security shall:

(a) Provide health insurance on a guarantee-issue basis in accordance with s. 409.814(15), to all individuals, dependents, employees, and employees of participating employers that are eligible for Florida Health Security as provided in s. 409.814(15).

(b) Rate health plans issued to Florida Health Security members using a modified community rating methodology defined in s. 627.6699(3) in which the premium for a member is determined without regard to the health condition of the member or dependent.

(c) Guarantee the renewal of a health plan at the option of the member, except for nonpayment of a premium, fraud or misrepresentation, noncompliance with a provision of the plan, or a determination by the Department of Insurance that continued issuance of the plan is not in the best interest of the public.

(d) Engage in fair marketing practices.

(e) Comply with part II and part VII of chapter 627, except for provisions relating to benefits that conflict with the security health benefit plan.

(f) Use the services of a licensed insurance agent for soliciting insurance, procuring insurance applications, or engaging in any other activity for which an insurance agent's license is required.

(15) An accountable health partnership that elects to participate in Florida Health Security is not required to offer other health benefit plans through the community health purchasing alliance.

(16) An accountable health partnership that offers health plans to small employers, state employees, or Medicaid recipients is not required to offer health plans to participants in the Florida Health Security program.

(17) Notwithstanding any other law, an insurer or a health maintenance organization is not required to participate in Florida Health Security or in the Medicaid program.

Section 22. Section 408.7061, Florida Statutes, is created to read:

408.7061 Limited accountable health partnerships.—

(1) An insurer, a health maintenance organization, or a limited health service plan licensed under chapter 536 may apply to the agency for designation as a limited accountable health partnership for the purpose of providing limited health services such as, but not limited to, ambulance services, dental care services, vision-care services, mental health services, substance-abuse services, chiropractic services, podiatric-care services, pharmaceutical services, or other services that do not constitute the full benefits of a health-benefit plan otherwise provided for under s. 408.706. Such designation allows the designee to respond to a request for proposal issued pursuant to s. 408.702(6)(e) for such limited services.

(2) An applicant for designation under this section must meet all requirements of s. 408.706 with respect to the limited benefits to be provided.

(3) This section does not apply to accountable health partnerships designated under s. 408.706. An accountable health partnership may respond to a request for proposal issued under s. 408.706(6)(e) for limited services without also needing to be designated as a limited accountable health partnership under this section.

Section 23. Subsection (1) of section 408.902, Florida Statutes, is amended to read:

408.902 MedAccess program; creation; program title.—

(1) Effective July 1, 1995 ~~1994~~, and only if the agency does not receive approval of a federal 1115 waiver to implement Florida Health Security, there is hereby created the MedAccess program to be administered by the Agency for Health Care Administration. The MedAccess program is ~~shall~~ not be subject to the requirements of the Department of Insurance or chapter 627. The director of the agency shall appoint an administrator of the MedAccess program which shall be located in the Division of State Health Purchasing.

Section 24. Subsection (3) is added to section 409.2557, Florida Statutes, to read:

409.2557 State agency for administering child support enforcement program.—

(3) The department shall adopt rules to implement the provisions of s. 13623 of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66), except for provisions applicable to insurers for which the Department of Insurance is provided such rulemaking authority pursuant to s. 624.31. The department shall enter into a cooperative agreement with the Department of Labor and Employment Security and the Agency for Health Care Administration for implementing the provisions of this federal act.

Section 25. Section 409.810, Florida Statutes, is created to read:

409.810 Short title.—Sections 409.810-409.820 may be cited as the "Florida Health Security Act."

Section 26. Section 409.811, Florida Statutes, is created to read:

409.811 Legislative findings and intent.—The Legislature finds that an unacceptably large number of state residents are unable to access affordable health insurance. The Legislature finds that health status, health care, and the purchase of health insurance are individual responsibilities. It is the policy of this state to encourage the purchase of health insurance by individuals. It is, therefore, the intent of the Legislature to establish a program that provides affordable health insurance coverage to uninsured residents of the state.

Section 27. Section 409.812, Florida Statutes, is created to read:

409.812 Definitions.—As used in ss. 409.810-409.820, the term:

(1) "Accountable health partnership" means an organization established under s. 408.706.

(2) "Agency" means the Agency for Health Care Administration.

(3) "Applicant" means an employer or individual who has provided a written application for enrollment in Florida Health Security, but whose application has not received final action.

(4) "Benchmark premium" means the maximum price of the security health benefit plan to which state and federal subsidies are applied.

(5) "Community health partnership" means a network of providers owned, operated, or under contract with a county, political subdivision, or tax district to provide health care services, through a contract with the agency, to indigent or low-income persons.

(6) "Community health purchasing alliance" means a state-chartered, nonprofit organization established pursuant to s. 408.702.

(7) "Covered individual" means a person enrolled in Florida Health Security.

(8) "Dependent child" means a child, until the end of the calendar year in which the child reaches 25 years of age, who is:

(a) Dependent on the eligible member for financial support and can be claimed as a dependent exemption in the Internal Revenue Code and the federal income tax regulations; and

(b) Living in the household with the member or is a full-time or part-time student in the state.

(9) "District" means the geographical territory assigned to a community health purchasing alliance as specified in s. 408.032(5).

(10) "Employer" means a person who is subject to a federal payroll tax imposed by the Federal Unemployment Tax Act.

(11) "Enrollment ceiling" means the maximum number of members that may be enrolled at any time in Florida Health Security. The maximum number shall be established annually in the General Appropriations Act, but enrollment may not exceed the number of members which requires a commitment of 90 percent of the revenue required to pay, on an annual basis, the state's share of the premium.

(12) "Family" means a Florida Health Security member, an eligible spouse, or a dependent child or dependent children.

(13) "Gross family income" includes, but is not limited to, wages, pensions, veterans' benefits, annuities, interest, dividends, rental income, income from self-employment, commissions, child support, alimony, public benefits such as Aid to Families with Dependent Children (AFDC), unemployment compensation, workers' compensation, social security benefits, and loan or mortgage payments for those included in the member's family.

(14) "Guarantee-issue basis" means a health plan that must be offered to an individual regardless of health status, preexisting conditions, or claims history.

(15) "Health insurance" means coverage under either of the following:

(a) A health plan offered by any health maintenance organization or licensed health insurer, except for plans that are limited to the following: a limited benefit, specified disease, or specified accident; individual hospital indemnity; accident only; limited benefit convalescent care; Medicare supplement; credit; dental; vision; long-term care; disability income; coverage issued as a supplement to workers' compensation liability insurance and employer liability or similar insurance; or motor vehicle medical payment only; or

(b) An employee welfare benefit plan that includes health benefits established under the Employee Retirement Income Security Act of 1974, as amended.

(16) "Managed care" means systems or techniques generally used by third-party payers or their agents to affect access to and control payment for health care services. Managed-care techniques include one or more of the following: prior, concurrent, and retrospective review of the medical necessity and appropriateness of services or site of services; contracts with selected health care providers; financial incentives or disincentives related to the use of specific providers, services, or service sites; controlled access to and coordination of services by a case manager; and payer efforts to identify treatment alternatives and modify benefit restrictions for high-cost patient care.

(17) "Medicaid" means the medical assistance program authorized by Title XIX of the Social Security Act, and regulations thereunder, and chapter 409, as administered in this state by the agency.

(18) "Medicare" means the health insurance program authorized by Title XVIII of the Social Security Act for persons aged 65 and older and certain disabled persons under the age of 65.

(19) "Member" means an eligible person enrolled in Florida Health Security.

(20) "Premium" means the entire cost of an insurance plan, including the administration fee, the risk assumption charge, and crime cost.

(21) "Premium subsidy" means the monthly payment by the Medicaid program per member for participation in Florida Health Security.

(22) "Public institution" means a federal, state, county, or privately operated adult or juvenile correctional facility; a state mental health hospital; a federal, state, county, or privately operated intermediate care facility for the developmentally disabled; a skilled nursing facility; or an intermediate care facility.

(23) "Resident" means a United States citizen or legal alien who meets the proof of Florida residency criteria established by the agency and approved by the federal Health Care Financing Administration. For purposes of the Florida Health Security program, resident means a person who has resided in the state continuously for the 6 months immediately preceding the date of application for Florida Health Security.

(24) "Security health benefit plan" means the standard benefit plan established by the Department of Insurance under s. 627.6699(12). The health benefit committee established under s. 627.6699(12)(a)1. may make any modification necessary to include low coinsurance amounts for primary or preventive services without increasing the cost of the plan. The health benefit committee shall modify the standard benefit plan of the Department of Insurance to include coverage for brand name anti-convulsive drugs when certified by a physician to be medically necessary. Such coverage may include an additional copayment for the brand-name drug. The health benefit committee shall modify the standard benefit plan of the Department of Insurance to include outpatient and inpatient rehabilitative services equivalent to those provided in the Florida Health Security Program submitted to the Legislature on December 20, 1993. The standard plan shall also be modified to include diabetes supplies, including glucose test strips necessary to maintain the health of the person with diabetes. The copayments for these services and supplies may be adjusted as necessary to prevent the premium from increasing.

(25) "Space" means an allocation of a Florida Health Security member opening, subject to the enrollment ceiling established in the General Appropriations Act each year.

Section 28. Section 409.813, Florida Statutes, is created to read:

409.813 Establishment of the Florida Health Security program.— Effective July 1, 1994, or upon approval of Florida Health Security financing by the federal Health Care Financing Administration, whichever is later, there is created a voluntary health insurance program entitled Florida Health Security. The director of the agency shall appoint an administrator of Florida Health Security. The program shall be located within the agency's Division of State Health Purchasing.

Section 29. Section 409.814, Florida Statutes, is created to read:

409.814 Eligibility.—

(1) To be eligible for the Florida Health Security program and a premium subsidy, a person must:

(a) Be a state resident;

(b) Have a gross family income equal to or less than 150 percent of the federal poverty level;

(c) Have been without health insurance continuously for the 12 months immediately preceding the date of application for the Florida Health Security program. To purchase family coverage, all family members living in the household that will be covered under the program must have been without health insurance for the 12-month period. To purchase spouse-dependent or dependent-only coverage for a family member, the family member must have been without coverage for the 12-month period;

(d) Not be eligible for Medicaid;

(e) Not be eligible for Medicare; and

(f) Not be residing in a public institution.

(2) Persons eligible pursuant to subsection (1) shall be enrolled as members of Florida Health Security and receive a premium subsidy unless the spaces allocated to the district in which they reside are full.

(3) Application may be made by an individual, an individual on behalf of the family or one or more dependents, or by an employer on behalf of his employees.

(4) Employers applying on behalf of employees meeting the eligibility criteria for Florida Health Security shall offer coverage to all employees that meet such criteria.

(5) Applicants shall provide documentation verifying eligibility for premium subsidies. Employers applying for premium subsidies on behalf of employees shall require employees who choose to participate to provide verification of eligibility for each employee, family member, or dependent applying for premium subsidies.

(6) Employers participating in Florida Health Security shall deduct any required employee contributions from wages and remit the employee contribution and any employer contribution to the program. An employer is not required by law or rule to pay any portion of a premium or to participate in Florida Health Security.

(7) Each applicant must complete an application form developed by the agency which includes the name, age, gender, family relationship, and social security number of each person to be covered. Applicants for the premium subsidy shall also provide documentation of gross family income, place and length of state residency, citizenship or appropriate United States residency status, and prior health insurance status of all persons to be covered.

(8) The agency shall require verification of members' continued eligibility once every 12 months and conduct periodic audits of a sample of those receiving benefits. Within 30 days after a change, members are responsible for reporting any changes in residence, family composition, employment, any changes in income sufficient to alter the member's contribution requirements, or any other information required by the agency to properly determine and verify eligibility.

(9) Applications for group coverage in Florida Health Security may be submitted at any time when spaces are available and must be accompanied by the initial monthly premium. Eligibility shall be determined within 30 days after receipt of a complete application. Coverage for the employer group shall begin on the first day of the month following the month in which eligibility was determined.

(10) Members may be disenrolled for failure to meet eligibility criteria or for nonpayment of premiums.

(11) Eligibility shall be denied to individuals who have transferred income-producing assets to non-income-producing assets in order to become eligible for the Florida Health Security program. Eligibility shall be denied for a period of 3 years.

(12) Except as provided in (11), the agency may not consider assets in determining eligibility for the program.

(13) Any individual who is found to have provided erroneous information on an application for Florida Health Security or who fails to report changes that may affect any individual's or employer's premium contribution level or eligibility for Florida Health Security shall reimburse the agency, county, political subdivision, or tax district for the full cost of premium subsidies paid on the individual's behalf, or on behalf of the individual's dependents. Any individual who knowingly provides erroneous information on an application for Florida Health Security or who knowingly fails to report changes that may affect any individual's or employer's premium contribution level or eligibility for Florida Health Security is guilty of a first-degree misdemeanor and shall reimburse the agency for the full cost of premium subsidies paid on the individual's behalf, or on behalf of the individual's dependents, and is subject to a fine of \$250 per month for each month's benefits that were received in excess of benefits to which the individual or the individual's dependents were entitled.

(14) Any employer who is found to have provided erroneous information on any application must pay the full amount of the premium subsidy paid by the state, county, political subdivision, or tax district for the preceding 12 months on behalf of any employees of the insuring employer about whom erroneous information is given. Any employer who knowingly provides erroneous information on any application is guilty of a first-degree misdemeanor and must pay the full amount of the subsidy paid by the state, county, political subdivision, or tax district for the preceding 12 months on behalf of any employees of the insuring employer about whom erroneous information is given and is subject to a \$250 fine per employee covered under the program.

(15) Individuals may apply for Florida Health Security whenever spaces are available.

(a) An individual shall apply during a 60-day open enrollment period beginning on July 1 of each year in order to be considered on a guarantee-issue basis.

(b) If an individual is denied coverage due to health status after the 60-day open enrollment period, that individual may, upon request of the applicant, be placed on a waiting list for the next 60-day open enrollment period.

Section 30. Section 409.815, Florida Statutes, is created to read:

409.815 Coverage.—

(1) Members of Florida Health Security shall purchase the health benefits defined in s. 409.812(24) with the following limitations:

(a) Preexisting condition exclusions, as delineated for health benefit plans in accordance with s. 627.6561, shall apply except for those individuals who were enrolled in Medicaid at the time of application or applied for Florida Health Security within 60 days after the loss of Medicaid eligibility; veterans; and children or parents enrolled in the Florida Healthy Kids program.

(b) Benefits available under workers' compensation insurance are not covered.

(c) A health care provider or health facility may not be required to provide an item or service under a benefit standard of this act if the provider or the facility objects to doing so on the basis of a religious belief or an established moral conviction. However, a facility that does not offer or provide an emergency service to a patient in the facility shall, at the request of the patient or other person authorized to give consent to medical treatment, arrange for the transfer of the patient to another health care provider or facility.

(2) Benefits will be provided by accountable health partnerships or community health partnerships through the Florida Health Security program.

(3)(a) Individuals and families who elect to pay the individual or family and employer share of the benchmark premium may select the security health benefit plan from any participating accountable health partnership in their county of residence.

(b) A county, political subdivision, or tax district that has established a community health partnership may elect to pay the individual and employer share of the premium and the difference between the benchmark premium and the premium established by the community health partnership's actuary for individuals and families:

1. Who wish to participate in Florida Health Security;
2. Whose gross family income is no greater than 100 percent of the current federal poverty level; and
3. Who are unemployed or whose employers do not choose to enroll their employees in Florida Health Security.

If the county, political subdivision, or tax district elects to pay the employee and employer share of the premium, the individuals and families for whom the premium is paid shall receive the security health benefit plan only from the community health partnership, except if emergency services are provided under s. 395.1041, the hospital or physician providing emergency services shall be reimbursed at the same level as hospitals and physicians who are members of the community health partnership. However, all such patients, when medically stable, shall be transferred to a medically appropriate referral hospital that participates in the community health partnership.

(c) A county, political subdivision, or tax district may elect to pay the employee and employer share of the Florida Health Security premium for individuals identified in paragraph (b) to an accountable health partnership.

(d) A county, political subdivision, or tax district may elect to pay the individual, employer, and state share of the benchmark premium and the difference between the benchmark premium and the premium established by the community health partnership's actuary for individuals and families:

1. Who wish to participate in Florida Health Security; and
2. Whose gross family income is no less than 100 percent or greater than 150 percent of the current federal poverty level.

If the county, political subdivision, or tax district elects to pay the employee, employer, and state share of the premium, the individuals and families for whom the employee, employer, and state portion of the premium is paid, shall receive the security health benefit plan only from the community health partnership. If emergency services are provided under s. 395.1041, the hospital or physician providing emergency services shall be reimbursed at the same level as hospitals and physicians who are members of the community health partnership. However, all such patients, when medically stable, shall be transferred to a medically appropriate referral hospital that participates in the community health partnership.

(4) If an individual or family is participating in Florida Health Security through their employer, the employer:

- (a) Shall select plans in accordance with s. 408.703(5); and
- (b) Must offer at least one plan with a premium equal to or less than the benchmark premium if available in the area.

(5) If the individual selects a plan with a premium that is above the benchmark premium, the individual or the individual's employer, if the employer contributes to the premium, must pay any additional costs of the plan selected.

(6) A member may change accountable health partnerships only at the time of annual renewal, except:

- (a) For cause;
- (b) When an individual participating through his employer changes jobs and his new employer does not offer the plan in which he is enrolled; or
- (c) When the member moves to an area not covered by the accountable health partnership.

(7) A member whose coverage is terminated for nonpayment of premiums is not eligible for coverage until he has been without coverage for 12 months unless the member provides documentation that nonpayment was for reasons beyond the member's control, including an employer's failure to remit premiums or an error by the community health purchasing alliance or its contract administrator.

Section 31. Section 409.816, Florida Statutes, is created to read:

409.816 Contribution requirements.—

(1) For fiscal year 1994-1995, the monthly benchmark premium is \$116 for individual coverage and \$348 for family coverage.

(a) Federal financial participation is limited to the Florida Medicaid federal financial participation rate as determined by the federal Health Care Financing Administration.

(b) State financial participation is limited to the difference between the federal participation rate and the required member contribution based on a sliding scale of gross family income.

(c) The amount of the premium subsidy provided by Florida Health Security is limited to the total state and federal share of the benchmark premium.

(d) The level of a member's premium subsidy is based on gross family income using a sliding scale.

(e) The member, or his employer if the employer contributes to the plan, is responsible for any additional cost due to the selection of a plan that exceeds the benchmark premium.

(2) The Florida Health Security program is not an entitlement. A ceiling shall be placed on annual federal and state expenditures and program eligibility spaces based on the General Appropriations Act each year.

Section 32. Section 409.817, Florida Statutes, is created to read:

409.817 Florida Health Security administration.—The agency shall:

(1) Develop and administer the process for paying accountable health partnerships for Florida Health Security members in compliance with ss. 408.70-408.706.

(2) Provide for the payment of premium subsidies for eligible members who purchase health insurance plans through the Florida Health Security program.

(3) Recommend to the Legislature the annual benchmark premium for individual, spouse-dependent, dependent-only, and family coverage.

(4) Contract through a competitive-bid process with a contract administrator in each community health purchasing alliance district to perform the functions specified in s. 409.818(1).

(5) Establish the policies and procedures for determining eligibility for membership in Florida Health Security.

(6) Establish the procedures to be followed for billing and collecting premiums for Florida Health Security members.

(7) Develop a management information system and reporting requirements for the Florida Health Security program.

(8) Establish standards for the administrative functions performed by contract administrators.

(9) Ensure that persons who are eligible for Medicaid are not enrolled in Florida Health Security.

(10) Determine the premium subsidy for the Florida Health Security benchmark premium.

(11) Monitor the accuracy of the eligibility determination functions performed by the contractors, including the information reported by Florida Health Security members and their employers.

(12) Market Florida Health Security directly or through a contractor. However, such marketing may not include individual solicitation of insurance, procurement of applications, or any other activities for which an insurance agent's license is required.

(13) Prepare an annual report to the Legislature by September 30 each year on the impact that Florida Health Security has had in reducing the number of state residents without health insurance.

(14) Establish each quarter the maximum number of members that may be enrolled in Florida Health Security in each community health purchasing alliance district, subject to the enrollment ceiling established by the Legislature.

Section 33. Section 409.818, Florida Statutes, is created to read:

409.818 Agency responsibilities for contract operations.—

(1) The agency shall provide, through contract administrators, administrative services for the Florida Health Security program. Contract administrators shall:

(a) Distribute marketing materials to inform the public of the benefits of Florida Health Security.

(b) Distribute application forms for membership in Florida Health Security through accountable health partnerships, community health partnerships, and their licensed and appointed insurance agents.

(c) Verify application forms for completeness and accuracy after receipt from licensed and appointed insurance agents.

(d) Verify eligibility for membership in Florida Health Security.

(e) Determine the portion of the total premium to be paid by the member.

(f) Establish and maintain a database for the Florida Health Security program.

(g) Process member enrollment forms after receipt from licensed and appointed insurance agents, and transmit member enrollment information to accountable health partnerships.

(h) Bill and collect premiums from Florida Health Security members.

(i) Provide follow-up services for collecting delinquent premiums.

(j) Pay premiums to accountable health partnerships or community health partnerships.

(k) Certify each month the information required by the agency to obtain the state and federal funding for the benchmark premium.

(l) Enroll and disenroll members from accountable health partnerships or community health partnerships.

(2) The contract administrators are responsible for the full cost of a premium subsidy that is in excess of the error tolerance level established by the agency and the federal Health Care Financing Administration.

(3) A contract administrator may not engage in any activity for which an insurance agent's license is required.

Section 34. Section 409.819, Florida Statutes, is created to read:

409.819 Community health partnerships.—

(1) A community health partnership may be created by a county, political subdivision, or tax district for the sole purpose of providing health care services to Florida Health Security members.

(2) A county, political subdivision, or tax district that establishes a community health partnership may enroll individuals in the Florida Health Security program whose gross family income is no greater than 150 percent of the current federal poverty level. The Agency for Health Care Administration may not require a county, political subdivision, or tax district to finance any part of the Florida Health Security program with local funds. A community health partnership may not require an individual or an employer to pay any portion of the premium for benefits provided under the Florida Health Security program.

(3) Each county, political subdivision, or tax district that seeks to offer health care services to Florida Health Security members, either directly or indirectly through a contract with a network of providers, shall obtain designation as a community health partnership from the agency. A community health partnership is not required to obtain a certificate of authority as a health maintenance organization from the Department of Insurance under part I of chapter 641. A community health partnership that offers services to persons with incomes above 150 percent of the fed-

eral poverty level must obtain a certificate of authority from the Department of Insurance under part I of chapter 461. The agency shall adopt rules for designating community health partnerships. To qualify as a community health partnership, a county, political subdivision, or tax district shall submit information to the agency, in a format prescribed by the agency, which demonstrates that the entity:

(a) Is capable of providing, either directly or indirectly, all of the services included in the security health benefit plan, except for limitations approved by the agency;

(b) Has the ability and structure to arrange for the appropriate level and type of health care services;

(c) Has the ability to monitor and evaluate the quality of care provided by its provider network;

(d) Has the ability to assure enrollees adequate access to providers of health care, including geographic availability and adequate numbers and types;

(e) Has the ability to monitor access to its provider network; and

(f) Has a satisfactory grievance procedure and the ability to respond to enrollees' calls, questions, and complaints.

(4) As a condition of receiving state funds, each community health partnership shall annually provide the agency a description of all services and levels of service which the partnership will provide, a description of all income eligibility criteria for entry into the program, and a certification that the services will be made available to all persons in a specified geographic area who request the same, irrespective of health status, claims history, or projected claims history. Each community health partnership must demonstrate to the agency, by way of actuarial certification or other satisfactory evidence, that it has reserves, sources of funds, provider agreements, or otherwise that reasonably assures that the partnership has the resources necessary to provide the services to which it is committed. In addition, each partnership shall provide assurances that it:

(a) Has the ability to accept and will accept the standard health claim form adopted by the Department of Insurance under s. 627.647.

(b) Will not discriminate in accepting or retaining plan members based on health status, claims history, or prospective claims experience.

(c) Has the ability to and will provide a description of all services to be provided by the program to each member within 10 days after enrollment.

(d) Will comply with all rules adopted by the agency regarding the content and clarity of advertising or public information programs and the readability and accuracy of program descriptions.

(e) Will not engage in unfair practices with respect to exposure to HIV infections and related matters.

(f) Will provide text of services available to be translated in a language other than English.

(g) Will prohibit persons other than regularly salaried officers and employees of the community health partnership from conducting any enrollment activities unless such persons are licensed as health insurance agents in accordance with chapter 626, and are appointed in writing by the partnership. Such salaried officers or employees may enroll members who seek services at the site where community health partnerships' health care services are available or members who have previously been determined to be eligible through the provision of health care services by the community health partnership provider.

(5) Community health partnerships shall assume responsibility for:

(a) Distribution of Florida Health Security enrollment application forms.

(b) Transmission of Florida Health Security enrollment data to the contract administrator.

(c) Receipt of the federal share of the benchmark premium from the contract administrator.

(d) Accurate recordkeeping of state and federal funds.

(6) Upon approval by the agency, a community health partnership may:

(a) Determine eligibility for membership in Florida Health Security.

(b) Verify application forms for completeness and accuracy.

(c) Establish and maintain a separate data base for Florida Health Security members.

(d) Perform premium billing and collection for Florida Health Security members who are required to contribute to the benchmark premium.

(7) The community health partnership shall:

(a) Maintain at all times in the form of cash, short-term investments as approved by the agency, or restricted funds or deposits approved by the agency, an amount equal to one-and-one-half times the cash requirements to deliver the proposed services as outlined in Florida Health Security.

(b) Offer the security health benefit plan as defined in s. 409.812(24).

(c) File for approval by the agency any variation in basic services offered from those delineated by the agency.

(d) Ensure that the funding of Florida Health Security, as offered and approved by the agency, is actuarially sound.

(e) Ensure that there is an actual and dedicated revenue source to fund the activities of the community health partnership.

(8) The community health partnership may not issue any health benefit plan until it has received approval from the agency.

(9) A community health partnership otherwise in compliance with this section may enter into a contract with the agency to provide a set of comprehensive health care services provided under Florida Health Security and to comply with the provisions and disclosures required by this section. Each covered individual shall be given a copy of a member handbook that contains the benefits provided and all of the disclosures required by this section.

(a) Every community health partnership member handbook must clearly state all of the services to which a covered individual is entitled under the contract and must include a clear and understandable statement of any limitations on the services or kinds of services to be provided, including any copayment feature or schedule of benefits required by the contract or by any insurer or entity that is underwriting any of the services offered by the community health partnership. The member handbook must also state where and in what manner the comprehensive health care services may be obtained.

(b) Each covered individual shall receive a clear and understandable description of the method of the community health partnership for resolving grievances, and the method shall be set forth in the contract and member handbook. The organization shall also furnish, at the time of initial enrollment and when necessary due to substantial changes to the grievance process, a separate and additional communication prepared or approved by the agency notifying the covered individual of his rights and responsibilities under the grievance process.

(c) A community health partnership may coordinate benefits on the same basis as an insurer under s. 627.4235.

(d) A community health partnership providing medical benefits or payments to a covered individual who suffers injury, disease, or illness by virtue of the negligent act or omission of a third party is entitled to reimbursement from the covered individual in accordance with s. 768.76(4).

(e) A community health partnership that provides coverage, benefits, or services for a member of the family of the covered individual shall, as to such family member's coverage, benefits, or services, also provide that the coverage, benefits, or services applicable for children shall be provided with respect to a preenrolled newborn child of the covered individual, or covered family member of the covered individual, from the moment of birth. The coverage, benefits, or services for a newborn child must consist of coverage for injury or sickness, including the necessary care or treatment of a medically diagnosed congenital defect, birth abnormality, or prematurity, and transportation costs of the newborn to and from the nearest appropriate facility appropriately staffed and equipped to treat the newborn's condition, when such transportation is certified by the attending physician as medically necessary to protect the health and safety of the newborn child.

(f) Each community health partnership contract or member handbook must state that emergency services shall be provided to a covered individual in an emergency situation that does not permit treatment through the community health partnership's providers, without prior notification to and approval of the community health partnership. If emergency services are provided under s. 395.1041, the hospital or physician providing emergency services must be reimbursed at the same level as hospitals and physicians who are members of the community health partnership. However, all such patients, when medically stable, must be transferred to a medically appropriate referral hospital that participates in the community health partnership. The community health partnership contract or member handbook must contain a definition of emergency services, describe procedures for the community health partnership to determine whether the services qualify for reimbursement as emergency services, and contain specific examples of what constitutes an emergency.

(g) The contract and member handbook must clearly disclose the intent of the community health partnership as to the applicability or nonapplicability of coverage to preexisting conditions. If coverage of the contract is not applicable to preexisting conditions, the contract must specify, in substance, that coverage pertains solely to accidental bodily injuries resulting from accidents occurring after the effective date of coverage and that sicknesses are limited to those which first manifest themselves subsequent to the effective date of coverage.

(h) A community health partnership contract that provides coverage for a member of the family of the covered individual must, as to such family member's coverage, provide that coverage, benefits, or services applicable for children shall be provided with respect to an adopted child of the covered individual, which child is placed in compliance with chapter 63, from the moment of placement in the residence of the covered individual. The contract may not exclude coverage for any preexisting condition of the child. In the case of a newborn child, coverage shall begin from the moment of birth if a written agreement to adopt such child has been entered into by the covered individual prior to the birth of the child, whether or not such agreement is enforceable. However, coverage for such child is not required if the child is not ultimately placed in the residence of the covered individual in compliance with chapter 63.

(i) Each community health partnership shall provide that termination of coverage by the community health partnership is without prejudice to any continuous loss that commenced while the coverage was in force, but any extension of benefits beyond the period the coverage was in force may be predicated upon the continuous total disability of the covered individual and may be limited to payment for the treatment of a specific accident or illness incurred while the covered individual was a member. Such extension of benefits may be limited to the occurrence of the earliest of the following events:

1. The expiration of 12 months.
2. A succeeding carrier elects to provide replacement coverage without limitation as to the disability condition.
3. The maximum benefits payable under the coverage have been paid.

If maternity coverage is not covered by the succeeding carrier, a reasonable extension of benefits or accrued liability provision is required, which provision provides for continuing the contract benefits in connection with maternity expenses for a pregnancy that commenced while the contract was in effect. The extension must be for the period of that pregnancy and may not be based upon total disability.

(10) If a contract exists between a community health partnership and a provider, and the community health partnership fails to meet its obligations to pay fees for services already rendered to a covered individual, the community health partnership is liable for such fees rather than the covered individual, and the contract must so state. A covered individual of a community health partnership is not liable to any provider of health care services for any services covered by the community health partnership.

(11)(a) With respect to benefits offered by a community health partnership, a person may not, unless licensed and appointed as a health insurance agent in accordance with the applicable provisions of the Florida Insurance Code:

1. Solicit contracts or procure applications; or
2. Engage or hold himself out as engaging in the business of analyzing or abstracting health services contracts or of counseling or advising or

giving opinions to persons relative to such contracts other than as a consulting actuary advising a community health partnership or as a salaried bona fide, full-time employee so counseling and advising his employer relative to coverage for the employer and his employees.

(b) All qualifications, disciplinary provisions, licensing, and appointment procedures, fees, and related matters contained in the Florida Insurance Code which apply to the licensing and appointment of health insurance agents by insurers apply to community health partnerships and to persons licensed or appointed by the community health partnership as their agents.

(c) A examination, license, or appointment is not required of any regular salaried officer or employee of a community health partnership who devotes substantially all of his services to activities other than the solicitation of community health partnership memberships from the public and who receives no commission or other compensation directly dependent upon the solicitation of such memberships. Such salaried officers or employees may enroll members who seek services at the site where community health partnerships' health care services are available or members who have previously been determined to be eligible through the provision of health care services by the community health partnership provider.

(12) If the negotiations by a community health partnership with an individual leading up to the enrollment of the individual are conducted in a language other than English, the community health partnership shall supply to the covered individual a written translation of the member handbook in the language used to negotiate the enrollment.

(13) Each community health partnership shall, annually within 3 months after the end of its fiscal year, in a form prescribed by the Department of Insurance, file for review and comment an actuarial certification that:

(a) The community health partnership is actuarially sound, which certification must consider the rates, benefits, and expenses of, and any other funds available for the payment of obligations of, the community health partnership; and

(b) Claims incurred but not reported and claims reported but not fully paid have been adequately provided for.

Within 60 days after receipt of the certification, the department shall provide the community health partnership with any comments as to the community health partnership's actuarial soundness.

(14) If a community health partnership or the agency determines that it is no longer in the best interest of the community health partnership to continue providing coverage to participants in Florida Health Security, the community health partnership shall immediately cease enrollment in its plan and shall begin to disenroll participants on the renewal date of the plan.

(15) If a community health partnership elects to terminate its participation in the Florida Health Security program, the community health partnership shall provide notice to the agency at least 120 days prior to the termination of its participation.

(16) Counties, political subdivisions, tax districts, or community health partnerships that provide health care services, either directly or through contracts with health care providers, may subcontract with accountable health partnerships to provide services to Florida Health Security members.

(17) The agency shall provide technical assistance to those counties, political subdivisions, or tax districts that seek to become community health partnerships.

(18)(a) Effective July 1, 1994, the Department of Health and Rehabilitative Services shall establish up to five pilot programs to facilitate enrollment in the Florida Health Security program. The department shall place public assistance staff in those county offices where community health partnerships have been established to determine eligibility for Florida Health Security and to determine eligibility for Medicaid if the applicant is not eligible for Florida Health Security.

(b) The department shall report to the Governor, the Speaker of the House of Representatives, and the President of the Senate on the effectiveness of the pilot programs no later than January 1, 1996.

Section 35. Section 409.8191, Florida Statutes, is created to read:

409.8191 Community health partnership quality assurance program; second medical opinion required.—

(1) The community health partnerships shall ensure that the health care services provided to members are rendered under reasonable standards of quality of care consistent with the prevailing standards of medical practice in the community.

(2) Each community health partnership shall have an ongoing internal quality assurance program for its health care services. The program must include, but is not limited to:

(a) A written statement of goals and objectives which stresses quality of care rendered to members;

(b) A written statement that describes how state-of-the-art methodology has been incorporated into an ongoing system for monitoring care that is oriented to individual cases and, when implemented, interprets and analyzes patterns of care rendered to individual patients by individual providers;

(c) Written procedures for taking appropriate remedial action whenever, as determined under the quality assurance program, inappropriate or substandard services have been provided or services that should have been furnished have not been provided; and

(d) A written plan for reviewing physicians and other licensed medical providers which includes an ongoing review within the community health partnerships.

(3)(a) Each community health partnership shall give the member the right to a second medical opinion in any instance in which the member disputes the community health partnership's or the physician's opinion of the reasonableness or necessity of surgical procedures or is subject to a serious injury or illness.

(b) The second opinion, if requested, must be provided by a physician chosen by the member who may select:

1. A contract or employed physician listed in a directory that shall be provided by the community health partnership; or

2. A noncontract physician located in the same geographical service area of the community health partnership.

(c) For a second opinion provided by a contract physician, the community health partnership may not charge a fee to the member in an amount in excess of the fees established by contract for services provided to members by referral contract physicians. The community health partnership shall pay the amount of all charges, which are usual, reasonable, and customary in the community, for second-opinion services performed by a physician who is not under contract with the community health partnership, but may require the member to be responsible for up to 40 percent of such amount. The community health partnership may require that any tests deemed necessary by a noncontract physician be conducted by the community health partnership. The community health partnership may deny reimbursement rights granted under this section if the member seeks in excess of three such referrals per year and if the community health partnership deems such subsequent referral costs to be evidence that the member has unreasonably overutilized the second-opinion privilege. A member who is denied reimbursement under this section shall have recourse to grievance procedures specified in this chapter. The community health partnership's physician's professional judgment concerning the treatment of a member derived after review of a second opinion shall control as to the treatment obligations of the community health partnership. Treatment not authorized by the community health partnership shall be at the member's expense.

(4) The community health partnership shall demonstrate its capability to provide health care services in the geographic areas it is proposing to service. The community health partnership shall ensure that the health care services it provides to members are accessible to the members, with reasonable promptness, with respect to geographic locations, hours of operation, provision of after-hours service, and staffing patterns with generally accepted norms of the health maintenance organization industry for meeting member needs.

(5) The community health partnership shall exercise reasonable care in assuring that services provided are performed by providers who are licensed to provide such services.

(6) The community health partnership shall have a system for verifying and examining the credentials of each of its providers. The community health partnership shall maintain in a central file the credentials, including a copy of the current state license, of each of its physicians.

(7) Each community health partnership shall establish standards and procedures reasonably necessary to provide for maintaining a readily accessible medical records system that is adequate to provide necessary information, including accurate documentation of all services provided for each enrolled person.

(8) The community health partnership shall provide, through contract or otherwise, for periodic review of its medical facilities and services.

Section 36. Section 409.8192, Florida Statutes, is created to read:

409.8192 Community health partnership external quality assurance assessment.—

(1) The agency shall require each community health partnership to have an external quality assurance assessment performed by a review organization approved by the agency, as a condition of doing business in the state. The assessment shall be conducted within 2 years after the effective date of the contract, and every 2 years thereafter, or when the agency deems an additional assessment is necessary.

(2) The review organization must have nationally recognized experience in managed-care activities and in the appraisal of medical practice and quality assurance in a managed-care setting. The review organization may not be involved in operating the health maintenance organization or the prepaid health clinic, nor in the delivery of health care services to its members. The review organization must not have contracted or consulted with the community health partnership under quality assurance assessment within the last 2 years.

(3) A representative of the agency may accompany the review organization throughout the assessment process, but may not participate in the final assessment determination. The review organization shall monitor and evaluate the quality and appropriateness of patient care, the community health partnership's pursuance of opportunities to improve patient care and resolve identified problems, and the effectiveness of the internal quality assurance program required for community health partnership under this chapter.

(4) The assessment process must include a review of:

(a) All documentation necessary to determine the current professional credentials of employed health care providers or physicians providing service under contract to the community health partnership.

(b) At least a representative sample of not fewer than 50 medical records of individual members. When selecting a sample, any and all medical records are subject to review. The sample of medical records must be representative of all members' records.

(5) Each community health partnership shall submit its books, documents, and medical records and take appropriate action necessary to facilitate the assessment process.

(6) The review organization shall issue a written report of its findings to the community health partnership's governing board. A copy of the report shall be submitted to the agency by the organization within 30 business days after its receipt by the community health partnership.

(7) The expenses of the assessment process of each community health partnership, including any expenses incurred under this section, shall be paid by the community health partnership.

Section 37. Section 409.8193, Florida Statutes, is created to read:

409.8193 Information disclosure; community health partnership hospitals and physicians.—

(1) Each community health partnership shall maintain a current list, by geographic area, of all hospitals that are routinely and regularly used by the community health partnership, indicating to which hospitals the community health partnership may refer particular members for non-emergency services. The list must also include all physicians who are directly employed by the community health partnership or who are under contract or other arrangement with the community health partnership to provide health care services to members. The list must contain the following information for each physician:

- (a) Name.
- (b) Office location.
- (c) Medical area or areas of specialty.
- (d) Board certification or eligibility in any area.
- (e) License number.
- (2) The list shall be made available, upon request, to the agency.

