A bill to be entitled

An act relating to health care coverage; repealing s. 408.50, F.S., relating to prospective payment arrangements between hospitals and health insurers; repealing s. 408.70, F.S., relating to managed competition in the state health care markets; repealing s. 408.9091, F.S., relating to the Cover Florida Health Care Access Program; amending s. 627.6699, F.S., relating to the Employee Health Care Access Act; repealing s. 1004.29, F.S., relating to the university health services support organizations; repealing s. 1004.30, F.S., relating to confidential and exempt records and information maintained by university health services support organizations; amending ss. 112.363, 408.07, 627.6475, 945.603, and 1001.76, F.S.; conforming references to changes made by the act; providing an effective date.

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

Section 1. Sections 408.50, 408.70, 408.9091, 1004.29 and 1004.30, Florida Statutes, are repealed.

Section 2. Subsections (2), (5), and (7) of section 627.6475, Florida Statutes, are amended to read:

(2) DEFINITIONS.—As used in this section:

(a) ~~"Board," "carrier,"~~ "Carrier" and "health benefit plan" have the same meaning ascribed in s. 627.6699(3).

(b) "Health insurance issuer," "issuer," and "individual health insurance" have the same meaning ascribed in s. 627.6487(2).

~~(c) "Reinsuring carrier" means a health insurance issuer that elects to comply with the requirements set forth in subsection (7).~~

(d) "Risk-assuming carrier" means a health insurance issuer that elects to comply with the requirements set forth in subsection (6).

(e) "Eligible individual" has the same meaning ascribed in s. 627.6487(3).

(5) ISSUER'S ELECTION TO BECOME A RISK-ASSUMING CARRIER.—

(a) Each health insurance issuer that offers individual health insurance must elect to become a risk-assuming carrier ~~or a reinsuring carrier~~ for purposes of this section. Each such issuer must make an initial election, binding through December 31, 1999. The issuer's initial election must be made no later than October 31, 1997. By October 31, 1997, all issuers must file a final election, which is binding for 2 years, from January 1, 1998, through December 31, 1999, after which an election shall be binding for a period of 5 years. The office may permit an issuer to modify its election at any time for good cause shown, after a hearing.

~~(b) The office shall establish an application process for issuers seeking to change their status under this subsection.~~

(b) ~~(c)~~ An election to become a risk-assuming carrier is subject to approval under this subsection.

~~(d) An issuer that elects to cease participating as a reinsuring carrier and to become a risk-assuming carrier may not reinsure or continue to reinsure any individual health benefits plan under subsection (7) once the issuer becomes a risk-assuming carrier, and the issuer must pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured. An issuer that elects to cease participating as a risk-assuming carrier and to become a reinsuring carrier may reinsure individual health insurance under the terms set forth in subsection (7) and must pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured.~~

(7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.—

~~(a) The individual health reinsurance program shall operate subject to the supervision and control of the board of the small employer health reinsurance program established pursuant to s. 627.6699(11). The board shall establish a separate, segregated account for eligible individuals reinsured pursuant to this section, which account may not be commingled with the small employer health reinsurance account.~~

~~(b) A reinsuring carrier may reinsure with the program coverage of an eligible individual, subject to each of the following provisions:~~

~~1. A reinsuring carrier may reinsure an eligible individual within 60 days after commencement of the coverage of the eligible individual.~~

~~2. The program may not reimburse a participating carrier with respect to the claims of a reinsured eligible individual until the carrier has paid incurred claims of at least $5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier is responsible for 10 percent of the next $50,000 and 5 percent of the next $100,000 of incurred claims during a calendar year, and the program shall reinsure the remainder.~~

~~3. The board shall annually adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment may not be less than the annual change in the medical component of the "Commerce Price Index for All Urban Consumers" of the Bureau of Labor Statistics of the United States Department of Labor, unless the board proposes and the office approves a lower adjustment factor.~~

~~4. A reinsuring carrier may terminate reinsurance for all reinsured eligible individuals on any plan anniversary.~~

~~5. The premium rate charged for reinsurance by the program to a health maintenance organization that is approved by the Secretary of Health and Human Services as a federally qualified health maintenance organization pursuant to 42 U.S.C. s. 300e(c)(2)(A) and that, as such, is subject to requirements that limit the amount of risk that may be ceded to the program, which requirements are more restrictive than subparagraph 2., shall be reduced by an amount equal to that portion of the risk, if any,~~

~~which exceeds the amount set forth in subparagraph 2., which may not be ceded to the program.~~

~~6. The board may consider adjustments to the premium rates charged for reinsurance by the program or carriers that use effective cost-containment measures, including high-cost case management, as defined by the board.~~

~~7. A reinsuring carrier shall apply its case-management and claims-handling techniques, including, but not limited to, utilization review, individual case management, preferred provider provisions, other managed-care provisions, or methods of operation consistently with both reinsured business and nonreinsured business.~~