Section 38. Section 409.8194, Florida Statutes, is created to read:

409.8194 Community health partnership internal risk-management program.—Each community health partnership, as a part of its administrative functions, shall establish an internal risk-management program that includes the components required in chapter 395.

Section 39. Section 409.820, Florida Statutes, is created to read:

409.820 Florida Health Security funding.—

(1) Savings realized by enrolling persons who are eligible for Medicaid in managed care programs, which are not included in the General Appropriations Act each year, shall be documented and confirmed by the Social Services Estimating Conference annually. Members may not be enrolled in Florida Health Security until there is sufficient money to pay the state subsidy for the remainder of the fiscal year for the member to be enrolled.

(2) The agency shall collect and analyze the data needed to project Florida Health Security participation rates, caseloads, and expenditures. The agency shall report each quarter the caseload and expenditure trends and projections to the Social Services Estimating Conference.

(3) The Social Services Estimating Conference shall determine each quarter the enrollment ceiling of the number of Florida Health Security spaces which can be funded through the trust fund. If, at any time, the Social Services Estimating Conference determines that there are insufficient savings to fund the current enrollment in Florida Health Security on an annualized basis, all additional enrollment must cease and additional enrollment may not resume until sufficient savings are estimated to fund such enrollment.

(4) In order to protect the integrity of Florida Health Security, the estimate of Medicaid savings, the proposed caseload enrollment cap, and the data required in paragraph (2) must be actuarially sound and verified by an independent actuary prior to submission for approval to the Administration Commission. The independent actuary shall be retained by the Administration Commission; however, the agency may also employ actuaries.

Section 40. The Agency for Health Care Administration may make program modifications necessary to overcome any objections of the federal Health Care Financing Administration to obtain approval for waivers necessary to implement the Florida Health Security program; provided that the agency does not seek a waiver of federally qualified health center services as a mandatory Medicaid service, sections 1902(a)(10)(A) and 1905(a)(2)(c) of the Social Security Act, or request a waiver of cost-based reimbursement requirements for federally qualified health centers; provided that employers shall not be required to pay any portion of a premium; and provided that there is no change in program benefits or increase in program costs, the legislative intent of the Florida Health Security Act is sustained, and the modifications are subject to the provisions of chapter 216, Florida Statutes.

Section 41. Section 409.901, Florida Statutes, is amended to read:

409.901 Definitions.—As used in ss. 409.901-409.920, except as otherwise specifically provided, the term:

(1) "Agency" means the Agency for Health Care Administration. The agency is the Medicaid agency for the state, as provided under federal law.

(2)(1) "Applicant" means an individual whose written application for medical assistance provided by Medicaid under ss. 409.903-409.906 has been submitted to the agency department, but has not received final action. This term includes an individual, who need not be alive at the time of application, whose application is submitted through a representative or a person acting for the individual.

(3)(2) "Benefit" means any benefit, assistance, aid, obligation, promise, debt, liability, or the like, related to any covered injury, illness, or necessary medical care, goods, or services.

(4)(2) "Claim" means any communication, whether oral, written, or electronic (electronic impulse or magnetic), which is used by any person to apply for payment from the Medicaid program or its fiscal agent for each item or service purported by any person to have been provided by a person to any Medicaid recipient.

(5)(4) "Collateral" means:

(a) Any and all causes of action, suits, claims, counterclaims, and demands which accrue to the recipient or to the recipient's legal representative, related to any covered injury, illness, or necessary medical care, goods, or services which necessitated that Medicaid provide medical assistance.

(b) All judgments, settlements, and settlement agreements rendered or entered into and related to such causes of action, suits, claims, counterclaims, demands, or judgments.

(c) Proceeds, as defined in this section.

(6)(5) "Covered injury or illness" means any sickness, injury, disease, disability, deformity, abnormality disease, necessary medical care, pregnancy, or death for which a third party is, may be, could be, should be, or has been liable, and for which Medicaid is, or may be, obligated to provide, or has provided, medical assistance.

(7) "Florida Health Security" means the state-administered insurance program created under ss. 409.810-409.820.

~~(6) "Department" means the Department of Health and Rehabilitative Services. The department is the Medicaid agency for the state, as provided under federal law.~~

(8)(7) "Legal representative" means a guardian, conservator, survivor, or personal representative of a recipient or applicant, or of the property or estate of a recipient or applicant.

(9)(8) "Medicaid" means the medical assistance program authorized by Title XIX of the Social Security Act, 42 U.S.C. s. 1396 et seq., and regulations thereunder, as administered in this state by the agency department.

(10)(9) "Medicaid agency" means the single state agency that administers or supervises the administration of the state Medicaid plan under federal law.

(11)(10) "Medicaid program" means the program authorized under Title XIX of the federal Social Security Act that provides for payments for medical items or services, or both, on behalf of any person who is determined by the agency department to be eligible on the date of service for Medicaid assistance.

(12)(11) "Medicaid provider" or "provider" means a person or entity that has a Medicaid provider agreement in effect with the agency department and is in good standing with the agency department.

(13)(12) "Medicaid provider agreement" or "provider agreement" means a contract between the agency department and a provider for the provision of services or goods, or both, to Medicaid recipients pursuant to Medicaid.

(14)(13) "Medicaid recipient" or "recipient" means an individual whom the agency department determines is eligible, pursuant to federal and state law, to receive medical assistance and related services for which the agency department may make payments under the Medicaid program. For the purposes of determining third-party liability, the term includes an individual formerly determined to be eligible for Medicaid, an individual who has received medical assistance under the Medicaid program, or an individual on whose behalf Medicaid has become obligated.

(15)(14) "Medicaid-related records" means records that relate to the provider's business or profession and to a Medicaid recipient. Medicaid-related records include records related to non-Medicaid customers, clients, or patients but only to the extent that the documentation is shown by the agency department to be necessary to determine a provider's entitlement to payments under the Medicaid program.

(16)(15) "Medical assistance" means any provision of, payment for, or liability for medical services by Medicaid to, or on behalf of, any recipient.

(17)(16) "Medical services" or "medical care" means medical or medically related institutional or noninstitutional care, goods, or services covered by the Medicaid program. The term includes, without limitation, physician services, inpatient hospital services, outpatient hospital services, independent laboratory services, X-ray services, and prescribed drug services, and such other services as are covered by the Medicaid program.

(18)(17) "Payment," as it relates to third-party benefits, means performance of a duty, promise, or obligation, or discharge of a debt or liability, by the delivery, provision, or transfer of third-party benefits for medical services. To "pay" means to do any of the acts set forth in this subsection.

(19)(18) "Proceeds" means whatever is received upon the sale, exchange, collection, or other disposition of the collateral or proceeds thereon and includes insurance payable by reason of loss or damage to the collateral or proceeds. Money, checks, deposit accounts, and the like are "cash proceeds." All other proceeds are "noncash proceeds."

(20)(19) "Third party" means an individual, entity, or program, excluding Medicaid, that is, may be, could be, should be, or has been liable for all or part of the cost of medical services related to any medical assistance covered by Medicaid.

(21)(20) "Third-party benefit" means any benefit that is or may be available at any time through contract, court award, judgment, settlement, agreement, or any arrangement between a third party and any person or entity, including, without limitation, a Medicaid recipient, a provider, another third party, an insurer, or the *agency department*, for any Medicaid-covered injury, illness, goods, or services, including costs of medical services related thereto, for personal injury or for death of the recipient, but specifically excluding policies of life insurance on the recipient, unless available under terms of the policy to pay medical expenses prior to death. The term includes, without limitation, collateral, as defined in this section, health insurance, any benefit under a health maintenance organization, a preferred provider arrangement, a prepaid health clinic, liability insurance, uninsured motorist insurance or personal injury protection coverage, medical benefits under workers' compensation, and any obligation under law or equity to provide medical support.

Section 42. Effective upon becoming a law, subsection (8) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.—The department may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined by the department to be eligible on the dates on which the services were provided. Any service under this section may be provided only when medically necessary, shall be provided in accordance with state and federal law, and is subject to the availability of moneys and any limitation established by the general appropriations act or chapter 216.

(8) NURSING FACILITY SERVICES.—The department shall pay for 24-hour-a-day nursing and rehabilitative services for a recipient in a nursing facility licensed under part II of chapter 400 or in a rural hospital, as defined in s. 395.602, or in a Medicare certified skilled nursing facility operated by a hospital that, as defined by s. 395.002(10), is licensed under part I of chapter 395, which services are ordered by and provided under the direction of a licensed physician. However, if a nursing facility has been destroyed or otherwise made uninhabitable by natural disaster or other emergency and another nursing facility is not available, the department must pay for similar services temporarily in a hospital licensed under part I of chapter 395 provided federal funding is approved and available.

Section 43. Section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.—The *agency department* shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the *agency department* and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, and

other mechanisms the *agency department* considers efficient and effective for purchasing services or goods on behalf of recipients. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216. *A Medicaid-funding formula may not be altered in any way unless the agency consults with the Legislature pursuant to the provisions of s. 216.177(2), and any such alteration must be ratified by the respective substantive committees of the Senate and the House of Representatives and by the President of the Senate and the Speaker of the House of Representatives.*

(1) Reimbursement to hospitals licensed under part I of chapter 395 must be made prospectively or on the basis of negotiation.

(a) Reimbursement for inpatient care is limited to 45 days per state fiscal year per recipient, except for children under age 21, in which case the only limitation is medical necessity or the payment amount. Reimbursement for hospital outpatient care is limited to \$1,000 per state fiscal year per recipient, unless an exception has been made by the *agency department*, and with the exception of a Medicaid recipient under age 21, in which case the only limitation is medical necessity.

(b) Hospitals that provide services to a disproportionate share of low-income Medicaid recipients, or that participate in the regional perinatal intensive care center program under chapter 383, or that participate in the statutory teaching hospital disproportionate share program, or that participate in any other the extraordinary disproportionate share program, may receive additional reimbursement. The total amount of payment for disproportionate share hospitals shall be fixed by the General Appropriations Act. The computation of these payments must be made in compliance with all federal regulations and the methodologies described in ss. 409.911, 409.912, 409.913, 409.915, 409.916, and 409.917 409.914.

(2)(a) Reimbursement to nursing homes licensed under part II of chapter 400 and intermediate care facilities for the mentally retarded licensed under chapter 393 must be made prospectively. Reimbursement to hospitals licensed under part I of chapter 395 for the provision of swing-bed nursing home services must be made on the basis of the average statewide nursing home payment. Reimbursement to a hospital licensed under part I of chapter 395 for the temporary provision of skilled nursing services to nursing home residents who have been displaced as the result of a natural disaster or other emergency may not exceed the average county nursing home payment for those services in the county in which the hospital is located and is limited to the period of time which the *agency department* considers necessary for continued placement of the nursing home residents in the hospital. *Reimbursement to a hospital licensed under part I of chapter 395 for the provision of skilled nursing services must be made on the basis of the average nursing home payment for those services in the county in which the hospital is located. When a hospital is located in a county that does not have any community nursing homes, reimbursement must be determined by averaging the nursing home payments in counties that surround the county in which the hospital is located. Reimbursement to hospitals, including the Medicaid payment of Medicare copayments, for skilled nursing services shall be limited to 30 days, unless a prior authorization has been obtained from the department. In no case shall Medicaid reimbursement to hospitals for skilled nursing services for a patient who is dually eligible for Medicare and Medicaid exceed 30 days from the date that Medicaid begins meeting the copayment obligation of the patient. Medicaid reimbursement may be extended by the department beyond 30 days, and approval must be based upon verification by the patient's physician that the patient requires short-term rehabilitative and recuperative services only, in which case an extension of no more than 15 days may be approved.*

(b) The *agency department* shall establish and implement a Florida Title XIX Long-Term Care Reimbursement Plan (Medicaid) for nursing home care which utilizes a rate-setting mechanism whereby the rates are reasonable and adequate to cover a nursing home's cost which must be incurred by an efficiently and economically operated facility in order to provide care and services in conformance with the applicable state and federal laws, rules, regulations, and quality and safety standards and to ensure that individuals eligible for medical assistance have reasonable geographic access to such care. In the establishment of any maximum rate of payment, whether overall or component, the *agency department* shall base the maximum rate of payment on the results of scientifically valid analysis and conclusions derived from objective statistical data pertinent to the particular maximum rate of payment.

(3) The following Medicaid services and goods shall be reimbursed on a fee-for-service basis. For each allowable service or goods furnished in accordance with Medicaid rules, policy manuals, handbooks, and state and federal law, the payment shall be the amount billed by the provider, the provider's usual and customary charge, or the maximum allowable fee established by the *agency department*, whichever amount is less, with the exception of those services or goods for which the *agency department* makes payment using a methodology based on average costs or negotiated fees.

- (a) Advanced registered nurse practitioner services.
- (b) Birth center services.
- (c) Chiropractic services.
- (d) Community mental health services.
- (e) Dental services, including oral and maxillofacial surgery.
- (f) Durable medical equipment.
- (g) Hearing services.
- (h) Occupational therapy for Medicaid recipients under age 21.
- (i) Optometric services.
- (j) Orthodontic services.
- (k) Personal care for Medicaid recipients under age 21.
- (l) Physical therapy for Medicaid recipients under age 21.
- (m) Podiatric services.
- (n) Portable X-ray services.
- (o) Private-duty nursing for Medicaid recipients under age 21.
- (p) Respiratory therapy for Medicaid recipients under age 21.
- (q) Speech therapy for Medicaid recipients under age 21.
- (r) Visual services.

(4) Alternative health plans, health maintenance organizations, and prepaid health plans shall be reimbursed a fixed, prepaid amount negotiated by the *agency department* and prospectively paid to the provider monthly for each Medicaid recipient enrolled. *All Medicaid prepaid contracts shall be reimbursed at 95 percent of the average adjusted capitation per person. The average adjusted capitation per person formula may include only Medicaid recipients not in prepaid managed care plans or in other prepaid arrangements in which the prepaid amount is calculated using the average capitation per person formula. The average adjusted capitation per person shall be calculated based on audited data. The most current available 12 full months of actual cost data will be used for calculating the average adjusted capitation per person.* The amount may not exceed the average amount the *agency department* determines it would have paid, based on claims experience, for recipients in the same or similar category of eligibility.

(5) An ambulatory surgical center shall be reimbursed the lesser of the amount billed by the provider or the Medicare-established allowable amount for the facility.

(6) A provider of early and periodic screening, diagnosis, and treatment services to Medicaid recipients who are children under age 21 shall be reimbursed using an all-inclusive rate stipulated in a fee schedule established by the *agency department*. A provider of the visual, dental, and hearing components of such services shall be reimbursed the lesser of the amount billed by the provider or the Medicaid maximum allowable fee established by the *agency department*.

(7) A provider of family planning services shall be reimbursed the lesser of the amount billed by the provider or an all-inclusive amount per type of visit for physicians and advanced registered nurse practitioners, as established by the *agency department* in a fee schedule.

(8) A provider of home-based or community-based services rendered pursuant to a federally approved waiver shall be reimbursed based on an established or negotiated rate for each service. These rates shall be established according to an analysis of the expenditure history and prospective budget developed by each contract provider participating in the waiver program, or under any other methodology adopted by the *agency department* and approved by the Federal Government in accordance with the waiver.

(9) A provider of home health care services or of medical supplies and appliances shall be reimbursed the lesser of the amount billed by the provider or the *agency's department's* established maximum allowable amount, except that, in the case of the rental of durable medical equipment, the total rental payments may not exceed the purchase price of the equipment over its expected useful life or the *agency's department's* established maximum allowable amount, whichever amount is less.

(10) A ~~provider of hospice care services~~ shall be reimbursed through a ~~prospective cost reimbursement~~ *prospective* system for each Medicaid hospice patient at Medicaid rates using the methodology established for hospice reimbursement under Title XVIII of the federal Social Security Act ~~provider~~.

(11) A provider of independent laboratory services shall be reimbursed the least of the amount billed by the provider, the provider's usual and customary charge, or the Medicaid maximum allowable fee established by the *agency department*.

(12)(a) A physician shall be reimbursed the lesser of the amount billed by the provider or the Medicaid maximum allowable fee established by the agency.

(b) The agency shall adopt a fee schedule based on a resource-based relative value scale for pricing Medicaid physician services. Under this fee schedule, physicians shall be paid a dollar amount for each service based on the average resources required to provide the service, including, but not limited to, estimates of average physician time and effort, practice expense, and the costs of professional liability insurance. The fee schedule shall provide increased reimbursement for preventive and primary care services and lowered reimbursement for specialty services by utilizing at least two conversion factors, one for cognitive services and another for procedural services. The fee schedule ~~may shall~~ not increase total Medicaid physician expenditures unless moneys are available, and shall be phased in over a 2-year period beginning on July 1, 1994. The ~~agency for Health Care Administration~~ shall seek the advice of a ~~16-member~~ *16-member* advisory panel in formulating and adopting the fee schedule. The panel shall consist of Medicaid physicians licensed under ~~chapter chapters~~ 458 or ~~chapter~~ 459, and shall be composed of ~~50-percent~~ *50-percent* primary care physicians and ~~50-percent~~ *50-percent* specialty care physicians.

(c) The agency shall monitor closely the utilization rate for physicians services and identify any trends ~~that which may~~ indicate an effort to increase the volume of services to counteract any losses that might result from the new fee schedule. The agency shall prepare a report to the Legislature on the overall effect of the resource-based relative value scale fee schedule by December 31, 1996.

(d) Notwithstanding paragraph (b), reimbursement fees to physicians for providing total obstetrical services to Medicaid recipients, which includes prenatal, delivery, and postpartum care, shall be at least \$1,500 per delivery for a pregnant woman with low medical risk and at least \$2,000 per delivery for a pregnant woman with high medical risk, effective April 1, 1992. However, reimbursement to physicians working in Regional Perinatal Intensive Care Centers designated pursuant to chapter 383, for services to certain pregnant Medicaid recipients with a high medical risk, may be made according to obstetrical care and neonatal care groupings and rates established by the agency. Nurse midwives licensed under chapter 464 or midwives licensed under chapter 467 shall be reimbursed at no less than 80 percent of the low medical risk fee. However, midwives licensed under chapter 467 ~~may shall~~ not receive Medicaid reimbursement for home deliveries conducted for Medicaid recipients, but shall be reimbursed for prenatal and postpartal care provided to such recipients. The agency shall by rule determine, for the purpose of this paragraph, what constitutes a high or low medical risk pregnant woman and ~~may shall~~ not pay more based solely on the fact that a caesarean section was performed, rather than a vaginal delivery. *Reimbursement for labor management must be prorated when services are received by a Medicaid recipient in a licensed birth center.* The agency shall by rule determine a prorated payment for obstetrical services in cases where only part of the total prenatal, delivery, or postpartum care was performed.

(13) Premiums, deductibles, and coinsurance for Medicare services rendered to Medicaid eligible persons shall be reimbursed in accordance with fees established by Title XVIII of the Social Security Act.

(14) A provider of prescribed drugs shall be reimbursed the least of the amount billed by the provider, the provider's usual and customary charge, or the Medicaid maximum allowable fee established by the *agency department*, plus a dispensing fee.

(15) A provider of primary care case management services rendered pursuant to a federally approved waiver shall be reimbursed by payment of a fixed, prepaid monthly sum for each Medicaid recipient enrolled with the provider.

(16) A provider of rural health clinic services and federally qualified health center services shall be reimbursed at a rate per visit based on total reasonable costs of the clinic, as determined by the ~~agency department~~ in accordance with federal regulations.

(17) A provider of targeted case management services shall be reimbursed pursuant to an established fee, except where the Federal Government requires that a public provider be reimbursed on the basis of average actual costs.

(18) A provider of transportation services shall be reimbursed the lesser of the amount billed by the provider or the Medicaid maximum allowable fee established by the ~~agency department~~, except when the ~~agency department~~ has entered into a direct contract with the provider for the provision of an all-inclusive service, or when services are provided pursuant to an agreement negotiated between the ~~agency department~~ and the provider.

(19) County public health clinic services may be reimbursed at a rate per visit based on total reasonable costs of the clinic, as determined by the ~~agency department~~ in accordance with federal regulations under the authority of 42 C.F.R. s. 431.615. However, this cost-based reimbursement may ~~shall~~ not be implemented until the State Health Officer has certified that cost accounting systems have been modified and are in place prior to implementation in a specific county in order to ensure accurate and timely reporting of Medicaid-related costs in accordance with established Medicaid reimbursement standards. This ~~subsection is section shall be repealed effective June 30, 1995, unless otherwise provided for in the General Appropriations Act or other provision of law. The agency department shall develop a methodology to adequately evaluate the cost-effectiveness of this method of reimbursement and shall make recommendations to the Legislature based on this evaluation prior to the 1995 Regular Legislative Session.~~

Section 44. Notwithstanding any other law to the contrary, Medicaid recipients and state employees may not be covered by community health purchasing alliances unless the Agency for Health Care Administration consults with the Legislature pursuant to the provisions of section 216.177(2), Florida Statutes, and such coverage of Medicaid recipients must be ratified by the full Senate and the House of Representatives.

Section 45. Section 409.9117, Florida Statutes, is amended to read:
409.9117 Primary care disproportionate share program.—

(1) ~~Effective October 1, 1994, if the agency has not received approval of a federal section 1115 waiver for the Florida Health Security program, and if there is sufficient federal disproportionate share allotment available, and if the state share is provided by a county, political subdivision, or tax district, then the agency, subject to the provisions of chapter 216, is authorized to establish a primary care disproportionate share program for the care of indigent persons in this state. In order to be eligible to receive funds from this program, a hospital must:~~

(a) ~~Be qualified to participate in the disproportionate share program specified in s. 409.911, the "regular disproportionate share program," and~~

(b) ~~Be owned by or have a contract with a county, tax district, or political subdivision for the purpose of delivering health services to indigent persons. If federal funds are available for disproportionate share programs in addition to those otherwise provided by law, there shall be created a primary care disproportionate share program.~~

(2) ~~In the establishment and funding of this program, the agency shall use the following criteria in addition to those specified in s. 409.911, payments may not make payments be made to a hospital unless the hospital agrees to:~~

(a) ~~Has at least a minimum of 5 percent of charity care days as a percent of total adjusted patient days as defined in s. 409.911, except there is no reduction for 50 percent of restricted and unrestricted revenues provided to the hospital by local governments or tax districts, and a minimum of at least 6 percent of Medicaid days as a percent of total adjusted patient days as calculated by the agency from the hospital's most recent audited Medicare and Medicaid cost reports.~~

(b) ~~Within 1 year from the date of the initial contract, agree to provide services to Medicaid recipients on a prepaid capitated basis under s. 409.912, to at least all recipients in the area who elect such coverage. Cooperate with a Medicaid prepaid health plan, if one exists in the community.~~

(c)(b) ~~Agrees to ensure the availability of primary and specialty care physicians to Medicaid recipients who are not enrolled in a prepaid capitated arrangement and who are in need of access to such physicians.~~

(d)(e) ~~Agrees to coordinate and provide primary care services free of charge, except copayments, to all persons with incomes up to 100 percent of the federal poverty level, and to provide such services based on a sliding fee scale to all persons with incomes up to 200 percent of the federal poverty level, except that eligibility may be limited to persons who reside within a more limited area, as agreed to by the agency and the hospital.~~

(e)(d) ~~Agrees to contract with any federally qualified health center, if one exists within the agreed geopolitical boundaries, concerning the provision of primary care services, in order to guarantee delivery of services in a nonduplicative fashion, and to provide for referral arrangements, privileges, and admissions, as appropriate. The hospital shall agree to provide at an onsite or offsite facility primary care services within 24 hours to which all Medicaid recipients and persons eligible under this paragraph who do not require emergency room services are referred during normal daylight hours.~~

(f)(e) ~~Agrees to cooperate with the agency, the county, and other entities to ensure the provision of certain public health services, case management, referral and acceptance of patients, and sharing of epidemiological data, as the agency and the hospital find mutually necessary and desirable to promote and protect the public health within the agreed geopolitical boundaries.~~

(g)(f) ~~In cooperation with the county in which the hospital resides, agrees to develop a low-cost, outpatient-only outpatient, prepaid health care program for persons who are not eligible for the Medicaid program, and who reside within the area.~~

(h)(g) ~~Agrees to provide inpatient services to residents within the area who are not eligible for Medicaid or Medicare, and who do not have private health insurance, regardless of ability to pay, on the basis of available space, except that nothing shall prevent the hospital from establishing bill collection programs based on ability to pay.~~

(i)(h) ~~Agrees to work with the agency, the Florida Healthy Kids Corporation, the Florida Health Care Purchasing Cooperative, the Florida Health Access Corporation, and business health coalitions, as appropriate, to develop a feasibility study and plan to provide a low-cost comprehensive health insurance plan to persons who reside within the area and who do not have access to such a plan.~~

(j)(i) ~~Agrees to work with public health officials and other experts to provide community health education and prevention activities designed to promote healthy lifestyles and appropriate use of health services.~~

(k)(j) ~~Agrees to work with the local health council to develop a plan for promoting access to affordable health care services for all persons who reside within the area, including, but not limited to, public health services, primary care services, inpatient services, and affordable health insurance generally.~~

(l) ~~Agrees to work with the Department of Health and Rehabilitative Services and county public health officials to develop a comprehensive program to measure and develop approaches to meet the more prevalent and critical public health needs as jointly approved by all agencies after conducting a community health needs assessment survey.~~

Any hospital that fails to comply with any of the provisions of this subsection, or any other contractual condition, may not receive payments under this section until full compliance is achieved.

(3) ~~The following formula shall be used by the agency to calculate the total amount earned for hospitals that participate in the primary care disproportionate share program:~~

$$\begin{aligned} & DSF \\ TAP = & \frac{\quad}{\quad} \times TA \\ & TDSF \end{aligned}$$

Where:

DSF = The disproportionate share factor for each hospital qualifying for the primary care disproportionate share program which is the number of uninsured persons in the area times 20 plus the number of Medicaid inpatient days of the hospital.

TDSF = The sum of the *DSF*s for all hospitals qualifying for the primary care disproportionate share program.

TA = Total appropriation for the primary care disproportionate share program.

TAP = Total additional payment for a hospital qualifying for the primary care disproportionate share program.

(4) *The agency is authorized to receive funds from a county, political subdivision, or tax district having jurisdiction over participating hospitals, for the purpose of making payments, including federal matching funds, through the primary care disproportionate share program. Funds received from a county, political subdivision, or tax district for this purpose shall be separately accounted for and shall not be commingled with other state or local funds in any manner.*

(5) *Payments made by the agency to hospitals eligible to participate in this program shall be made in accordance with federal rules and regulations.*

(a) *If the Federal Government prohibits, restricts, or changes in any manner the methods by which funds are distributed for this program, the agency shall not distribute any additional funds and shall return all funds to the entity from which the funds were received, except as provided in paragraph (b).*

(b) *If the Federal Government imposes a restriction that still permits a partial or different distribution, the agency may continue to disburse funds to hospitals participating in the primary care disproportionate share program in a federally approved manner, provided:*

1. *Each entity that contributes to the primary care disproportionate share program agrees to the new manner of distribution as shown by a written document signed by the governing authority of each entity; and*

2. *The Executive Office of the Governor, Office of Planning and Budgeting, the House of Representatives, and the Senate are provided at least 7 days' prior notice of the proposed change in the distribution and do not disapprove such change.*

(c) *No distribution shall be made under the alternative method specified in paragraph (b) unless all parties agree, or unless those parties who disagree have returned to them all funds not yet disbursed.*

(6) *Each hospital eligible to participate in the primary care disproportionate share program shall notify the agency of its intention to participate, within a time period specified by the agency and according to such additional terms and conditions as may be specified by the agency. Any hospital that does not notify the agency within the specified time period, or according to the terms and conditions set forth by the agency, shall not be eligible to participate in the primary care disproportionate share program. A notice of intention to withdraw from the program is revocable, once issued, only after the quarter in which funds have been distributed under this program.*

Section 46. Section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.—The *agency department* shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. The *agency department* shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies designed to facilitate the cost-effective purchase of a case-managed continuum of care. The *agency department* shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services.

(1) The *agency department* may enter into agreements with appropriate agents of other state agencies or of any agency of the Federal Government and accept such duties in respect to social welfare or public aid as may be necessary to implement the provisions of Title XIX of the Social Security Act and ss. 409.901-409.920.

(2) The *agency department* may contract with health maintenance organizations certified pursuant to part I of chapter 641 for the provision of services to recipients.

(3) The *agency department* may contract with county public health units and other entities authorized by chapter 154 to provide health care services on a prepaid or fixed-sum basis to recipients, which entities may provide such prepaid services either directly or through arrangements with other providers. Such prepaid health care services are exempt from the provisions of part I of chapter 641.

(4) The *agency department* may contract with any public or private entity on a prepaid or fixed-sum basis for the provision of health care services to recipients.

(a) An entity may provide prepaid services to recipients, either directly or through arrangements with other entities, if each entity involved in providing services:

1. Is organized primarily for the purpose of providing health care or other services of the type regularly offered to Medicaid recipients;

2. Ensures that services meet the standards set by the *agency department* for quality, appropriateness, and timeliness;

3. Makes provisions satisfactory to the *agency department* for insolvency protection and ensures that neither enrolled Medicaid recipients nor the *agency department* will be liable for the debts of the entity;

4. Submits to the *agency department*, if a private entity, a financial plan that the *agency department* finds to be fiscally sound and that provides for working capital in the form of cash or equivalent liquid assets excluding revenues from Medicaid premium payments equal to at least the first 3 months of operating expenses or \$200,000, whichever is greater;

5. Furnishes evidence satisfactory to the *agency department* of adequate liability insurance coverage or an adequate plan of self-insurance to respond to claims for injuries arising out of the furnishing of health care;

6. Provides, through contract or otherwise, for periodic review of its medical facilities and services, as required by the *agency department*; and

7. Provides organizational, operational, financial, and other information required by the *agency department*.

(b) Entities that provide no prepaid health care services other than Medicaid services under contract with the *agency department* are exempt from the provisions of part I of chapter 641.

(5) The *agency department* may contract on a prepaid or fixed-sum basis with any health insurer that:

(a) Pays for health care services provided to enrolled Medicaid recipients in exchange for a premium payment paid by the *agency department*;

(b) Assumes the underwriting risk; and

(c) Is organized and licensed under applicable provisions of the Florida Insurance Code and is currently in good standing with the Department of Insurance.

(6) *Except as provided under subsection (7), the agency department shall not contract on a prepaid or fixed-sum basis for Medicaid services with an entity which knows or reasonably should know that any officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of 5 percent common or preferred stock, or the entity itself, has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty, to:*

(a) Fraud;

(b) Violation of federal or state antitrust statutes, including those prescribing price fixing between competitors and the allocation of customers among competitors;

(c) Commission of a felony involving embezzlement, theft, forgery, income tax evasion, bribery, falsification or destruction of records, making false statements, receiving stolen property, making false claims, or obstruction of justice; or

(d) Any crime in any jurisdiction which directly relates to the provision of health services on a prepaid or fixed-sum basis.

(7)(a) *An entity prohibited from contracting with the agency under subsection (6) may petition the agency for approval to provide prepaid health care services to Medicaid recipients no sooner than 5 years after the date of completion of sentence for any violation specified in subsection (6). The agency may contract with the entity after determining that it is no longer in the public interest to continue to deny the entity's eligibility.*

(b) *In considering whether it is in the public interest to continue to prohibit the entity from contracting, the agency shall consider the following factors:*

1. *The nature and details of the crime including whether the crime resulted in financial loss to Medicaid or other publicly funded health care program;*
2. *The acts that resulted in the conviction, or similar acts, were committed over a period of one year or more;*
3. *The person or entity has a prior criminal, civil, or administrative sanction record;*
4. *The degree of culpability of the person or entity;*
5. *Prompt or voluntary payment of any damages or penalties imposed;*
6. *Cooperation with any state or federal investigation or prosecution of any crime, provided that a good-faith exercise of any constitutional, statutory, or other right during any portion of the investigation or prosecution shall not be considered lack of cooperation;*
7. *Disassociation from any other parties convicted of the crime;*
8. *Reinstatement or clemency in the jurisdiction in which the crime at issue occurred;*
9. *A demonstration of good citizenship by the person or entity; and*
10. *Successful compliance with other state licensing and regulatory requirements in relation to other licenses or certificates of authority held by the person or entity.*

(c) *The entity shall have the burden of showing by a preponderance of evidence based on the above factors that it is no longer in the public interest to continue to deny the entity's eligibility.*

(d) *The agency shall issue a statement approving or denying the entity's eligibility within 90 days after determining that the petition is complete. If the petition for approval is denied, the entity may seek review pursuant to s. 120.57. The hearing officer shall review the agency's action. If the petition is denied, the entity may petition for approval no sooner than 1 year from the date a final order is entered.*

(8)(7) *The agency department may apply for waivers of applicable federal laws and regulations as necessary to implement more appropriate systems of health care for Medicaid recipients and reduce the cost of the Medicaid program to the state and federal governments and shall implement such programs, after legislative approval, within a reasonable period of time after federal approval. These programs must be designed primarily to reduce the need for inpatient care, custodial care and other long-term or institutional care, and other high-cost services.*

(9)(9) *The agency department shall establish a postpayment utilization control program designed to identify recipients who may inappropriately overuse or underuse Medicaid services and shall provide methods to correct such misuse.*

(10)(9) *The agency department shall develop and provide coordinated systems of care for Medicaid recipients and may contract with public or private entities to develop and administer such systems of care among public and private health care providers in a given geographic area.*

(11)(10) *The agency department shall operate or contract for the operation of utilization management and incentive systems designed to encourage cost-effective use services.*

(12)(11) *The agency department shall identify health care utilization and price patterns within the Medicaid program that are not cost-effective or medically appropriate and assess the effectiveness of new or alternate methods of providing and monitoring service, and may implement such methods as it considers appropriate.*

(13)(12) *An entity contracting on a prepaid or fixed-sum basis shall, in addition to meeting any applicable statutory surplus requirements, also maintain at all times in the form of cash, short-term investments allowable as admitted assets by the Department of Insurance, and restricted funds or deposits controlled by the agency department or the Department of Insurance, by January 1, 1992, an amount equal to its monthly prepaid Medicaid revenues; and by and after January 1, 1993, an amount equal to one-and-one-half times its monthly prepaid Medicaid revenues. In the event an entity's surplus falls below any applicable statutory requirements, or an entity's total of cash, short-term investments allowable as admitted assets by the Department of Insurance, and restricted funds or deposits controlled by the agency department or the Department of Insurance falls below one-and-one-half times its monthly prepaid Medicaid revenues, the agency department shall prohibit the entity from engaging in enrollment activities, shall cease to process new enrollments for the entity, and shall not renew the entity's contract until the required balance is achieved. The requirements of this subsection shall not apply:*

(a) *Where a public entity agrees to fund any deficit incurred by the contracting entity; or*

(b) *Where the entity's performance and obligations are guaranteed in writing by a nonprofit guaranteeing organization which:*

1. *Has been in operation for at least 5 years and has assets in excess of \$50 million; or*
2. *Submits a written guarantee acceptable to the agency department which is irrevocable during the term of the contracting entity's contract with the agency department and, upon termination of the contract, until the agency department receives proof of satisfaction of all outstanding obligations incurred under the contract.*

(14) *Each entity that contracts with the agency on a prepaid or fixed-sum basis for the provision of Medicaid services shall reimburse any hospital or physician that is inside or outside the entity's authorized service area as specified in its contract with the agency, and that provides services authorized by the entity to Medicaid recipients, at the least of the following amounts:*

- (a) *The usual charges made to the public by the hospital or physician;*
- (b) *The Medicaid per diem rate or reimbursement rate established for the hospital or physician service; or*
- (c) *A rate negotiated with the hospital or physician before the services are provided.*

(15) *The agency shall establish a health care quality-improvement system for those entities contracting with the agency under subsection (3) or subsection (4) which incorporates all the standards and guidelines developed by the Medicaid Bureau of the federal Health Care Financing Administration as a part of the Quality Assurance Reform Initiative. The system must include, but is not limited to:*

(a) *Guidelines for internal quality-assurance programs including standards for:*

1. *Written quality-assurance program descriptions.*
2. *Responsibilities of the governing body for monitoring, evaluating, and making improvements in care.*
3. *An active quality-assurance committee.*
4. *Quality-assurance program supervision.*
5. *Requiring the program to have adequate resources to effectively carry out its specified activities.*
6. *Provider participation in the quality-assurance program.*
7. *Delegation of quality-assurance program activities.*
8. *Credentialing and recredentialing of providers.*
9. *Enrollee rights and responsibilities.*
10. *Availability of and accessibility to services and care.*
11. *Ambulatory care facilities.*

12. Accessibility to and availability of medical records, as well as proper recordkeeping and a process for record review.
 13. Utilization review of all services offered.
 14. A continuity-of-care system.
 15. Quality-assurance program documentation.
 16. Coordination of quality-assurance activities with other management activities.
- (b) Guidelines that require the entities to conduct quality-of-care reviews that:
1. Target specific conditions and specific health service delivery issues for focused monitoring and evaluation;
 2. Use clinical care standards or practice guidelines to objectively evaluate the care the entity delivers or fails to deliver for the targeted clinical conditions and health services delivery issues; and
 3. Use quality indicators derived from the clinical care standards or practice guidelines to screen and monitor care and services delivered.
- (c) Guidelines for external quality-review of each contractor which require focused reviews of patterns of care, individual-care review in specific situations, and follow-up activities on previous pattern-of-care review findings and individual-care review findings. In designing the external quality-review function and determining how it is to operate as part of the state's overall quality-improvement system, the agency must construct its external quality-review organization contracts to address:
1. Delineation of the role of the external quality-review organization;
 2. Length of the external quality-review organization contract with the state;
 3. Participation of the entities in designing external quality-review organization review activities;
 4. Potential variation in the type of clinical conditions and health services delivery issues to be reviewed at each plan;
 5. Determination of the number of focused pattern-of-care reviews to be conducted for each plan;
 6. Methods for implementing focused reviews;
 7. Individual-care review; and
 8. Follow-up activities.

(16) The agency shall require the Medicaid prepaid health plan and MediPass provider to attempt to contact all new members, at least twice if necessary, in order to perform a health risk-assessment. The health risk-assessment instrument must include questions regarding the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening history of members under 21 years of age and questions regarding pregnancy history. The prepaid health plan shall request members to release medical records to the plan or its providers from providers who treated the members prior to their plan enrollment. The prepaid health plan and MediPass provider must use the health risk-assessments and the released medical records to identify members who have not received screenings in the past according to the agency-approved periodic schedule. The prepaid health plan and MediPass provider must contact, up to twice if necessary, any member who is more than 2 months behind in the periodic screening schedule to urge that member or the member's responsible party to make an appointment for a screening visit. The agency shall require the prepaid health plan and MediPass provider to report their EPSDT screening rates, the trimester of pregnancy when prenatal care began, and the rate of low-birth-weight babies born to plan members or MediPass members. The agency shall monitor the MediPass provider's and the prepaid health plan's compliance with this section.

(17) The agency shall by rule develop a process whereby a Medicaid prepaid-plan enrollee who wishes to enter hospice care may be disenrolled from the prepaid plan within 24 hours after contacting the agency regarding such request. The agency rule must include a methodology by

which the agency can recoup prepaid-plan payments on a pro-rata basis if payment has been made for the enrollment month when disenrollment occurs. The prepaid-plan provider must be held harmless for failure by an enrollee to properly communicate the need for disenrollment.

(18) All infants born to mothers receiving health care through an entity contracting with the agency under subsections (1)-(5) must be given, and documentation in the medical record must indicate that they were given, the following:

- (a) Healthy Start infant screening.
- (b) Healthy Start care coordination.
- (c) Healthy Start enhanced services in accordance with the infant screening results.
- (d) Immunizations in accordance with standards set by the Centers for Disease Control and Prevention and the American Academy of Pediatrics.

(19) All pregnant women receiving prenatal care through an entity contracting with the agency under subsections (1)-(5) must be given, and documentation in the medical record must indicate that they were given, the following:

- (a) Healthy Start prenatal screen.
- (b) Healthy Start care coordination.
- (c) Healthy Start enhanced services in accordance with the prenatal screening results.
- (d) Referral to the Special Supplemental Food Program for Women, Infants, and Children.
- (e) Counseling and services for voluntary sterilization to all women and their partners.
- (f) A scheduled postpartum visit for the purpose of voluntary family planning to include discussion of all methods of contraception.

Section 47. Paragraph (a) of subsection (1) of section 409.9122, Florida Statutes, is amended, and subsections (6) and (7) are added to that section, to read:

409.9122 Mandatory Medicaid managed care enrollment.—

(1)(a) The agency is directed to contract for an independent comprehensive evaluation of the primary care case management program in districts 5 and 6, known as MediPass, and report the findings to the Legislature on or before December 31, 1994. The evaluation shall include, but not be limited to, an assessment of the program's impact on quality of care, access to Medicaid services, cost-effectiveness, and provider and recipient satisfaction. It is the intent of the Legislature that the agency apply for a federal freedom of choice waiver and any other federal waivers necessary to expand MediPass to five additional districts by December 31, 1994, and, subject to evaluation findings that the program is cost-effective, provides quality health care, and improves access to health services, to the remaining districts in the state by June 30 ~~December 31~~, 1996.

(6)(a) All Medicaid recipients shall be enrolled in a managed care plan or MediPass no later than June 30, 1996. A recipient shall be given continuously during his eligibility a choice of managed care plans, but once a plan has been selected, the recipient must remain in the selected plan until the annual renewal date, unless the recipient moves to an area not served by the selected plan.

(b) The agency may not engage in practices designed to favor one health maintenance organization over another, or designed to influence Medicaid recipients to enroll in MediPass rather than a health maintenance organization or enroll in a health maintenance organization rather than MediPass. Nothing in this subsection prohibits the agency from reporting performance criteria about any plan adopted by rule.

(c) A recipient who is institutionalized in a mental health facility or a long-term care facility, including a skilled nursing facility or intermediate care facility for the developmentally disabled, or who is eligible for institutional care and is not receiving services under a home waiver, a community-based waiver, or any other Medicaid waiver program, or who is a qualified Medicare beneficiary, is not subject to this subsection.

(d) The agency may not implement this subsection unless it receives all necessary federal waivers and authorizations.

(7)(a) The agency may submit a waiver to the federal Health Care Financing Administration to establish prepaid Medicaid mental health and substance abuse programs. The prepaid plans shall be cost neutral.

(b) The agency shall appoint an advisory panel to review issues and concerns associated with providing services through managed health care plans to individuals who are eligible for Medicaid and who exhibit symptoms of acute or chronic mental illness, alcohol abuse, or drug abuse, or children who are severely emotionally disturbed or in the state's custody. The advisory panel shall submit its recommendations to the agency by October 1, 1994. The agency may not implement the mandatory Medicaid managed care plan enrollment provisions of this act for this special population until the advisory panel has developed a specific plan addressing how the unique service needs of these individuals will be met.

Section 48. Section 409.915, Florida Statutes, is amended to read:

409.915 County contributions to Medicaid.—~~Although~~ The state is responsible for the full portion of the state share of the matching funds required for the Medicaid program. In order to acquire a certain portion of these funds, the state shall charge the counties for certain items of care and service as provided in this section. *Notwithstanding any other provision of this section, if the federal waivers necessary to modify the Medicaid state plan and to implement Florida Health Security are obtained, the services delivered under Florida Health Security are not subject to this section.*

(1) Each county shall participate in the following items of care and service:

(a) Payments for inpatient hospitalization in excess of 12 days, but not in excess of 45 days, with the exception of pregnant women and children whose income is in excess of the federal poverty level and who do not participate in the Medicaid medically needy program.

(b) Payments for nursing home or intermediate facilities care in excess of \$170 per month, with the exception of skilled nursing care for children under age 21.

(2) A county's participation must be 35 percent of the total cost of providing the items listed in subsection (1), except that the payments for items listed in paragraph (1)(b) may not exceed \$55 per month per person.

(3) Each county shall set aside sufficient funds to pay for items of care and service provided to the county's eligible recipients for which county contributions are required, regardless of where in the state the care or service is rendered.

(4) Each county shall pay into the General Revenue Fund, unallocated, its pro rata share of the total county participation based upon statements rendered by the ~~agency department~~ in consultation with the counties.

(5) The Department of Banking and Finance shall withhold from the cigarette tax receipts or any other funds to be distributed to the counties the individual county share that has not been remitted within 60 days after billing.

(6) In any county in which a special taxing district or authority is located which will benefit from the medical assistance programs covered by this section, the board of county commissioners may divide the county's financial responsibility for this purpose proportionately, and each such district or authority must furnish its share to the board of county commissioners in time for the board to comply with the provisions of subsection (3). Any appeal of the proration made by the board of county commissioners must be made to the Department of Banking and Finance, which shall then set the proportionate share of each party.

Section 49. The Agency for Health Care Administration shall conduct a study of Medicaid reimbursement to prepaid health plans and health maintenance organizations. The study must include an analysis of the actuarial soundness of the capitation rates, an assessment of the adequacy of reimbursement to prepaid health plans and health maintenance organizations, an assessment of the impact of the level of Medicaid reimbursement on access to health care and quality of care, and a determination of the existence of either adverse or favorable selection. The study shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 1, 1994.

Section 50. For purposes of sections 464.024, 464.025, 464.026, 464.027, 464.028, 468.315, 468.316, 468.317, 468.318, 468.319, 468.37, 468.371, 468.372, 468.373, 468.374, 483.831, 483.832, 483.833, 483.834, and 483.835, Florida Statutes, as created by this act, the term "eligible facility" means:

- (1) A hospital licensed under chapter 395, Florida Statutes; and
- (2) A federally supported migrant or community health center authorized under section 329 or section 330 of the United States Public Health Services Act.

Section 51. Section 464.024, Florida Statutes, is created to read:

464.024 Multi-skill cross-training; legislative findings and intent.—The Legislature finds that the health care manpower shortage in this state necessitates flexible utilization of health care personnel employed in eligible facilities. Cross-training of experienced health care professionals should yield greater staffing efficiencies and enhance access to acute health care. Quality of care can be assured through the establishment of uniform training and certification criteria and through the limitation of cross-training to basic functions that can be safely performed by cross-trained health care personnel. Cross-training of experienced personnel should augment eligible-facility staffing capabilities, but not replace or otherwise substitute for the utilization of trained professionals when they are available. Likewise, personnel should perform cross-trained functions only when their primary professional responsibilities can be safely assumed by other professional co-workers. It is the intent of the Legislature that the board expedite the development of a program for cross-training and certifying specified eligible-facility health care personnel to perform limited nursing functions.

Section 52. Section 464.025, Florida Statutes, is created to read:

464.025 Personnel qualifications for cross-training.—

(1) To participate in a cross-training program to perform limited nursing functions, a person must be:

(a) Certified as a radiologic technologist pursuant to part IV, chapter 468;

(b) Registered as a respiratory therapist or certified as a respiratory care practitioner pursuant to part V, chapter 468; or

(c) Licensed as a clinical laboratory technologist pursuant to chapter 483, part IV.

(2) Eligible health care personnel must also have a minimum of 2 years' professional health care experience and be employed in an eligible facility.

Section 53. Section 464.026, Florida Statutes, is created to read:

464.026 Cross-training functions; limitations; supervision; rulemaking.—

(1) The cross-training of other health care personnel to perform nursing functions is limited to changing dressings, wrapping sprains, and taking vital signs.

(2) Only eligible facilities may conduct cross-training programs.

(3) The board shall adopt rules to implement the cross-training program by January 1, 1995, including, but not limited to, rules prescribing:

(a) The uniform minimum curriculum content of cross-training programs; and

(b) The supervisory responsibility of an eligible facility's director of nursing for ongoing oversight of the performance of limited nursing functions by cross-trained personnel.

Section 54. Section 464.027, Florida Statutes, is created to read:

464.027 Certification of cross-trained personnel; community colleges; rulemaking.—

(1) Community colleges may conduct competency-based examinations of personnel completing cross-training programs authorized under ss. 464.024-464.028, and shall notify the board upon an individual's successful completion of the cross-training examination.

(2) The board shall issue a certification of cross-training to an individual who successfully completes a cross-training program and examination.

(3) The board shall adopt rules by January 1, 1995, to implement the certification program, including, but not limited to, rules prescribing:

(a) The minimum content and criteria for the administration of competency-based examinations for initial or renewal certification, including completion of an approved cross-training program;

(b) The minimum frequency of the administration of the certification examination by community colleges to ensure maximum access to examinations and timely utilization of cross-trained personnel;

(c) The coordination required between community colleges and eligible facilities regarding examination sites and schedules;

(d) The application requirements for certification, including a uniform application form and application fee to cover the costs incurred by a community college in administering the certification examination;

(e) The procedures governing notification to the board by community colleges of individuals who successfully complete an approved certification examination; and

(f) A uniform certification form to be issued by the board to individuals successfully completing the certification examination.

Section 55. Section 464.028, Florida Statutes, is created to read:

464.028 Certification conditions; renewal; rules; continuing education; disciplinary action.—

(1) A certification to perform limited nursing functions is valid only while the certified individual is employed in an eligible facility. The certification becomes invalid upon cessation of employment in an eligible facility and is not transferable to employment in any other health care setting. However, the certification remains valid upon termination of employment in an eligible facility and reemployment in another eligible facility.

(2) The board shall adopt rules:

(a) Establishing time frames and requirements for recertification of a cross-trained individual who, after an interruption of employment, is employed at an eligible facility;

(b) Establishing continuing education requirements for certified cross-trained individuals; and

(c) Providing for disciplinary action against a certified cross-training individual, including termination of cross-training certification.

(3) Cross-training certification shall immediately be terminated upon the termination or expiration of the individual's primary professional license.

Section 56. Section 468.315, Florida Statutes, is created to read:

468.315 Multi-skill cross-training; legislative findings and intent.—The Legislature finds that the health care manpower shortage in this state necessitates flexible utilization of health care personnel employed in eligible facilities. Cross-training of experienced health care professionals should yield greater staffing efficiencies and enhance access to acute health care. Quality of care can be assured through the establishment of uniform training and certification criteria and through the limitation of cross-training to basic functions that can be safely performed by cross-trained health care personnel. Cross-training of experienced personnel should augment eligible-facility staffing capabilities, but not replace or otherwise substitute for the utilization of trained professionals when they are available. Likewise, personnel should perform cross-trained functions only when their primary professional responsibilities can be safely assumed by other professional co-workers. It is the intent of the Legislature that the department expedite the development of a program for cross-training and certifying specified eligible-facility health care personnel to perform limited radiologic technology functions.

Section 57. Section 468.316, Florida Statutes, is created to read:

468.316 Personnel qualifications for cross-training.—

(1) To participate in a cross-training program to perform limited radiologic technology functions a person must be:

(a) Licensed as a registered nurse or practical nurse pursuant to chapter 464;

(b) Registered as a respiratory therapist or certified as a respiratory care practitioner under part V of chapter 468; or

(c) Licensed as a clinical laboratory technologist under part IV of chapter 483.

(2) Eligible health care personnel must also have a minimum of 2 years' professional health care experience and be employed in an eligible facility.

Section 58. Section 468.317, Florida Statutes, is created to read:

468.317 Cross-training functions; limitations; supervision; rulemaking.—

(1) Cross-training of other health care personnel to perform radiologic technology functions is limited to taking basic x-rays of chest, abdomen, extremities, skull, and spine.

(2) Only eligible facilities may conduct cross-training programs.

(3) The department shall adopt rules to implement the cross-training program by July 1, 1995, including, but not limited to, rules prescribing:

(a) The uniform minimum curriculum content of cross-training programs; and

(b) The supervisory responsibility of an eligible facility's radiology department director for ongoing oversight of the performance of radiologic technology functions by cross-trained personnel.

Section 59. Section 468.318, Florida Statutes, is created to read:

468.318 Certification of cross-trained personnel; duties of the department; fee.—

(1) The department is authorized to conduct competency-based examinations of personnel completing a cross-training program authorized under ss. 468.315-468.319.

(2) The department shall issue a certification of cross-training to an individual who successfully completes a cross-training program and examination.

(3) The department shall adopt rules, by July 1, 1995, to implement the certification program, including, but not limited to, rules prescribing:

(a) The minimum content and criteria for the administration of competency-based examinations for initial or renewal certification, including completion of an approved cross-training program;

(b) The minimum frequency of the administration of the certification examination by the department to ensure maximum access to examinations and timely utilization of cross-trained personnel;

(c) The application requirements for certification, including a uniform application form and application fee to cover the costs incurred by the department in administering the certification examination;

(d) The procedures governing notification to individuals who successfully complete an approved certification examination; and

(e) A uniform certification form to be issued by the department to individuals successfully completing the certification examination.

Section 60. Section 468.319, Florida Statutes, is created to read:

468.319 Certification conditions; renewal; rules; continuing education; disciplinary action.—

(1) A certification to perform limited radiologic technology functions is valid only while the certified individual is employed in an eligible facility. The certification becomes invalid upon cessation of employment in an eligible facility and is not transferable to employment in any other health care setting. However, the certification remains valid upon termination of employment in an eligible facility and reemployment in another eligible facility.

(2) The department shall adopt rules:

(a) Establishing time frames and requirements for recertification of a cross-trained individual who, after an interruption of employment, is employed at an eligible facility;

(b) Establishing continuing education requirements for certified cross-trained individuals; and

(c) Providing for disciplinary action against a certified cross-trained individual, including termination of certification.

(3) Cross-training certification shall immediately be terminated upon the termination or expiration of the individual's primary professional license.

Section 61. Section 468.37, Florida Statutes, is created to read:

468.37 Multi-skill cross-training; legislative findings and intent.— The Legislature finds that the health care manpower shortage in this state necessitates flexible utilization of health care personnel employed in eligible facilities. Cross-training of experienced health care professionals should yield greater staffing efficiencies and enhance access to acute health care. Quality of care can be assured through the establishment of uniform training and certification criteria and through the limitation of cross-training to basic functions that can be safely performed by cross-trained health care personnel. Cross-training of experienced personnel should augment eligible-facility staffing capabilities, but not replace or otherwise substitute for the utilization of trained professionals when they are available. Likewise, personnel should perform cross-trained functions only when their primary professional responsibilities can be safely assumed by other professional co-workers. It is the intent of the Legislature that the board, with the assistance of the Advisory Council on Respiratory Care, expedite the development of a program for cross-training and certifying specified eligible-facility health care personnel to perform limited respiratory care functions.

Section 62. Section 468.371, Florida Statutes, is created to read:

468.371 Personnel qualifications for cross-training.—

(1) To participate in a cross-training program to perform limited respiratory care functions, a person must be:

(a) Licensed as a registered nurse or practical nurse under chapter 464;

(b) Certified as a radiologic technologist under part IV of chapter 468; or

(c) Licensed as a clinical laboratory technologist under part IV of chapter 483.

(2) Eligible health care personnel must also have a minimum of 2 years' professional health care experience and be employed in an eligible facility.

Section 63. Section 468.372, Florida Statutes, is created to read:

468.372 Cross-training functions; limitations; supervision; rulemaking.—

(1) Cross-training of other health care personnel to perform respiratory care functions is limited to the initiation of nasal oxygen therapy and blood gas analysis, including drawing arterial specimens.

(2) Only eligible facilities may conduct cross-training programs.

(3) The board, with the assistance of the Advisory Council on Respiratory Care, shall adopt rules to implement the cross-training program by January 1, 1995, including, but not limited to, rules prescribing:

(a) The uniform minimum curriculum content of cross-training programs; and

(b) The supervisory responsibility of an eligible facility's director of respiratory care for ongoing oversight of the performance of respiratory care functions by cross-trained personnel.

Section 64. Section 468.373, Florida Statutes, is created to read:

468.373 Certification of cross-trained personnel; community colleges; rulemaking.—

(1) Community colleges may conduct competency-based examinations of personnel completing cross-training programs authorized under ss. 468.37-468.374, and shall notify the board upon an individual's successful completion of the cross-training examination.

(2) The board shall issue a certification of cross-training to an individual who successfully completes a cross-training program and examination.

(3) The board, with the assistance of the Advisory Council on Respiratory Care, shall adopt rules, by January 1, 1995, to implement the certification program, including, but not limited to, rules prescribing:

(a) The minimum content and criteria for the administration of competency-based examinations for initial or renewal certification, including completion of an approved cross-training program;

(b) The minimum frequency of the administration of the certification examination by community colleges to ensure maximum access to examinations and timely utilization of cross-trained personnel;

(c) The coordination required between community colleges and eligible facilities regarding examination sites and schedules;

(d) The application requirements for certification, including a uniform application form and application fee to cover the costs incurred by a community college in administering the certification examination;

(e) The procedures governing notification to the board by community colleges of individuals who successfully complete an approved certification examination; and

(f) A uniform certification form to be issued by the board to individuals successfully completing the certification examination.

Section 65. Section 468.374, Florida Statutes, is created to read:

468.374 Certification conditions; renewal; rules; continuing education; disciplinary action.—

(1) A certification to perform limited respiratory care functions is valid only while the certified individual is employed in an eligible facility. The certification becomes invalid upon cessation of employment in the eligible facility and is not transferable to employment in any other health care setting. However, the certification remains valid upon termination of employment in an eligible facility and reemployment in another eligible facility.

(2) The board shall adopt rules:

(a) Establishing time frames and requirements for recertification of a cross-trained individual who, after an interruption of employment, is employed at an eligible facility;

(b) Establishing continuing education requirements for certified cross-trained individuals; and

(c) Providing for disciplinary action against a certified cross-trained individual, including termination of certification.

(3) Cross-training certification shall immediately be terminated upon the termination or expiration of the individual's primary professional license.

Section 66. Section 483.831, Florida Statutes, is created to read:

483.831 Multi-skill cross-training; legislative findings and intent.— The Legislature finds that the health care manpower shortage in this state necessitates flexible utilization of health care personnel employed in eligible facilities. Cross-training of experienced health care professionals should yield greater staffing efficiencies and enhance access to acute health care. Quality of care can be assured through the establishment of uniform training and certification criteria and through the limitation of cross-training to basic functions that can be safely performed by cross-trained health care personnel. Cross-training of experienced personnel should augment eligible-facility staffing capabilities, but not replace or otherwise substitute for the utilization of trained professionals when they are available. Likewise, personnel should perform cross-trained functions only when their primary professional responsibilities can be safely assumed by other professional co-workers. Therefore, it is the intent of the Legislature that the board expedite the development of a program for cross-training and certifying specified eligible-facility health care personnel to perform limited clinical laboratory functions. Multiskill cross-training, as referred to in this part, does not apply to activities regulated by the Agency for Health Care Administration pursuant to s. 483.051(9).

Section 67. Section 483.832, Florida Statutes, is created to read:

483.832 Personnel qualifications for cross-training.—

(1) To participate in a cross-training program to perform limited clinical laboratory functions, a person must be:

- (a) Licensed as a registered nurse or practical nurse under chapter 464;
- (b) Certified as a radiologic technologist under chapter 468; or
- (c) Registered as a respiratory therapist or certified as a respiratory care practitioner under part V of chapter 468.

(2) Eligible health care personnel must also have a minimum of 2 years' professional health care experience and be employed in an eligible facility.

Section 68. Section 483.833, Florida Statutes, is created to read:

483.833 Cross-training functions; limitations; supervision; rulemaking.—

(1) Cross-training of other health care personnel to perform clinical laboratory functions is limited to automated procedures for complete blood count with automated differential only, BUN, electrolytes, glucose, and macroscopic (dipstick) urinalysis.

(2) Only eligible facilities may conduct cross-training programs.

(3) The board shall adopt rules to implement the cross-training program by January 1, 1995, including, but not limited to, rules prescribing:

- (a) The uniform minimum curriculum content of cross-training programs; and
- (b) The supervisory responsibility of an eligible facility's laboratory director for ongoing oversight of the performance of clinical laboratory functions by cross-trained personnel.

Section 69. Section 483.834, Florida Statutes, is created to read:

483.834 Certification of cross-trained personnel; community colleges; rulemaking.—

(1) Community colleges may conduct competency-based examinations of personnel completing cross-training programs authorized under ss. 483.831-483.835 and shall notify the board upon an individual's successful completion of the cross-training examination.

(2) The board shall issue a certification of cross-training to an individual who successfully completes a cross-training program and examination.

(3) The board shall adopt rules, by January 1, 1995, to implement the certification program, including, but not limited to, rules prescribing:

- (a) The minimum content and criteria for the administration of competency-based examinations for initial or renewal certification, including completion of an approved cross-training program;
- (b) The minimum frequency of the administration of the certification examination by community colleges to ensure maximum access to examinations and timely utilization of cross-trained personnel;
- (c) The coordination required between community colleges and eligible facilities regarding examination sites and schedules;
- (d) The application requirements for certification, including a uniform application form and application fee to cover the costs incurred by a community college in administering the certification examination;

(e) The procedures governing notification to the board by community colleges of individuals who successfully complete an approved certification examination; and

(f) A uniform certification form to be issued by the board to individuals successfully completing the certification examination.

Section 70. Section 483.835, Florida Statutes, is created to read:

483.835 Certification conditions; rules; renewal; continuing education; disciplinary action.—

(1) A certification to perform limited clinical laboratory functions is valid only while the certified individual remains employed in an eligible facility. The certification becomes invalid upon cessation of employment in the eligible facility and is not transferable to employment in any other

health care setting. However, the certification remains valid upon termination of employment in an eligible facility and reemployment in another eligible facility.

(2) The board shall adopt rules:

(a) Establishing timeframes and requirements for recertification of a cross-trained individual who, after an interruption of employment, is employed at an eligible facility;

(b) Establishing continuing education requirements for certified cross-trained individuals; and

(c) Providing for disciplinary action against a certified cross-trained individual, including termination of cross-training certification.

(3) Cross-training certification shall immediately be terminated upon the termination or expiration of the individual's primary professional license.

Section 71. Cross-training programs; legislative report.—The Board of Nursing, the Board of Medicine, the Board of Clinical Laboratory Personnel, the Agency for Health Care Administration, and the Department of Health and Rehabilitative Services shall jointly evaluate by July 1, 1997, the cross-training programs provided by this act. The evaluation must consider the impact of cross-training on health care personnel, access to care, and quality of care. The boards, the agency, and the department shall submit a joint report to the President of the Senate, the Speaker of the House of Representatives, the minority leaders of each house of the Legislature, and the chairpersons of the appropriate committees of the Senate and the House of Representatives on the findings of the evaluation by January 1, 1998. The report must include recommendations for terminating, continuing, or modifying the cross-training programs, or replacing the programs with alternative training programs to produce multi-skilled health care personnel. The report must also include any necessary recommendations to conform the programs to the requirements of the Federal Clinical Laboratory Improvement Act.

Section 72. Section 624.31, Florida Statutes, is created to read:

624.31 Compliance with OBRA requirements.—Authorized health insurers, health maintenance organizations, multiple-employer welfare arrangements, fraternal benefit societies, assessable mutual insurers, prepaid health plans, prepaid limited health service organizations, and self-insurance plans providing health benefits, shall comply with the requirements of s. 13622 and s. 13623 of the Omnibus Budget Reconciliation Act of 1993 (Pub. L. No. 103-66). The Department of Insurance shall adopt rules to administer this section.

Section 73. Section 627.4239, Florida Statutes, is created to read:

627.4239 Coverage for drugs used in treatment of cancer.—

(1) DEFINITIONS.—As used in this section, the term:

(a) "Medical literature" means scientific studies published in a peer-reviewed national professional journal.

(b) "Standard reference compendium" means:

- 1. The United States Pharmacopeia Drug Information;
- 2. The American Medical Association Drug Evaluations; or
- 3. The American Hospital Formulary Service Drug Information.

(2) COVERAGE FOR TREATMENT OF CANCER.—

(a) An insurer may not exclude coverage in any individual or group insurance policy issued, amended, delivered, or renewed in this state which covers the treatment of cancer for any drug prescribed for the treatment of cancer on the ground that the drug is not approved by the United States Food and Drug Administration for a particular indication, if that drug is recognized for treatment of that indication in a standard reference compendium or in the medical literature.

(b) Coverage for a drug required by this section also includes the medically necessary services associated with the administration of the drug.

(3) APPLICABILITY AND SCOPE.—This section may not be construed to:

(a) Alter any other law with regard to provisions limiting coverage for drugs that are not approved by the United States Food and Drug Administration.

(b) Require coverage for any drug if the United States Food and Drug Administration has determined that the use of the drug is contraindicated.

(c) Require coverage for a drug that is not otherwise approved for any indication by the United States Food and Drug Administration.

Section 74. Effective October 1, 1994, section 627.6045, Florida Statutes, is created to read:

627.6045 Preexisting condition.—An individual health insurance policy must comply with the following provisions:

(1) Preexisting condition provisions may not exclude coverage for a period beyond 12 months following the individual's effective date of coverage and may relate only to:

(a) Conditions that, during the 6-month period immediately preceding the effective date of coverage, had manifested themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received; or

(b) A pregnancy existing on the effective date of coverage.

(2) In determining whether a preexisting condition provision applies to an eligible insured or dependent, credit must be given for the time the person was covered under previous coverage if the previous coverage was similar to or exceeded the coverage provided under the new policy and if the previous coverage was continuous to a date not more than 62 days before the effective date of the new coverage, exclusive of any applicable waiting period under the plan.

Section 75. Subsections (15) and (16) are added to section 627.6472, Florida Statutes, to read:

627.6472 Exclusive provider organizations.—

(15) Upon the development of outpatient practice guidelines applicable to optometrists, dermatologists, and ophthalmologists under s. 408.02, but not later than December 31, 1994, a policyholder seeking optometric, dermatological, or ophthalmological services may not be required to obtain a referral from a network provider or case manager before obtaining such services and may not be denied direct access to a board-certified optometrist or board-eligible or board-certified dermatologist or ophthalmologist who has contracted to provide services as an exclusive provider. The exclusive provider organization may not establish adverse incentives to impair or inhibit direct access to those providers.

(16)(a) Effective January 1, 1995, at least annually, each exclusive provider organization shall make available, upon request of a subscriber, a point of service plan as an option to any other plan that is offered to the subscriber. For the purposes of this section, a point of service plan is a plan that allows a subscriber freedom of choice to use nonparticipating providers. A nonparticipating provider is a provider who is not employed by or not under contract with the exclusive provider organization, or who is not otherwise participating in the network of providers used by the exclusive provider organization.

(b) The indemnification of a subscriber for the services of a nonparticipating provider may be subject to deductibles, copayments, and coinsurance approved by the department, provided that a subscriber may not be subject to a coinsurance requirement of more than 25 percent.

(c) Any additional premium for a point of service plan shall be approved by the department.

Section 76. Effective January 1, 1995, section 627.6691, Florida Statutes, is created to read:

627.6691 Health Insurance Coverage Continuation Act.—

(1) SHORT TITLE.—This section may be cited as the "Health Insurance Coverage Continuation Act."

(2) PURPOSE AND INTENT.—The purpose and intent of this section are to ensure the continued access to affordable health insurance

coverage by employees of small employers and their dependents and other qualified beneficiaries who are not currently protected by the Consolidated Omnibus Budget Reconciliation Act of 1985.

(3) APPLICABILITY.—This section does not apply if continuation-of-coverage benefits are available to covered employees or other qualified beneficiaries pursuant to s. 4980B of the United States Internal Revenue Code, ch. 18 of the Employee Retirement Income Security Act, 29 U.S.C. ss. 1161 et seq., or ch. 6A of the Public Health Service Act, 42 U.S.C. ss. 300bb-1 et seq.

(4) DEFINITIONS.—As used in this section, the term:

(a) "Applicable premium" means, with respect to any period of continuation of coverage or qualified beneficiaries, the premium charged by the plan for such period of coverage for similarly situated beneficiaries with respect to whom a qualifying event has not occurred, regardless of whether such premium is paid by the employer or employee.

(b) "Carrier" means a carrier as defined in s. 627.6699(3) that issued the small employer's group health plan.

(c) "Continuation coverage" means coverage under the group health plan that meets the requirements of paragraph (5)(a).

(d) "Covered employee" means an individual who is or was provided coverage under a group health plan by virtue of the individual's employment or previous employment with a small employer.

(e) "Gross misconduct" means willful and wanton behavior, the occurrence or recurrence of which manifests a wrongful intent or evil design by an employee in violating the employer's standards of behavior or legal business practices.

(f) "Group health plan" means any health benefit plan as defined in s. 627.6699(3) maintained by a small employer, which plan provides health care benefit coverage for the employer's employees or former employees, or for the families of such employees or former employees.

(g) "Qualified beneficiary" means any individual who, on the day before the qualifying event for the covered employee, is a beneficiary under the group health plan by virtue of the individual being:

1. The covered employee, except if the employee is terminated for gross misconduct;
2. The spouse of the covered employee; or
3. The dependent child of the covered employee.

(h) "Qualifying event" means, with respect to any covered employee, any of the following events which, but for the election of continuation coverage, would result in a loss of coverage to a qualified beneficiary:

1. The death of the covered employee.
2. The termination or reduction of hours of the covered employee's employment, except that termination of an employee for gross misconduct does not constitute a qualifying event.
3. The divorce or legal separation of the covered employee from the covered employee's spouse.
4. A covered employee becoming entitled to benefits under Title XVIII of the Social Security Act (Medicare).
5. A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.

(i) "Small employer" means any person that is actively engaged in business and that, on at least 50 percent of its working days during the preceding calendar year, employed fewer than 20 employees, the majority of whom were employed in this state.

(5) CONTINUATION OF COVERAGE UNDER GROUP HEALTH BENEFIT PLANS.—

(a) A group health benefit plan issued to a small employer shall provide that each qualified beneficiary who would lose coverage under the plan because of a qualifying event is entitled, without evidence of insurability, to elect, within the election period provided in this section, continuation coverage under the employer's group health plan. Qualified beneficiaries electing continuation coverage shall be subject to all the terms and conditions applicable under the plan.

(b) A qualified beneficiary is not entitled to continuation of coverage under the plan if, at the time of election, the beneficiary is or becomes:

1. Covered by Title XVIII of the Social Security Act (Medicare), as amended or superseded.

2. Covered under any other group health plan, if the qualified beneficiary will not be subject to any exclusion or limitation because of a preexisting condition of that beneficiary and the new plan provides benefits which are similar to or exceed those provided for in the group health plan under which the beneficiary has the ability to elect continuation of coverage.

(c) Coverage under the plan must, at a minimum, extend for the period beginning on the date of the qualifying event and ending not earlier than the earliest of the following:

1. The date that is 12 months after the date on which the covered employee's benefits under the plan would otherwise have ceased because of the termination of or reduction in the employee's employment; however, if the qualified beneficiary is 55 years of age or older at any point during the 12-month period, the period of coverage ends when the qualified beneficiary becomes entitled to benefits under Title XVIII of the Social Security Act (Medicare).

2. The date on which coverage ceases under the plan by reason of a failure to make timely payment of the applicable premium with respect to any qualified beneficiary.

3. In the case of a qualified beneficiary other than the covered employee, the date that is 12 months after the date on which the qualified beneficiary's benefits under the plan would otherwise have ceased by reason of any of the following qualifying events:

- a. The death of the covered employee.
- b. The divorce or legal separation of the covered employee from the covered employee's spouse.
- c. The covered employee becoming entitled to benefits under Title XVIII of the Social Security Act (Medicare).
- d. A dependent child ceasing to be a dependent child under the generally applicable requirements of the plan.

4. In the case of an individual who is a qualified beneficiary by reason of being the spouse of a covered employee, the date on which such individual remarries and becomes covered under a group health plan.

5. After the election for continuation coverage has been made, the date on which the qualified beneficiary becomes:

a. A covered employee under any other group health plan, if the qualified beneficiary will not be subject to any exclusion or limitation because of a preexisting condition of that beneficiary and if the new plan provides benefits that are similar to or exceed those provided for in the group health plan under which the beneficiary has the ability to elect continuation of coverage; or

b. Entitled to benefits under Title XVIII of the Social Security Act (Medicare).

6. The date on which the employer terminates coverage under the group health plan for all employees.

7. In the case of a qualified beneficiary who is determined, under Title II or Title XVI of the Social Security Act, to have been disabled at the time of an applicable qualifying event, the date 29 months after the date the qualified beneficiary's benefits under the policy would otherwise have terminated because of a qualifying event. However, if such qualified beneficiary is no longer disabled, continuation of coverage shall terminate at the later of the date specified in subparagraph 1. or subparagraph 3., as applicable, or the first month that begins more than 31 days after the date of the final determination under Title II or Title XVI of the Social Security Act that the qualified beneficiary is no longer disabled.

(d) If the employer terminates coverage for all employees under the group health plan for all employees and if such group health plan is replaced by similar coverage under another group health plan, the following conditions apply:

1. The qualified beneficiary shall have the right to become covered under the new group health plan for the balance of the period that he would have remained covered under the prior plan, in accordance with this section, had the termination not occurred.

2. The prior plan shall continue to provide benefits to the extent of its accrued liabilities and extension of benefits as if the replacement had not occurred.

(e)1. A qualified beneficiary must give written notice to the carrier within 30 days after the occurrence of a qualifying event or within 30 days after the determination under Title II or Title XVI of the Social Security Act that such qualified beneficiary was disabled at the time of the applicable qualifying event. Unless otherwise specified in the notice, a notice by any qualified beneficiary constitutes notice on behalf of all qualified beneficiaries. Such written notice shall inform the carrier of the occurrence of a qualifying event giving rise to the potential election by a qualified beneficiary of continuation of coverage under the group health plan issued by that carrier, except that in cases where the covered employee has been involuntarily discharged, the nature of such discharge need not be disclosed. Such written notice shall, at a minimum, identify the employer, the group health plan number, the name and address of all qualified beneficiaries, and such other information required by the carrier under the terms of the plan or the department by rule, to the extent that such information is known by the qualified beneficiary.

2. Within 14 days after the receipt of written notice under subparagraph 1., the carrier shall send each qualified beneficiary by certified mail an election and premium notice form, approved by the department, which form shall provide for the qualified beneficiary's election or non-election of continuation of coverage under the plan and the applicable premium amount due after the election to continue coverage. The carrier shall notify the employer of any qualified beneficiary's election or non-election of continuation of coverage under the employer's group health plan. This subparagraph does not require separate mailing of notices to each qualified beneficiary residing in the same household.

(f)1. A covered employee or other qualified beneficiary who wishes continuation of coverage must elect such continuation in writing to the carrier issuing the employer's group health plan within 30 days after receiving notice from the carrier under subparagraph (e)2. and must pay the applicable premium for the period ending on the last day of the calendar month in which such 30-day period ends. After the election, the carrier must bill the qualified beneficiary for premiums once each month, with a due date of the first of the month of coverage and allowing a 30-day grace period for payment.

2. Except as otherwise specified in an election, any election by a qualified beneficiary shall be deemed to include an election of continuation of coverage on behalf of any other qualified beneficiary residing in the same household who would lose coverage under the plan by reason of a qualifying event. This subparagraph does not preclude a qualified beneficiary from electing continuation of coverage on behalf of any other qualified beneficiary.

3. The applicable premium shall not exceed 110 percent of the current premiums paid by other similarly situated beneficiaries covered under the plan for the applicable policy period.

(g) If a carrier fails to comply with the notice requirements of subparagraph (e)2. and such noncompliance results in the failure of an eligible qualified beneficiary to elect continuation under the group health plan, the qualified beneficiary shall be deemed to have timely elected continuation of coverage within the election period and shall be covered under the plan at the expense of the noncomplying carrier. The liability exposure of a noncomplying carrier under this paragraph shall be limited to that period which includes the effective date of coverage pursuant to an affirmative election through the date on which the qualified beneficiary receives actual notice. This paragraph does not apply to the extent that the failure of the carrier to comply with applicable notice requirements was due to noncompliance by the qualified beneficiary with notice requirements applicable to the qualified beneficiary.

(6) NOTICE REQUIRED IN POLICIES, CONTRACTS, CERTIFICATES, AND PLAN BOOKLETS.—The carrier shall include a notification of the right to continue coverage as provided by this section and the procedures for requesting such continuation in each policy, contract, and certificate of coverage, and in the plan booklet. The plan booklet shall also contain all information necessary for a qualified beneficiary to comply with the notice requirements of subparagraph (5)(e)1., and shall contain a form for such notice.

Section 77. 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) This section applies to a health benefit plan that provides coverage to a small employer in this state, unless the policy is marketed directly to the individual employee, and the employer does not participate in the collection or distribution of premiums or facilitate the administration of the policy in any manner. *This section does not apply to a health benefit plan issued under the Florida Health Security Act or to a carrier who issues coverage under the Florida Health Security Act.*

Section 78. Effective upon this act becoming a law, subsection (25) is added to section 641.31, Florida Statutes, to read:

641.31 Health maintenance contracts.—

(25) *Upon the development of outpatient practice guidelines applicable to optometrists, ophthalmologists, and dermatologists under s. 408.02, but no later than December 31, 1994, a health maintenance organization contract may not require a subscriber who is seeking optometric, ophthalmological, or dermatological services to obtain a referral from a primary care physician, but must provide direct access to a board-certified optometrist, or a board-eligible or board-certified dermatologist or ophthalmologist who is under contract with the health maintenance organization. The health maintenance organization may not establish adverse incentives to impair or inhibit such direct access.*

Section 79. Effective January 1, 1995, section 641.351, Florida Statutes, is created to read:

641.351 Managed patient choice; required point of service option.—

(1) At least annually, each health maintenance organization shall make available, upon request of a subscriber, a point of service plan as an option to any other plan that is offered to the subscriber. For the purposes of this section, a point of service plan is a plan that allows a subscriber freedom of choice to use nonparticipating providers. A nonparticipating provider is a provider who is not employed by or under contract with the health maintenance organization, or who is not otherwise participating in the network of providers used by the health maintenance organization.

(2) Notwithstanding s. 641.2017, a health maintenance organization shall make available a point of service plan upon the request of an employer. If more than 50 percent of the health maintenance organization's business is point of service, the health maintenance organization must either be licensed as a health insurer pursuant to chapter 624 or be affiliated with a licensed health insurer.

(3) The indemnification of a subscriber for the services of a nonparticipating provider may be subject to deductibles, copayments, and coinsurance payments approved by the department, provided that a subscriber may not be subject to a coinsurance payment requirement of more than 25 percent.