~~(c)1. The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring eligible individuals pursuant to this section. The methodology must include a system for classifying individuals which reflects the types of case characteristics commonly used by carriers in this state. The methodology must provide for the development of basic reinsurance premium rates, which shall be multiplied by the factors set for them in this paragraph to determine the premium rates for the program. The basic reinsurance premium rates shall be established by the board, subject to the approval of the office, and shall be set at levels that reasonably approximate gross premiums charged to eligible individuals for individual health insurance by health insurance issuers. The premium rates set by the board may vary by geographical area, as determined under this section, to reflect differences in cost. An eligible~~

~~individual may be reinsured for a rate that is five times the rate established by the board.~~

~~2. The board shall periodically review the methodology established, including the system of classification and any rating factors, to ensure that it reasonably reflects the claims experience of the program. The board may propose changes to the rates that are subject to the approval of the office.~~

~~(d) If individual health insurance for an eligible individual is entirely or partially reinsured with the program pursuant to this section, the premium charged to the eligible individual for any rating period for the coverage issued must be the same premium that would have been charged to that individual if the health insurance issuer elected not to reinsure coverage for that individual.~~

~~(e)1. Before March 1 of each calendar year, the board shall determine and report to the office the program net loss in the individual account for the previous year, including administrative expenses for that year and the incurred losses for that year, taking into account investment income and other appropriate gains and losses.~~

~~2. Any net loss in the individual account for the year shall be recouped by assessing the carriers as follows:~~

~~a. The operating losses of the program shall be assessed in the following order subject to the specified limitations. The first tier of assessments shall be made against reinsuring carriers in an amount that may not exceed 5 percent of each reinsuring carrier's premiums for individual health insurance. If such assessments have been collected and additional moneys are~~

~~needed, the board shall make a second tier of assessments in an amount that may not exceed 0.5 percent of each carrier's health benefit plan premiums.~~

~~b. Except as provided in paragraph (f), risk-assuming carriers are exempt from all assessments authorized pursuant to this section. The amount paid by a reinsuring carrier for the first tier of assessments shall be credited against any additional assessments made.~~

~~c. The board shall equitably assess reinsuring carriers for operating losses of the individual account based on market share. The board shall annually assess each carrier a portion of the operating losses of the individual account. The first tier of assessments shall be determined by multiplying the operating losses by a fraction, the numerator of which equals the reinsuring carrier's earned premium pertaining to direct writings of individual health insurance in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of all such premiums earned by reinsuring carriers in the state during that calendar year. The second tier of assessments shall be based on the premiums that all carriers, except risk-assuming carriers, earned on all health benefit plans written in this state. The board may levy interim assessments against reinsuring carriers to ensure the financial ability of the plan to cover claims expenses and administrative expenses paid or estimated to be paid in the operation of the plan for the calendar year prior to the association's anticipated receipt of annual assessments for that calendar year. Any interim assessment is due and payable~~

~~within 30 days after receipt by a carrier of the interim assessment notice. Interim assessment payments shall be credited against the carrier's annual assessment. Health benefit plan premiums and benefits paid by a carrier that are less than an amount determined by the board to justify the cost of collection may not be considered for purposes of determining assessments.~~

~~d. Subject to the approval of the office, the board shall adjust the assessment formula for reinsuring carriers that are approved as federally qualified health maintenance organizations by the Secretary of Health and Human Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent, if any, that restrictions are placed on them which are not imposed on other carriers.~~

~~3. Before March 1 of each year, the board shall determine and file with the office an estimate of the assessments needed to fund the losses incurred by the program in the individual account for the previous calendar year.~~

~~4. If the board determines that the assessments needed to fund the losses incurred by the program in the individual account for the previous calendar year will exceed the amount specified in subparagraph 2., the board shall evaluate the operation of the program and report its findings and recommendations to the office in the format established in s. 627.6699(11) for the comparable report for the small employer reinsurance program.~~

~~(f) Notwithstanding paragraph (e), the administrative expenses of the program shall be recouped by assessing risk-assuming carriers and reinsuring carriers, and such amounts may not be considered part of the operating losses of the plan for~~

~~the purposes of this paragraph. Each carrier's portion of such administrative expenses shall be determined by multiplying the total of such administrative expenses by a fraction, the numerator of which equals the carrier's earned premium pertaining to direct writing of individual health benefit plans in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of such premiums earned by all carriers in the state during such calendar year.~~

~~(g) Except as otherwise provided in this section, the board and the office shall have all powers, duties, and responsibilities with respect to carriers that issue and reinsure individual health insurance, as specified for the board and the office in s. 627.6699(11) with respect to small employer carriers, including, but not limited to, the provisions of s. 627.6699(11) relating to:~~

~~1. Use of assessments that exceed the amount of actual losses and expenses.~~

~~2. The annual determination of each carrier's proportion of the assessment.~~

~~3. Interest for late payment of assessments.~~

~~4. Authority for the office to approve deferment of an assessment against a carrier.~~