(4) Any additional premium for a point of service plan shall be approved by the department pursuant to s. 641.31.

(5) A health maintenance organization may also offer a plan that permits a subscriber to use a preferred provider network of an affiliated insurer under terms and conditions approved by the department.

Section 80. Section 641.47, Florida Statutes, is amended to read:

641.47 Definitions.—As used in this part, the term:

(1) "Agency" means the Agency for Health Care Administration.

(2) "Emergency medical condition" means:

(a) *A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:*

1. *Serious jeopardy to patient health, including the health of a pregnant woman or fetus.*
2. *Serious impairment to bodily functions.*
3. *Serious dysfunction of any bodily organ or part.*

(b) *With respect to a pregnant woman:*

1. *That there is inadequate time to effect safe transfer to another hospital prior to delivery;*

2. *That a transfer may pose a threat to the health and safety of the patient or fetus; or*

3. *That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.*

(3) "Emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of the facility.

(1) ~~"Health care services" means comprehensive health care services, as defined in s. 641.19, when applicable to a health maintenance organization, and means basic services, as defined in s. 641.402(1), when applicable to a prepaid health clinic.~~

(2) ~~"Department" means the Department of Health and Rehabilitative Services.~~

(4)(3) "Geographic area" means the county or counties, or any portion of a county or counties, within which the health maintenance organization provides or arranges for comprehensive health care services to be available to its subscribers.

(5) "Health care services" means comprehensive health care services, as defined in s. 641.19, when applied to a health maintenance organization, and means basic services, as defined in s. 641.402, when applied to a prepaid health clinic.

(6)(4) "Minimum services" includes any of the following: emergency care, inpatient hospital services, physician care, ambulatory diagnostic treatment, and preventive health care services.

(7)(5) "Organization" means any health maintenance organization as defined in s. 641.19 or ~~and~~ any prepaid health clinic as defined in s. 641.402(5).

(8)(6) "Provider" means any physician, hospital, or other institution, organization, or person that furnishes health care services and is licensed or otherwise authorized to practice in the state.

(9) "Quality-of-care grievance" means a grievance by a subscriber, enrollee, or provider regarding the delivery of services or care pertaining to a health condition that could reasonably be expected to deteriorate or result in irreparable damage due to a lack of provision of a health care service or care, inappropriate delay in the provision of a health care service or care, provision of substandard service or care, or the unnecessary provision of a health care service or care.

(10)(7) "Subscriber" means an individual who has contracted, or on whose behalf a contract has been entered into, with a health maintenance organization for health care services.

Section 81. Section 641.49, Florida Statutes, is amended to read:

641.49 Certification of health maintenance organization and prepaid health clinic as health care providers; application procedure.—

(1) ~~A No~~ person or governmental unit ~~may not shall~~ establish, conduct, or maintain a health maintenance organization or a prepaid health clinic in this state without first obtaining a health care provider certificate under this part.

(2) The Department of Insurance shall not issue a certificate of authority under part I or part II of this chapter to any applicant ~~that~~ which does not possess a valid health care provider certificate issued by the ~~agency department~~ pursuant to this part.

(3) Each application for a health care provider certificate ~~must shall~~ be on a form prescribed by the ~~agency department~~. The following information and documents shall be maintained by the organization and shall be available for inspection or examination at the offices of the organization by the ~~agency department~~ at anytime during regular business hours. The ~~agency must department shall~~ give reasonable notice to the organization prior to any onsite inspection or examination conducted pursuant to this section. The ~~agency department~~ may require that the following information or documents be submitted with the application:

(a) A copy of the articles of incorporation and all amendments thereto.

(b) A copy of the bylaws, rules and regulations, or similar form of document, if any, regulating the conduct of the affairs of the applicant.

(c) A list of the names, addresses, and official capacities with the organization of the persons who are to be responsible for the conduct of the affairs of the organization, including all officers and directors of the corporation. Such persons shall fully disclose to the *agency department* and the directors of the organization the extent and nature of any contracts or arrangements between them and the health maintenance organization, including any possible conflicts of interest.

(d) The name and address of the applicant and the name by which the organization is to be known.

(e) A statement generally describing the organization and its operations.

(f) A copy of the form for each group and individual contract, certificate, subscriber handbook, and any other similar documents issued to subscribers.

(g) A statement describing the manner in which health services *will* ~~shall~~ be regularly available *which includes a toll-free telephone number that is accessible 24-hours-a-day*.

(h) The locations of the facilities at which health care services *will* ~~shall~~ be regularly available to subscribers.

(i) The type of health care personnel engaged to provide the health care services and the quantity of the personnel of each type.

(j) A statement giving the present and projected number of subscribers to be enrolled yearly for the next 3 years.

(k) A statement indicating the source of emergency care on a 24-hour basis.

(l) A statement that the physicians employed by the applicant have been formally organized as a medical staff and that the applicant's governing body has designated a chief of medical staff *who is a physician licensed under chapter 458 or chapter 459*.

(m) A statement describing the manner in which the organization assures the maintenance of a medical records system in accordance with accepted ~~medical records'~~ standards and practices *for medical records*.

(n) If general anesthesia is to be administered in a facility not licensed by the *agency department*, a copy of architectural plans to meet the requirements for institutional occupancy (NFPA 101 Life Safety Code, current edition as adopted by the State Fire Marshal).

(o) Description of the organization's quality assurance program, including committee structure, criteria and procedures for corrective action which complies with s. 641.51.

(p) For health maintenance organizations only:

1. A description and supporting documentation concerning how the applicant will comply with the internal risk management program requirements.

2. An explanation of how coverage is to be effected outside the health maintenance organization's stated geographic area for emergency services.

3. *A statement that it will distribute to its subscribers or enrollees which describes the Statewide Provider and Subscriber Assistance Program and the organization's grievance procedure, along with the agency's toll-free hotline telephone number.*

(q) A statement and map describing with reasonable accuracy the specific geographic area to be served.

(r) A nonrefundable application fee of \$1,000.

(s) Such additional information as the *agency department* may reasonably require.

Section 82. Section 641.495, Florida Statutes, is amended to read:

641.495 Requirements for issuance and maintenance of certificate.—

(1) The *agency department* shall issue a health care provider certificate to any entity *that files filing* a completed application in conformity with s. 641.48, upon payment of the prescribed fee, and upon the *applicant proving to the satisfaction of the agency department's being satisfied* that the applicant has the ability to provide a quality of care *that is* consistent with the prevailing professional standards of care, *including standards of care as prescribed by chapters 394 and 397, and that the which* entity otherwise meets the requirements of this part. A certificate, unless sooner suspended or revoked, ~~shall automatically expires~~ *expire* 2 years ~~after from~~ the date of issuance unless renewed by the organization. The certificate shall be renewed upon application for renewal and payment of a renewal fee of \$1,000, *if provided that the organization is in compliance with the requirements of this part and any rules adopted under this part hereunder*. An application for renewal of a certificate *must* ~~shall~~ be made 90 days prior to expiration of the certificate, on forms provided by the *agency department*. ~~The Renewal of an application does shall~~ not require the resubmission of any documents previously filed with the *agency department* if such documents have remained valid and unchanged since their original filing.

(2) The organization *must* ~~shall~~ demonstrate its capability to provide health care services in the geographic area proposed *to be served service*. In addition, each health maintenance organization shall notify the *agency department* of its intent to expand its geographic area at least 60 days prior to the date it begins providing health care services in the new area. ~~Before~~ *Prior to the date the health maintenance organization begins* enrolling members in the new area, *the health maintenance organization* ~~it~~ must submit *to the agency* a notarized affidavit, signed by two officers of the organization who have the authority to bind the organization, ~~to the department~~ describing and affirming its existing and projected capability to provide health care services to its projected number of subscribers in the new area. The notarized affidavit *must* ~~shall~~ further assure that, 15 days prior to providing services in the new area, the health maintenance organization *will* ~~shall~~ be able, through documentation or otherwise, to demonstrate that it ~~is~~ *shall* be capable of providing services to its projected subscribers for at least the first 60 days of operation. If the *agency department* determines that the organization is not capable of providing health care services to its projected number of subscribers in the new area, the *agency department* may issue an order pursuant to the procedures of chapter 120 prohibiting the organization from expanding into the new area. In any proceeding pursuant to chapter 120, the *agency has department* ~~shall have~~ the burden of establishing that the organization is not capable of providing health care services to its projected number of subscribers in the new area.

(3) The organization shall ensure that the health care services it provides to subscribers, including physician services *specified in the definition of the term "health maintenance organization" in as required by s. 641.19(7)(d) and (e)*, are accessible to the subscribers, with reasonable promptness, with respect to geographic location, hours of operation, provision of after-hours service, and staffing patterns within generally accepted industry norms for meeting the projected subscriber needs.

(a) *The agency shall develop by rule a procedure for evaluating, on an ongoing basis, the impact that the severing of relationships with providers by a health maintenance organization may have on the ability of the health maintenance organization to deliver services to its subscribers and enrollees as required under this section.*

(b) *The organization must submit documentation of its efforts to recruit and retain minority professionals in numbers that are ethnically comparable to and reflective of its subscriber or enrollee populations.*

(c) *Notwithstanding any provision to the contrary, an organization may not prohibit a provider from providing medical services to a patient who is enrolled in another organization if the provider desires to contract with the other organization.*

(4) The organization shall exercise reasonable care in assuring that services provided are performed by providers who are licensed to provide such services.

(5) The organization *must* ~~shall~~ have a system for verification and examination of the credentials of each of its providers. The organization shall maintain in a central file the credentials, including a copy of the current Florida license, of each of its physicians. *The organization must also have a system for verifying and examining the credentials and the job descriptions of each health care professional who renders health care in a facility.*

(6) Every organization shall establish standards and procedures reasonably necessary to provide for the maintenance of a readily accessible medical records system which is adequate to provide necessary information including an accurate documentation of all services provided for every enrolled person.

(7) ~~If in the event that~~ the organization employs providers to render health care to subscribers, the contracts, certificates, and subscriber handbooks *must* ~~shall~~ contain a provision, if applicable, disclosing that, for certain types of described medical procedures, services may be provided by physician assistants, nurse practitioners, or other individuals who are not licensed physicians.

(8)(a) Every organization *must* ~~shall~~ have a subscriber grievance procedure, which is outlined in all master group and individual contracts as well as in any certificate or handbook provided to subscribers. *The grievance procedure must establish methods for classifying emergency, urgent, and routine grievances and must establish standard timeframes within which each such grievance must be resolved. The organization must notify subscribers or enrollees that they may submit their grievances to the Statewide Provider and Subscriber Assistance Program, as provided in s. 408.7056(4).*

(b) Each organization's grievance procedure, as required under paragraph (a), *must include, at a minimum:*

1. A procedure for addressing subscriber or enrollee quality-of-care grievances which is separate from a procedure for addressing payment, reimbursement, or contractual complaints or grievances. Such a procedure *must* notify the provider, subscriber, or enrollee who submits a quality-of-care grievance that he may contact the agency's toll-free hotline for assistance in resolving the quality-of-care grievance. *In addition, such procedure must notify the subscriber or enrollee who submits a contractual grievance that the subscriber or enrollee may contact the Department of Insurance's Consumer Services toll-free hotline for assistance in resolving contractual grievances.*

2. A statement explaining that a verbal complaint is considered an informal grievance and outlining the procedure for its resolution.

3. A statement explaining that a grievance is a written complaint and describing the formal process for its resolution.

4. The name of the appropriate grievance coordinator or a listing of grievance coordinators who are responsible for implementing the organization's grievance process. *The listing must include the address of each grievance coordinator, the address for the agency's office that is responsible for the enforcement of this part, and the address of the Statewide Provider and Subscriber Assistance Panel.*

5. A listing of the telephone numbers that a subscriber or enrollee may call to present a complaint, pursue a grievance inquiry, or contact a grievance coordinator. *Each number must be toll-free within the subscriber's geographic area, as defined under s. 641.19. The organization must ensure an adequate number of telephone lines, based on its projected number of subscribers, as required by s. 641.49(3)(j), to handle incoming complaints and grievance inquiries.*

6. The agency's toll-free hotline number.

7. The telephone number for the Statewide Provider and Subscriber Assistance Program.

8. The telephone number for local community resources for providing subscriber assistance, when available.

(c) Each organization *must* initiate action to resolve a complaint or grievance involving an emergency medical condition within 3 hours after receipt and initiate action to resolve all urgent grievances within 2 days and routine grievances within 5 days after receipt, unless the provider or subscriber and the organization mutually agree to extend the timeframe. *However, the organization must make an initial determination on resolution of the complaint or grievance within 20 days after its receipt and final resolution within 10 days after receipt of a request for reconsideration by the subscriber or enrollee.*

(d) A provider or subscriber may, simultaneously with submitting a grievance to the organization, submit a copy to the agency and the Department of Insurance.

(e) Each organization shall provide the agency and the Department of Insurance with a copy of the final decision letter which must detail the organization's resolution of the grievance and the basis for its decision.

(f) Each organization shall notify the provider, subscriber, or enrollee in its final-decision letter that if the grievance is not resolved to the satisfaction of the provider, subscriber, or enrollee, the grievance may be appealed to the Statewide Provider and Subscriber Assistance Panel for consideration within 30 days.

(g) The agency and the Department of Insurance shall, as appropriate, coordinate with local community resources to assist in the resolution of subscriber or enrollee complaints and grievances or to assist the subscriber or enrollee in understanding the grievance and appeal process.

(h) Each organization *must* process grievances within 5 days after receipt, unless the provider or subscriber and the organization mutually agree to extend the timeframe. *However, a grievance must be initially processed within 20 days after its receipt.*

(i) A provider or subscriber may, simultaneously with submitting a grievance to the organization, submit a copy to the agency and the Statewide Provider and Subscriber Assistance Program for consideration within the timeframes provided in paragraph (c).

(j) Each organization shall provide the agency with a copy of the final-decision letter, which must detail the organization's resolution of the grievance and the basis for its decision.

~~(9) The organization shall provide, through contract or otherwise, for periodic review of its medical facilities and services.~~

(9)(10) The provisions of part I of chapter 395 do not apply to a health maintenance organization if, on or before January 1, 1991, the organization provides not more than 10 outpatient holding beds for short-term and hospice-type patients in an ambulatory care facility for its members, provided such health maintenance organization maintains current accreditation by the Joint Commission on Accreditation of Health Care Organizations, the Accreditation Association for Ambulatory Health Care, or the National Committee for Quality Assurance.

(10)(a) Each organization *must* ensure that emergency inpatient, outpatient, and physician services are available 24-hours-a-day, 7-days-a-week, either directly from the organization or through arrangements with other health care providers. *Provision must be made for coverage of services that are delivered by health care providers with whom a contractual or other arrangement has not been established.*

(b) Each organization *must* ensure that the services it provides, whether provided directly or indirectly, are accessible to the subscriber or enrollee with reasonable promptness.

(c) Each organization *must* develop a method for distinguishing among emergency, urgent, and routine cases and *must* provide that:

1.a. A procedure is available to ensure immediate screening, examination, and evaluation of patients to determine whether an emergency medical condition exists. *Such determination must be made at a hospital by a physician who is on the hospital staff, is a hospital employee, or is under contract with the hospital, or, to the extent permitted by applicable law, must be made by other appropriate personnel under the supervision of the hospital physician.*

b. Each condition determined to be an emergency medical condition is authorized for immediate treatment, care, or surgery sufficient to relieve or eliminate the emergency medical condition.

c. Medical care and followup as provided in subparagraphs 2.-4. is made available for a case in which the screening, examination, and evaluation have resulted in the determination that an emergency medical condition does not exist or for a case in which the subscriber or enrollee has contacted his primary care physician for nonemergency care;

2. Urgent cases will be seen within 24 hours after the first request by the subscriber or enrollee, or after the determination that an emergency medical condition does not exist;

3. Routine symptomatic cases will be seen as soon as possible, but not longer than 5 days after the first request by the subscriber or enrollee for services or after the determination that an emergency medical condition does not exist; and

4. Routine nonsymptomatic cases will be seen within 2 weeks after the first request by the subscriber or enrollee, or after the determination that an emergency medical condition does not exist.

(d) Each organization must outline, in the simplest language, its procedures for after-hours and out-of-area emergency services and care; the procedure for accessing such services and care; and the responsibilities of the organization for providing prehospital transport and treatment, emergency services and care, and trauma services and care.

(e) Prehospital transport and treatment of, and emergency services and care to, a subscriber or enrollee must be provided pursuant to ss. 401.45 and 395.1041. Trauma care services and care must be provided pursuant to ss. 395.401-395.405.

(f)1. An organization may not require prior authorization for payment for the receipt of prehospital transport or treatment, or of emergency services and care, of its subscribers or enrollees.

2. Reimbursement of services provided in compliance with paragraph (d) by a provider that has a provider contract with the health maintenance organization must be as provided under the contract.

3. Reimbursement of services by a provider that has not entered into a contract with the health maintenance organization is to be as negotiated between the provider and the health maintenance organization, or the lesser of the provider's charges or the usual and customary provider charges for similar services in the community where services were provided.

(11) Each organization must have an emergency management plan specifying what actions the organization will take to ensure the ongoing provision of health services in a natural or manmade disaster.

Section 83. By December 31, 1994, the Agency for Health Care Administration shall adopt rules to implement the revisions to section 408.7056 and sections 641.47-641.58, Florida Statutes, which are made by this act.

Section 84. Health Care Network Negotiations and Antitrust Investigation Act.—

(1) This section may be cited as the "Health Care Network Negotiations and Antitrust Investigation Act."

(2) The Legislature finds that:

(a) Recent health care reforms require continually changing relationships among and between health insurers, hospitals, physicians, and other health care providers.

(b) These reforms are a matter of great public importance.

(c) Managed-care plans responsible for the delivery of medical services and the financing of health care are developing rapidly as the market for health care services continues to consolidate and evolve.

(d) Managed-care plans enter contracts with health care providers for the delivery of health and medical care services and employ various techniques to control costs.

(e) Integrated networks are being organized by commercial insurance companies, health care service corporations, and hospitals.

(f) Independent health care providers are seeking to combine into large networks to enhance their competitive positions with regard to these integrated networks.

(g) The formation of health care provider networks for the purpose of contracting for and delivering efficient and high-quality medical services will provide a pro-competitive mechanism for independent health care providers and small group practices.

(h) The economic viability of health care networks, including provider networks, may depend upon a sufficient membership to deliver a full range of health and medical services.

(i) The creation of health care provider networks may enhance competition and may provide benefits to patients by offering increased options for the delivery of health and medical care services.

(j) The Federal Trade Commission and the United States Department of Justice have recently released guidelines to provide greater clarity concerning Federal antitrust enforcement policy and to promote the ability of some health care providers to assure that their conduct comports with Federal antitrust rules.

(k) The federal and state antitrust laws currently allow the formation of health care provider and other networks; however, notwithstanding the recently developed federal guidelines, the current laws may not provide adequate guidance as to the lawful parameters within which such networks may operate in a rapidly changing industry.

(3) Recognizing that the ability to provide quality health care to the public requires competitive markets in all aspects of the health care industry, and recognizing the need of health care providers and other entities to have access to adequate information, the Legislature directs the presidents of Florida State University, the University of Florida, the University of Miami, Stetson University, and Nova University to designate a faculty member from each of their respective law schools to form an advisory council to determine whether the guidance provided by the federal antitrust agencies effectively meets the needs of providers in this state while safeguarding the interests of consumers in this state.

(a) The advisory council shall be staffed by the Attorney General, and the advisory council shall have the authority to hire such additional consultants and specialists as it considers necessary.

(b) The findings and recommendations of the advisory council shall be contained in a final report that must be submitted to the Legislature by December 31, 1994. This report must include a specific plan of implementation for any recommendations developed by the advisory council.

(4) In reaching its findings and recommendations, the advisory council shall consider, among other things, the following factors:

(a) The impact of exclusive arrangements on the creation of market power and the creation of efficiencies by provider networks; and

(b) State and federal antitrust laws and current and incipient federal antitrust guidelines to assess their impact, their ability to provide adequate direction to health care providers and other entities that wish to form bargaining networks, and their ability to ensure efficient competition in health care in this state.

(5) In developing its final report, the advisory council shall collect and identify, at a minimum, the following data and information:

(a) The number of provider groups that have organized, or have begun to organize, within this state for the purpose of negotiating contracts with health care plans, insurers, or employers;

(b) The number of requests for advisory opinions submitted by networks of health care providers within this state to the Attorney General of the state, the United States Department of Justice, and the Federal Trade Commission, relating to whether such networks may negotiate contracts with health care plans, insurers, and employers, as well as the number of such requests that were approved or disapproved and the characteristics of the provider networks within each category; and

(c) The number of legal challenges brought by the Attorney General of the state, the United States Department of Justice, the Federal Trade Commission, or any private party against any network, or proposed network, of health care providers within this state, as well as the basis for any such challenge.

(6) The advisory council shall also consider the results of comparable activities in other states.

(7) To fund the duties and activities of the advisory council, the sum of \$250,000 is appropriated to the advisory council from the Health Care Cost Containment Trust Fund authorized under section 408.20, Florida Statutes.

(8) This section expires December 31, 1994.

Section 85. The Agency for Health Care Administration, in consultation with the Florida Hospital Association, the Association of Voluntary Hospitals, the Florida League of Hospitals, the Florida Association of Homes for the Aging, and the Florida Health Care Association, shall develop recommendations to determine the appropriate placement of Medicaid skilled nursing patients in skilled nursing facilities. The recommendations shall take into account the types of patients treated in hospital skilled nursing units, including typical patient acuity levels and the average length of stay in such units. Notwithstanding any other law, Medicaid reimbursement to hospitals for skilled nursing services may not be contingent upon the development of the recommendations by the agency. The recommendations developed by the agency shall be presented to the President of the Senate and the Speaker of the House of Representatives by December 31, 1994.

Section 86. (1) Entities that were providing diagnostic imaging services and were in existence prior to January 1, 1992, which, on or before that date, were owned 50 percent by a hospital or an affiliate of that hospital and 50 percent by physicians, are exempt from the provisions of section 455.236(4)(a), Florida Statutes, for purposes other than radiation therapy services, provided that each such entity submits to utilization review and rate review by the Agency for Health Care Administration. If, after review, the Agency for Health Care Administration finds that the rates being charged for services are above those customarily charged for such services by similar facilities in the community, the agency may issue an administrative order pursuant to chapter 120, Florida Statutes, setting rates for each service being provided by the entity at the average level being charged for similar services in the community.

(2) The entity may annually request a review of any charges set pursuant to subsection (1) and may present evidence to the Agency for Health Care Administration on its own behalf. The provisions of chapter 120, Florida Statutes, apply to this process.

Section 87. There is appropriated to the Agency for Health Care Administration from the Health Maintenance Organization Quality Care Trust Fund the sum of \$360,000 and 5 FTE positions to be used to establish voluntary consumer assistance efforts throughout the state and to perform the activities of the Statewide Provider and Subscriber Assistance Panel.

Section 88. There is appropriated to the Department of Insurance from the Health Maintenance Organization Quality Care Trust Fund the sum of \$75,000 to fund the compilation of a data base of complaints and grievances specific to accountable health partnerships and health maintenance organizations, as provided under this act.

Section 89. In order to fund the Florida Health Security program, the Agency for Health Care Administration is authorized to transfer to the Florida Health Security Trust Fund, as follows:

(1) Up to \$17,234,381 in general revenue funds and \$22,077,619 in Medical Care Trust Fund moneys generated from savings due to the managed care initiatives implemented pursuant to section 47 of this act;

(2) Up to \$328,331 in general revenue funds from the managed care savings to implement the provisions of this act which are not part of the Florida Health Security program.

Section 90. Effective July 1, 1994, or upon receipt of the federal section 1115 waiver for the Florida Health Security program, whichever occurs later, the following amounts are appropriated to the Agency for Health Care Administration and the following positions are authorized:

(1) \$36,348,487 from the Florida Health Security Trust Fund for the state and federal share of the premium subsidies in the Florida Health Security program which shall be capped at an average monthly enrollee caseload of 28,925.

(2) 24 positions and \$1,623,579 from the Florida Health Security Trust Fund for Florida Health Security program development and administration.

(3) 8 positions and \$682,533 from the Florida Health Security Trust Fund for the establishment of a fraud and abuse detection and investigation program for the Florida Health Security program.

(4) \$250,000 from the Florida Health Security Trust Fund for public education and for the evaluation and reporting of the Florida Health Security program.

(5) \$150,000 from the Florida Health Security Trust Fund for the Medicaid fiscal agent interface, payments, and maintenance for the Florida Health Security program.

(6) \$200,000 from the Florida Health Security Trust Fund to fund the actuarial requirements of the Florida Health Security program.

(7) \$2,651,900 from the Florida Health Security Trust Fund from additional federal earnings anticipated to be earned by the Florida Health Security program.

Section 91. The powers, duties and functions, personnel, property, and unexpended balances of appropriations associated with 10 career-service positions, including \$289,700 from the General Revenue Fund and \$289,700 from the Administrative Trust Fund, are transferred from the MedAccess program to the Division of Quality Assurance of the Agency

for Health Care Administration to monitor and assess quality assurance of provider networks within the Agency for Health Care Administration.

Section 92. The powers, duties and functions, personnel, property, and unexpended balances of appropriations associated with 11 career-service positions are transferred from the MedAccess program to the community health purchasing alliances program within the Agency for Health Care Administration, including \$637,340 from the General Revenue Fund.

Section 93. The following amounts are appropriated to the Agency for Health Care Administration:

(1) \$75,000 from the General Revenue Fund and \$75,000 from the Administrative Trust Fund for the health maintenance organization reimbursement rate study authorized in this act.

(2) \$50,000 from the General Revenue Fund for the State Contractor Health Insurance Task Force.

Section 94. There is appropriated to the Department of Health and Rehabilitative Services \$203,331 from the General Revenue Fund and \$203,232 from the Administrative Trust Fund for the implementation of five pilot programs authorized in section 34 of this act and 10 additional positions are authorized.

Section 95. Section 407.61; subsections (7), (9), (12), and (37) of section 408.07; section 408.072; subsections (2), (3), (4), (5), (6), (7), (8), (9), (10), (11), (12), and (13) of section 408.08; and section 408.085, Florida Statutes, and subsection (2) of section 455.25, Florida Statutes, as amended by chapter 92-178, Laws of Florida, are repealed.

Section 96. Effective upon this act becoming a law, section 16 of chapter 92-178, Laws of Florida, appearing as section 455.2555, Florida Statutes, is repealed. This section shall operate retroactively to July 1, 1992, and a licensing board may not impose or collect an administrative fine from a provider under section 16 of chapter 92-178, Laws of Florida.

Section 97. Section 33 of chapter 92-33, Laws of Florida, as amended by section 5 of chapter 93-129, Laws of Florida, is repealed, and the Division of Medical Quality Assurance of the Department of Business and Professional Regulation is not transferred to the Agency for Health Care Administration but remains within that department.

Section 98. Except as otherwise expressly provided in this act, this act shall take effect July 1, 1994.

And the title is amended as follows:

In title, strike everything before the enacting clause and insert: A bill to be entitled An act relating to health care; amending s. 20.42, F.S.; requiring Senate confirmation of the Director of Health Care Administration; deleting hospital budget review from duties of the Division of Health Policy and Cost Control and Health Care Board; amending s. 61.12, F.S.; providing for garnishment of wages to pay health insurance premiums for dependent children; amending s. 216.136, F.S.; providing additional duties of the Social Services Estimating Conference with respect to estimates and forecasts for Florida Health Security; creating s. 255.0516, F.S.; requiring contractors to comply with certain statutory provisions; amending s. 287.088, F.S.; requiring certain state agency contractors, including construction contractors, to ensure employee access to group health benefit plans; creating a task force to study health insurance requirements for state contractors; amending s. 316.003, F.S., providing definitions relating to the regulation of motor vehicles; defining the term "nonemergency, nonmedical transportation service vehicle"; creating s. 316.6151, F.S., relating to licensure and inspection of nonemergency, non-medical transportation service vehicles; providing for the regulation of such vehicles by the Department of Highway Safety and Motor Vehicles; providing a cross reference; authorizing such vehicles to operate statewide; exempting from this regulation certain vehicles owned and operated by a physician's office or medical care facility; providing a civil fine; providing for an injunction; providing that actions are cumulative to other actions available by law; creating s. 381.0407, F.S.; providing for urban community-based primary care networks; amending s. 395.1055, F.S.; providing for the care and treatment of patients in certain hospital distinct part nursing units; amending s. 400.051, F.S.; exempting certain hospitals from regulations governing nursing homes and related facilities; amending s. 400.602, F.S.; providing for issuance of additional hospice licenses; amending s. 408.02, F.S.; providing for practice guidelines for specified medical services; amending s. 408.033, F.S.; providing for local health councils to include planning for seriously mentally ill and sub-

stance-abuse-impaired persons; amending s. 408.301, F.S.; providing legislative findings with respect to chronically ill children who require a comprehensive system of care; providing legislative findings with respect to persons who have mental illnesses and substance abuse disorders; amending s. 408.40, F.S.; deleting reference to budget review proceedings of the Public Counsel; amending s. 408.702, F.S.; requiring community health purchasing alliances to request proposals from limited accountable health partnerships; amending s. 408.703, F.S.; providing requirements for employers in offering point of service plans to employees; amending s. 408.704, F.S.; providing that the agency is responsible for establishing the sole data system for accountable health partnership reporting; creating s. 408.7043, F.S.; providing certain limitations on the commingling of claims experience, rates, and charges for members of Florida Health Security by an accountable health partnership, a community health partnership, or a contract administrator; amending s. 408.7056, F.S.; revising the statewide provider and subscriber assistance program; providing additional program requirements; amending s. 408.706, F.S.; providing requirements for accountable health partnerships that participate in Florida Health Security; creating s. 408.7061, F.S.; authorizing certain entities to be designated as limited accountable health partnerships for the purpose of providing specific limited services; specifying applicability of s. 408.706, F.S.; amending s. 408.902, F.S.; delaying the effective date and providing a contingency for the creation of the MedAccess program; amending s. 409.2557, F.S.; providing rulemaking authority for the enforcement of certain federal laws; creating s. 409.810, F.S.; creating the Florida Health Security Act; creating s. 409.811, F.S.; providing legislative findings and intent; creating s. 409.812, F.S.; providing definitions; establishing Florida Health Security, subject to approval of financing by the Federal Government; requiring the Director of the Agency for Health Care Administration to appoint a director of Florida Health Security; creating s. 409.814, F.S.; providing eligibility criteria for membership in Florida Health Security; providing application requirements for individuals; providing application requirements for employers who apply on behalf of employees; requiring the agency to verify a member's continued eligibility; providing circumstances under which a member may be disenrolled; providing penalties for a member or employer who provides erroneous information or who fails to provide certain information; providing for an open enrollment period during which coverage is offered on a guarantee-issue basis; creating s. 409.815, F.S.; providing for certain exclusions for preexisting conditions and benefits available under workers' compensation insurance; providing for coverage under Florida Health Security to be provided by accountable health partnerships or community health partnerships; providing for a county, political subdivision, or tax district to establish a community health partnership; providing for the provision of emergency services; requiring that members be offered at least one benefit plan with a premium equal to or less than a benchmark premium established by the agency; providing certain limitations on changing accountable health partnerships; providing certain limitations on membership eligibility following termination of coverage; creating s. 409.816, F.S.; providing contribution requirements for premiums; providing certain limitations on state and federal contributions; creating s. 409.817, F.S.; providing duties of the Agency for Health Care Administration in administering Florida Health Security; creating s. 409.818, F.S.; providing duties of the agency for contract operations under Florida Health Security; creating s. 409.819, F.S.; authorizing a county, political subdivision, or tax district to create a community health partnership; providing enrollment criteria; providing requirements for qualification as a community health partnership; requiring that a community health partnership have adequate sources of revenue; providing disclosure requirements; providing requirements for coverage of a newborn or adopted child; providing for certain limitations on benefits; providing for liability for certain fees; providing for application of the Florida Insurance Code to certain services provided by a community health partnership; requiring actuarial certification of a community health partnership; providing requirements for a community health partnership that terminates its participation in Florida Health Security; providing for subcontracts for health care services with accountable health partnerships; requiring the Department of Health and Rehabilitative Services to establish pilot programs; requiring a report; creating s. 409.8191, F.S.; establishing a quality assurance program for community health partnerships; requiring that a community health partnership give its members the right to a second medical opinion; providing for grievance procedures; requiring the verification of the credentials of providers; requiring each community health partnership to establish a medical records system; creating s. 409.8192, F.S.; providing for external quality assurance for community health partnerships; providing requirements for an assessment process; requiring reports; creating s. 409.8193, F.S.; providing disclosure require-

ments for hospitals and physicians used by community health partnerships; creating s. 409.8194, F.S.; requiring community health partnerships to establish an internal risk management program; creating s. 409.820, F.S.; providing that members may not be enrolled in Florida Health Security until there is sufficient funding; requiring the agency to make certain reports to the Social Services Estimating Conference; requiring the Social Services Estimating Conference to establish the enrollment ceiling for Florida Health Security; providing circumstances under which the Agency for Health Care Administration may make modifications in Florida Health Security; amending s. 409.901, F.S.; conforming definitions to the transfer of duties from the Department of Health and Rehabilitative Services to the Agency for Health Care Administration; amending s. 409.905, F.S.; providing for reimbursement to certain hospitals for the provision of skilled nursing services; amending s. 409.908, F.S., relating to reimbursement of Medicaid providers; requiring legislative consultation and ratification for Medicaid funding formulas to be altered; providing a method for calculating reimbursement under Medicaid prepaid contracts; revising the reimbursement methodology for Medicaid hospice patients; providing for reimbursement to certain hospitals for the provision of skilled nursing services; providing limitations; providing prerequisites for coverage of Medicaid recipients and state employees by community health purchasing alliances; amending s. 409.9117, F.S.; revising the primary care disproportionate share program; providing for eligibility; providing a formula; amending s. 409.912, F.S.; providing for review of an entity's eligibility to contract with the agency; conforming provisions to the transfer of duties from the Department of Health and Rehabilitative Services to the Agency for Health Care Administration; specifying reimbursement for services provided outside an entity's service area; requiring the agency to establish a health care quality-improvement system for certain Medicaid prepaid plan providers; specifying the elements of the system; requiring Medicaid prepaid plan providers to provide certain member services; requiring the agency to develop a process for disenrollment of certain prepaid plan enrollees; specifying certain care, and documentation of care, provided to Medicaid prepaid plan enrollee infants and pregnant women; amending s. 409.9122, F.S.; providing for the enrollment of certain Medicaid recipients in a managed care plan or MediPass by a specified date; prohibiting the agency from discriminating against managed care providers; authorizing the Agency for Health Care Administration to establish a Medicaid mental health and substance abuse program pursuant to a federal waiver; requiring the agency to appoint an advisory panel; amending s. 409.915, F.S.; providing that services provided under Florida Health Security are not subject to certain requirements for matching funds from the counties; requiring the agency to study Medicaid reimbursement to prepaid health plans and health maintenance organizations; requiring a report; creating s. 464.024, F.S.; creating a cross-training program allowing limited nursing functions to be performed by certain personnel in eligible facilities; creating s. 464.025, F.S.; establishing personnel qualifications for the program; creating s. 464.026, F.S.; providing limitations on cross-training functions; authorizing the Board of Nursing to establish program requirements by rule; creating s. 464.027, F.S.; providing for cross-training certification examinations conducted by community colleges; providing for the issuance of cross-training certification to successful applicants; providing for the adoption of rules; providing for fees; creating s. 464.028, F.S.; providing for the adoption of rules; providing for disciplinary action; creating s. 468.315, F.S.; creating a cross-training program allowing limited radiologic technology functions to be performed by certain personnel in eligible facilities; creating s. 468.316, F.S.; establishing personnel qualifications for the program; creating s. 468.317, F.S.; providing limitations on cross-training functions; authorizing the Department of Health and Rehabilitative Services to establish program requirements by rule; creating s. 468.318, F.S.; providing for cross-training certification examinations conducted by the Department of Health and Rehabilitative Services; providing for the issuance of cross-training certification to successful applicants; providing for the adoption of rules; providing for fees; creating s. 468.319, F.S.; providing for invalidation and renewal of certification; providing for the adoption of rules; providing for disciplinary actions; creating s. 468.37, F.S.; creating a cross-training program allowing limited respiratory care functions to be performed by certain personnel in eligible facilities; creating s. 468.371, F.S.; establishing personnel qualifications for the program; creating s. 468.372, F.S.; providing limitations on cross-training functions; authorizing the Board of Medicine with the assistance of the Advisory Council on Respiratory Care to establish program requirements by rule; creating s. 468.373, F.S.; providing for cross-training certification examinations conducted by community colleges; providing for the issuance of cross-training certification to successful applicants; providing for the adoption of rules; providing for fees;

creating s. 468.374, F.S.; providing for invalidation and renewal of certification; providing for the adoption of rules; providing for disciplinary actions; creating s. 483.831, F.S.; creating a cross-training program allowing limited clinical laboratory functions to be performed by certain personnel in eligible facilities; creating s. 483.832, F.S.; establishing personnel qualifications for the program; creating s. 483.833, F.S.; providing limitations on cross-training functions; authorizing the Board of Medicine to establish program requirements by rule; creating s. 483.834, F.S.; providing for cross-training certification examinations conducted by community colleges; providing for the issuance of cross-training certification to successful applicants; providing for the adoption of rules; providing for fees; creating s. 483.835, F.S.; providing for invalidation and renewal of certification; providing for the adoption of rules; providing for disciplinary action; requiring a joint evaluation report on the program; creating s. 624.31, F.S.; requiring certain health care providers to comply with certain federal laws; creating s. 627.4239, F.S.; providing requirements for insurers in providing coverage for drugs used in the treatment of cancer; creating s. 627.6045, F.S.; specifying policy requirements with respect to preexisting conditions; amending s. 627.6472, F.S.; prescribing responsibilities of exclusive provider organizations with respect to outpatient treatment by providers of specified medical services; requiring exclusive provider organizations to offer point of service plans; limiting requirements for coinsurance; creating s. 627.6691, F.S.; providing for continuation of coverage under group health benefit plans; providing definitions; providing for notice; amending s. 627.6699, F.S.; providing applicability of the Employee Health Care Access Act with respect to plans under Florida Health Security; amending s. 641.31, F.S.; providing certain limitations on health maintenance organization contracts; creating s. 641.351, F.S.; requiring health maintenance organizations to offer point of service plans; limiting requirements for coinsurance; providing for use of a preferred provider network; amending s. 641.47, F.S., which provides definitions relating to the quality of services provided by health maintenance organizations and prepaid health clinics; revising the section and adding a definition for the terms "agency," "emergency services and care," "emergency medical condition," and "quality-of-care grievance"; amending s. 641.49, F.S., which provides an application procedure for certification of health maintenance organizations and prepaid health clinic providers; requiring a health maintenance organization to submit with its application for certification a toll-free telephone number for subscriber or enrollee assistance and a statement providing certain specified information which it will distribute to subscribers and enrollees; changing references from the Department of Health and Rehabilitative Services to the Agency for Health Care Administration; amending s. 641.495, F.S., which provides certain requirements applicable to the issuance and maintenance of a health care provider certificate; requiring an applicant for a certificate to prove its ability to provide services consistent with standards of care prescribed by ch. 394 and ch. 397, F.S.; providing for rules for evaluating the impact of the severing of provider relationships by health maintenance organizations on their ability to deliver required services; providing that a health maintenance organization may not prohibit a provider from providing services to patients enrolled in other organizations; requiring organizations to document efforts to recruit and retain minority professionals; providing guidelines for grievance procedures; providing requirements pertaining to emergency services; providing for reimbursement to persons who provide emergency services; changing references from the Department of Health and Rehabilitative Services to the Agency for Health Care Administration; requiring health maintenance organizations and prepaid health clinics to have a system for verifying and examining health care professional credentials and job descriptions; deleting the requirement for periodic review of the medical facilities and services of health maintenance organizations and prepaid health clinics; requiring organizations to have an emergency management plan; requiring the agency to adopt rules; creating the Health Care Network Negotiations and Antitrust Investigation Act; providing legislative findings; directing the presidents of specified public and private universities to designate law faculty members to serve on an advisory council to determine whether guidance provided by the federal antitrust agencies effectively meets the needs of providers in this state while protecting the interests of consumers; providing for a report; providing an appropriation to the advisory council; requiring the agency to develop recommendations regarding the appropriate placement of Medicaid skilled nursing patients in skilled nursing facilities; exempting certain facilities that provide diagnostic imaging services from the provisions of s. 455.236(4)(a), F.S., relating to patient referrals; providing appropriations and authorizing additional positions; repealing s. 407.61, F.S., relating to Health Care Cost Containment Board studies; repealing s. 408.072, F.S., relating to reviews of hospital budgets; repealing s. 408.08(2)-(13), F.S., relating to duties of

the board with respect to hospital inspections and audits; repealing s. 408.085, F.S., relating to comprehensive inpatient rehabilitation hospitals; repealing s. 455.25(2), F.S., relating to disclosure of financial interests to patients; repealing s. 16, ch. 92-178, Laws of Florida, relating to imposition of a fee schedule on providers of designated health care services and providing for retroactive applicability of such repeal; prohibiting collection of administrative fines; repealing s. 33, ch. 92-33, Laws of Florida, as amended; abrogating the transfer of the Division of Medical Quality Assurance from the Department of Business and Professional Regulation to the Agency for Health Care Administration; providing effective dates.

SENATOR WEXLER PRESIDING

Senator Hargrett moved the following amendment to **Amendment 1** which was adopted:

Amendment 1A (with Title Amendment)—On page 19, between lines 8 and 9, insert:

Section 9. Paragraph (d) of subsection (3) of section 383.14, Florida Statutes, is amended to read:

383.14 Screening for metabolic disorders, other hereditary and congenital disorders, and environmental risk factors.—

(3) DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES; POWERS AND DUTIES.—The department shall administer and provide certain services to implement the provisions of this section and shall:

(d) Maintain a confidential registry of cases, including information of importance for the purpose of followup services to prevent mental retardation, to correct or ameliorate physical handicaps, and for epidemiologic studies, if indicated. Such registry shall be exempt from the provisions of s. 119.07(1). This exemption is subject to the Open Government Sunset Review Act in accordance with s. 119.14. *The department may provide case information to any person it has under contract to provide therapeutic services and the confidential status of such case information is retained.*

All provisions of this subsection shall be coordinated with the provisions and plans established under this chapter, chapter 411, and Pub. L. No. 99-457.

Section 10. Sickle-cell program.—The Department of Health and Rehabilitative Services shall, to the extent that resources are available.

(1) Establish a program to provide for the education and screening of persons with the sickle-cell trait;

(2) Establish a statewide tracking and follow-up system for infants identified with the sickle-cell trait;

(3) Make grants and reimbursements to designated not-for-profit organizations on a statewide basis to establish and maintain programs for educating and screening of persons with the sickle-cell trait; and

(4) Monitor participating facilities for program compliance with the terms contained in service contracts.

(Renumber subsequent section.)

And the title is amended as follows:

In title, on page 175, line 1, after "networks;" insert: amending s. 383.14, F.S.; providing that confidential status is retained when the department provides case information to any persons it has under contract for therapeutic services; requiring the Department of Health and Rehabilitative Services to establish a sickle-cell program to the extent that resources are available; providing for education and screening, a statewide tracking and follow-up system, and grants and reimbursements to not-for-profit organizations;

Senator Myers moved the following amendment to **Amendment 1** which was adopted:

Amendment 1B—On page 52, strike all of lines 13-20 and insert: committee shall modify the standard benefit plan to include the following services and supplies equivalent to those provided in the Florida Health Security Plan submitted to the Legislature on December 20, 1993: outpatient and inpatient rehabilitative services; substance abuse services; and diabetic supplies, including glucose test strips, necessary to maintain the health of a diabetic person. The copayments for these services and supplies may

Senators Grant, Dudley and Crenshaw offered the following amendment to **Amendment 1** which was moved by Senator Grant and adopted:

Amendment 1C (with Title Amendment)—On page 52, line 22, after the period (.) insert: This act and the Florida Health Security benefit plan are intended to maintain the status quo on the coverage for procedures regulated under chapter 390. Such coverage is not mandatory, but is permissible.

And the title is amended as follows:

In title, on page 176, line 26, after the second semicolon (;) insert: providing that coverage under the act and the plan for procedures regulated under chapter 390, F.S., relating to terminations of pregnancy, is permissible but not mandatory;

Senator Gutman moved the following amendment to **Amendment 1** which failed:

Amendment 1D—On page 58, strike all of lines 18 and 19 and insert: be given the same choices of managed care plans, as Medicaid recipients pursuant to s. 408.7042, including community and accountable health partnerships. If the individuals and families select a community health partnership or an accountable health partnership and if emergency services are

Senator Silver moved the following amendment to **Amendment 1** which was adopted:

Amendment 1E—On page 65, line 23, after the semicolon (;) insert: provided, however, that subsections 627.419(2), (3), and (4) apply to the security health benefit plan;

Senators McKay and Forman offered the following amendments to **Amendment 1** which were moved by Senator McKay and adopted:

Amendment 1F—On page 52, line 14, after "include" insert: , outpatient and inpatient mental health services,

Amendment 1G—On page 52, line 15, after "services" insert: , substance abuse services,

Senator Foley moved the following amendment to **Amendment 1** which was adopted:

Amendment 1H—On page 46, between lines 3 and 4, insert:

(18) *Notwithstanding any other provisions of law to the contrary, accountable health partnerships may contract with specialty hospitals licensed under chapter 395.*

Senator Myers moved the following amendment to **Amendment 1** which was adopted:

Amendment 1I—On page 82, line 30, before the semicolon (;) insert: , as provided in s. 1902(a)(13)(E) of the Social Security Act

Senator Silver moved the following amendment to **Amendment 1** which was adopted:

Amendment 1J (with Title Amendment)—On page 21, between lines 7 and 8, insert:

(10)(9) The agency shall establish a demonstration project to evaluate the effectiveness of practice parameters with regard to the costs of defensive medicine and professional liability insurance.

(e) A participating physician who is named as a defendant in a cause of action accruing on or after October 1, 1994, but before October 1, 1998, may introduce evidence of compliance with the practice parameters as an affirmative defense to a liability claim. *If a participating physician raises compliance with a state-endorsed practice parameter as an affirmative defense, the patient may present rebuttal evidence to the contrary. Except as stated in this paragraph, this section does not change existing burdens of proof or rules of evidence.*

(f) The agency shall review the demonstration project and shall make recommendations to the Legislature by December 31, 1994, as to the effectiveness of practice parameters on reducing the cost of defensive medicine and professional liability insurance and whether using proof of compliance with the parameters as an affirmative defense *as set forth in paragraph (e)* should apply to all physicians who practice in conformity with the appropriate practice parameters.

(Renumber subsequent section.)

And the title is amended as follows:

In title, on page 175, line 11, after the first semicolon (;) insert: amending s. 408.02, F.S.; revising provisions pertaining to the demonstration project on practice parameters which relate to defenses to certain liability claims;

Senator Hargrett moved the following amendment to **Amendment 1** which was adopted:

Amendment 1K (with Title Amendment)—On page 120, between lines 2 and 3, insert:

Section 51. Paragraphs (d) and (m) of subsection (3) of section 455.236, Florida Statutes, are amended to read:

455.236 Financial arrangements between referring health care providers and providers of health care services.—

(3) DEFINITIONS.—For the purpose of this section, the word, phrase, or term:

(d) "Designated health services" means, for purposes of this section, clinical laboratory services, physical therapy services, *pharmacy services*, comprehensive rehabilitative services, diagnostic imaging services, and radiation therapy services.

(m) "Referral" means any referral of a patient by a health care provider for health care services, including, without limitation:

1. The forwarding of a patient by a health care provider to another health care provider or to an entity *that* which provides or supplies designated health services or any other health care item or service; or

2. The request or establishment of a plan of care by a health care provider, which includes the provision of designated health services or other health care item or service.

3. Except for the purposes of s. 455.239, the following orders, recommendations, or plans of care *do shall* not constitute a referral by a health care provider:

a. By a radiologist for diagnostic imaging services.

b. By a physician specializing in the provision of radiation therapy services for such services.

c. By a medical oncologist for drugs and solutions to be prepared and administered intravenously to such oncologist's patient, as well as for the supplies and equipment used in connection therewith to treat such patient for cancer and the complications thereof.

d. By a cardiologist for cardiac catheterization services.

e. By a pathologist for diagnostic clinical laboratory tests and pathological examination services, if furnished by or under the supervision of such pathologist pursuant to a consultation requested by another physician.

f. By a health care provider who is the sole provider or member of a group practice for designated health services or other health care items or services that are prescribed or provided solely for such referring health care provider's or group practice's own patients, and that are provided or performed by or under the direct supervision of such referring health care provider or group practice.

g. By a health care provider for services provided by an ambulatory surgical center licensed under chapter 395.

h. By a health care provider for diagnostic clinical laboratory services where such services are directly related to renal dialysis.

i. By a urologist for lithotripsy services.

j. By a dentist for dental services performed by an employee of or health care provider who is an independent contractor with the dentist or group practice of which the dentist is a member.

k. By a physician for infusion therapy services to a patient of that physician or a member of that physician's group practice.

l. By a nephrologist for renal dialysis services and supplies.

m. By a radiologist for radio-pharmaceuticals consumed at his office.

n. By a physician providing pharmaceuticals to his patients, if the pharmaceuticals are valued at less than \$100 per prescription or the pharmaceuticals are consumed at his office.

(Renumber subsequent section.)

And the title is amended as follows:

In title, on page 181, line 26, after "report;" insert: amending s. 455.236, F.S.; including pharmacy services as designated health services for purposes of restrictions on referrals; providing exclusions for certain pharmacy services;

Senators Turner and Jones offered the following amendment to **Amendment 1** which was moved by Senator Jones and adopted:

Amendment 1L—On page 96, strike all of lines 10-13 and insert: risk fee. However, midwives licensed under chapter 467 shall not receive Medicaid reimbursement for home deliveries conducted for Medicaid recipients, but shall be reimbursed for prenatal and post-partal care provided to such recipients. The

THE PRESIDENT PRESIDING

RECONSIDERATION OF AMENDMENT

On motion by Senator Myers, the Senate reconsidered the vote by which **Amendment 1K** was adopted.

POINT OF ORDER

Senator Myers raised a point of order that pursuant to Rule 7.1, **Amendment 1K** contained language of a bill not reported favorably by a Senate committee and was therefore out of order.

RULING ON POINT OF ORDER

On recommendation of Senator Kirkpatrick, Chairman of the Committee on Rules and Calendar, the President ruled the point well taken and the amendment out of order.

MOTION

On motion by Senator Hargrett, by two-thirds vote, Rule 7.1 was waived to allow consideration of **Amendment 1K**.

The question recurred on **Amendment 1K** which was adopted.

RECONSIDERATION OF AMENDMENT

On motion by Senator Sullivan, the Senate reconsidered the vote by which **Amendment 1L** was adopted. The question recurred on **Amendment 1L** which was adopted.

Senator Diaz-Balart moved the following amendment to **Amendment 1** which was adopted:

Amendment 1M (with Title Amendment)—On page 120, between lines 2 and 3, insert:

Section 50. Section 461.018, Florida Statutes, is created to read:

461.018 Limited scope of practice; area of need.—Those persons holding valid certificates on October 1, 1991, who were certified pursuant to chapters 88-205 and 88-392, Laws of Florida; and who have been practicing under a board-approved protocol for at least 2 years are eligible to receive a license to practice without supervision under their present limited scope of practice of the nonsurgical treatment of corns, calluses, and ingrown toenails in a specially designated area of need as provided by rule of the board.

(Renumber subsequent sections)

And the title is amended as follows:

In title, on page 181, line 26, after the second semicolon (;) insert: creating s. 461.018, F.S.; providing for limited scope of practice of podiatric medicine within a specified area of need;

Senator Kiser moved the following amendment to **Amendment 1**:

Amendment 1N (with Title Amendment)—On page 137, between lines 4 and 5, insert:

Section 73. Subsection (1) of section 627.410, Florida Statutes, is amended to read:

627.410 Filing, approval of forms.—

(1)(a) A ~~Ne~~ basic insurance policy or annuity contract form, or application form where written application is required and is to be made a part of the policy or contract, or group certificates issued under a master contract ~~delivered in this state~~, or printed rider or endorsement form or form of renewal certificate, ~~may not shall~~ be delivered or issued for delivery in this state, unless the form has been filed with the department at its offices in Tallahassee by or in behalf of the insurer which proposes to use such form and has been approved by the department.

(b) ~~In addition to the exception in s. 627.6515(2)(f), this provision does not apply to surety bonds or to specially rated inland marine risks, nor to policies, riders, endorsements, or forms of unique character which are designed for and used with relation to insurance upon a particular subject (other than as to health insurance), or which relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or health insurance policies and are used at the request of the individual policyholder, contract holder, or certificateholder. As to group insurance policies effectuated and delivered outside this state but covering persons resident in this state, the group certificates to be delivered or issued for delivery in this state shall be filed with the department for information purposes only.~~

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 184, line 12, after the semicolon (;) insert: amending s. 627.410, F.S.; deleting provisions that prevent certain group insurance certificates to be filed for informational purposes only;

POINT OF ORDER

Senator Holzendorf raised a point of order that pursuant to Rule 7.1 **Amendment 1N** contained language of a bill not reported favorably by a Senate committee and was therefore out of order.

Further consideration of **Amendment 1N** was deferred.

Senator Grant moved the following amendment to **Amendment 1** which was adopted:

Amendment 1O (with Title Amendment)—On page 137, between lines 4 and 5, insert:

Section 73. Effective October 1, 1994, paragraph (a) of subsection (1) of section 627.4233, Florida Statutes, is amended to read:

627.4233 Total disability defined.—

(1) If an individual or group policy of disability income insurance provides for the waiver of premiums or payment of claims upon total disability:

(a) The policy must, at a minimum, provide that for the first 12 months of the disability, a person is totally disabled if the person is unable to perform ~~any~~ of the material and substantial duties of the person's regular occupation, or must include a provision at least as favorable to the insured.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 184, line 12, after the semicolon (;) insert: amending s. 627.4233, F.S.; clarifying certain provisions relating to the definition of total disability;

Senator Silver moved the following amendment to **Amendment 1**:

Amendment 1P—On page 95, strike all of lines 14-17 and insert: ~~Administration shall seek the advice of a 19-member 16-member advisory panel in formulating and adopting the fee schedule. The panel shall consist of Medicaid physicians licensed under chapters 458, and 459, 460, and 461, and shall be composed~~

Senator Dudley moved the following substitute amendment which was adopted:

Amendment 1Q—On page 95, strike all of lines 14-17 and insert: Administration shall seek the advice of a 19-member 16-member advisory panel in formulating and adopting the fee schedule. The panel shall consist of Medicaid physicians licensed under chapters 458, and 459, 460, 461 and 463 and shall be composed

Senator Grant moved the following amendment to **Amendment 1** which failed:

Amendment 1R (with Title Amendment)—On page 137, between lines 4 and 5, insert:

Section 73. Effective October 1, 1994, paragraph (a) of subsection (1) of section 627.4233, Florida Statutes, is amended to read:

627.4233 Total disability defined.—

(1) If an individual or group policy of disability income insurance provides for the waiver of premiums or payment of claims upon total disability:

(a) The policy must, at a minimum, provide that for the first 12 months of the disability, a person is totally disabled if the person is unable to perform any of the material and substantial duties of the person's regular occupation, or must include a provision at least as favorable to the insured.

Section 74. Effective October 1, 1994, subsection (2) of section 627.6561, Florida Statutes, is renumbered as subsection (3) and amended, and a new subsection (2) is added to said section, to read:

627.6561 Preexisting condition.—A group health insurance policy must comply with the following provisions:

(2) Notwithstanding the provisions of subsection (1), group policies that provide coverage for loss of income due to a disability may contain a provision excluding coverage for preexisting conditions. Coverage for disability due to preexisting conditions may be excluded when the disability begins within 12 months following the effective date of an insured's coverage.

(3) In determining whether a preexisting condition provision applies to an eligible insured or dependent, credit must be given for the time the person was covered under previous coverage if the previous coverage was similar to or exceeded the coverage provided under the new policy and if the previous coverage was continuous to a date not more than 30 days prior to the effective date of the new coverage, exclusive of any applicable waiting period under the plan.

Section 75. Except as otherwise provided in this bill, this bill shall take effect July 1, 1994.

And the title is amended as follows:

In title, on page 184, line 12, after the semicolon (;) insert: amending s. 627.4233, F.S.; clarifying certain provisions relating to the definition of total disability; amending s. 627.6561, F.S.; authorizing certain group policies to exclude coverage for preexisting conditions under certain circumstances; revising a time limitation for coverage of preexisting conditions;

The vote was:

Yeas—11 Nays—21

Senator Silver moved the following amendment to **Amendment 1**:

Amendment 1S (with Title Amendment)—On page 120, between lines 2 and 3, insert:

Section 50. Paragraph (k) of subsection (3) of section 455.236, Florida Statutes, is amended to read:

455.236 Financial arrangements between referring health care providers and providers of health care services.—

(3) DEFINITIONS.—For the purpose of this section, the word, phrase, or term:

(k) "Investment interest" means an equity or debt security issued by an entity, including, without limitation, shares of stock in a corporation, units or other interests in a partnership, bonds, debentures, notes, or

other equity interests or debt instruments. Except for purposes of s. 455.239, the following investment interests shall be excepted from this definition:

1. An investment interest in an entity that is the sole provider of designated health services in a rural area;

2. An investment interest in notes, bonds, debentures, or other debt instruments issued by an entity which provides designated health services, as an integral part of a plan by such entity to acquire such investor's equity investment interest in the entity, provided that the interest rate is consistent with fair market value, and that the maturity date of the notes, bonds, debentures, or other debt instruments issued by the entity to the investor is not later than October 1, 1996.

3. An investment interest in real property resulting in a landlord-tenant relationship between the health care provider and the entity in which the equity interest is held, unless the rent is determined, in whole or in part, by the business volume or profitability of the tenant or exceeds fair market value; or

4. An investment interest in an entity which owns or leases and operates a hospital licensed under chapter 395 or a nursing home facility licensed under chapter 400.

5. An investment interest in an entity which operates or owns a clinical laboratory provided that interest is in registered securities issued by a publicly held corporation:

a. Whose shares are traded on a national exchange or on the over-the-counter market; and

b. Whose total assets at the end of the corporation's most recent fiscal quarter exceeded \$100 million.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 181, line 26, after the second semicolon (;) insert: amending s. 455.236, F.S.; redefining the term "investment interest," with respect to financing arrangements between certain health care providers and service providers;

Senator Dudley moved the following substitute amendment which was adopted:

Amendment 1T (with Title Amendment)—On page 120, between lines 2 and 3, insert:

Section 50. Paragraph (k) of subsection (3) of section 455.236, Florida Statutes, is amended to read:

455.236 Financial arrangements between referring health care providers and providers of health care services.—

(3) DEFINITIONS.—For the purpose of this section, the word, phrase, or term:

(k) "Investment interest" means an equity or debt security issued by an entity, including, without limitation, shares of stock in a corporation, units or other interests in a partnership, bonds, debentures, notes, or other equity interests or debt instruments. Except for purposes of s. 455.239, the following investment interests shall be excepted from this definition:

1. An investment interest in an entity that is the sole provider of designated health services in a rural area;

2. An investment interest in notes, bonds, debentures, or other debt instruments issued by an entity which provides designated health services, as an integral part of a plan by such entity to acquire such investor's equity investment interest in the entity, provided that the interest rate is consistent with fair market value, and that the maturity date of the notes, bonds, debentures, or other debt instruments issued by the entity to the investor is not later than October 1, 1996.

3. An investment interest in real property resulting in a landlord-tenant relationship between the health care provider and the entity in which the equity interest is held, unless the rent is determined, in whole or in part, by the business volume or profitability of the tenant or exceeds fair market value; or

4. An investment interest in an entity which owns or leases and operates a hospital licensed under chapter 395 or a nursing home facility licensed under chapter 400.

5. An investment interest in an entity which operates or owns a clinical laboratory provided that interest is in registered securities issued by a publicly held corporation:

a. Whose shares are traded on a national exchange or on the over-the-counter market; and

b. Whose total assets at the end of the corporation's most recent fiscal quarter exceeded \$100 million.

c. No more than 5 percent of whose shares are owned by physicians.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 181, line 26, after the second semicolon (;) insert: redefining the term "investment interest," with respect to financing arrangements between certain health care providers and service providers;

Senator Dudley moved the following amendment to **Amendment 1**:

Amendment 1U (with Title Amendment)—On page 120, between lines 2 and 3, insert:

Section 50. Section 455.239, Florida Statutes, is amended to read:

455.239 Designated health care services; licensure required.—

(1) An entity, as defined in s. 455.236, which furnishes designated health care services may not operate in this state unless licensed by the Agency for Health Care Administration ~~Department of Health and Rehabilitative Services~~ pursuant to subsection (2).

(2) The ~~agency department~~ shall adopt rules for licensing requirements for designated health care services including, but not limited to, rules providing for:

(a) A licensure fee of not less than \$400 and not more than \$1,500 to be assessed annually;

(b) Parameters of quality with respect to the provision of ancillary services by respective entities;

(c) Periodic inspection of the facilities of an entity for the purpose of evaluating the premises, operation, supervision, and procedures of the entity to ensure compliance with quality parameters as established in ~~agency department~~ rules; ~~and~~

(d) The submission by an entity of information on its ownership, including identification of the owners who are health care providers, as defined in s. 455.236 ~~s. 455.251~~, and each investor's percentage of ownership.

(e) Denial or revocation of licensure if the information submitted discloses that a referring physician is an investor in an outpatient, nongroup practice clinic that offers designated health services.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 181, line 26, after the second semicolon (;) insert: amending s. 455.239, F.S.; providing for the Agency for Health Care Administration to license certain entities; providing for the agency to deny or revoke licensure under certain circumstances;

Senator Dudley moved the following substitute amendment which was adopted:

Amendment 1V (with Title Amendment)—On page 120, between lines 2 and 3, insert:

Section 50. Section 455.239, Florida Statutes, is amended to read:

455.239 Designated health care services; licensure required.—

(1) An entity, as defined in s. 455.236, which furnishes designated health care services may not operate in this state unless licensed by the Agency for Health Care Administration ~~Department of Health and Rehabilitative Services~~ pursuant to subsection (2).

(2) The ~~agency department~~ shall adopt rules for licensing requirements for designated health care services including, but not limited to, rules providing for:

(a) A licensure fee of not less than \$400 and not more than \$1,500 to be assessed annually;

(b) Parameters of quality with respect to the provision of ancillary services by respective entities;

(c) Periodic inspection of the facilities of an entity for the purpose of evaluating the premises, operation, supervision, and procedures of the entity to ensure compliance with quality parameters as established in ~~agency department~~ rules; ~~and~~

(d) The submission by an entity of information on its ownership, including identification of the owners who are health care providers, as defined in s. 455.236 ~~s. 455.251~~, and each investor's percentage of ownership.

(e) Denial or revocation of licensure if the information submitted discloses that a referring physician is a prohibited investor in an outpatient, nongroup practice clinic that offers designated health services.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 181, line 26, after the second semicolon (;) insert: amending s. 455.239, F.S.; providing for the Agency for Health Care Administration to license certain entities; providing for the agency to deny or revoke licensure under certain circumstances;

Senator Williams moved the following amendment to **Amendment 1** which was adopted:

Amendment 1W (with Title Amendment)—On page 137, between lines 4 and 5, insert:

Section 73. Subsection (3) of section 627.641, Florida Statutes, is amended to read:

627.641 Coverage for newborn children.—

(3) This section does not apply to disability income, dental, specified-disease, Medicare supplement, or hospital indemnity policies or to normal maternity policy provisions applicable to the mother.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 184, line 12, after the semicolon (;) insert: amending s. 627.641, F.S.; providing that the required coverage for newborn children does not apply to dental, specified-disease, or Medicaid supplement policies;

RECONSIDERATION OF AMENDMENT

On motion by Senator Hargrett, the Senate reconsidered the vote by which **Amendment 1W** was adopted. **Amendment 1W** was withdrawn.

Senator Jenne offered the following amendment to **Amendment 1** which was moved by Senator Forman and adopted:

Amendment 1X—On page 137, line 11, after "a" insert: United States

Senator Kiser moved the following amendment to **Amendment 1**:

Amendment 1Y (with Title Amendment)—On page 138, between lines 11 and 12, insert:

Section 74. Section 627.430, Florida Statutes, is created to read:

627.430 Individual health coverage; policies issued.—

(1) DEFINITIONS.—As used in this section, the term:

(a) "Guaranteed-issue basis" means an insurance policy that must be offered to an individual or dependent of the individual, regardless of health status, preexisting conditions, or claims history.

(b) "Health benefit plan" means any hospital or medical policy or certificate, hospital or medical service plan contract, or health maintenance

organization subscriber contract. The term does not include accident-only, specified disease, individual hospital indemnity, credit, dental-only, vision-only Medicare supplement, long-term care, or disability income insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical-payment insurance.

(c) "Individual carrier" means a carrier that offers health benefit plans that are issued to individuals, where the individual is a policy owner or the individual is a certificateholder under a policy issued inside or outside of Florida.

(e) "Modified community rating" means a method used to develop carrier premiums which spreads financial risk across a large population and allows adjustments for age, family composition, tobacco usage, and geographic area no smaller than a county line.

(f) "Qualifying previous coverage" and "qualifying existing coverage" mean benefits or coverage provided under:

1. An employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health plan; including benefits provided pursuant to COBRA; or

2. An individual health insurance policy, including coverage issued by a health maintenance organization, a fraternal benefit society, or a multiple-employer welfare arrangement, that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that such policy has been in effect in Florida for a period of at least 1 year, including, but not limited to, an individual conversion policy or contract issued pursuant to s. 627.6675 or s. 641.3922 or health benefit plans issued pursuant to the Florida Health Security Act of 1994.

(2) **AVAILABILITY OF COVERAGE.**—Beginning January 1, 1995, every individual carrier issuing health benefit plans to individuals in this state must, as a condition of transacting business in this state, offer all health benefit plans, including the Standard and Basic plans developed under s. 627.6699(12), on a guarantee-issue basis to any individual who was covered under qualifying previous coverage which was continuous to a date not more than 62 days before the date of application and who elects to be covered under the plan and agrees to make the required premium payments under the plan and satisfy other provisions of the plan. The Standard and Basic plans offered must be rated using modified community rating.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 184, line 15, after the semicolon (;) insert: creating s. 627.430, F.S.; providing for individual health coverage and policy issuance requirements;

POINT OF ORDER

Senator Holzendorf raised a point of order that pursuant to Rule 7.1 **Amendment 1Y** contained language of a bill not reported favorably by a Senate committee and was therefore out of order.

Further consideration of **Amendment 1Y** was deferred.

Senator Dudley moved the following amendment to **Amendment 1** which was adopted:

Amendment 1Z (with Title Amendment)—On page 148, strike all of lines 8-20 and insert:

Section 77. Paragraph (a) of subsection (4) and paragraph (a) of subsection (12) of section 627.6699, Florida Statutes, are amended to read:

627.6699 Employee Health Care Access Act.—

(4) **APPLICABILITY AND SCOPE.**—

(a) This section applies to a health benefit plan that provides coverage to a small employer in this state, unless the policy is marketed directly to the individual employee, and the employer does not participate in the collection or distribution of premiums or facilitate the administration of the policy in any manner. *This section does not apply to a health benefit plan issued under the Florida Health Security Act or to a carrier that issues coverage under the Florida Health Security Act.*

(12) **STANDARD, BASIC, AND LIMITED HEALTH BENEFIT PLANS.**—

(a)1. By May 15, 1993, the commissioner shall appoint a health benefit plan committee composed of four representatives of carriers which shall include at least two representatives of HMOs, at least one of which is a staff model HMO, two representatives of agents, four representatives of small employers, and one employee of a small employer, and two consumers. The carrier members shall be selected from a list of individuals recommended by the board. The commissioner may require the board to submit additional recommendations of individuals for appointment. As alliances are established under s. 408.702, each alliance shall also appoint an additional member to the committee.

2. The committee shall develop changes to the form and level of coverages for the standard health benefit plan and the basic health benefit plan, and shall submit the forms, and levels of coverages to the department by September 30, 1993. The department must approve such forms and levels of coverages by November 30, 1993, and may return the submissions to the committee for modification on a schedule that allows the department to grant final approval by November 30, 1993.

3. The plans shall comply with all of the requirements of this subsection.

4. The plans must be filed with and approved by the department prior to issuance or delivery by any small employer carrier.

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

And the title is amended as follows:

In title, on page 184, line 31, after the first semicolon (;) insert: adding two consumer members to the health benefit plan committee;

Senator Myers moved the following amendment to **Amendment 1** which was adopted:

Amendment 1AA—On page 148, line 20, insert: *The health benefit committee shall modify the Department of Insurance standard benefit plan to include the following services and supplies equivalent to those provided in the Florida Health Security Plan submitted to the Legislature on December 20, 1993: outpatient and inpatient rehabilitative services; substance abuse services; and diabetic supplies, including glucose test strips, necessary to maintain the health of a diabetic person. The copayments for these services and supplies may be adjusted as necessary to*

Senator Bankhead moved the following amendment to **Amendment 1** which was adopted:

Amendment 1BB (with Title Amendment)—On page 149, between lines 6 and 7, insert:

(26) *For subscribers who are residents of a continuing care facility certified under chapter 651 or a retirement facility consisting of a nursing home and residential apartments, the subscriber's primary care physician shall refer the subscriber to the retirement facility's skilled nursing facility or on site licensed home health agency, if the primary care physician finds that it is in the best interest of the patient, the facility agrees to be reimbursed at the HMO's contract rate negotiated with similar providers for the same services and supplies, and the facility meets all guidelines established by the health maintenance organization related to quality of care, utilization, referral authorization, risk assumption, use of the HMO's network, and other criteria applicable to providers under contract for the same services and supplies.*

And the title is amended as follows:

In title, on page 185, line 2, following the semicolon (;) insert: prescribing responsibilities of the primary care physician of a subscriber who is a resident of a continuing care facility or retirement facility;

Senator Dudley moved the following amendment to **Amendment 1**:

Amendment 1CC (with Title Amendment)—On page 170, between lines 2 and 3, insert:

Section 87. Section 464.0125, Florida Statutes, is created to read:

464.0125 Prescribing medicinal drugs.—An advanced registered nurse practitioner licensed and certified pursuant to this chapter is authorized to prescribe medicinal drugs as defined in s. 465.003, including controlled substances as defined in s. 893.03(3), (4), and (5); diphenylxalate; and methylphenidate. In addition, an advanced registered nurse practitioner certified as a nurse anesthetist pursuant to s. 464.012 is authorized to order controlled substances as defined in s. 893.031(2). Prescribing shall be undertaken pursuant to s. 395.0191 and to standing protocols and general physician supervision as required by s. 464.003(3)(c) and, as to nurse anesthetists, pursuant to the provisions of s. 464.012(4)(a). A prescription written by an advanced registered nurse practitioner may be filled only in a pharmacy that is permitted or registered under chapter 465 and may be dispensed only by a pharmacist licensed under chapter 465, unless the dispensing is done in a manner consistent with a special pharmacy permit issued pursuant to s. 465.0196.

Section 88. Section 465.0265, Florida Statutes, is created to read:

465.0265 Dispensing of prescriptions written by advanced registered nurse practitioners.—A prescription written by an advanced registered nurse practitioner constitutes prima facie evidence that the prescription is valid. A pharmacist is authorized to dispense the medicinal drugs described in s. 464.0125 pursuant to such a prescription. A pharmacist may conclusively presume that a prescription written by an advanced registered nurse practitioner is issued pursuant to a valid protocol. A pharmacist has no duty or responsibility to verify the existence of a protocol authorizing the prescription. Each such prescription shall contain the license number of the advanced registered nurse practitioner, or, if an oral prescription, the pharmacist shall write the license number on the written record of the oral prescription. The dispensing pharmacist shall write the license number on the prescription label. Reasonable reliance upon a prescription written by an advanced registered nurse practitioner does not subject a pharmacist to any civil, criminal, or administrative action.

Section 89. Subsection (18) of section 893.02, Florida Statutes, is amended to read:

893.02 Definitions.—The following words and phrases as used in this chapter shall have the following meanings, unless the context otherwise requires:

(18) "Practitioner" means a physician licensed pursuant to chapter 458; a dentist licensed pursuant to chapter 466; a veterinarian licensed pursuant to chapter 474; an osteopathic physician licensed pursuant to chapter 459; a naturopath licensed pursuant to chapter 462; or a podiatrist licensed pursuant to chapter 461, provided such practitioner holds a valid federal controlled substance registry number; or an advanced registered nurse practitioner licensed pursuant to chapter 464 and subject to ss. 395.0191 and 464.0125.

And the title is amended as follows:

In title, on page 187, line 16, after the semicolon (;) insert: creating s. 464.0125, F.S.; authorizing advanced registered nurse practitioners who meet certain criteria to prescribe certain medicinal drugs; creating s. 465.0265, F.S.; authorizing advanced registered nurse practitioners to prescribe drugs; authorizing pharmacists to dispense drugs under such prescriptions; providing that reasonable reliance upon a prescription written by an advanced registered nurse practitioner does not subject a pharmacist to civil, criminal, or administrative action; amending s. 893.02, F.S.; revising the definition of the term "practitioner," as used in the Florida Comprehensive Drug Abuse Prevention and Control Act, to include an advanced registered nurse practitioner;

Senator Sullivan moved the following substitute amendment which was adopted:

Amendment 1DD (with Title Amendment)—On page 170, between lines 2 and 3, insert:

Section 87. Section 464.0125, Florida Statutes, is created to read:

464.0125 Prescribing medicinal drugs.—An advanced registered nurse practitioner licensed and certified pursuant to this chapter is authorized to prescribe medicinal drugs as defined in s. 465.003, including controlled substances as defined in s. 893.03(3), (4), and (5); diphenylxalate; and methylphenidate. In addition, an advanced registered nurse practitioner certified as a nurse anesthetist pursuant to s. 464.012 and s. 395.0191 is authorized to order controlled substances as defined in s. 893.031(2). Prescribing shall be undertaken pursuant to s. 395.0191 and

to standing protocols and general physician supervision as required by s. 464.003(3)(c) and, as to nurse anesthetists, pursuant to the provisions of s. 464.012(4)(a). A prescription written by an advanced registered nurse practitioner may be filled only in a pharmacy that is permitted or registered under chapter 465 and may be dispensed only by a pharmacist licensed under chapter 465, unless the dispensing is done in a manner consistent with a special pharmacy permit issued pursuant to s. 465.0196.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 187, line 16, after the semicolon (;) insert: creating s. 464.0125, F.S.; authorizing advanced registered nurse practitioners who meet certain criteria to prescribe certain medicinal drugs;

Further consideration of CS for CS for SB 3060 as amended was deferred.

On motion by Senator Wexler, the rules were waived by unanimous consent and the Senate reverted to introduction for the purpose of introducing the following bill outside the extended call:

INTRODUCTION OF BILL

By Senator Wexler—

SB 3174—A bill to be entitled An act relating to taxation; amending s. 212.08, F.S.; providing an exemption for labor charges for repair and maintenance of certain aircraft; amending s. 69.041(4), F.S., as added by s. 2, House Bill 2557 (1994), which provides requirements relating to the right of the Department of Revenue to participate in the disbursement of surplus funds in mortgage foreclosure actions; clarifying applicability of those requirements; amending s. 125.0104, F.S., as amended by s. 3, House Bill 2557 (1994); clarifying applicability of changes related to the local collection and administration of tourist development taxes; amending s. 44, House Bill 2557 (1994); clarifying when an amendment by that act to s. 193.1142, F.S., which prescribes a requirement for assessment rolls, takes effect; amending s. 46, House Bill 2557 (1994); clarifying when certain amendments by that act to s. 196.011, F.S., relating to applications for tax exemption, take effect; amending s. 196.101, F.S., as amended by s. 36, House Bill 2557 (1994), relating to the exemption for totally and permanently disabled persons; conforming the physician's certification to changes made by that act; amending s. 199.232, F.S.; clarifying the time period within which a refund of intangible personal property tax may not be made; amending s. 212.05, F.S., as amended by s. 8, House Bill 2557 (1994), relating to the sales, storage, and use tax; clarifying applicability of an exemption for charges for detective, burglar protection, and other protection security services which was enacted by that act; amending s. 212.18, F.S., as amended by s. 12, House Bill 2557 (1994), to restore the amount of the sales tax dealer registration fees which was changed without coding indicating that a change was being made; amending s. 215.26, F.S., as amended by s. 50, House Bill 2557 (1994), relating to repayment of funds erroneously paid into the State Treasury; clarifying exceptions to applicability which were enacted by that act; amending s. 220.727, F.S., as amended by s. 51, House Bill 2557 (1994); clarifying when payments of estimated tax are deemed paid; revising internal cross-references to conform to the reorganization of the section by that act; amending s. 74, House Bill 2557 (1994), which amends s. 320.131, F.S., relating to temporary tags; delaying the effective date of the fee increase made by that act; repealing ss. 18 and 19, House Bill 2557 (1994), which amend s. 624.5091, F.S., effective July 1, 1994, relating to insurer retaliatory provisions; to clarify the applicability of that section to certain taxes and assessments; reenacting similar provisions effective upon becoming a law; providing for retroactive operation in part; providing effective dates.

—which was read by title.

On motions by Senator Wexler, by unanimous consent, **SB 3174** was taken up out of order and by two-thirds vote read the second time by title.

Further consideration of **SB 3174** was deferred.

RECESS

On motion by Senator Bankhead, the Senate recessed at 1:06 p.m. to reconvene at 2:30 p.m.