~~5. Limited immunity from legal actions or carriers.~~

~~6. Development of standards for compensation to be paid to agents. Such standards shall be limited to those specifically enumerated in s. 627.6699(13)(d).~~

~~7. Monitoring compliance by carriers with this section.~~

Section 3. Section 627.6699, Florida Statutes, is amended to read:

627.6699 Employee Health Care Access Act.-

(2) PURPOSE AND INTENT.—The purpose and intent of this section is to promote the availability of health insurance coverage to small employers regardless of their claims experience or their employees' health status, to establish rules regarding renewability of that coverage, to establish limitations on the use of exclusions for preexisting conditions, to provide for development of a standard health benefit plan and a basic health benefit plan to be offered to all small employers, ~~to provide for establishment of a reinsurance program for coverage of small employers~~, and to improve the overall fairness and efficiency of the small group health insurance market.

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

(a) "Actuarial certification" means a written statement, by a member of the American Academy of Actuaries or another person acceptable to the office, that a small employer carrier is in compliance with subsection (6), based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the carrier in establishing premium rates for applicable health benefit plans.

(b) "Basic health benefit plan" and "standard health benefit plan" mean low-cost health care plans developed pursuant to subsection (12).

~~(c) "Board" means the board of directors of the program.~~

(c) ~~(d)~~ "Carrier" means a person who provides health benefit plans in this state, including an authorized insurer, a health maintenance organization, a multiple-employer welfare arrangement, or any other person providing a health benefit plan that is subject to insurance regulation in this state. However, the term does not include a multiple-employer welfare arrangement, which multiple-employer welfare arrangement operates solely for the benefit of the members or the members and the employees of such members, and was in existence on January 1, 1992.

(d) ~~(e)~~ "Case management program" means the specific supervision and management of the medical care provided or prescribed for a specific individual, which may include the use of health care providers designated by the carrier.

(e) ~~(f)~~ "Creditable coverage" has the same meaning ascribed in s. 627.6561.

(f) ~~(g)~~ "Dependent" means the spouse or child of an eligible employee, subject to the applicable terms of the health benefit plan covering that employee.

(g) ~~(h)~~ "Eligible employee" means an employee who works full time, having a normal workweek of 25 or more hours, and who has met any applicable waiting-period requirements or other requirements of this act. The term includes a self-employed individual, a sole proprietor, a partner of a partnership, or an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include a part-time, temporary, or substitute employee.

(h) ~~(i)~~ "Established geographic area" means the county or counties, or any portion of a county or counties, within which the carrier provides or arranges for health care services to be available to its insureds, members, or subscribers.

(i) ~~(j)~~ "Guaranteed-issue basis" means an insurance policy that must be offered to an employer, employee, or dependent of the employee, regardless of health status, preexisting conditions, or claims history.

(j) ~~(k)~~ "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; similar supplemental plans provided under a separate policy, certificate, or contract of insurance, which cannot duplicate coverage under an underlying health plan and are specifically designed to fill gaps in the underlying health plan, coinsurance, or deductibles; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical-payment insurance.

(k) ~~(l)~~ "Late enrollee" means an eligible employee or dependent as defined under s. 627.6561(1)(b).

(l) ~~(m)~~ "Limited benefit policy or contract" means a policy or contract that provides coverage for each person insured under the policy for a specifically named disease or diseases, a specifically named accident, or a specifically named limited

market that fulfills an experimental or reasonable need, such as the small group market.

(m) ~~(n)~~ "Modified community rating" means a method used to develop carrier premiums which spreads financial risk across a large population; allows the use of separate rating factors for age, gender, family composition, tobacco usage, and geographic area as determined under paragraph (5)(j); and allows adjustments for: claims experience, health status, or duration of coverage as 2permitted under subparagraph (6)(b)5.; and administrative and acquisition expenses as 2permitted under subparagraph (6)(b)5.

(n) ~~(o)~~ "Participating carrier" means any carrier that issues health benefit plans in this state except a small employer carrier that elects to be a risk-assuming carrier.

~~(p) "Plan of operation" means the plan of operation of the program, including articles, bylaws, and operating rules, adopted by the board under subsection (11).~~

~~(q) "Program" means the Florida Small Employer Carrier Reinsurance Program created under subsection (11).~~

(o) ~~(r)~~ "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

~~(s) "Reinsuring carrier" means a small employer carrier that elects to comply with the requirements set forth in subsection (11).~~

(p) ~~(t)~~ "Risk-assuming carrier" means a small employer carrier that elects to comply with the requirements set forth in subsection (10).

(q) ~~(u)~~ "Self-employed individual" means an individual or sole proprietor who derives his or her income from a trade or business carried on by the individual or sole proprietor which results in taxable income as indicated on IRS Form 1040, schedule C or F, and which generated taxable income in one of the 2 previous years.