AFTERNOON SESSION

The Senate was called to order by the President at 2:44 p.m. A quorum present—39:

Mr. President	Dantzler	Hargrett	Myers
Bankhead	Diaz-Balart	Holzendorf	Scott
Beard	Dudley	Jenne	Siegel
Boczar	Dyer	Jennings	Silver
Brown-Waite	Foley	Johnson	Sullivan
Burt	Forman	Jones	Turner
Casas	Grant	Kiser	Weinstein
Childers	Grogan	Kurth	Wexler
Crenshaw	Gutman	McKay	Williams
Crist	Harden	Meadows	

SPECIAL AND CONTINUING ORDER

The Senate resumed consideration of—

SB 3174—A bill to be entitled An act relating to taxation; amending s. 212.08, F.S.; providing an exemption for labor charges for repair and maintenance of certain aircraft; amending s. 69.041(4), F.S., as added by s. 2, House Bill 2557 (1994), which provides requirements relating to the right of the Department of Revenue to participate in the disbursement of surplus funds in mortgage foreclosure actions; clarifying applicability of those requirements; amending s. 125.0104, F.S., as amended by s. 3, House Bill 2557 (1994); clarifying applicability of changes related to the local collection and administration of tourist development taxes; amending s. 44, House Bill 2557 (1994); clarifying when an amendment by that act to s. 193.1142, F.S., which prescribes a requirement for assessment rolls, takes effect; amending s. 46, House Bill 2557 (1994); clarifying when certain amendments by that act to s. 196.011, F.S., relating to applications for tax exemption, take effect; amending s. 196.101, F.S., as amended by s. 36, House Bill 2557 (1994), relating to the exemption for totally and permanently disabled persons; conforming the physician's certification to changes made by that act; amending s. 199.232, F.S.; clarifying the time period within which a refund of intangible personal property tax may not be made; amending s. 212.05, F.S., as amended by s. 8, House Bill 2557 (1994), relating to the sales, storage, and use tax; clarifying applicability of an exemption for charges for detective, burglar protection, and other protection security services which was enacted by that act; amending s. 212.18, F.S., as amended by s. 12, House Bill 2557 (1994), to restore the amount of the sales tax dealer registration fees which was changed without coding indicating that a change was being made; amending s. 215.26, F.S., as amended by s. 50, House Bill 2557 (1994), relating to repayment of funds erroneously paid into the State Treasury; clarifying exceptions to applicability which were enacted by that act; amending s. 220.727, F.S., as amended by s. 51, House Bill 2557 (1994); clarifying when payments of estimated tax are deemed paid; revising internal cross-references to conform to the reorganization of the section by that act; amending s. 74, House Bill 2557 (1994), which amends s. 320.131, F.S., relating to temporary tags; delaying the effective date of the fee increase made by that act; repealing ss. 18 and 19, House Bill 2557 (1994), which amend s. 624.5091, F.S., effective July 1, 1994, relating to insurer retaliatory provisions; to clarify the applicability of that section to certain taxes and assessments; reenacting similar provisions effective upon becoming a law; providing for retroactive operation in part; providing effective dates.

—which had been previously considered this day.

Senator Foley moved the following amendment which failed:

Amendment 1 (with Title Amendment)—On page 3, strike lines 6-14 and insert:

Section 1. Effective October 1, 1994, paragraph (b) of subsection (5) of section 212.08, Florida Statutes, is amended and paragraph (ee) is added to subsection (7) of that section, to read:

212.08 Sales, rental, use, consumption, distribution, and storage tax; specified exemptions.—The sale at retail, the rental, the use, the consumption, the distribution, and the storage to be used or consumed in this state of the following are hereby specifically exempt from the tax imposed by this part.

(5) EXEMPTIONS; ACCOUNT OF USE.—

(b) Machinery and equipment used to increase productive output.—

1. Industrial machinery and equipment purchased for use in new businesses which manufacture, process, compound, or produce for sale, or for exclusive use in spaceport activities as defined in s. 212.02, items of tangible personal property at fixed locations are exempt from the tax imposed by this chapter upon an affirmative showing by the taxpayer to the satisfaction of the department that such items are used in a new business in this state. Such purchases must be made prior to the date the business first begins its productive operations, and delivery of the purchased item must be made within 12 months of that date.

2. Industrial machinery and equipment purchased for use in expanding manufacturing facilities or plant units which manufacture, process, compound, or produce for sale, or for exclusive use in spaceport activities as defined in s. 212.02, items of tangible personal property at fixed locations in this state are exempt from any amount of tax imposed by this chapter in excess of \$100,000 per calendar year upon an affirmative showing by the taxpayer to the satisfaction of the department that such items are used to increase the productive output of such expanded business by not less than 10 percent.

3.a. To receive an exemption provided by subparagraph 1. or subparagraph 2., a qualifying business entity shall apply to the department for a temporary tax exemption permit. The application shall state that a new business exemption or expanded business exemption is being sought. Upon a tentative affirmative determination by the department pursuant to subparagraph 1. or subparagraph 2., the department shall issue such permit.

b. The applicant shall be required to maintain all necessary books and records to support the exemption. Upon completion of purchases of qualified machinery and equipment pursuant to subparagraph 1. or subparagraph 2., the temporary tax permit shall be delivered to the department or returned to the department by certified or registered mail.

c. If, in a subsequent audit conducted by the department, it is determined that the machinery and equipment purchased as exempt under subparagraph 1. or subparagraph 2. did not meet the criteria mandated by this paragraph or if commencement of production did not occur, the amount of taxes exempted at the time of purchase shall immediately be due and payable to the department by the business entity, together with the appropriate interest and penalty, computed from the date of purchase, in the manner prescribed by this chapter.

d. In the event a qualifying business entity fails to apply for a temporary exemption permit or if the tentative determination by the department required to obtain a temporary exemption permit is negative, a qualifying business entity shall receive the exemption provided in subparagraph 1. or subparagraph 2. through a refund of previously paid taxes. No refund may be made for such taxes unless the criteria mandated by subparagraph 1. or subparagraph 2. have been met and commencement of production has occurred.

4. The department shall promulgate rules governing applications for, issuance of, and the form of temporary tax exemption permits; provisions for recapture of taxes; and the manner and form of refund applications and may establish guidelines as to the requisites for an affirmative showing of increased productive output, commencement of production, and qualification for exemption.

5. The exemptions provided in subparagraphs 1. and 2. do not apply to machinery or equipment purchased or used by electric utility companies, communications companies, phosphate or other solid minerals severance, mining, or processing operations, oil or gas exploration or production operations, ~~printing or publishing firms~~, any firm subject to regulation by the Division of Hotels and Restaurants of the Department of Business Regulation, or any firm which does not manufacture, process, compound, or produce for sale, or for exclusive use in spaceport activities as defined in s. 212.02, items of tangible personal property.

6. For the purposes of the exemptions provided in subparagraphs 1. and 2., these terms have the following meanings:

a. "Industrial machinery and equipment" means "section 38 property" as defined in s. 48(a)(1)(A) and (B)(i) of the Internal Revenue Code, provided "industrial machinery and equipment" shall be construed by regulations adopted by the Department of Revenue to mean tangible property used as an integral part of the manufacturing, processing, compounding,

or producing for sale, or for exclusive use in spaceport activities as defined in s. 212.02, of items of tangible personal property. Such term includes parts and accessories only to the extent that the exemption thereof is consistent with the provisions of this paragraph.

b. "Productive output" means the number of units actually produced by a single plant or operation in a single continuous 12-month period, irrespective of sales. Increases in productive output shall be measured by the output for 12 continuous months immediately following the completion of installation of such machinery or equipment over the output for the 12 continuous months immediately preceding such installation. However, if a different 12-month continuous period of time would more accurately reflect the increase in productive output of machinery and equipment purchased to facilitate an expansion, the increase in productive output may be measured during that 12-month continuous period of time if such time period is mutually agreed upon by the Department of Revenue and the expanding business prior to the commencement of production; provided, however, in no case may such time period begin later than 2 years following the completion of installation of the new machinery and equipment. The units used to measure productive output shall be physically comparable between the two periods, irrespective of sales.

And the title is amended as follows:

In title, on page 1, line 3, after the semicolon (;) insert: removing a prohibition against application of the exemption for machinery and equipment used in new or expanding businesses to printing or publishing firms;

On motion by Senator Wexler, by two-thirds vote SB 3174 was read the third time by title, passed and certified to the House. The vote on passage was:

Yeas—37 Nays—None

The Senate resumed consideration of—

CS for CS for SB 3060—A bill to be entitled An act relating to health care; amending s. 20.42, F.S.; requiring Senate confirmation of the Director of Health Care Administration; deleting hospital budget review from duties of the Division of Health Policy and Cost Control and Health Care Board; amending s. 216.136, F.S.; providing additional duties of the Social Services Estimating Conference with respect to estimates and forecasts for Florida Health Security; creating s. 255.0516, F.S.; requiring contractors to comply with certain statutory provisions; amending s. 287.088, F.S.; requiring certain state agency contractors, including construction contractors, to ensure employee access to group health benefit plans; creating a task force to study health insurance requirements for state contractors; amending s. 400.602, F.S.; providing for issuance of additional hospice licenses; amending s. 408.02, F.S.; providing for practice guidelines for specified medical services; amending s. 408.40, F.S.; deleting reference to budget review proceedings of the Public Counsel; creating s. 408.7043, F.S.; providing certain limitations on the commingling of claims experience, rates, and charges for members of Florida Health Security by an accountable health partnership, a community health partnership, or a contract administrator; creating s. 408.7054, F.S.; providing for antitrust law exemptions for certain health care provider networks meeting specified criteria; amending s. 408.706, F.S.; providing additional requirements for accountable health partnerships that participate in Florida Health Security; providing that an insurer or a health maintenance organization is not required to participate in Florida Health Security or the Medicaid program; amending s. 408.902, F.S.; delaying the effective date and providing a contingency for creating the MedAccess program; creating s. 409.810, F.S.; creating the Florida Health Security Act; creating s. 409.811, F.S.; providing legislative findings and intent; creating s. 409.812, F.S.; providing definitions; creating s. 409.813, F.S.; establishing Florida Health Security, subject to approval of financing by the Federal Government; requiring the Director of the Agency for Health Care Administration to appoint a director of Florida Health Security; creating s. 409.814, F.S.; providing eligibility criteria for membership in Florida Health Security; providing application requirements for individuals; providing application requirements for employers who apply on behalf of employees; requiring the agency to verify a member's continued eligibility; providing circumstances under which a member may be disenrolled; providing penalties for a member or employer who provides erroneous information or who fails to provide certain information; providing for an open enrollment period during which coverage is offered on a guarantee-issue basis; creating s. 409.815, F.S.; providing for certain exclu-

sions for preexisting conditions and benefits available under workers' compensation insurance; providing for coverage under Florida Health Security to be provided by accountable health partnerships or community health partnerships; providing for a county, political subdivision, or tax district to establish a community health partnership; providing for the provision of emergency services; requiring that members be offered at least one benefit plan with a premium equal to or less than a benchmark premium established by the agency; providing certain limitations on changing accountable health partnerships; providing certain limitations on membership eligibility following termination of coverage; creating s. 409.816, F.S.; providing contribution requirements for premiums; providing a benchmark premium; providing for a member's premium subsidy to be based on gross family income; limiting the annual expenditures for Florida Health Security based on the General Appropriations Act; creating s. 409.817, F.S.; providing duties of the agency in administering Florida Health Security; creating s. 409.818, F.S.; providing duties of the agency for contract operations under Florida Health Security; creating s. 409.819, F.S.; authorizing a county, political subdivision, or tax district to create a community health partnership; providing enrollment criteria; providing requirements for qualification as a community health partnership; providing duties of a community health partnership; requiring that a community health partnership have adequate sources of revenue; providing disclosure requirements; providing requirements for coverage of a newborn or adopted child; providing for certain limitations on benefits; providing for liability for certain fees; providing for application of the Florida Insurance Code to certain services provided by a community health partnership; requiring actuarial certification of a community health partnership; providing requirements for a community health partnership that terminates its participation in Florida Health Security; providing for subcontracts for health care services with accountable health partnerships; requiring the Department of Health and Rehabilitative Services to establish pilot programs; requiring a report; creating s. 409.820, F.S.; providing that members may not be enrolled in Florida Health Security until there is sufficient funding; requiring the agency to make certain reports to the Social Services Estimating Conference; requiring the Social Services Estimating Conference to establish the enrollment ceiling for Florida Health Security; amending s. 409.901, F.S.; providing definitions; amending s. 409.908, F.S., relating to reimbursement of Medicaid providers; requiring legislative consultation and ratification for Medicaid funding formulas to be altered; providing a method for calculating reimbursement under Medicaid prepaid contracts; requiring certain consultation with and ratification by the Legislature before Medicaid recipients are enrolled in community health purchasing alliances; amending s. 409.9122, F.S.; providing for the enrollment of certain Medicaid recipients in a managed care plan or MediPass by a specified date; authorizing the Agency for Health Care Administration to establish a Medicaid mental health and substance abuse program pursuant to a federal waiver; requiring the agency to appoint an advisory panel; amending s. 409.915, F.S.; providing that services provided under Florida Health Security are not subject to certain requirements for matching funds from the counties; creating s. 627.4239, F.S.; providing for insurer coverage of certain drugs used in cancer treatment; creating s. 627.6045, F.S.; specifying policy requirements with respect to preexisting conditions; amending s. 627.6472, F.S.; prescribing responsibilities of exclusive provider organizations with respect to outpatient treatment by providers of specified medical services; creating s. 627.6691, F.S.; providing for continuation of coverage under group health benefit plans; providing definitions; providing for notice; amending s. 627.6691, F.S.; providing applicability of the Employee Health Care Access Act with respect to plans under Florida Health Security; amending s. 641.31, F.S.; prescribing responsibilities of health maintenance organizations with respect to outpatient treatment by providers of specified medical services; providing legislative findings and intent; prohibiting Medicaid recipients from being included in coverage by community health purchasing alliances unless certain conditions are met; requiring the Agency for Health Care Administration to study the impact of transferring medically needy recipients from Medicaid to Florida Health Security and Medicaid reimbursements to prepaid health plans and to report the findings of both studies to the Legislature; repealing s. 407.61, F.S., relating to Health Care Cost Containment Board studies; repealing s. 408.072, F.S., relating to reviews of hospital budgets; repealing s. 408.08(2)-(13), F.S., relating to duties of the board with respect to hospital inspections and audits; repealing s. 408.085, F.S., relating to comprehensive inpatient rehabilitation hospitals; repealing s. 455.25(2), F.S., relating to disclosure of financial interests to patients; repealing s. 455.2555, F.S., relating to imposition of a fee schedule on providers of designated health services; providing effective dates.

—which had been previously considered and amended this day.

Senator Grant moved the following amendments to **Amendment 1** which were adopted:

Amendment 1EE (with Title Amendment)—On page 139, between lines 4 and 5, insert:

Section 75. Subsection (1) of section 627.647, Florida Statutes, is amended to read:

627.647 Standard health claim form.—

(1) The department shall prescribe a standard health claim form to be used by all hospitals and a standard health claim ~~forms form~~ to be used by all physicians, dentists, and pharmacists. Such forms shall be in a format that allows for the use of generally accepted coding systems by providers in order to facilitate the processing of claims. Such forms shall provide for the disclosure by the claimant of the name, policy number, and address of every insurance policy which may cover the claimant with respect to the submitted claim except those policies specified in s. 627.4235(5). The required information on diagnosis, dental procedures, medical procedures, services, date of service, supplies, and fees may also be met by an attachment to the appropriate ~~physician~~ claim form. However, for the purpose of filing Medicaid claims, such attachments shall be prohibited. Such standard health claim forms shall be accepted by all insurers and all agencies, departments, and divisions of the state.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 184, line 17, after the semicolon (;) insert: amending s. 627.647, F.S.; revising provisions relating to standard health claim forms;

Amendment 1FF (with Title Amendment)—On page 140, between lines 7 and 8, insert:

Section 76. Effective October 1, 1994, subsection (2) of section 627.6561, Florida Statutes, is renumbered as subsection (3) and amended, and a new subsection (2) is added to said section, to read:

627.6561 Preexisting condition.—A group health insurance policy must comply with the following provisions:

(2) *Notwithstanding the provisions of subsection (1), group policies that provide coverage for loss of income due to a disability may contain a provision excluding coverage for preexisting conditions. Coverage for disability due to preexisting conditions may be excluded when the disability begins within 12 months following the effective date of an insured's coverage.*

(3)(2) In determining whether a preexisting condition provision applies to an eligible insured or dependent, credit must be given for the time the person was covered under previous coverage if the previous coverage was similar to or exceeded the coverage provided under the new policy and if the previous coverage was continuous to a date not more than 30 days prior to the effective date of the new coverage, exclusive of any applicable waiting period under the plan.

Section 77. Except as otherwise provided in this bill, this bill shall take effect July 1, 1994.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 184, line 24, after the semicolon (;) insert: amending s. 627.6561, F.S.; authorizing certain group policies to exclude coverage for preexisting conditions under certain circumstances; revising a time limitation for coverage of preexisting conditions;

Senator Gutman moved the following amendment to **Amendment 1** which was adopted:

Amendment 1GG (with Title Amendment)—On page 170, between lines 2 and 3, insert:

Section 87. Subsection (1) of section 483.035, Florida Statutes, is amended to read:

483.035 Clinical laboratories operated by practitioners for exclusive use; licensure and regulation.—

(1) A clinical laboratory operated by one or more practitioners licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, or chapter 466, exclusively in connection with the diagnosis and treatment of their own patients, must be licensed under this part and must comply with the provisions of this part, except that the agency shall adopt rules for staffing, *personnel, including education and training of personnel*, proficiency testing, and construction standards relating to the licensure and operation of the laboratory based upon and not exceeding the same standards contained in the federal Clinical Laboratory Improvement Amendments of 1988 and the federal regulations adopted thereunder.

Section 88. Subsection (9) of section 483.051, Florida Statutes, is amended to read:

483.051 Powers and duties of the agency.—The agency shall adopt rules to implement this part, which rules must include, but are not limited to, the following:

(9) **ALTERNATE-SITE TESTING.**—*Notwithstanding the provisions of part IV, the agency shall be responsible for alternate-site testing. The agency, in consultation with the Board of Clinical Laboratory Personnel, shall adopt, by rule, all the criteria for alternate-site testing to be performed under the supervision of a clinical laboratory director. The clinical laboratory director shall be responsible for selecting the tests to be performed, the test-specific training requirements, and the persons who will perform the tests, specific to the needs of the institution in accordance with the agency rule.* The elements to be addressed in the rule include, but are not limited to:

(a) A hospital internal needs assessment, including a patient benefit analysis and an evaluation of proposed methodologies;

(b) A protocol of implementation, including the level of complexity of tests to be performed, which shall not exceed moderate complexity as defined in the federal Clinical Laboratory Improvement Amendments of 1988 and the federal regulations adopted thereunder, and who will perform the tests;

(c) Criteria to be used in selecting the method of testing to be used for alternate-site testing;

(d) Any minimum training and education requirements for those who will perform alternate-site testing. *Documented licensure or certification in a medical profession, not limited to laboratory professionals, shall constitute the minimum training and education requirements, such as documented training, licensure, certification, or other medical professional background not limited to laboratory professionals;*

(e) Documented inservice training as well as initial and ongoing competency validation;

(f) An appropriate internal and external quality-control protocol;

(g) An internal mechanism for identifying and tracking alternate-site testing by the central laboratory; and

(h) Recordkeeping requirements.

Alternate-site testing locations must register when the clinical laboratory applies to renew its license. For purposes of this subsection, the term "alternate-site testing" means any laboratory testing done under the administrative control of a hospital *clinical laboratory director*, but performed out of the physical or administrative confines of the central laboratory.

Section 89. Subsection (1) of section 483.23, Florida Statutes, is amended to read:

483.23 Offenses; criminal penalties.—

(1)(a) It is unlawful for any person to:

1. Operate, maintain, direct, or engage in the business of operating a clinical laboratory unless he has obtained a clinical laboratory license from the agency or is exempt under s. 483.031.

2. Conduct, maintain, or operate a clinical laboratory, other than an exempt laboratory or a laboratory operated under s. 483.035, unless the clinical laboratory is under the direct and responsible supervision and direction of a person licensed under part IV of this chapter.

3. Allow any person other than an individual licensed under part IV of this chapter to perform clinical laboratory procedures, except in the operation of a laboratory exempt under s. 483.031 or a laboratory operated under s. 483.035 or in the administration of testing performed under s. 483.051(9).

4. Violate or aid and abet in the violation of any provision of this part or the rules adopted under this part.

(b) The performance of any act specified in paragraph (a) constitutes a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Section 90. Section 483.26, Florida Statutes, is amended to read:

483.26 Technical advisory panel.—The Agency for Health Care Administration shall may establish a technical advisory panel to assist the agency in rule revisions that are necessary as a result of this act. ~~This panel shall be composed of representatives of the health care community and, at a minimum, include representatives from the Florida Society of Pathologists, the Florida Coalition of Professional Laboratory Organizations, the Florida Nurses Association, the Florida Hospital Association, and the Florida Perfusion Society, and a nonpathologist representative of the Florida Medical Association~~ This advisory input should be sought to expand public participation in agency decisions and to draw on the expertise of representatives from the various segments of health care ~~which have an interest in laboratory procedures.~~

Section 91. Section 483.800, Florida Statutes, is amended to read:

483.800 Declaration of policy and statement of purpose.—The purpose of this part is to protect the public health, safety, and welfare of the people of this state from the hazards of improper performance by clinical laboratory personnel. Clinical laboratories provide essential services to practitioners of the healing arts by furnishing vital information that is essential to a determination of the nature, cause, and extent of the condition involved. Unreliable, and inaccurate, and untimely reports may cause unnecessary anxiety, suffering, and financial burdens and may even contribute directly to death. The protection of public and individual health requires the licensure of clinical laboratory personnel who meet minimum requirements for safe practice. The Legislature finds that laboratory testing technology continues to advance rapidly. ~~The Legislature also finds that a hospital training program under the direction of the hospital clinical laboratory director offers an opportunity for individuals already trained in health care professions to expand the scope of their careers.~~ The Legislature further finds that there is an immediate need for properly trained personnel to ensure patient access to testing. Therefore, the Legislature recognizes the patient-focused benefits of hospital-based training for laboratory and nonlaboratory personnel for testing within the laboratory ~~and at alternate sites~~, and recognizes the benefits of a training program approved by the Board of Clinical Laboratory Personnel under the direction of the hospital clinical laboratory director.

Section 92. Subsection (3) is added to section 483.801, Florida Statutes, to read:

483.801 Exemptions.—This part applies to all clinical laboratories and clinical laboratory personnel within this state, except:

(3) *Persons engaged in testing performed under s. 483.051(9) or at laboratories regulated under s. 483.035(1) or exempt under s. 483.031(2).*

Section 93. Subsection (3) of section 483.803, Florida Statutes, is amended to read:

483.803 Definitions.—As used in this part, the term:

(3) "Clinical laboratory personnel" includes a clinical laboratory director, supervisor, technologist, blood gas analyst, or technician who performs or is responsible for laboratory test procedures, but the term does not include trainees, persons who perform screening for blood banks or plasmapheresis centers, phlebotomists, ~~or~~ persons employed by a clinical laboratory to perform ~~manual pretesting duties~~ or clerical, personnel, or other administrative responsibilities, *or persons engaged in testing performed under s. 483.051(9) or at laboratories regulated under s. 483.035(1) or exempt under s. 483.031(2).*

Section 94. Section 483.811, Florida Statutes, is amended to read:

483.811 Approval of laboratory personnel training programs.—

(1) The board shall approve clinical laboratories for training programs upon presentation of satisfactory evidence that such laboratories are adequately staffed by qualified personnel and comply with rules adopted by the board to ensure that such laboratories provide training in clinical laboratory techniques adequate to prepare individuals to meet the requirements for licensure under this part.

(2) The board shall adopt rules for training programs, including, but not limited to, rules relating to curriculum, educational objectives, evaluation procedures, personnel licensure requirements, preentry educational requirements, and length of clinical training.

(3) ~~A clinical laboratory operated by one or more practitioners who hold the facilities of the laboratory out as available for the performance of diagnostic tests for other practitioners or their patients, receives any referral work, or performs laboratory work for patients referred by another practitioner is subject to the provisions of this part. The board shall adopt rules for the licensure, education, and training of personnel in laboratories operated pursuant to s. 483.035 based upon and not exceeding the standards contained in the federal Clinical Laboratory Improvement Amendments of 1988 and the federal regulations adopted thereunder. This subsection does not apply to a clinical laboratory operated by one or more practitioners who hold the facilities of the laboratory out as available for the performance of diagnostic tests for other practitioners or their patients. If a clinical laboratory receives any referred work, or performs any work for patients referred by another practitioner, all provisions of this part apply.~~

(4) The board shall approve training programs for laboratory technicians in a hospital or clinical laboratory which programs are under the supervision of a clinical laboratory director. The training must be accepted in lieu of educational requirements for licensure, but a trainee must have a high school diploma or its equivalent. Any person who completes a training program must pass, before licensure, an examination given by the department.

(5) The department may inspect laboratory personnel training programs.

(6) If the board finds that an approved program no longer meets the required standards, the department may rescind the approval.

Section 95. Section 483.813, Florida Statutes, is amended to read:

483.813 Clinical laboratory personnel license.—A person may not conduct a clinical laboratory examination or report the results of such examination unless such person is licensed under this part to perform such procedures. However, this provision does not apply to any practitioner of the healing arts authorized to practice in this state *or to persons engaged in testing performed under s. 483.051(9) or at laboratories regulated under s. 483.035(1) or exempt under s. 483.031(2).* The department may grant a temporary license to any candidate it deems properly qualified, for a period not to exceed 6 months.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 187, line 16, after the semicolon (;) insert: amending s. 483.035, F.S.; providing responsibility of the Agency for Health Care Administration for personnel standards for exclusive-use laboratories; amending s. 483.051, F.S.; revising provisions relating to alternate-site testing; providing responsibility of the agency; providing certain responsibilities of clinical laboratory directors; deleting requirement for consultation with the Board of Clinical Laboratory Personnel; directing the agency to solicit certain comments; specifying a testing protocol; specifying minimum training and education for those who perform testing; amending ss. 483.23, 483.800, 483.801, 483.803, and 483.813, F.S.; providing that provisions governing the regulation and licensure of clinical laboratory personnel do not apply to persons engaged in alternate-site testing or in testing performed at practitioners' exclusive-use laboratories or laboratories that perform only waived tests; revising the definition of "clinical laboratory personnel"; amending s. 483.26, F.S.; requiring establishment of a technical advisory panel; providing composition; amending s. 483.811, F.S.; deleting reference to board responsibility for regulation of personnel in laboratories operated under s. 483.035(1), F.S.;

Senator Silver moved the following amendment to **Amendment 1**:

Amendment 1HH (with Title Amendment)—On page 170, between lines 2 and 3, insert:

Section 87. (1) LEGISLATIVE INTENT.—

(a) It is the intent of the Legislature to ensure that consumers have a choice of outstanding medical and specialized care centers within the state. The state shall promote the development of health care facilities that are recognized as centers of excellence. Florida has a valuable resource and has made a substantial investment in its medical schools, teaching and research centers and institutes, and other health facilities and comprehensive health care clinics that would qualify as centers of excellence. The Legislature recognizes the need for the citizens of this state to have access to the specialized treatment and research available at centers of excellence. The Legislature further recognizes the need for the research institutions to have access to a wide variety of patients to fulfill the research and teaching missions.

(b) Recognizing the need to maintain and nurture these centers, the Legislature intends that the state shall establish a program for the designation of centers of excellence. These centers shall enhance the state's health care system by assisting the Agency for Health Care Administration and other state agencies in carrying out a variety of health care access, quality, and cost control functions, and serving as laboratories for the development of state-of-the-art patient care, teaching, and research programs; develop new technologies; enhance service delivery in underserved areas and underserved populations; encourage the development of innovative patient care and service delivery models; and develop other strategies for enhancing access to care, improving the quality of care, and reducing overall health care costs.

(2) CERTIFICATION.—

(a) On January 1, 1995, the agency shall submit a report to the Legislature recommending the criteria to be used in the designating of centers of excellence. In developing the criteria, the agency shall consult with persons interested in the issue, representatives of hospitals, health insurance companies, medical schools, teaching hospitals, health care providers, and other interested persons and groups. Effective July 1, 1995, the Agency for Health Care Administration may certify a hospital or other health care facility located within the state and licensed by the agency or certified by the federal Health Care Financing Administration, including clinics affiliated with major research or teaching hospitals in Florida or other states, as a center of excellence in one or more specialty areas.

(b) A "center of excellence" is defined as a facility or program of a facility that performs specialized procedures with enough frequency to become expert, reducing patient morbidity and mortality, performs significant teaching or research functions, serves as a referral center for patients living outside the geographic area of the facility, and has a demonstrated commitment to indigent care.

(c) Commencing July 1, 1995, the agency shall establish a demonstration project to test the designation of health care facilities as centers of excellence. At a minimum, the agency shall adopt, by rule, uniform statewide standards for a 2-year certification of a hospital or other health facility program as a center of excellence in the areas of trauma care, maternal, infant, and perinatal care; cancer care; and cardiac care. These areas have been selected initially for the development of certification standards because they represent major causes of death in this state or have previously been designated for the development of regionalized systems of care. The agency shall develop center of excellence standards in consultation with the state medical schools, statutory teaching hospitals, insurance industry representatives, health care facilities, health care professionals, and other groups and organizations interested in the development of centers of excellence.

(d) The certified centers of excellence shall advise the agency on the development of certification standards for purposes of designating additional centers of excellence and to monitor the effect of the certification of centers of excellence on improving patient outcomes, provider competition, regionalization of care, and national assessments of the quality of Florida's centers of excellence.

(3) ESSENTIAL PROVIDERS.—Facilities and programs of facilities that are certified as centers of excellence may be included in the provider networks used by all health plans offered by health insurers, licensed pursuant to chapter 627, Florida Statutes, health maintenance organizations, licensed pursuant to chapter 641, Florida Statutes, and community health partnerships, designated pursuant to chapter 409, Florida Statutes, to permit referral to these centers for services relating to their certification, irrespective of their geographic location in the state. These referrals may be considered in-plan coverage. The rates charged to the

networks by the centers of excellence shall be negotiated, but there will be no obligation on the part of any provider network to contract with any center of excellence.

(4) TECHNICAL ASSISTANCE.—Certified centers of excellence shall participate on technical advisory panels to the agency and must provide advice to the agency, as appropriate, in developing statewide practice guidelines and medical review criteria; constructing and implementing outcome measurement models; and determining the types of data needed by purchasers and consumers to assess quality, access, and costs, while ensuring that such assessments are fair and meaningful; designing health facility and professional licensure reforms; experimenting with new technologies; assessing the effect of new procedures, equipment, and delivery modes on patient care and patient outcomes; adapting medical technologies for use in other facilities; conducting quality of care symposiums for other health care facilities, health professionals, and allied health professionals; determining ways to control health care costs and maintain high quality state-of-the-art medicine; designing and piloting new and innovative multi-disciplinary, community-based service delivery methodologies; establishing strategies for enhancing the delivery of health care to rural communities; enhancing telecommunications capabilities of the health care system; and developing health professional and consumer education programs. Requests for technical assistance from the centers of excellence shall be routed through and prioritized by the agency.

(5) LEGISLATIVE REPORT.—The Agency for Health Care Administration shall, by December 31, 1995, submit a report to the President of the Senate and the Speaker of the House of Representatives, based on a study of the centers of excellence demonstration program in achieving legislative objectives and recommendations for any changes to or enhancements of the program. This study shall also assess the costs associated with the certification and operation of centers of excellence, including recommendations to ensure the financial viability of centers of excellence and to further expand centers of excellence in other specialty areas and the number of centers that are available to the residents of Florida.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 187, line 16, following the semicolon (;) insert: establishing a program creating a center of excellence program to assist the Agency for Health Care Administration and others in implementing certain programs; providing certification requirements; providing for a demonstration project; providing for the inclusion of certified centers in the provider networks; requiring participation on technical advisory panels; requiring a report;

Senator Silver offered the following substitute amendment which was moved by Senator Bankhead and adopted:

Amendment III (with Title Amendment)—On page 170, between lines 2 and 3, insert:

Section 87. (1) LEGISLATIVE INTENT.—

(a) It is the intent of the Legislature to ensure that consumers have a choice of outstanding medical and specialized care centers within the state. The state shall promote the development of health care facilities that are recognized as centers of excellence. Florida has a valuable resource and has made a substantial investment in its medical schools, teaching and research centers and institutes, and other health facilities and comprehensive health care clinics that would qualify as centers of excellence. The Legislature recognizes the need for the citizens of this state to have access to the specialized treatment and research available at centers of excellence. The Legislature further recognizes the need for the research institutions to have access to a wide variety of patients to fulfill the research and teaching missions.

(b) Recognizing the need to maintain and nurture these centers, the Legislature intends that the state shall establish a program for the designation of centers of excellence. These centers shall enhance the state's health care system by assisting the Agency for Health Care Administration and other state agencies in carrying out a variety of health care access, quality, and cost control functions, and serving as laboratories for the development of state-of-the-art patient care, teaching, and research programs; develop new technologies; enhance service delivery in underserved areas and underserved populations; encourage the development of innovative patient care and service delivery models; and develop other strategies for enhancing access to care, improving the quality of care, and reducing overall health care costs.

(2) CERTIFICATION.—

(a) On January 1, 1995, the agency shall submit a report to the Legislature recommending the criteria to be used in the designating of centers of excellence. In developing the criteria, the agency shall consult with persons interested in the issue, representatives of hospitals, health insurance companies, medical schools, teaching hospitals, health care providers, and other interested persons and groups. Effective July 1, 1995, the Agency for Health Care Administration may certify a hospital or other health care facility located within the state and licensed by the agency or certified by the federal Health Care Financing Administration, including clinics affiliated with major research or teaching hospitals in Florida or other states, as a center of excellence in one or more specialty areas.

(b) A "center of excellence" is defined as a facility or program of a facility that performs specialized procedures with enough frequency to become expert, reducing patient morbidity and mortality, performs significant teaching or research functions, serves as a referral center for patients living outside the geographic area of the facility, and has a demonstrated commitment to the overall improvement of health care available in Florida through privately funded medical research, volunteerism, philanthropy, indigent care or other community service health programs.

(c) Commencing July 1, 1995, the agency shall establish a demonstration project to test the designation of health care facilities as centers of excellence. At a minimum, the agency shall adopt, by rule, uniform statewide standards for a 2-year certification of a hospital or other health facility program as a center of excellence in the areas of trauma care, maternal, infant, and perinatal care; cancer care; and cardiac care. These areas have been selected initially for the development of certification standards because they represent major causes of death in this state or have previously been designated for the development of regionalized systems of care. The agency shall develop center of excellence standards in consultation with the state medical schools, statutory teaching hospitals, insurance industry representatives, health care facilities, health care professionals, and other groups and organizations interested in the development of centers of excellence.

(d) The certified centers of excellence shall advise the agency on the development of certification standards for purposes of designating additional centers of excellence and to monitor the effect of the certification of centers of excellence on improving patient outcomes, provider competition, regionalization of care, and national assessments of the quality of Florida's centers of excellence.

(3) ESSENTIAL PROVIDERS.—Facilities and programs of facilities that are certified as centers of excellence may be included in the provider networks used by all health plans offered by health insurers, licensed pursuant to chapter 627, Florida Statutes, health maintenance organizations, licensed pursuant to chapter 641, Florida Statutes, and community health partnerships, designated pursuant to chapter 409, Florida Statutes, to permit referral to these centers for services relating to their certification, irrespective of their geographic location in the state. These referrals may be considered in-plan coverage. The rates charged to the networks by the centers of excellence shall be negotiated, but there will be no obligation on the part of any provider network to contract with any center of excellence.

(4) TECHNICAL ASSISTANCE.—Certified centers of excellence shall participate on technical advisory panels to the agency and must provide advice to the agency, as appropriate, in developing statewide practice guidelines and medical review criteria; constructing and implementing outcome measurement models; and determining the types of data needed by purchasers and consumers to assess quality, access, and costs, while ensuring that such assessments are fair and meaningful; designing health facility and professional licensure reforms; experimenting with new technologies; assessing the effect of new procedures, equipment, and delivery modes on patient care and patient outcomes; adapting medical technologies for use in other facilities; conducting quality of care symposiums for other health care facilities, health professionals, and allied health professionals; determining ways to control health care costs and maintain high quality state-of-the-art medicine; designing and piloting new and innovative multi-disciplinary, community-based service delivery methodologies; establishing strategies for enhancing the delivery of health care to rural communities; enhancing telecommunications capabilities of the health care system; and developing health professional and consumer education programs. Requests for technical assistance from the centers of excellence shall be routed through and prioritized by the agency.

(5) LEGISLATIVE REPORT.—The Agency for Health Care Administration shall, by December 31, 1995, submit a report to the President of the Senate and the Speaker of the House of Representatives, based on a study of the centers of excellence demonstration program in achieving legislative objectives and recommendations for any changes to or enhancements of the program. This study shall also assess the costs associated with the certification and operation of centers of excellence, including recommendations to ensure the financial viability of centers of excellence and to further expand centers of excellence in other specialty areas and the number of centers that are available to the residents of Florida.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 187, line 16, following the semicolon (;) insert: establishing a program creating a center of excellence program to assist the Agency for Health Care Administration and others in implementing certain programs; providing certification requirements; providing for a demonstration project; providing for the inclusion of certified centers in the provider networks; requiring participation on technical advisory panels; requiring a report;

Senator Forman moved the following amendments to **Amendment 1** which were adopted:

Amendment 1JJ (with Title Amendment)—On page 170, between lines 2 and 3, insert:

Section 87. RARE AND CHRONIC DISEASE ADVISORY COUNCIL.—

(1) There is created the Rare and Chronic Disease Advisory Council, consisting of 17 members appointed as follows:

(a) Seven physicians who specialize in the treatment of patients with hemophilia, genetic emphysema, immune deficiencies, cystic fibrosis, Gaucher's disease, epilepsy, and growth impairments, appointed by the Director of the Agency for Health Care Administration.

(b) Three consumers who suffer from, or who have a family member who suffers from, hemophilia, genetic emphysema, and immune deficiencies, respectively, appointed by the Director of the Agency for Health Care Administration.

(c) Four consumers who suffer from, or who have a family member who suffers from, cystic fibrosis, Gaucher's disease, epilepsy, and growth impairments, respectively, appointed by the Insurance Commissioner.

(d) Three individuals representing the insurance industry, including one individual who represents health maintenance organizations and one representing the Florida Comprehensive Health Association, appointed by the Insurance Commissioner.

(2) Appointments to the council shall be made no later than June 15, 1994. The council shall elect a chairperson and a vice-chairperson from the membership of the council. Members of the council shall not receive any salary, compensation, or reimbursement of expenses for matters related to their service on the council.

(3) The council shall advise the Agency for Health Care Administration and the Department of Insurance with regard to benefits covered by the Medicaid program and Florida Health Security, on rare and chronic diseases, and shall make recommendations including, but not limited to the following:

(a) The inclusion of providers with special expertise in the diagnosis and treatment of rare and chronic diseases within preferred provider organizations, exclusive provider organizations, health maintenance organizations, and other health care provider networks.

(b) Minimum standards of care for persons with rare and chronic diseases, including the development of a quality assurance program that provides cost-effective quality care in the treatment of such diseases.

(c) The adoption of expedited grievance procedures for persons with chronic illnesses.