(r) ~~(v)~~ "Small employer" means, in connection with a health benefit plan with respect to a calendar year and a plan year, any person, sole proprietor, self-employed individual, independent contractor, firm, corporation, partnership, or association that is actively engaged in business, has its principal place of business in this state, employed an average of at least 1 but not more than 50 eligible employees on business days during the preceding calendar year the majority of whom were employed in this state, employs at least 1 employee on the first day of the plan year, and is not formed primarily for purposes of purchasing insurance. In determining the number of eligible employees, companies that are an affiliated group as defined in s. 1504(a) of the Internal Revenue Code of 1986, as amended, are considered a single employer. For purposes of this section, a sole proprietor, an independent contractor, or a self-employed individual is considered a small employer only if all of the conditions and criteria established in this section are met.

(s) ~~(w)~~ "Small employer carrier" means a carrier that offers health benefit plans covering eligible employees of one or more small employers.

~~(9) SMALL EMPLOYER CARRIER'S ELECTION TO BECOME A RISK-ASSUMING CARRIER OR A REINSURING CARRIER.—~~

~~(a) A small employer carrier must elect to become either a risk-assuming carrier or a reinsuring carrier. By October 31, 1993, all small employer carriers must file a final election, which is binding for 2 years, from January 1, 1994, through December 31, 1995, after which an election shall be binding for a period of 5 years. Any carrier that is not a small employer carrier and intends to become a small employer carrier must file its designation when it files the forms and rates it intends to use for small employer group health insurance; such designation shall be binding for 2 years after the date of approval of the forms and rates, and any subsequent designation is binding for 5 years. The office may permit a carrier to modify its election at any time for good cause shown, after a hearing.~~

~~(b) The commission shall establish an application process for small employer carriers seeking to change their status under this subsection.~~

~~(c) An election to become a risk-assuming carrier is subject to approval under subsection (10).~~

~~(d) A small employer carrier that elects to cease participating as a reinsuring carrier and to become a risk-assuming carrier is prohibited from reinsuring or continuing to reinsure any small employer health benefits plan under subsection (11) as soon as the carrier becomes a risk-assuming carrier and must pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured. A small employer carrier that elects~~

~~to cease participating as a risk-assuming carrier and to become a reinsuring carrier is permitted to reinsure small employer health benefit plans under the terms set forth in subsection (11) and must pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured.~~

(9) ~~(10)~~ ELECTION PROCESS TO BECOME A RISK-ASSUMING CARRIER.—

(a)1. A small employer carrier may become a risk-assuming carrier by filing with the office a designation of election under subsection (9) in a format and manner prescribed by the commission. The office shall approve the election of a small employer carrier to become a risk-assuming carrier if the office finds that the carrier is capable of assuming that status pursuant to the criteria set forth in paragraph (b).

2. The office must approve or disapprove any designation as a risk-assuming carrier within 60 days after filing.

(b) In determining whether to approve an application by a small employer carrier to become a risk-assuming carrier, the office shall consider:

1. The carrier's financial ability to support the assumption of the risk of small employer groups.

2. The carrier's history of rating and underwriting small employer groups.

3. The carrier's commitment to market fairly to all small employers in the state or its service area, as applicable.

~~4. The carrier's ability to assume and manage the risk of enrolling small employer groups without the protection of the reinsurance program provided in subsection (11).~~

~~(c) A small employer carrier that becomes a risk-assuming carrier pursuant to this subsection is not subject to the assessment provisions of subsection (11).~~

~~(d) The office shall provide public notice of a small employer carrier's designation of election under subsection (9) to become a risk-assuming carrier and shall provide at least a 21-day period for public comment prior to making a decision on the election. The office shall hold a hearing on the election at the request of the carrier.~~

(c) ~~(e)~~ The office may rescind the approval granted to a risk-assuming carrier under this subsection if the office finds that the carrier no longer meets the criteria of paragraph (b).

~~(11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.—~~

~~(a) There is created a nonprofit entity to be known as the "Florida Small Employer Health Reinsurance Program."~~

~~(b)1. The program shall operate subject to the supervision and control of the board.~~

~~2. Effective upon this act becoming a law, the board shall consist of the director of the office or his or her designee, who shall serve as the chairperson, and 13 additional members who are representatives of carriers and insurance agents and are appointed by the director of the office and serve as follows:~~

~~a. Five members shall be representatives of health insurers licensed under chapter 624 or chapter 641. Two members~~

~~shall be agents who are actively engaged in the sale of health insurance. Four members shall be employers or representatives of employers. One member shall be a person covered under an individual health insurance policy issued by a licensed insurer in this state. One member shall represent the Agency for Health Care Administration and shall be recommended by the Secretary of Health Care Administration.~~

~~b. A member appointed under this subparagraph shall serve a term of 4 years and shall continue in office until the member's successor takes office, except that, in order to provide for staggered terms, the director of the office shall designate two of the initial appointees under this subparagraph to serve terms of 2 years and shall designate three of the initial appointees under this subparagraph to serve terms of 3 years.~~

~~3. The director of the office may remove a member for cause.~~

~~4. Vacancies on the board shall be filled in the same manner as the original appointment for the unexpired portion of the term.~~