(d) The designation of physicians specializing in the treatment of chronically ill patients as primary care physicians for the purpose of providing direct access to such specialists by persons with rare and chronic diseases.

(e) The development and dissemination of informational brochures regarding the availability of new drugs and treatment proposals for rare and chronic diseases.

(4) No later than September 15, 1994, the council shall furnish to the Insurance Commissioner and the Director of Health Care Administration the council's findings and recommendations with respect to the matters referred to in subsection (3). The council expires on September 15, 1994.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 182, line 26, after the semicolon (;) insert: creating the rare and chronic disease advisory council; specifying membership; specifying appointments and duties; requiring a report;

Amendment 1KK (with Title Amendment)—On page 170, between lines 2 and 3, insert:

Section 87. To provide for a comprehensive study regarding the need for expansion of coverage under Medicaid of life-sustaining dialysis services for Medicaid eligible kidney disease patients, and to make the results available, along with the Agency for Health Care Administration's recommendations for addressing this issue, available to the Florida Legislature no later than December 1994 for consideration during the next regular legislative session.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 187, line 16, after the semicolon (;) insert: providing a study for dialysis services for Medicaid eligible kidney disease patients;

Senator Grant moved the following amendments to **Amendment 1** which were adopted:

Amendment 1LL—On page 170, between lines 2 and 3, insert:

Section 87. Medicaid or Medicare provider peer review organization; immunity from liability.—

(1) As used in this section, the term:

(a) "Medicaid or Medicare provider" means a physician licensed under chapter 458, Florida Statutes, an osteopathic physician licensed under chapter 459, Florida Statutes, a podiatrist licensed under chapter 461, Florida Statutes, an optometrist licensed under chapter 463, Florida Statutes, a chiropractor licensed under chapter 460, Florida Statutes, a pharmacist licensed under chapter 465, Florida Statutes, or a dentist licensed under chapter 466, Florida Statutes, or a hospital or ambulatory surgical center licensed under chapter 395, Florida Statutes.

(b) "Medicaid or Medicare provider peer review organization" or "organization" means a peer review organization that is designated by the Department of Health and Rehabilitative Services under section 409.913, Florida Statutes, to review goods and services furnished by a Medicaid or Medicare provider and paid for by the Medicaid or Medicare program, for the purpose of minimizing fraudulent and abusive behavior and neglect of patients.

(2)(a) There is no monetary liability on the part of, and a cause of action for damages does not arise against, any member of a duly appointed Medicaid or Medicare provider peer review organization, or any Medicaid or Medicare provider furnishing any information to such organization, or any person, including any person acting as a witness, incident reporter to, or investigator for, a Medicaid or Medicare provider peer review organization, for any act or proceeding undertaken or performed within the scope of the functions of any such organization if the organization member or Medicaid or Medicare provider acts without intentional fraud.

(b) This section does not affect the official immunity of an officer or employee of a public corporation.

(3) Except as provided in subsection (2), this section does not confer immunity from liability on any professional society or hospital or upon any health professional while performing services other than as a member of a Medicaid or Medicare provider peer review organization or upon any person, including any person acting as a witness, incident reporter to, or investigator for, a Medicaid or Medicare provider peer review organization, for any act or proceeding undertaken or performed outside the scope of the functions of such organization.

Amendment 1MM (with Title Amendment)—On page 148, strike all of lines 8-20 and insert:

Section 77. Paragraph (a) of subsection (4) of section 627.6699, Florida Statutes, is amended and paragraph (e) is added to that subsection to read:

627.6699 Employee Health Care Access Act.—

(4) APPLICABILITY AND SCOPE.—

(a) This section applies to a health benefit plan that provides coverage to a small employer in this state, unless the policy is marketed directly to the individual employee, and the employer does not participate in the collection or distribution of premiums or facilitate the administration of the policy in any manner. *This section does not apply to a health benefit plan issued under the Florida Health Security Act or to a carrier who issues coverage under the Florida Health Security Act. The health benefit committee shall modify the Department of Insurance standard benefit plan to include outpatient and inpatient rehabilitative services equivalent to those provided in the Florida Health Security Plan submitted to the Legislature on December 20, 1993. The copayments for these services may be adjusted as necessary to prevent the premium from increasing.*

(e) *This section does not prohibit a trustee group, as defined in s. 627.6516, whose membership consists of both small employers and other employers, from entering into a single contract for health insurance with an authorized insurer on behalf of the entire membership of the trust, provided that the contract complies with this section with respect to the small employer members.*

And the title is amended as follows:

In title, on page 184, line 31, after the first semicolon (;) insert: 627.6699, F.S.; providing applicability of the Employee Health Care Access Act with respect to plans under the Florida Health Security Act; providing for certain trustee groups; amending

Senator Diaz-Balart moved the following amendment to **Amendment 1** which was adopted:

Amendment 1NN (with Title Amendment)—On page 120, between lines 2 and 3, insert:

Section 50. Paragraph (b) of subsection (7) of section 458.347, Florida Statutes, is amended to read:

458.347 Physician assistants.—

(7) PHYSICIAN ASSISTANT CERTIFICATION.—

(b)1. Notwithstanding the provisions of subparagraph (a)2. and subparagraph (a)3.a., the department shall examine each applicant who the board certifies:

a. Has completed the application form and remitted a nonrefundable application fee not to exceed \$500 and an examination fee not to exceed \$300, plus the actual cost to the department to *provide the examination for purchase of a proficiency examination from a national organization or, if unavailable, for development of a proficiency examination by the department.* The examination fee is refundable if the applicant is found to be ineligible to take the examination.

b. Is an unlicensed physician who graduated from a foreign medical school listed with the World Health Organization who has not previously taken and failed the examination of the National Commission on Certification of Physician Assistants and who has been certified by the board as having met the requirements for licensure as a medical doctor by examination as set forth in s. 458.311(1), (3), (4), and (5), with the exception that the applicant is not required to have completed an approved residency of at least 1 year and the applicant is not required to have passed the licensing examination specified under s. 458.311 or hold a valid, active certificate issued by the Educational Commission for Foreign Medical Graduates.

c. *Was eligible and Has* applied for certification as a physician assistant in this state between July 1, 1990, and June 30, 1991, *and applies for certification before October 1, 1994.*

d. Was a resident of this state on July 1, 1990, or was licensed or certified in any state in the United States as a physician assistant on July 1, 1990.

2. The board may grant temporary certification to an applicant who meets the requirements of subparagraph 1. Between meetings of the Physician Assistant Committee, the executive director of the board may grant temporary certification to practice based on the completion of all temporary certification requirements. All such administratively issued certifications shall be reviewed and acted on at the next regular meeting of the Physician Assistant Committee and the board. The temporary certificate shall expire upon receipt and notice of scores to the certificate-holder from the first available examination specified in subparagraph 1. following certification by the board. An applicant who fails the proficiency examination is no longer temporarily certified and is ineligible for any further temporary certification.

3. *Notwithstanding any other provision of law, the examination specified pursuant to subparagraph 1. shall be administered, in a manner determined by the department, no sooner than 9 months after the effective date of this act. The department may develop, contract for development, purchase, or approve an examination pursuant to this section that adequately measures an applicant's ability to practice with reasonable skill and safety. The department may purchase from a national organization an examination approved by the board for use in this state. The examination shall have been previously validated and administered in its totality.* The minimum passing score on the examination shall be established by the department with the advice of the board. However, if the exam is purchased, but the board shall not require an examination passing score to be higher than the passing score for certification established by the National Commission on Certification of Physician Assistants for each particular examination, nor shall the method of scoring such examinations differ from that of said commission and defined in rules of the board. Applicants certified by the board for examination shall receive at least 6 months' notice of eligibility prior to the administration of the examination. Any applicant who fails the examination five times is not eligible for reexamination under this paragraph. Any applicant who passes the examination and meets the requirements of this section shall be certified as a physician assistant with all rights defined thereby.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 181, line 26, after the second semicolon (;) insert: amending s. 458.347, F.S.; providing for development of a Department of Business and Professional Regulation examination for physician assistant certification; revising requirements for certification of physician assistants certified under ch. 458, F.S.;

Senators Casas, Kirkpatrick and Diaz-Balart offered the following amendment to **Amendment 1** which was moved by Senator Casas and adopted:

Amendment 100 (with Title Amendment)—On page 173, between lines 9 and 10, insert:

Section 98. Notwithstanding the provisions of section 458.311 or section 458.313, Florida Statutes, and any other provision of law, any foreign-trained physician who completed, in November 1990 or 1992, a special preparatory medical update course authorized by the Florida Board of Medicine and the University of Miami Medical School and who subsequently passed the final course examination and the MOCK FLEX examination or who have a certificate of successful completion from the University of Miami is exempt from taking any licensure examination required by either of those sections, including the licensure examination of the National Board of Medical Examiners or of the Federation of State Medical Boards of the United States, Inc. (FLEX) or the United States Medical Licensing Examination (USMLE).

(1) Any such foreign-trained physician shall be issued a restricted license if the person:

(a) Applies to the department and submits an application fee which is non-refundable and equivalent to that for full licensure; and

(b) Graduated from an allopathic medical school or allopathic college; and

(c) Is not under discipline, investigation, or prosecution in any jurisdiction for an action that would constitute a violation of chapter 455 or chapter 458, Florida Statutes, and that substantially threatened or threatens the public's health, safety, or welfare.

(2) The board or the department may require an applicant to appear before the board or the department before issuing the restricted license. The board or the department may impose reasonable conditions on the applicant's license to practice medicine. These conditions may include:

(a) Periodic and random departmental audits of the licensee's patient records and review of those records by the board or the department.

(b) Periodic appearances of the licensee before the board or the department.

(c) Submission of written reports to the board or the department.

A restricted licensee shall practice under the direct supervision of a full licensee.

(3)(a) A restricted license issued by the department pursuant to this section shall be valid for 2 years. A restricted licensee shall be subject to the requirements of chapters 455 and 458, Florida Statutes, and other law not in conflict with this section. Upon expiration of the restricted license, a restricted licensee shall become a full licensee if the restricted licensee:

1. Is not under discipline, investigation, or prosecution for a violation that posed or poses a substantial threat to the public's health, safety, or welfare; and

2. Pays all renewal fees required of a full licensee.

(b) The department shall renew a restricted license upon payment of the same fees required for renewal for a full license if the restricted licensee is under discipline, investigation, or prosecution for a violation that posed or poses a substantial threat to the public's health, safety, or welfare and the board or the department has not permanently revoked the restricted license. A restricted licensee who has renewed the license shall become eligible for full licensure when the licensee is no longer under discipline, investigation, or prosecution.

(5) The board shall adopt rules necessary to carry out this section.

And the title is amended as follows:

In title, on page 188, line 7, following the semicolon (;) insert: providing for licensure of certain foreign-trained physicians;

Senator Wexler moved the following amendments to **Amendment 1** which were adopted:

Amendment 1PP (with Title Amendment)—On page 148, between lines 20 and 21, insert:

Section 78. Section 641.28, Florida Statutes, is amended to read:

641.28 Civil remedy.—In any civil action brought to enforce the terms and conditions of a health maintenance organization contract in which the subscriber or enrollee prevails, the court shall enter judgment against the health maintenance organization and in favor of the subscriber or enrollee for prevailing party is entitled to recover reasonable attorney's fees and court costs. When so awarded, the attorney's fees and court costs must be included in the judgment. This section shall not be construed to authorize a civil action against the department or, its employees, or the Insurance Commissioner or against the Agency for Health Care Administration or Department of Health and Rehabilitative Services, its employees, or director the secretary of that department.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 184, line 31, after the semicolon (;) insert: amending s. 641.28, F.S.; requiring a health maintenance organization to pay reasonable attorney's fees and court costs when a subscriber or enrollee receives a favorable judgment in a civil action brought to enforce a health maintenance organization contract;

SENATOR DANTZLER PRESIDING

Amendment 1QQ (with Title Amendment)—On page 150, between lines 8 and 9, insert:

Section 80. Section 641.3917, Florida Statutes, is amended to read:

641.3917 Civil liability.—

(1) The provisions of this part are cumulative to rights under the general civil and common law, and no action of the Agency for Health Care Administration or the Department of Insurance shall abrogate such rights to damage or other relief in any court.

(2) Any person may bring a civil action against a health maintenance organization if such person is damaged:

(a) By a violation by the organization of any of the following provisions: s. 641.31, s. 641.3108, or s. 641.3903; or

(b) By the organization's not attempting in good faith to settle claims when, under all the circumstances, the organization could and should have done so, had it acted fairly and honestly toward its subscribers and enrollees and with regard for their interests.

Notwithstanding the foregoing provisions, a person pursuing a remedy under this section need not prove that such act was committed or performed with such frequency as to indicate a general business practice.

(2)(a) As a condition precedent to bringing an action under this section, the department and the health maintenance organization must be given 60 days' written notice of the violation. If the department returns a notice for lack of specificity, the 60-day time period does not begin until a proper notice is filed.

(b) The notice must be on a form provided by the department and must state with specificity the following information and such other information as the department requires:

1. The statutory provision, including the specific language of the statute, which the health maintenance organization has allegedly violated.

2. The facts and circumstances giving rise to the violation.

3. The name of any individual involved in the violation.

4. Reference to specific contractual provisions, if any, that are relevant to the violation.

5. A statement that the notice is given in order to perfect the right to pursue the civil remedy authorized by this section.

(c) Within 20 days after receipt of a notice, the department may return the notice if it does not provide the specific information required under this section, but the department must indicate the specific deficiencies found in the notice. A determination by the department to return a notice for lack of specificity is exempt from the requirements of chapter 120.

(d) An action does not lie if, within 60 days after filing the notice, the damages are paid or the circumstances giving rise to the violation are corrected.

(3) A health maintenance organization that is the recipient of a notice filed pursuant to this section shall report to the department on the disposition of the alleged violation.

(4) The applicable statute of limitation for an action under this section is tolled for a period of 65 days by the mailing of the notice required under this subsection or the mailing of a subsequent notice required under this subsection.

(5) Upon adverse adjudication at trial or upon appeal, the health maintenance organization is liable for damages, together with court costs and reasonable attorney's fees incurred by the plaintiff.

(6) Punitive damages may not be awarded under this section unless the acts giving rise to the violation occurred with such frequency as to indicate a general business practice and those acts were willful, wanton, and malicious or were in reckless disregard for the rights of any subscriber or enrollee of the health maintenance organization.

(7) A person who pursues a claim under this subsection must post in advance the costs of discovery. Such costs shall be awarded to the health maintenance organization if no punitive damages are awarded to the plaintiff.

(8) This section does not authorize a civil action against the department or its employees or the Insurance Commissioner.

(9) The civil remedy authorized under this section does not preempt any other remedy or cause of action provided for under any other statute or under the common law of this state. Any person may obtain a judgment under either the common-law remedy of bad faith or this statutory remedy, but a person is not entitled to a judgment under both remedies. The requirements of chapter 766 do not apply to actions brought under this section. This section shall not be construed to create a common-law cause of action. The damages that are recoverable under this section include those damages that are a reasonably foreseeable result of a specified violation of this section by the health maintenance organization and may include an award or judgment in an amount that exceeds contractual limits.

(Renumber subsequent sections.)

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 185, line 7, after the semicolon (;) insert: amending s. 641.3917, F.S.; providing a cause of action against health maintenance organizations for unfair and deceptive trade practices; providing condition precedents for bringing action; providing for notice to the Department of Insurance; providing for costs and attorney's fees; providing for punitive damages under certain circumstances;

Amendment 1RR (with Title Amendment)—On page 173, between lines 9 and 10, insert:

Section 98. Section 627.0613, Florida Statutes, is renumbered as section 624.3075, Florida Statutes, and amended to read:

624.3075 627.0613 Consumer advocate.—

(1) The Insurance Commissioner must appoint a consumer advocate who must represent the general public of the state before the department, and who may, in addition, represent the interests of the insurance consumer public of this state before the Legislature and the courts. The consumer advocate must, for organizational purposes, report directly to the Insurance Commissioner, but is not otherwise under the authority of the department or of any employee of the department. The term of office of the insurance consumer advocate shall end when the term of office of the appointing Insurance Commissioner ends, except that the Insurance Commissioner may, only for good cause shown, remove the insurance consumer advocate from office prior to that date. The appointment of the insurance consumer advocate is subject to confirmation by concurrent resolution of the Legislature.

(2) The consumer advocate has such powers as are necessary to carry out the duties of the office of consumer advocate, including, but not limited to, the powers to:

(a)(1) Recommend to the department, by petition, the commencement of any proceeding or action; appear in any proceeding or action before the department; or appear in any proceeding before the Division of Administrative Hearings relating to subject matter under the jurisdiction of the department.

(b)(2) Have access to and use of all files, records, and data of the department.

(c)(3) Examine rate and form filings submitted to the department, hire consultants, actuaries, attorneys, and other professionals on a temporary or permanent basis as determined to be necessary by the consumer advocate to perform the duties and functions of the office or as necessary to aid in the review process, and recommend to the department any position deemed by the consumer advocate to be in the public interest.

(3)(4) The office of the insurance consumer advocate shall be a separate budget entity. The insurance consumer advocate shall prepare an annual budget for presentation to the Legislature independently from the budget request of the department, which budget must be adequate to carry out the duties of the office of consumer advocate.

(4) The insurance consumer advocate may submit reports to the President of the Senate and the Speaker of the House of Representatives or the public regarding any insurance matter affecting the public. The insurance consumer advocate must provide information with respect to any insurance matter affecting the public upon request of any member of the Legislature, and must be available to provide to committees of the Legislature the insurance consumer advocate's independent opinion of the impact of any proposed insurance legislation on the public.

(5) *Expenses of the office of insurance consumer advocate shall be paid out of the Insurance Commissioner's Regulatory Trust Fund or such other sources as specified in the General Appropriations Act.*

(6) *The Department of Insurance shall provide adequate office space within the Capitol Building for the office of insurance consumer advocate.*

Section 99. Section 98 of this act shall not be construed to terminate the term of office of the insurance consumer advocate in office on the effective date of this act or to make the appointment of such individual to such office subject to confirmation.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 188, line 7, after the semicolon (;) insert: amending and renumbering s. 627.0613, F.S.; specifying powers, duties, and term of office of the insurance consumer advocate; providing for removal only for cause; providing for confirmation; authorizing temporary and permanent employment of certain professionals; providing that the office of insurance consumer advocate is a separate budget entity; providing for reports and other information for the Legislature and the public; providing for payment of expenses of the office; providing for location of the office; providing a rule of construction;

Senator Turner moved the following amendment to **Amendment 1** which was adopted:

Amendment 1SS (with Title Amendment)—On page 40, between lines 28 and 29, insert:

Section 20. Subsection (2) of section 408.7045, Florida Statutes, is amended to read:

408.7045 Community health purchasing alliance marketing requirements.—

(2) Each alliance *must shall* make available to members marketing materials that accurately summarize the *health* benefit plans that are offered by *the its* accountable health partnerships in the alliance district and the rates, costs, and accreditation information relating to those plans. *Each alliance must encourage informed consumer behavior and responsible health plans by requiring written disclosure to alliance members of treatment policies, practice standards, and any restrictions or limits on covered health services, including, but not limited to, physician services, clinical laboratory tests, hospital and surgical procedures, prescription drugs and biologics, and radiological examinations by accountable health partnerships for each of their health benefit plans. This disclosure may not include proprietary information. This information must be provided yearly on a schedule to be established by each alliance and must be provided to all potential enrollees prior to enrollment.*

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 176, line 6, following the first semicolon (;) insert: amending s. 408.7045, F.S.; clarifying provisions relating to community health purchasing alliance marketing requirements; requiring written disclosure of specified information to alliance members;

Senator Johnson moved the following amendment to **Amendment 1** which was adopted:

Amendment 1TT—On page 52, line 15, after "services" insert: , including the testing and fitting of hearing aids for children,

Senator Myers moved the following amendment to **Amendment 1** which was adopted:

Amendment 1UU—On page 149, lines 12 and 13, strike "make available, upon request of a subscriber" and insert: offer a subscriber

Senator Holzendorf moved the following amendment to **Amendment 1** which was adopted:

Amendment 1VV (with Title Amendment)—On page 139, line 5 through 140, line 7, strike all of said lines and insert:

Section 75. Subsection (5) is added to section 627.6471, Florida Statutes, to read:

627.6471 Contracts for reduced rates of payment; limitations; coinsurance and deductibles.—

(5) *When psychotherapeutic services are covered, eligibility criteria shall be established by the insurer to assure that licensed providers whose licensing statutes authorized those psychotherapeutic services have equal access to apply for and be considered for selection as network providers. The insurer may not discriminate against a health care provider by excluding such practitioner from its provider network solely on the basis of the practitioner's license.*

Section 76. Subsections (15), (16), and (17) are added to section 627.6472, Florida Statutes, to read:

627.6472 Exclusive provider organizations.—

(15) *Upon the development of outpatient practice guidelines applicable to optometrists, dermatologists, and ophthalmologists under s. 408.02, but not later than December 31, 1994, a policyholder seeking optometric, dermatological, or ophthalmological services may not be required to obtain a referral from a network provider or case manager before obtaining such services and may not be denied direct access to a board-certified optometrist or board-eligible or board-certified dermatologist or ophthalmologist who has contracted to provide services as an exclusive provider. The exclusive provider organization may not establish adverse incentives to impair or inhibit direct access to those providers.*

(16)(a) *Effective January 1, 1995, at least annually, each exclusive provider organization shall make available, upon request of a subscriber, a point of service plan as an option to any other plan that is offered to the subscriber. For the purposes of this section, a point of service plan is a plan that allows a subscriber freedom of choice to use nonparticipating providers. A nonparticipating provider is a provider who is not employed by or not under contract with the exclusive provider organization, or who is not otherwise participating in the network of providers used by the exclusive provider organization.*

(b) *The indemnification of a subscriber for the services of a nonparticipating provider may be subject to deductibles, copayments, and coinsurance approved by the department, provided that a subscriber may not be subject to a coinsurance requirement of more than 25 percent.*

(c) *Any additional premium for a point of service plan shall be approved by the department.*

(17) *When psychotherapeutic services are covered, eligibility criteria shall be established by the insurer to assure that licensed providers whose licensing statutes authorized those psychotherapeutic services have equal access to apply for and be considered for selection as network providers. The insurer may not discriminate against a health care provider by excluding such practitioner from its provider network solely on the basis of the practitioner's license.*

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 184, strike line 18 and insert: amending ss. 627.6471, 627.6472, F.S.; providing for eligibility criteria for professionals who furnish psychotherapeutic services to be included in provider networks; prescribing

Senator Forman moved the following amendment to **Amendment 1** which was adopted:

Amendment 1WW—On page 52, strike lines 15-17 and insert: rehabilitative services and mental health services as follows:

(a) Outpatient rehabilitative therapy up to 30 treatments initially per calendar year with an additional 30 treatments after evaluation, if medically necessary;

(b) Inpatient hospital rehabilitative therapy up to 30 days of treatment per calendar year with an additional 30 days per calendar year after evaluation, if medically necessary;

(c) Inpatient mental health treatment services up to 30 days per calendar year;

(d) Residential mental health services up to 30 days per calendar year.

Further, a condition of the plan is that no person may be denied hospital admission or services based on inability to pay upon admission. The standard plan must also be

Senator Sullivan moved the following amendment to **Amendment 1** which was adopted:

Amendment 1XX (with Title Amendment)—On page 173, between lines 9 and 10, insert:

Section 98. Subsection (13) of section 945.603, Florida Statutes, is amended to read:

945.603 Powers and duties of authority.—The purpose of the authority is to assist in the delivery of health care services for inmates in the Department of Corrections by advising the department on the professional conduct of primary, convalescent, dental, and mental health care and the management of costs consistent with quality care, by advising the Governor and the Legislature on the status of the department's health care delivery system, and by assuring that adequate standards of physical and mental health care for inmates are maintained at all department institutions. For this purpose, the authority has the authority to:

(13) Employ or contract with health care providers, medical personnel, management consultants, consulting engineers, architects, surveyors, attorneys, accountants, financial experts, and such other employees, entities, or agents as may be necessary in its judgment and fix their compensation. *Contracts with consultants to conduct surveys of correctional institutions constitute contracts for auditing services and are not subject to the competitive sealed bid requirements of s. 287.057.*

(Renumber subsequent section.)

And the title is amended as follows:

In title, on page 188, line 7, following the semicolon (;) insert: amending s. 945.603, F.S.; exempting the Correctional Medical Authority from competitive sealed bid requirements certain authority contracts with consultants;

Senator Grant moved the following amendment to **Amendment 1** which failed:

Amendment 1YY—On page 15, line 3, after "stretcher" insert: or wheelchair

Senator Grant moved the following amendment to **Amendment 1** which was adopted:

Amendment 1ZZ—On page 16, line 10, strike "in chapter 401" and insert: by law or ordinance

Senator Gutman moved the following amendment to **Amendment 1** which was adopted:

Amendment 1AAA—On page 36, strike all of lines 4-8 and insert: *specialized care. This care should be provided in the least restrictive setting possible, consistent with the optimum treatment of the patient's condition.*

Senators Dudley and Johnson offered the following amendment to **Amendment 1** which was moved by Senator Dudley and adopted:

Amendment 1BBB (with Title Amendment)—On page 148, between lines 20 and 21, insert:

Section . Subsection (1) of section 628.6011, Florida Statutes, is amended to read:

628.6011 Assessable mutual insurers.—

(1) An "assessable mutual insurer" is an insurer incorporated in Florida without permanent capital stock which has only policyholders, insureds, or risks located in Florida and which transacts insurance only within Florida. An assessable mutual insurer may be formed only in accordance with part I. Members of the assessable mutual have a contingent liability for discharge of its liabilities as provided in this part. An assessable mutual may be authorized to offer only property, health, and casualty insurance. *When the assessable mutual elects to change or drop the endorsement of the sponsoring association, it must be approved by a two-thirds vote of the members of the assessable mutual. In obtaining the approval of the members of the assessable mutual, the failure of a member to respond to a solicitation for a vote shall not be deemed to be*

a grant of proxy or choice. If a proxy is used, it must be clearly labeled as such on a separate form, containing directions as to the vote to be cast and a notice that the failure to respond shall not be deemed to be a grant of proxy or a choice. This requirement shall apply to all certificates of authority issued after the effective date of this law.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 184, line 31, insert: amending s. 628.6011, F.S.; providing for conditions relating to sponsoring associations;

Senator Williams moved the following amendment to **Amendment 1** which was adopted:

Amendment 1CCC (with Title Amendment)—On page 148, strike all of lines 8-20 and insert:

Section 77. Paragraph (a) of subsection (4) and paragraph (b) of subsection (12) of section 627.6699, Florida Statutes, are amended to read:

627.6699 Employee Health Care Access Act.—

(4) APPLICABILITY AND SCOPE.—

(a) This section applies to a health benefit plan that provides coverage to a small employer in this state, unless the policy is marketed directly to the individual employee, and the employer does not participate in the collection or distribution of premiums or facilitate the administration of the policy in any manner. *This section does not apply to a health benefit plan issued under the Florida Health Security Act or to a carrier who issues coverage under the Florida Health Security Act.*

(12) STANDARD, BASIC, AND LIMITED HEALTH BENEFIT PLANS.—

(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 that 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" 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 providers. Any such written agreement between a provider and a small employer carrier must contain a provision under which the parties agree that the insured individual or covered member has no obligation to make payment for any medical service rendered by the provider which is determined not to be medically necessary. A carrier may use preferred provider arrangements or exclusive provider arrangements to the same extent as allowed in group products that are not issued to small employers.

b. A procedure for utilization review by the small employer carrier or its designees.

This subparagraph does not prohibit a small employer carrier from including in its policy or contract additional managed-care and cost-containment provisions, subject to the approval of the department, which have potential for controlling costs in a manner that does not result in inequitable treatment of insureds or subscribers. The carrier may use such provisions to the same extent as authorized for group products that are not issued to small employers.

4. The standard health benefit plan shall include:

a. Coverage for inpatient hospitalization;

b. Coverage for outpatient services;

- c. Coverage for newborn children pursuant to s. 627.6575;
- d. Coverage for child care supervision services pursuant to s. 627.6579;
- e. Coverage for adopted children upon placement in the residence pursuant to s. 627.6578;
- f. Coverage for mammograms pursuant to s. 627.6613;
- g. Coverage for handicapped children pursuant to s. 627.6615;
- h. Emergency or urgent care out of the geographic service area; and
- i. Coverage for services provided by a hospice licensed under s. 400.602 in cases where such coverage would be the most appropriate and the most cost-effective method for treating a covered illness; and
- j. Coverage for home and alternative site infusion therapy that is medically necessary and cost-effective, excluding parenteral nutrition therapy.

5. The standard health benefit plan and the basic health benefit plan may include a schedule of benefit limitations for specified services and procedures. If the committee develops such a schedule of benefits limitation for the standard health benefit plan or the basic health benefit plan, a small employer carrier offering the plan must offer the employer an option for increasing the benefit schedule amounts by 4 percent annually.

6. The basic health benefit plan shall include all of the benefits specified in subparagraph 4.; however, the basic health benefit plan shall place additional restrictions on the benefits and utilization and may also impose additional cost containment measures.

7. Sections 627.419(2), (3), and (4), 627.6574, 627.6616, 627.6618, and 627.668 apply to the standard health benefit plan and to the basic health benefit plan. However, notwithstanding said provisions, the plans may specify limits on the number of authorized treatments, if such limits are reasonable and do not discriminate against any type of provider.

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.

And the title is amended as follows:

In title, on page 184, line 31, after the first semicolon (;) insert: providing an additional benefit included under a standard health benefit plan offered by small employers;

Senator Silver moved the following amendment to **Amendment 1**:

Amendment 1DDD—On page 95, strike all of lines 14-17 and insert: ~~Administration~~ shall seek the advice of a ~~19-member~~ ~~16-member~~ advisory panel in formulating and adopting the fee schedule. The panel shall consist of Medicaid physicians licensed under chapters 458, ~~and~~ 459, 460, ~~and~~ 461, and shall be composed

Senators Silver and Dudley offered the following substitute amendment which was moved by Senator Silver and adopted:

Amendment 1EEE—On page 95, strike all of lines 14-17 and insert: ~~Administration~~ shall seek the advice of a ~~20-member~~ ~~16-member~~ advisory panel in formulating and adopting the fee schedule. The panel shall consist of Medicaid physicians licensed under chapters 458, ~~and~~ 459, 460, 461, ~~and~~ 463 and shall be composed

Senator Silver moved the following amendments to **Amendment 1** which were adopted:

Amendment 1FFF—On page 52, line 20, after the period (.) insert: Such plans shall include substance-abuse benefits as recommended by the Agency for Health Care Administration Basic Benefit Advisory Committee. Benefits taken at the end of one benefit year cannot be linked to benefits in the next year for greater benefits than would be allowed in one year.

Amendment 1GGG—On page 71, line 1, after "services" insert: and substance abuse services

Amendment 1HHH (with Title Amendment)—On page 173, between lines 9 and 10 insert:

Section 98. (1) Any entity that was providing diagnostic imaging services and was in existence before January 1, 1992, of which 50 percent was owned by a hospital or an affiliate of that hospital and 50 percent was owned by physicians, is exempt from section 455.236(4)(a), Florida Statutes, for purposes other than radiation therapy services, provided that each such entity submits to utilization review and rate review by the Agency for Health Care Administration. If, after review, the Agency for Health Care Administration finds that the rates being charged by the entity for such services are above those customarily charged for such services by similar facilities in the community, the agency may issue an administrative order under chapter 120, Florida Statutes, setting rates for each service being provided by the entity at the average level that is being charged for similar services in the community.

(2) The entity may annually request a review of any charges set under subsection (1) and may present evidence to the Agency for Health Care Administration on its own behalf. Chapter 120, Florida Statutes, applies to these procedures.

(Renumber subsequent section.)

And the title is amended as follows:

In title, on page 188, line 7, after the semicolon (;) insert: providing an exemption from s. 455.236(4)(a), F.S., for certain entities that were providing diagnostic imaging services before a specified date; providing for the Agency for Health Care Administration to review the rates charged for the services of such a facility and to set the rates in certain circumstances; providing for the entity to appeal such rates;

RECONSIDERATION OF AMENDMENT

On motion by Senator Dudley, the Senate reconsidered the vote by which **Amendment 1 HHH** was adopted.

Senators Dudley and Silver offered the following substitute amendment which was moved by Senator Dudley and adopted:

Substitute Amendment for Amendment 1HHH—On page 169, line 19, after the comma (,) insert: provided that no one physician can own more than 1 percent of the entity, and

Senator Silver moved the following amendment to **Amendment 1** which was adopted:

Amendment 1III (with Title Amendment)—On page 173, between lines 9 and 10, insert:

Section 98. Section 242.621, Florida Statutes, is created to read:

242.621 Appropriation to first accredited osteopathic medical school.—

(1) Subject to the provisions set forth in this section, the Legislature shall provide an annual appropriation to the first accredited school of osteopathic medicine. Payments of moneys from such appropriation shall be made semiannually at the beginning of the first and third quarters.

(2) In order for a school of osteopathic medicine to qualify under the provisions of this section and to be entitled to the benefits provided by this section, such school:

(a) Must be primarily operated and established to offer, afford, and render an osteopathic medical education to residents of the state qualifying for admission to such institution;

(b) Must be operated by a municipality or county of this state, or by a nonprofit organization heretofore or hereafter established exclusively for educational purposes;

(c) Must, upon the formation and establishment of an accredited school of osteopathic medicine, transmit and file with the Department of Education documentary proof that such institution has been certified and approved by the Bureau of Professional Education of the American Osteopathic Association and the Southern Association of Colleges and Schools and has adequately met the requirements in regard to its administrative facilities, administrative plant, clinical facilities, curriculum, and all other such requirements as may be necessary to qualify as a recognized, approved, and accredited school of osteopathic medicine;

(d) Must certify to the Department of Education the name, address, and educational history of each student approved and accepted for enrollment in such institution for the ensuing school year.

(3) The Department of Education shall, within 60 days after the receipt of the student enrollment of the school of osteopathic medicine, pay to the school, each year, the amount appropriated for students accepted and approved for enrollment in such institution, provided that each osteopathic medical student is a legal resident of the state or that, if the student is not of legal age, his parents or legal guardian are residents of the state at the time of the student's acceptance and approval as an osteopathic medical student. If a student resigns or is dismissed from such institution for any reason whatsoever before the end of a school year, then the institution shall, within 30 days after such dismissal or resignation, remit to the state, through the Department of Education, a pro rata amount of the sum before paid by the state to the institution, which amount is to be computed by dividing the total number of days in the school year into the sum paid for that student and multiplying the result by the total number of days remaining in such school year after such resignation or dismissal.

(4) Such institution is prohibited from expending any of the sums received under the terms of this section for any purposes whatsoever, except for the operation and maintenance of a school of osteopathic medicine and for osteopathic medical research. The institution is further prohibited from expending any sums received under the terms of this section for the construction or erection of any buildings of any kind, nature, or description or for the maintenance and operation of a hospital in any form or manner whatsoever.

Section 99. This act shall take effect July 1, 1994, except that this section and section 24 shall take effect upon becoming a law.

And the title is amended as follows:

In title, on page 188, strike all of line 7 and insert: a report; creating s. 242.621, F.S.; providing for appropriations to the state's first accredited school of osteopathic medicine in the same manner as appropriations to the state's first accredited school of medicine; providing effective dates.

Senator Grant moved the following amendment to **Amendment 1** which was adopted:

Amendment 1JJJ—On page 138, line 20, strike "6" and insert: 12

Senator Holzendorf moved the following amendment to **Amendment 1** which was adopted:

Amendment 1KKK—On page 68, lines 21-23, strike "actual and dedicated" and insert: authorized local

Senator Forman moved the following amendment to **Amendment 1** which was adopted:

Amendment 1LLL (with Title Amendment)—On page 158, strike all of lines 7-11

And the title is amended as follows:

In title, on page 186, strike all of lines 7-10 and insert: ability to deliver required services;

RECONSIDERATION OF AMENDMENT

On motion by Senator Dudley, the Senate reconsidered the vote by which **Amendment 1LLL** was adopted. The question recurred on **Amendment 1LLL** which failed.

Senator Sullivan moved the following amendment to **Amendment 1** which was adopted:

Amendment 1MMM (with Title Amendment)—On page 165, between lines 4 and 5, insert:

Section 83. Paragraph (b) of subsection (4) of section 766.314, Florida Statutes, is amended to read:

766.314 Assessments; plan of operation.—

(4) The following persons and entities shall pay into the association an initial assessment in accordance with the plan of operation:

(b)1. On or before October 15, 1988, all physicians licensed pursuant to chapter 458 or chapter 459 as of October 1, 1988, other than participating physicians, shall be assessed an initial assessment of \$250, which must be paid no later than December 1, 1988.

2. Any such physician who becomes licensed after September 30, 1988, and before January 1, 1989, shall pay into the association an initial assessment of \$250 upon licensure.

3. Any such physician who becomes licensed on or after January 1, 1989, shall pay an initial assessment equal to the most recent assessment made pursuant to this paragraph, paragraph (5)(a), or paragraph (7)(b).

4. However, if the physician is a physician specified in this subparagraph, the assessment is not applicable:

a. A resident physician, assistant resident physician, or intern in an approved postgraduate training program, as defined by the Board of Medicine or the Board of Osteopathic Medicine by rule;

b. A retired physician who has withdrawn from the practice of medicine but who maintains an active license as evidenced by an affidavit filed with the Department of Professional Regulation. Prior to reentering the practice of medicine in this state, a retired physician as herein defined must notify the Board of Medicine or the Board of Osteopathic Medicine and pay the appropriate assessments pursuant to this section;

c. A physician who holds a limited license pursuant to s. 458.317 and who is not being compensated for medical services;

d. A physician who is employed full time by the United States Department of Veterans Affairs and whose practice is confined to United States Department of Veterans Affairs hospitals; or

e. A physician who is a member of the Armed Forces of the United States and who meets the requirements of s. 455.02; or

f. A physician who is employed full time by the State of Florida and whose practice is confined to state-owned correctional institutions and state-owned mental health facilities.

And the title is amended as follows:

In title, on page 186, line 29, after the semicolon (;) insert: amending s. 766.314, F.S.; revising an exemption from the assessment on physicians for deposit with the Florida Birth-Related Neurological Injury Compensation Association;

Senator Jones moved the following amendment to **Amendment 1**:

Amendment 1NNN—On page 44, line 28, insert:

(11) The ability to recruit and retain alliance district health care providers in its provider network. For provider networks initially formed in an alliance district after July 1, 1993, an accountable health partnership shall make offers as to provider participation in its provider network to relevant alliance district health care providers for at least 60 percent of the available provider positions. A provider who is made an offer may participate in an accountable health partnership as long as the provider abides by the terms and conditions of the provider network contract, provides services at a rate or price equal to the rate or price negotiated by the accountable health partnership, and meets all of the accountable health partnership's qualifications for participation in its provider networks including, but not limited to, network adequacy criteria. For purposes of this subsection, "alliance district health care provider" means a health care provider who is licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 465 or chapter 467, or chapter 383 who has practiced in Florida for more than 1 year within the alliance district served by the accountable health partnership.

Senator Siegel moved the following substitute amendment which was adopted:

Amendment 1000—On page 44, line 28, insert:

(11) The ability to recruit and retain alliance district health care providers in its provider network. For provider networks initially formed in an alliance district after July 1, 1993, an accountable health partnership shall make offers as to provider participation in its provider network to relevant alliance district health care providers for at least 60 percent of the available provider positions. A provider who is made an offer may participate in an accountable health partnership as long as the provider abides by the terms and conditions of the provider network contract, provides services at a rate or price equal to the rate or price negotiated by the accountable health partnership, and meets all of the accountable health partnership's qualifications for participation in its provider networks including, but not limited to, network adequacy criteria. For pur-

poses of this subsection, "alliance district health care provider" means a health care provider who is licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 463, ~~or~~ chapter 465, chapter 467, or chapter 383 who has practiced in Florida for more than 1 year within the alliance district served by the accountable health partnership.

Senator Jones moved the following amendment to **Amendment 1** which was adopted:

Amendment 1PPP—On page 44, strike line 24 and insert:

Section 21. Subsection (11) of section 408.706, Florida Statutes, is amended, and subsections (14), (15), (16), (17), and (18) are

THE PRESIDENT PRESIDING

Senator Holzendorf moved the following amendment to **Amendment 1** which was adopted:

Amendment 1QQQ (with Title Amendment)—On page 137, between lines 4 and 5, insert:

Section 73. Paragraph (f) is added to subsection (2) of section 624.5092, Florida Statutes, to read:

624.5092 Administration of taxes; payments.—

(2)

(f) *No interest or penalties shall be assessed against any entity collecting workers' compensation premiums for underpayments of estimated insurance premium taxes to the extent that the total estimated and final payments made for the tax year equal or exceed the taxes actually due, and such underpayments are attributable to the difference between taxes due before applying the credit allowed for assessments imposed pursuant to s. 440.51 and taxes due after applying such credit. It is the intent of the Legislature that this paragraph be construed broadly and applied retroactively in a remedial manner.*

Section 74. Subsection (7) is added to section 624.4095, Florida Statutes, to read:

624.4095 Premiums written; restrictions.—

(7) *For the purposes of this section, annual net or gross written premiums shall be reduced by the amount of premiums paid by an insurer to another insurer or health maintenance organization to provide the services of a workers' compensation managed care arrangement, provided that such other insurer or health maintenance organization bears the risk of providing such services; provided, however, that the annual net or gross written premiums shall not be reduced by a total of more than 33 percent.*

Section 75. Subsection (1) of section 631.271, Florida Statutes, is amended to read:

631.271 Priority of claims.—

(1) The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth in this subsection. Every claim in each class shall be paid in full or adequate funds shall be retained for such payment before the members of the next class may receive any payment. No subclasses may be established within any class. The order of distribution of claims shall be:

(a) Class 1.—

1. All of the receiver's costs and expenses of administration.

2. All of the expenses of a guaranty association or foreign guaranty association in handling claims.

(b) ~~Class 2.—Claims of the Federal Government.~~

(c) ~~Class 3.—Debts due to employees for services performed, to the extent that such debts do not exceed \$2,000 for each employee and represent payment for services performed within 6 months before the filing of the petition for liquidation. Officers and directors are not entitled to the benefit of this priority. Such priority is in lieu of any other similar priority which may be authorized by law as to wages or compensation of employees.~~

(b)(d) Class 2 4.—All claims under policies for losses incurred, including third-party claims, all claims against the insurer for liability for

bodily injury or for injury to or destruction of tangible property which claims are not under policies, and all claims of a guaranty association or foreign guaranty association. All claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values, shall be treated as loss claims. That portion of any loss, indemnification for which is provided by other benefits or advantages recovered by the claimant, may not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligations of support or by way of succession at death or as proceeds of life insurance, or as gratuities. No payment by an employer to his employee may be treated as a gratuity.

(c)(e) Class 3 5.—Claims under nonassessable policies for unearned premiums or premium refunds ~~and claims of general creditors.~~

(d) Class 4.—*Claims of the Federal Government.*

(e) Class 5.—*Debts due to employees for services performed, to the extent that such debts do not exceed \$2,000 for each employee and represent payment for services performed within 6 months before the filing of the petition for liquidation. Officers and directors are not entitled to the benefit of this priority. Such priority is in lieu of any other similar priority that may be authorized by law as to wages or compensation of employees.*

(f) Class 6.—*Claims of general creditors.*

(g)(f) Class 7 6.—Claims of any state or local government. Claims, including those of any state or local government for a penalty or forfeiture, shall be allowed in this class, but only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of such claims shall be postponed to the class of claims under paragraph (j) (i).

(h)(g) Class 8 7.—Claims filed after the time specified in s. 631.181(3), except when ordered otherwise by the court to prevent manifest injustice, or any claims other than claims under paragraph (i) (h) or under paragraph (j) (i).

(i)(h) Class 9 8.—Surplus or contribution notes, or similar obligations, and premium refunds on assessable policies. Payments to members of domestic mutual insurance companies shall be limited in accordance with law.

(j)(i) Class 10 9.—The claims of shareholders or other owners.

Section . The amendments to section 631.271, Florida Statutes, made by this act apply to any distribution occurring on or after the effective date of this act, regardless of the date of the insolvency.

Section 76. Subsection (3) of section 631.713, Florida Statutes, is amended to read:

631.713 Application of part.—

(3) This part ~~does~~ shall not apply to:

(a) That portion or part of a variable life insurance contract or variable annuity contract not guaranteed by an insurer.

(b) That portion or part of any policy or contract under which the risk is borne by the policyholder.

(c) Any policy or contract or part thereof assumed by the impaired or insolvent insurer under a contract of reinsurance, other than reinsurance for which assumption certificates have been issued.

(d) Fraternal benefit societies as defined in s. 632.601.

(e) Health maintenance insurance.

(f) Dental service plan insurance.

(g) Pharmaceutical service plan insurance.

(h) Optometric service plan insurance.

(i) Ambulance service association insurance.

(j) Preneed funeral merchandise or service contract insurance.

(k) Prepaid health clinic insurance.

(l) Any annuity contract or group annuity contract that ~~which~~ is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under such contract or certificate.

(m) Any federal employees' group policy or contract that, under federal law, is prohibited from being subject to an assessment under s. 631.718.

Section 77. Subsections (2), (3), and (6) of section 631.717, Florida Statutes, are amended, and subsection (12) is added to that section, to read:

631.717 Powers and duties of the association.—

(2) If a domestic insurer is an insolvent insurer, the association shall, subject to the approval of the department:

(a) Guarantee, assume, or reinsure or cause to be guaranteed, assumed, or reinsured the covered policies of persons referred to in s. 631.713(2) ~~the insolvent insurer; and~~

(b) Provide such moneys, pledges, notes, guarantees, or other means as are proper and reasonably necessary to effectuate paragraph (a) in order to assure payment of the contractual obligations of the insolvent insurer with regard to persons referred to in s. 631.713(2); ~~and~~

~~(c) Provide such moneys, pledges, notes, guarantees, or other means as are reasonably necessary to discharge such duties.~~

(3) If a foreign or alien insurer is an insolvent insurer, the association shall, subject to the approval of the department:

(a) Guarantee, assume, or reinsure or cause to be guaranteed, assumed, or reinsured the covered policies of residents of this state; ~~and~~

(b) Provide such moneys, pledges, notes, guarantees, or other means as are proper and reasonably necessary to effectuate paragraph (a) in order to assure payment of the contractual obligations of the insolvent insurer with regard to persons referred to in s. 631.713(2); ~~to residents of this state; and~~

~~(c) Provide such moneys, pledges, notes, guarantees, or other means as are reasonably necessary to discharge such duties.~~

However, this subsection ~~does shall~~ not apply when the department has determined that the foreign or alien insurer's domiciliary jurisdiction or state of entry provides, by statute, protection substantially similar to that provided by this part for residents of this state.

(6) The association may assist and advise the department, upon its request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer. The association may also assist and advise departments of insurance of other states; other guaranty associations; and conservators, rehabilitators, and receivers appointed or acting in regard to any member insured wherever located, for the purpose of developing plans to coordinate protection of policyholders. Costs of such activities may be charged against the health insurance account, or the life insurance account, or the annuity account, created by s. 631.715, at the discretion of the board of directors, notwithstanding any other provision of this part.

(12)(a) When proceeding under subsections (2) and (3), the association may, with respect only to life and health insurance policies:

1. With respect to individual or group policies, make substitute coverage on an individual or group basis in accordance with subparagraph 2. available to each known insured, or owner if other than the insured, and with respect to an individual insured under a group policy as of the date the association became obligated who is not eligible for replacement group coverage.

2.a. In providing the substitute coverage required under subparagraph 1., the association may offer either to reissue the terminated policy or to issue an alternative policy.

b. Alternative or reissued policies must be offered without requiring evidence of insurability, and may not provide for any waiting period or exclusion that would not have applied under the terminated policy.

(b) The association may reinsure any alternative or reissued policy under this subsection.

(c) Alternative or reissued policies adopted by the association must be subject to the approval of the department upon such terms and conditions as the department deems appropriate, given the function and special purpose of the association. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency.

(d) Alternative or reissued policies must contain at least the minimum statutory provisions required under this code and must provide benefits that are not unreasonable in relation to the premium charged. The association must set the premium in accordance with a table of rates adopted by the association. The premium must reflect the amount of insurance to be provided and the age and class of risk of each insured, but must not reflect any changes in the health of the insured occurring after the original policy was last underwritten.

(e) Alternative policies issued by the association shall provide coverage of a type generally similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association.

(f) The association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy must cease on the date that such coverage is replaced with another similar policy by the association. Any reissued, reinsured, or alternative policy must, however, be subject to association coverage if the replacement insurer becomes impaired or insolvent as otherwise provided for in this part.

Section 78. Subsections (3), (5), and (9) of section 631.718, Florida Statutes, are amended to read:

631.718 Assessments.—

(3)(a) The amount of any Class A assessment ~~must shall~~ be determined by the board and may be made on a non-pro rata basis. Such assessment ~~may shall~~ not be credited against future insolvency assessments and ~~may shall~~ not exceed \$250 per member insurer in any one calendar year.

(b) The amount of any Class B assessment ~~must shall~~ be allocated for assessment purposes among the accounts pursuant to an allocation formula, which may be based on the premiums or reserves of the impaired or insolvent insurer.

~~(c) Class B assessments against foreign or alien insurers for each account shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies covered by each account for the calendar year preceding the assessment bear to such premiums received on business in this state for the calendar year preceding the assessment by all assessed member insurers.~~

(c)(d) Class B assessments against member insurers for each account ~~must shall~~ be based on ~~in the proportion that~~ the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account for the 3 most recent calendar years for which information is available preceding the year in which the insurer became impaired or insolvent, as the case may be, ~~in proportion bears~~ to such premiums received on business in this state for such calendar years by all assessed member insurers. ~~If data for 3 years is not available, the board of directors may use any data that is reasonably available.~~

(d)(e) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer ~~may shall~~ not be made until necessary to implement the purposes of this part.

(e)(f) Classification of assessments under subsection (2) and computation of assessments under this subsection ~~must shall~~ be made with a reasonable degree of accuracy, recognizing that exact determinations ~~are may~~ not always be possible.

(5)(a) The total of all assessments upon a member insurer for each account ~~may shall~~ not in any one calendar year exceed 1 percent of:

1. Except as provided in subparagraph 2., the sum of the insurer's premium written in this state regarding business covered by the account received during the 3 calendar years preceding the year in which the association became obligated, divided by 3.

2. If in any calendar year the association makes assessments for impairments or insolvencies that require assessments in more than one calendar year, the greater of:

a. The sum of the insurer's premium written in this state regarding business covered by the account received during the 3 calendar years preceding the year in which the association became obligated, divided by 3; or

b. The sum of the insurer's premium written in this state regarding business covered by the account received during the 3 calendar years preceding the year in which the assessment is made, divided by 3.

3. If data for the 3-year periods specified in this paragraph are not reasonably available, the association may use any reasonably available information to make the determination required by this paragraph ~~such as the insurer's premiums written in this state during the calendar year preceding the assessment on the policies covered by the account.~~

(b) In order to achieve coordination of the assessment process, the assessment provisions of this subsection apply to any assessments made on or after the effective date of this act, without regard to the date of the impairment or insolvency.

(c) If the maximum assessment, together with the other assets of the association in its nonadministrative accounts ~~either account~~, does not provide in any one year in any ~~either~~ account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds ~~shall~~ be assessed as soon thereafter as permitted by this part.

(9) Notwithstanding any provision to the contrary, no member insurer that is a nonprofit insurance company under s. 501(c)(3) of the United States Internal Revenue Code which issues annuity contracts or group annuity contracts pursuant to s. 121.35, or for the benefit of employees of educational institutions situated in this state for the purpose of providing retirement benefits may be assessed in any one calendar year an amount greater than the amount that ~~which~~ it paid to this state in the previous year as premium tax and corporate income tax on the business to which this part applies or 0.1 percent of written premium on such business in this state, whichever amount is greater.

Section 79. Subsection (1) of section 631.719, Florida Statutes, is amended to read:

631.719 Premium or income tax credits for assessments paid.—

(1) A member insurer may offset against its premium or income tax liability or liabilities to this state any assessment described in s. 631.718(8) as follows:

(a) For each assessment levied before January 1, 1995, ~~to the extent~~ of 0.1 percent of the amount of such assessment for each year following the year in which such assessment was paid.

(b) For each assessment levied and paid after December 31, 1994, 5 percent of the amount of the assessment for each of the 20 calendar years following the year in which the assessment was paid.

~~If in the event~~ a member insurer ceases ~~should cease~~ doing business, all uncredited assessments may be credited against its premium or corporate income tax liability or liabilities for the year it ceases doing business.

Section 80. Subsection (2) of section 631.821, Florida Statutes, is amended to read:

631.821 Powers and duties of the department.—

(2) Any action of the board of directors of the plan may be appealed to the department by any member HMO if such appeal is taken within 21 ~~30~~ days after the date of the action being appealed; however, the HMO must comply with such action under s. 631.818(2) pending exhaustion of appeal. Any appeal must ~~shall~~ be promptly determined by the department, and the final action or order of the department is ~~shall be~~ subject to judicial review in a court of competent jurisdiction.

Section 81. Subsection (3) of section 631.719, Florida Statutes, as created by section 95 of chapter 90-132, Laws of Florida, providing for the repeal of section 631.719, Florida Statutes, on July 1, 1994, is repealed.

And the title is amended as follows:

In title, on page 184, line 12, after the semicolon (;) insert: amending s. 624.5092, F.S.; prohibiting the assessment of interest or penalties against entities collecting workers' compensation premiums under certain circumstances; providing legislative intent; amending s. 624.4095, F.S., relating to premiums; providing for the reduction of certain premiums by the amount of premiums paid for certain workers' compensation man-

aged care arrangements; amending s. 631.271, F.S.; revising the priority of distribution of claims from an insurer's estate; specifying applicability; amending s. 631.713, F.S.; exempting certain policies and contracts from part III of ch. 631, F.S.; amending s. 631.717, F.S.; providing duties of the association; providing for alternative or reissued policies and specifying obligations thereunder; amending s. 631.718, F.S.; revising procedures for and limits on assessments by the association; specifying applicability; amending s. 631.719, F.S.; providing for premium tax or corporate income tax credits for assessments paid; amending s. 631.821, F.S.; specifying time for appeal of Florida Health Maintenance Organization Consumer Assistance Plan actions; requiring compliance pending exhaustion of appeal; repealing s. 631.719(3), F.S., relating to scheduled repeal of s. 631.719, F.S.;

Senator Foley moved the following amendment to **Amendment 1** which was adopted:

Amendment 1RRR (with Title Amendment)—On page 37, between lines 19 and 20, insert:

Section 16. Subsection (13) of section 408.701, Florida Statutes is amended to read:

408.701 Community health purchasing; definitions.—As used in ss. 408.70-408.706, the term:

(13) "Health care provider" or "provider" means a state-licensed or state-authorized facility, a facility principally supported with local government funds or funds from a charitable organization as defined in s. 737.501, a licensed practitioner, or a county public health unit established under Part I of chapter 154, or a federally supported primary care program such as a migrant or community health center authorized under sections 329 and 330 of the U.S. Public Health Services Act which delivers health care services to individuals, or a community facility that provides mental health or substance abuse services as defined in s. 394.455(7).

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 5, line 17, after the semicolon (;) insert: amending s. 408.701, F.S., expanding the definition of provider to include certain nonprofit and publicly funded entities;

Senator Gutman moved the following amendment to **Amendment 1**:

Amendment 1SSS—On page 170, between lines 2 and 3, insert:

Section 87. The Department of Revenue shall, before January 1, 1995, conduct a study and submit it to the legislature concerning the tax status of nonprofit hospitals. Such study shall include, but not be limited to:

(1) The value of current exemptions from taxation on sales, property, and intangibles;

(2) A methodology for measuring the value of the exemptions enumerated in subsection (1) as compared to the value, reduced to actual costs, of charity care provided;

(3) Analyses of profits earned by for-profit subsidiaries of such hospitals and the manner in which such profits are used; and

(4) Recommendations as to legislation which restricts the value of exemptions to no more than the value of charity care provided as measured by the actual cost thereof.

(Renumber subsequent sections.)

POINT OF ORDER

Senator Dudley raised a point of order that pursuant to Rules 7.1, 6.9 and 2.1, **Amendment 1SSS** contained language of a bill not reported favorably by a Senate committee and was therefore out of order.

RULING ON POINT OF ORDER

The President ruled the point well taken and the amendment out of order.

Senator Crenshaw moved the following amendment to **Amendment 1** which was adopted:

Amendment 1TTT (with Title Amendment)—On page 38, between lines 5 and 6 insert:

Section 17. Section 408.7021, Florida Statutes, is created to read:

408.7021 Alliances; compliance with public records and meetings requirements.—

(1) A community health purchasing alliance is an “agency” for the purpose of the applicability of chapter 119, and all records of an alliance are public records in the same manner as if such records were made or received by the Agency for Health Care Administration.

(2) The board of directors of a community health purchasing alliance is governed by the provisions of s. 286.011. All meetings between two or more members of the board of directors of a community health purchasing alliance and a representative or employee of the Agency for Health Care Administration, directly regarding matters to be voted upon by the board within 30 days following the meeting, are subject to the provisions of s. 286.011.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 175, line 25, after the first semicolon (;) insert: creating s. 408.7021, F.S.; providing for records of a community health purchasing alliance to be subject to ch. 119, F.S.; providing for certain meetings of the board of directors of a community health purchasing alliance to be subject to s. 286.011, F.S., relating to public meetings;

Senator Sullivan moved the following amendment to **Amendment 1** which was adopted:

Amendment 1UUU (with Title Amendment)—Between page 117, line 31 and page 118, line 1, insert:

(8) *The agency, in consultation with the Department of Health and Rehabilitative Services, shall select providers who meet the criteria established by the Children’s Medical Services Program Office of the department to serve as MediPass primary care providers for chronically ill children. The Children’s Medical Service Program Office shall make available its specialty services system for child recipients of Medicaid with chronic illnesses. Medicaid managed care providers shall use this service system or a comparable system of care based upon standards and criteria established by the agency, in consultation with the Children’s Medical Services Program Office. A comparable system of care includes tertiary, regional and community-based providers, facilities, and services and shall be coordinated with education and social service systems to ensure that the most appropriate and medically necessary services or levels of care are provided. Services available in the system include, but are not limited to, case management, health education, early intervention, primary care, subacute care, specialty care, tertiary care, home health care, hospice, long-term care, medical rehabilitation, enabling services such as transportation and home visits, skilled nursing service, respite care, and other services deemed necessary to maintain a chronically ill child at home. The Children’s Medical Services Program, Florida’s Title V Program for children with special health care needs, shall assure that a system of care is maintained or expanded to meet the needs of Florida’s chronically ill children and may collaborate with managed care providers to provide supplemental or long term care services.*

(9) *The agency, in consultation with the State Health Officer and the Assistant Secretary for Children’s Medical Services, shall develop patient care standards for use in contracting for and monitoring the quality of inpatient and ambulatory care for all Medicaid managed care providers including those serving children and adolescents with special health care needs, children and adults with mental health and substance abuse disorders, and high-risk perinatal patients.*

And the title is amended as follows:

In title, on page 181, line 19, after the semicolon (;) insert: directing the Agency for Health Care Administration to develop criteria that selects providers for chronically ill children;

Senators Forman and Myers offered the following amendment to **Amendment 1** which was moved by Senator Forman and failed:

Amendment 1VVV (with Title Amendment)—On page 172, line 23, strike “Section 407.61; subsections” and insert: Subsections

And the title is amended as follows:

In title, on page 187, strike all of lines 18 and 19 and insert: s.

The vote was:

Yeas—15 Nays—17

Senator Gutman moved the following amendment to **Amendment 1** which was adopted:

Amendment 1WWW (with Title Amendment)—On page 120, between lines 2 and 3, insert:

Section 50. Section 455.218, Florida Statutes, as amended by section 48 of chapter 92-33, Laws of Florida, section 16 of chapter 92-149, Laws of Florida, and section 23 of chapter 93-129, Laws of Florida, is amended to read:

(Substantial rewording of section. See s. 455.218, F.S., for present text.)

455.218 Examination of experienced foreign-trained professionals; licensure by endorsement; restricted practice; licensure.—

(1) Notwithstanding any other provision of law, the department, in consultation with the appropriate board, shall provide procedures under which a professional who is foreign-trained and who has held a foreign license to practice a profession which in this state is regulated within the department shall be examined and may be granted a license to practice that profession according to the provisions of this section. A person is eligible for such examination if the person:

(a) Is not under discipline, investigation, or prosecution in any jurisdiction for an action that would constitute a violation of this chapter or the appropriate professional practice act and that substantially threatened or threatens the public health, safety, or welfare;

(b) Applies to the department and submits an application fee which is nonrefundable and equivalent to that for full licensure within the appropriate profession;

(c) Submits an examination fee which shall be any fixed examination fee required of applicants for full licensure plus the actual per applicant cost to the department to provide the competency examination authorized by this section;

(d) Is a United States citizen or a permanent resident of the United States, has been granted temporary permanent resident status by the United States Immigration and Naturalization Service, or has applied to become a permanent resident of the United States; and is a resident of the state;

(e) Was a resident of the state immediately preceding the person’s application;

(f) Graduated from a professional or occupational school, college, or university appropriate to the profession as determined by rule of the department, in consultation with the appropriate board; and

(g) Actively practiced the profession in a foreign national jurisdiction outside the United States for at least the amount of time required of a professional seeking licensure by endorsement, if provided for by statute for that profession or, if endorsement is not provided for, at least 1 year.

(2) The department, in consultation with the appropriate board, may not permit an applicant for the examination pursuant to this section to sit for the examination more times than the law permits an applicant for full licensure to sit for that examination.

(3) If the applicant passes the examination, the appropriate board or the department shall require the applicant to appear before the board or the department before issuing the restricted license. The board or the department may impose reasonable restrictions on the applicant’s license to practice. These restrictions may include, but are not limited to:

(a) Periodic and random departmental audits of the licensee's patient or client records and review of those records by the board or the department.

(b) Periodic appearances of the licensee before the board or the department.

(c) Submission of written reports to the board or the department.

(d) Approved coursework.

(4) The board or the department may require a restricted licensee to practice under the direct supervision of a full licensee.

(5) The department, in consultation with the appropriate board, may approve preparatory coursework.

(6) The department, in consultation with the appropriate board, shall develop, provide, or contract for, or approve others to develop or provide, any examination required pursuant to this section. An examination administered pursuant to this section must adequately and reliably test the applicant's current ability to practice the profession with care, skill, and safety. The examination must be the same as that administered for full licensure, if reasonably available, or the examination must be comparable to that administered for full licensure. The department may use the appropriate board's assistance to develop or select an examination required by this section.

(7) The examinations offered under this section must, upon an applicant's request, be given in the applicant's native language, provided that translation costs are borne by the class of applicants seeking translation.

(8) Notwithstanding any other provision of law, the appropriate board, or the department when there is no board, shall issue the appropriate license by endorsement to a foreign-trained professional who, upon applying to the department and remitting the appropriate fee, demonstrates that he holds a valid license to practice that profession in another state of the United States, another national jurisdiction, or a state or territory of another jurisdiction, provided that, when the applicant secured his original license, the requirements for licensure were substantially equivalent to or more stringent than those existing in this state at that time. The department, may, by rule, specify states, territories, or nations the examinations and requirements of which are or were substantially equivalent to those of this state.

(9)(a) A restricted license issued by the department pursuant to this section is valid for 1 year. A restricted licensee is subject to the requirements of chapter 455, the applicable practice act, and any other law not in conflict with this section. Upon expiration of the restricted license, a restricted licensee may become a full licensee if the restricted licensee:

1. Is not under discipline, investigation, or prosecution for a violation that posed or poses a substantial threat to the public health, safety, or welfare;

2. Pays all renewal fees required of a full licensee; and

3. Receives approval from the appropriate board or the department.

(b) The appropriate board or the department shall renew a restricted license upon payment of the same fees required for renewal for a full license if the restricted licensee is under discipline, investigation, or prosecution for a violation that posed or poses a substantial threat to the public health, safety, or welfare and the board or the department has not permanently revoked the restricted license. A restricted licensee who has renewed the license is eligible for full licensure when the licensee is no longer under discipline, investigation, or prosecution and meets the criteria set forth in paragraph (a).

(10) The department shall adopt rules necessary to carry out the provisions of this section.

(Renumber subsequent sections.)

And the title is amended as follows:

In title, on page 181, line 26, following the second semicolon (;) insert: amending s. 455.218, F.S.; providing guidelines for professional licensure of foreign-trained professionals; providing for restricted licenses;

The vote was:

Yeas—18 Nays—14

Amendment 1 as amended was adopted.

On motion by Senator Forman, by two-thirds vote **CS for CS for SB 3060** as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—24 Nays—16

RECONSIDERATION

On motion by Senator Wexler, the Senate reconsidered the vote by which—

SB 3174—A bill to be entitled An act relating to taxation; amending s. 212.08, F.S.; providing an exemption for labor charges for repair and maintenance of certain aircraft; amending s. 69.041(4), F.S., as added by s. 2, House Bill 2557 (1994), which provides requirements relating to the right of the Department of Revenue to participate in the disbursement of surplus funds in mortgage foreclosure actions; clarifying applicability of those requirements; amending s. 125.0104, F.S., as amended by s. 3, House Bill 2557 (1994); clarifying applicability of changes related to the local collection and administration of tourist development taxes; amending s. 44, House Bill 2557 (1994); clarifying when an amendment by that act to s. 193.1142, F.S., which prescribes a requirement for assessment rolls, takes effect; amending s. 46, House Bill 2557 (1994); clarifying when certain amendments by that act to s. 196.011, F.S., relating to applications for tax exemption, take effect; amending s. 196.101, F.S., as amended by s. 36, House Bill 2557 (1994), relating to the exemption for totally and permanently disabled persons; conforming the physician's certification to changes made by that act; amending s. 199.232, F.S.; clarifying the time period within which a refund of intangible personal property tax may not be made; amending s. 212.05, F.S., as amended by s. 8, House Bill 2557 (1994), relating to the sales, storage, and use tax; clarifying applicability of an exemption for charges for detective, burglar protection, and other protection security services which was enacted by that act; amending s. 212.18, F.S., as amended by s. 12, House Bill 2557 (1994), to restore the amount of the sales tax dealer registration fees which was changed without coding indicating that a change was being made; amending s. 215.26, F.S., as amended by s. 50, House Bill 2557 (1994), relating to repayment of funds erroneously paid into the State Treasury; clarifying exceptions to applicability which were enacted by that act; amending s. 220.727, F.S., as amended by s. 51, House Bill 2557 (1994); clarifying when payments of estimated tax are deemed paid; revising internal cross-references to conform to the reorganization of the section by that act; amending s. 74, House Bill 2557 (1994), which amends s. 320.131, F.S., relating to temporary tags; delaying the effective date of the fee increase made by that act; repealing ss. 18 and 19, House Bill 2557 (1994), which amend s. 624.5091, F.S., effective July 1, 1994, relating to insurer retaliatory provisions; to clarify the applicability of that section to certain taxes and assessments; reenacting similar provisions effective upon becoming a law; providing for retroactive operation in part; providing effective dates.

—passed this day.

On motion by Senator Wexler, by two-thirds vote the Senate reconsidered the vote by which **SB 3174** was read the third time.

MOTION TO RECONSIDER AMENDMENT

Senator Gutman moved that the Senate reconsider the vote by which **Amendment 1** failed. The motion failed.

Senator Kirkpatrick moved the following amendment which was adopted:

Amendment 2 (with Title Amendment)—On page 16, between lines 21 and 22, insert:

Section 16. Effective July 1, 1994, paragraph (b) of subsection (1) of section 212.08, Florida Statutes, is amended to read:

212.08 Sales, rental, use, consumption, distribution, and storage tax; specified exemptions.—The sale at retail, the rental, the use, the consumption, the distribution, and the storage to be used or consumed in this state of the following are hereby specifically exempt from the tax imposed by this part.

(1) EXEMPTIONS; GENERAL GROCERIES.—

(b)1. Food or drinks not exempt under paragraph (a) shall be exempt, notwithstanding that paragraph, when purchased with food coupons or Special Supplemental Food Program for Women, Infants, and Children vouchers issued under authority of federal law.

2. This paragraph is effective only while federal law prohibits a state's participation in the federal food coupon program or Special Supplemental Food Program for Women, Infants, and Children if there is an official determination that state or local sales taxes are collected within that state on purchases of food or drinks with such coupons.

3. This paragraph shall not apply to any food or drinks on which federal law shall permit sales taxes without penalty, such as termination of the state's participation.

4. Notwithstanding any other provision of law, the department shall make refunds or allow credits to a distributor equal to the fee imposed and paid under s. 403.7197 on containers purchased by consumers with food coupons or Special Supplemental Food Program For Women, Infants, and Children vouchers issued under authority of federal law.

(Renumber subsequent section.)

And the title is amended as follows:

In title, on page 3, line 2, after the semicolon (;) insert: amending s. 212.08, F.S.; allowing credits on refunds for certain taxes imposed and paid under s. 403.7197, F.S.;

On motion by Senator Wexler, by two-thirds vote SB 3174 as amended was read the third time by title, passed, ordered engrossed and then certified to the House. The vote on passage was:

Yeas—36 Nays—1

On motions by Senator Forman, by two-thirds vote HB 2837 was withdrawn from the Committees on Health Care, Commerce and Appropriations.

On motion by Senator Forman, by unanimous consent—

HB 2837—A bill to be entitled An act related to trust funds; creating the Florida Health Security Trust Fund, to be administered by the Agency for Health Care Administration; providing for source of moneys and purposes; providing for future review and termination or re-creation of the fund; providing a contingent effective date.

—was taken up out of order and read the second time by title.

Senator Forman moved the following amendments which were adopted:

Amendment 1—On page 1, line 15, strike HB and insert: SB 3060

Amendment 2—On page 2, line 14, strike HB and insert: SB 3060

On motion by Senator Forman, by two-thirds vote HB 2837 as amended was read the third time by title, passed by the required constitutional three-fifths vote of the membership, and certified to the House. The vote on passage was:

Yeas—40 Nays—None

RECESS

On motion by Senator Kirkpatrick, the Senate recessed at 4:45 p.m. to reconvene at 5:30 p.m.

EVENING SESSION

The Senate was called to order by the President at 6:15 p.m. A quorum present—38:

Mr. President	Diaz-Balart	Jenne	Scott
Bankhead	Dudley	Jennings	Siegel
Beard	Dyer	Johnson	Silver
Boczar	Foley	Jones	Sullivan
Burt	Forman	Kirkpatrick	Turner
Casas	Grant	Kiser	Weinstein
Childers	Grogan	Kurth	Wexler
Crenshaw	Harden	McKay	Williams
Crist	Hargrett	Meadows	
Dantzer	Holzendorf	Myers	

EXECUTIVE BUSINESS

The Honorable Pat Thomas
President, The Florida Senate

April 14, 1994

Dear Mr. President:

The following executive appointments were referred to the Senate Committee on Executive Business, Ethics and Elections for action pursuant to Rule 12.7(a) of the Rules of the Florida Senate:

Office and Appointment	For Term Ending
Board of Acupuncture Appointee: Fraser, John Michael	09/30/93
Florida Building Code Administrators and Inspectors Board Appointee: Alexander, Stanton Malone	10/31/93
Acting Secretary of Business and Professional Regulation Appointee: Stuart, George Lewis, Jr.	Pleasure of Governor
Acting Capital Collateral Representative for the State of Florida Appointee: Minerva, Michael J.	07/31/97
Board of Dentistry Appointee: Jennings, Lewis	10/31/96
Education Practices Commission Appointee: Brogan, Frank Timothy	09/30/94
Commission on Ethics Appointee: Hazouri, Thomas Lester	06/30/95
Historic Florida Keys Preservation Board of Trustees Appointee: Olsen, Susan	06/30/97
Board of Directors, Prison Rehabilitative Industries and Diversified Enterprises, Inc. Appointee: Ogilvie, Charles H.	09/30/93
Florida Public Service Commission Appointee: Kiesling, Diane K.	01/01/94
Apalachee Regional Planning Council, Region 2 Appointee: Bullock, William Wycliffe	10/01/93
Coastal Rivers Basin Board of the Southwest Florida Water Management District Appointee: Henderson, Evelyn Chester	03/01/94
Pinellas-Anclote River Basin Board of the Southwest Florida Water Management District Appointee: Getting, Paul Lloyd	03/01/96

The Senate Committee on Executive Business, Ethics and Elections has failed to consider these appointments because the committee finds that:

- (a) the terms of the following persons have expired: John Michael Fraser, Alexander Stanton Malone, Charles H. Ogilvie, Diane K. Kiesling, William Wycliffe Bullock, and Evelyn Chester Henderson.
- (b) the following persons have resigned: Lewis Jennings, effective 10/14/93; Frank Timothy Brogan, effective 3/1/94; Thomas Lester Hazouri, effective 12/1/93; and Susan Olsen, effective 3/4/94.
- (c) Paul Lloyd Getting passed away on 10/3/93.
- (d) the ACTING Secretary position of George Lewis Stuart, Jr. is no longer valid, as he has been confirmed as the Secretary.
- (e) the ACTING Capital Collateral Representative position of Michael J. Minerva is no longer valid as he has been confirmed as the Capital Collateral Representative.

Based on the foregoing, the Senate Committee on Executive Business, Ethics and Elections respectfully advises and recommends that:

- (1) the Senate fail to consider the appointments during the 1994 Regular Session.

(2) the failure to consider the appointments be noted in the pages of the Journal of the Senate in accordance with s. 114.05(1)(e), Florida Statutes.

Respectfully submitted,
William H. Turner, Chairman

On motion by Senator Turner, the report was adopted and the Senate failed to consider the appointments identified in the foregoing report of the committee to the office and for the terms indicated, in accordance with the recommendations of the committee.

MESSAGES FROM THE HOUSE OF REPRESENTATIVES

RETURNING MESSAGES—FINAL ACTION

The Honorable Pat Thomas, President

I am directed to inform the Senate that the House of Representatives has accepted the Conference Committee Report as an entirety and passed CS for CS for SB 68, CS for SB's 2012, 230, 236, 248, 266, 274, 282, 392, 498, 674, 1306 and 1400; and also receded from House Amendment 1 to CS for SB 2016; and passed CS for SB 2016 as recommended by the Conference Committee Report.

John B. Phelps, Clerk

CS for CS for SB 68, CS for SB's 2012, 230, 236, 248, 266, 274, 282, 392, 498, 674, 1306 and 1400 contained in the foregoing message was ordered engrossed and then enrolled.

CS for SB 2016 was ordered enrolled.

ROLL CALLS ON SENATE BILLS

CS for CS for SB 3060
Amendment 1R

Yeas—11

Beard Brown-Waite Dudley
Foley Forman Grant
Harden Holzendorf Kiser
Myers Williams

Nays—21

Mr. President Boczar Burt Crenshaw Crist Dantzler
Dyer Grogan Hargrett Jenne Jennings Johnson
Jones Kurth Scott Siegel Silver Sullivan
Turner Weinstein Wexler

CS for CS for SB 3060
Amendment 1VVV

Yeas—15

Beard Boczar Burt Dantzler
Diaz-Balart Dudley Foley Forman
Grant Grogan Johnson Kurth
McKay Myers Wexler

Nays—17

Brown-Waite Crist Dyer Gutman Harden
Holzendorf Jennings Jones Kiser Meadows
Scott Siegel Silver Sullivan Turner
Weinstein Williams

CS for CS for SB 3060
Amendment 1WWW

Yeas—18

Mr. President Bankhead Beard Casas Crist
Dantzler Diaz-Balart Forman Gutman Hargrett
Holzendorf Jenne Jones Myers Scott
Turner Weinstein Williams

Nays—14

Boczar Brown-Waite Dudley Foley

Grant Grogan Harden
Jennings Kirkpatrick Kurth
Meadows Silver Sullivan
Wexler

CS for CS for SB 3060

Yeas—24

Mr. President Bankhead Brown-Waite Casas Crenshaw Crist
Dantzler Diaz-Balart Dudley Dyer Foley Forman
Gutman Jennings Johnson Jones Kirkpatrick McKay
Scott Siegel Sullivan Turner Weinstein Williams

Nays—16

Beard Boczar Burt Childers
Grant Grogan Harden Hargrett
Holzendorf Jenne Kiser Kurth
Meadows Myers Silver Wexler

SB 3174

Yeas—37

Mr. President Bankhead Beard Boczar Brown-Waite Burt Casas Childers Crenshaw Crist
Dantzler Diaz-Balart Dudley Dyer Foley Forman Grant Grogan Gutman Harden
Hargrett Holzendorf Jenne Jennings Johnson Jones Kiser Kurth McKay Meadows
Myers Siegel Silver Sullivan Turner Wexler Williams

Nays—None

SB 3174
After Reconsideration

Yeas—36

Mr. President Bankhead Beard Boczar Brown-Waite Burt Casas Crenshaw Crist
Diaz-Balart Dudley Dyer Foley Forman Grant Grogan Gutman Harden
Holzendorf Jennings Johnson Jones Kirkpatrick Kiser Kurth McKay Meadows
Myers Scott Siegel Silver Sullivan Turner Weinstein Wexler Williams

Nays—1

Jenne

ROLL CALLS ON HOUSE BILLS

HB 2837

Yeas—40

Mr. President Bankhead Beard Boczar Brown-Waite Burt Casas Childers Crenshaw Crist
Dantzler Diaz-Balart Dudley Dyer Foley Forman Grant Grogan Gutman Harden
Hargrett Holzendorf Jenne Jennings Johnson Jones Kirkpatrick Kiser Kurth McKay
Meadows Myers Scott Siegel Silver Sullivan Turner Weinstein Wexler Williams

Nays—None

April 14, 1994

JOURNAL OF THE SENATE

1435

CORRECTION AND APPROVAL OF JOURNAL

The Journal of April 13 was corrected and approved.

RECESS

On motion by Senator Kirkpatrick, the Senate recessed at 6:26 p.m. to reconvene at 10:00 a.m., Friday, April 15.