~~(c)1. The board shall submit to the office a plan of operation to assure the fair, reasonable, and equitable administration of the program. The board may at any time submit to the office any amendments to the plan that the board finds to be necessary or suitable.~~

~~2. The office shall, after notice and hearing, approve the plan of operation if it determines that the plan submitted by the board is suitable to assure the fair,~~

~~reasonable, and equitable administration of the program and provides for the sharing of program gains and losses equitably and proportionately in accordance with paragraph (j).~~

~~3. The plan of operation, or any amendment thereto, becomes effective upon written approval of the office.~~

~~(d) The plan of operation must, among other things:~~

~~1. Establish procedures for handling and accounting for program assets and moneys and for an annual fiscal reporting to the office.~~

~~2. Establish procedures for selecting an administering carrier and set forth the powers and duties of the administering carrier.~~

~~3. Establish procedures for reinsuring risks.~~

~~4. Establish procedures for collecting assessments from participating carriers to provide for claims reinsured by the program and for administrative expenses, other than amounts payable to the administrative carrier, incurred or estimated to be incurred during the period for which the assessment is made.~~

~~5. Provide for any additional matters at the discretion of the board.~~

~~(e) The board shall recommend to the office market conduct requirements and other requirements for carriers and agents, including requirements relating to:~~

~~1. Registration by each carrier with the office of its intention to be a small employer carrier under this section;~~

~~2. Publication by the office of a list of all small employer carriers, including a requirement applicable to agents~~

~~and carriers that a health benefit plan may not be sold by a carrier that is not identified as a small employer carrier;~~

~~3. The availability of a broadly publicized, toll-free telephone number for access by small employers to information concerning this section;~~

~~4. Periodic reports by carriers and agents concerning health benefit plans issued; and~~

~~5. Methods concerning periodic demonstration by small employer carriers and agents that they are marketing or issuing health benefit plans to small employers.~~

~~(f) The program has the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to groups or individuals. In addition thereto, the program has specific authority to:~~

~~1. Enter into contracts as necessary or proper to carry out the provisions and purposes of this act, including the authority to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions.~~

~~2. Sue or be sued, including taking any legal action necessary or proper for recovering any assessments and penalties for, on behalf of, or against the program or any carrier.~~

~~3. Take any legal action necessary to avoid the payment of improper claims against the program.~~

~~4. Issue reinsurance policies, in accordance with the requirements of this act.~~

~~5. Establish rules, conditions, and procedures for reinsurance risks under the program participation.~~

~~6. Establish actuarial functions as appropriate for the operation of the program.~~

~~7. Assess participating carriers in accordance with paragraph (j), and make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Interim assessments shall be credited as offsets against any regular assessments due following the close of the calendar year.~~

~~8. Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the program, and in any other function within the authority of the program.~~

~~9. Borrow money to effect the purposes of the program. Any notes or other evidences of indebtedness of the program which are not in default constitute legal investments for carriers and may be carried as admitted assets.~~

~~10. To the extent necessary, increase the $5,000 deductible reinsurance requirement to adjust for the effects of inflation.~~

~~(g) A reinsuring carrier may reinsure with the program coverage of an eligible employee of a small employer, or any dependent of such an employee, subject to each of the following provisions:~~

~~1. With respect to a standard and basic health care plan, the program must reinsure the level of coverage provided; and, with respect to any other plan, the program must reinsure the coverage up to, but not exceeding, the level of coverage provided under the standard and basic health care plan.~~

~~2. Except in the case of a late enrollee, a reinsuring carrier may reinsure an eligible employee or dependent within 60 days after the commencement of the coverage of the small employer. A newly employed eligible employee or dependent of a small employer may be reinsured within 60 days after the commencement of his or her coverage.~~

~~3. A small employer carrier may reinsure an entire employer group within 60 days after the commencement of the group's coverage under the plan. The carrier may choose to reinsure newly eligible employees and dependents of the reinsured group pursuant to subparagraph 1.~~

~~4. The program may not reimburse a participating carrier with respect to the claims of a reinsured employee or dependent until the carrier has paid incurred claims of at least $5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier shall be responsible for 10 percent of the next $50,000 and 5 percent of the next $100,000 of incurred claims during a calendar year and the program shall reinsure the remainder.~~

~~5. The board annually shall adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment~~

~~shall not be less than the annual change in the medical component of the "Consumer Price Index for All Urban Consumers" of the Bureau of Labor Statistics of the Department of Labor, unless the board proposes and the office approves a lower adjustment factor.~~

~~6. A small employer carrier may terminate reinsurance for all reinsured employees or dependents on any plan anniversary.~~

~~7. The premium rate charged for reinsurance by the program to a health maintenance organization that is approved by the Secretary of Health and Human Services as a federally qualified health maintenance organization pursuant to 42 U.S.C. s. 300e(c)(2)(A) and that, as such, is subject to requirements that limit the amount of risk that may be ceded to the program, which requirements are more restrictive than subparagraph 4., shall be reduced by an amount equal to that portion of the risk, if any, which exceeds the amount set forth in subparagraph 4. which may not be ceded to the program.~~

~~8. The board may consider adjustments to the premium rates charged for reinsurance by the program for carriers that use effective cost containment measures, including high-cost case management, as defined by the board.~~

~~9. A reinsuring carrier shall apply its case-management and claims-handling techniques, including, but not limited to, utilization review, individual case management, preferred provider provisions, other managed care provisions or methods of operation, consistently with both reinsured business and nonreinsured business.~~

~~(h)1. The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of basic reinsurance premium rates, which shall be multiplied by the factors set for them in this paragraph to determine the premium rates for the program. The basic reinsurance premium rates shall be established by the board, subject to the approval of the office, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard and basic health benefit plan. The premium rates set by the board may vary by geographical area, as determined under this section, to reflect differences in cost. The multiplying factors must be established as follows:~~

~~a. The entire group may be reinsured for a rate that is 1.5 times the rate established by the board.~~

~~b. An eligible employee or dependent may be reinsured for a rate that is 5 times the rate established by the board.~~

~~2. The board periodically shall review the methodology established, including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose~~

~~changes to the rates which shall be subject to the approval of the office.~~

~~(i) If a health benefit plan for a small employer issued in accordance with this subsection is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued must be consistent with the requirements relating to premium rates set forth in this section.~~

~~(j)1. Before July 1 of each calendar year, the board shall determine and report to the office the program net loss for the previous year, including administrative expenses for that year, and the incurred losses for the year, taking into account investment income and other appropriate gains and losses.~~

~~2. Any net loss for the year shall be recouped by assessment of the carriers, as follows:~~

~~a. The operating losses of the program shall be assessed in the following order subject to the specified limitations. The first tier of assessments shall be made against reinsuring carriers in an amount which shall not exceed 5 percent of each reinsuring carrier's premiums from health benefit plans covering small employers. If such assessments have been collected and additional moneys are needed, the board shall make a second tier of assessments in an amount which shall not exceed 0.5 percent of each carrier's health benefit plan premiums. Except as provided in paragraph (n), risk-assuming carriers are exempt from all assessments authorized pursuant to this section. The amount paid by a reinsuring carrier for the~~

~~first tier of assessments shall be credited against any additional assessments made.~~

~~b. The board shall equitably assess carriers for operating losses of the plan based on market share. The board shall annually assess each carrier a portion of the operating losses of the plan. The first tier of assessments shall be determined by multiplying the operating losses by a fraction, the numerator of which equals the reinsuring carrier's earned premium pertaining to direct writings of small employer health benefit plans in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of all such premiums earned by reinsuring carriers in the state during that calendar year. The second tier of assessments shall be based on the premiums that all carriers, except risk-assuming carriers, earned on all health benefit plans written in this state. The board may levy interim assessments against carriers to ensure the financial ability of the plan to cover claims expenses and administrative expenses paid or estimated to be paid in the operation of the plan for the calendar year prior to the association's anticipated receipt of annual assessments for that calendar year. Any interim assessment is due and payable within 30 days after receipt by a carrier of the interim assessment notice. Interim assessment payments shall be credited against the carrier's annual assessment. Health benefit plan premiums and benefits paid by a carrier that are less than an amount determined by the board to justify the cost of collection may not be considered for purposes of determining assessments.~~

~~c. Subject to the approval of the office, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved as federally qualified health maintenance organizations by the Secretary of Health and Human Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.~~

~~3. Before July 1 of each year, the board shall determine and file with the office an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.~~

~~4. If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified in subparagraph 2., the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the office within 180 days following the end of the calendar year in which the losses were incurred. The evaluation shall include an estimate of future assessments, the administrative costs of the program, the appropriateness of the premiums charged and the level of carrier retention under the program, and the costs of coverage for small employers. If the board fails to file a report with the office within 180 days following the end of the applicable calendar year, the office may evaluate the operations of the program and implement such amendments to the plan of operation the office deems necessary to reduce future losses and assessments.~~

~~5. If assessments exceed the amount of the actual losses and administrative expenses of the program, the excess shall be held as interest and used by the board to offset future losses or to reduce program premiums. As used in this paragraph, the term "future losses" includes reserves for incurred but not reported claims.~~

~~6. Each carrier's proportion of the assessment shall be determined annually by the board, based on annual statements and other reports considered necessary by the board and filed by the carriers with the board.~~

~~7. Provision shall be made in the plan of operation for the imposition of an interest penalty for late payment of an assessment.~~

~~8. A carrier may seek, from the office, a deferment, in whole or in part, from any assessment made by the board. The office may defer, in whole or in part, the assessment of a carrier if, in the opinion of the office, the payment of the assessment would place the carrier in a financially impaired condition. If an assessment against a carrier is deferred, in whole or in part, the amount by which the assessment is deferred may be assessed against the other carriers in a manner consistent with the basis for assessment set forth in this section. The carrier receiving such deferment remains liable to the program for the amount deferred and is prohibited from reinsuring any individuals or groups in the program if it fails to pay assessments.~~

~~(k) Neither the participation in the program as reinsuring carriers, the establishment of rates, forms, or~~

~~procedures, nor any other joint or collective action required by this act, may be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its carriers either jointly or separately.~~

~~(l) The board, as part of the plan of operation, shall develop standards setting forth the manner and levels of compensation to be paid to agents for the sale of basic and standard health benefit plans. In establishing such standards, the board shall take into consideration the need to assure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide ongoing service to the small employer, the levels of compensation currently used in the industry, and the overall costs of coverage to small employers selecting these plans.~~

~~(m) The board shall monitor compliance with this section, including the market conduct of small employer carriers, and shall report to the office any unfair trade practices and misleading or unfair conduct by a small employer carrier that has been reported to the board by agents, consumers, or any other person. The office shall investigate all reports and, upon a finding of noncompliance with this section or of unfair or misleading practices, shall take action against the small employer carrier as permitted under the insurance code or chapter 641. The board is not given investigatory or regulatory powers, but must forward all reports of cases or abuse or misrepresentation to the office.~~

~~(n) Notwithstanding paragraph (j), the administrative expenses of the program shall be recouped by assessment of risk-~~

~~assuming carriers and reinsuring carriers and such amounts shall not be considered part of the operating losses of the plan for the purposes of this paragraph. Each carrier's portion of such administrative expenses shall be determined by multiplying the total of such administrative expenses by a fraction, the numerator of which equals the carrier's earned premium pertaining to direct writing of small employer health benefit plans in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of such premiums earned by all carriers in the state during such calendar year.~~

~~(o) The board shall advise the office, the Agency for Health Care Administration, the department, other executive departments, and the Legislature on health insurance issues. Specifically, the board shall:~~

~~1. Provide a forum for stakeholders, consisting of insurers, employers, agents, consumers, and regulators, in the private health insurance market in this state.~~

~~2. Review and recommend strategies to improve the functioning of the health insurance markets in this state with a specific focus on market stability, access, and pricing.~~

~~3. Make recommendations to the office for legislation addressing health insurance market issues and provide comments on health insurance legislation proposed by the office.~~

~~4. Meet at least three times each year. One meeting shall be held to hear reports and to secure public comment on the health insurance market, to develop any legislation needed~~

~~to address health insurance market issues, and to provide comments on health insurance legislation proposed by the office.~~

~~5. Issue a report to the office on the state of the health insurance market by September 1 each year. The report shall include recommendations for changes in the health insurance market, results from implementation of previous recommendations, and information on health insurance markets.~~

(12) STANDARD, BASIC, HIGH DEDUCTIBLE, AND LIMITED HEALTH BENEFIT PLANS.—

(a)1. The Chief Financial Officer 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. ~~The carrier members shall be selected from a list of individuals recommended by the board. The Chief Financial Officer may require the board to submit additional recommendations of individuals for appointment.~~

2. The plans shall comply with all of the requirements of this subsection.

3. The plans must be filed with and approved by the office prior to issuance or delivery by any small employer carrier.

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

subparagraph 1. to submit recommended modifications to the office for approval.

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

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

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

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

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

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

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, 627.6612, 627.66121, 627.66122, 627.6616, 627.6618, 627.668, and 627.66911 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. The high deductible plan associated with a health savings account or a health reimbursement arrangement shall include all the benefits specified in subparagraph 4.

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

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

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

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

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

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

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

2. Before a small employer carrier issues a standard health benefit plan, a basic health benefit plan, or a limited benefit policy or contract, it must obtain from the prospective policyholder a signed written statement in which the prospective policyholder:

a. Certifies as to eligibility for coverage under the standard health benefit plan, basic health benefit plan, or limited benefit policy or contract;

b. Acknowledges the limited nature of the coverage and an understanding of the managed care and cost control features of the policy or contract;

c. Acknowledges that if misrepresentations are made regarding eligibility for coverage under a standard health benefit plan, a basic health benefit plan, or a limited benefit policy or contract, the person making such misrepresentations forfeits coverage provided by the policy or contract; and

d. If a limited plan is requested, acknowledges that the prospective policyholder had been offered, at the time of application for the insurance policy or contract, the opportunity to purchase any health benefit plan offered by the carrier and that the prospective policyholder had rejected that coverage.

A copy of such written statement shall be provided to the prospective policyholder no later than at the time of delivery of the policy or contract, and the original of such written statement shall be retained in the files of the small employer carrier for the period of time that the policy or contract remains in effect or for 5 years, whichever period is longer.

3. Any material statement made by an applicant for coverage under a health benefit plan which falsely certifies as to the applicant's eligibility for coverage serves as the basis for terminating coverage under the policy or contract.

4. Each marketing communication that is intended to be used in the marketing of a health benefit plan in this state must be submitted for review by the office prior to use and must contain the disclosures stated in this subsection.

(e) A small employer carrier may not use any policy, contract, form, or rate under this section, including applications, enrollment forms, policies, contracts, certificates, evidences of coverage, riders, amendments, endorsements, and disclosure forms, until the insurer has filed it with the office and the office has approved it under ss. 627.410 and 627.411 and this section.

(13) STANDARDS TO ASSURE FAIR MARKETING.—

(a) Each small employer carrier shall actively market health benefit plan coverage, including the basic and standard health benefit plans, including any subsequent modifications or additions to those plans, to eligible small employers in the state. Before January 1, 1994, if a small employer carrier denies coverage to a small employer on the basis of the health

status or claims experience of the small employer or its employees or dependents, the small employer carrier shall offer the small employer the opportunity to purchase a basic health benefit plan and a standard health benefit plan. Beginning January 1, 1994, small employer carriers must offer and issue all plans on a guaranteed-issue basis.

(b) No small employer carrier or agent shall, directly or indirectly, engage in the following activities:

1. Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

2. Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

(c) The provisions of paragraph (a) shall not apply with respect to information provided by a small employer carrier or agent to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

(d) No small employer carrier shall, directly or indirectly, enter into any contract, agreement, or arrangement with an agent that provides for or results in the compensation paid to an agent for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small

employer except if the compensation arrangement provides compensation to an agent on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

(e) A small employer carrier shall provide reasonable compensation~~, as provided under the plan of operation of the program,~~ to an agent, if any, for the sale of a basic or standard health benefit plan.

(f) No small employer carrier shall terminate, fail to renew, or limit its contract or agreement of representation with an agent for any reason related to the health status, claims experience, occupation, or geographic location of the small employers placed by the agent with the small employer carrier unless the agent consistently engages in practices that violate this section or s. 626.9541.

(g) No small employer carrier or agent shall induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

(h) Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial.

(i) The commission may establish regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

(j) A violation of this section by a small employer carrier or an agent shall be an unfair trade practice under s. 626.9541 or ss. 641.3903 and 641.3907.

(k) If a small employer carrier enters into a contract, agreement, or other arrangement with a third-party administrator to provide administrative, marketing, or other services relating to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this section.

(16) APPLICABILITY OF OTHER STATE LAWS.—

(a) Except as expressly provided in this section, a law requiring coverage for a specific health care service or benefit, or a law requiring reimbursement, utilization, or consideration of a specific category of licensed health care practitioner, does not apply to a standard or basic health benefit plan policy or contract or a limited benefit policy or contract offered or delivered to a small employer unless that law is made expressly applicable to such policies or contracts. A law restricting or limiting deductibles, coinsurance, copayments, or annual or lifetime maximum payments does not apply to any health plan policy, including a standard or basic health benefit plan policy or contract, offered or delivered to a small employer unless such law is made expressly applicable to such policy or contract. However, every small employer carrier must offer to eligible small employers the standard benefit plan and the basic benefit plan, as required by subsection (5), as such plans have been approved by the office pursuant to subsection (12).

(b) Except as provided in this section, a standard or basic health benefit plan policy or contract or limited benefit policy or contract offered to a small employer is not subject to any provision of this code which:

1. Inhibits a small employer carrier from contracting with providers or groups of providers with respect to health care services or benefits;

2. Imposes any restriction on a small employer carrier's ability to negotiate with providers regarding the level or method of reimbursing care or services provided under a health benefit plan; or

3. Requires a small employer carrier to either include a specific provider or class of providers when contracting for health care services or benefits or to exclude any class of providers that is generally authorized by statute to provide such care.

~~(c) Any second tier assessment paid by a carrier pursuant to paragraph (11)(j) may be credited against assessments levied against the carrier pursuant to s. 627.6494.~~

(c) ~~(d)~~ Notwithstanding chapter 641, a health maintenance organization is authorized to issue contracts providing benefits equal to the standard health benefit plan, the basic health benefit plan, and the limited benefit policy authorized by this section.

Section 4. Sub-subsection (d) of subsection (2) of section 112.363, Florida Statutes, is amended to read:

(2) ELIGIBILITY FOR RETIREE HEALTH INSURANCE SUBSIDY.—

(d) Payment of the retiree health insurance subsidy shall be made only after coverage for health insurance for the retiree or beneficiary has been certified in writing to the Department of Management Services. Participation in a former employer's group health insurance program is not a requirement for eligibility under this section. ~~Coverage issued pursuant to s. 408.9091 is considered health insurance for the purposes of this section.~~

Section 5. Subsections (42) through (45) are renumbered and subsection (41) of section 408.07, Florida Statutes, is amended to read:

~~(41) "Prospective payment arrangement" means a financial agreement negotiated between a hospital and an insurer, health maintenance organization, preferred provider organization, or other third-party payor which contains, at a minimum, the elements provided for in s. 408.50.~~

(41) ~~(42)~~ "Rate of return" means the financial indicators used to determine or demonstrate reasonableness of the financial requirements of a hospital. Such indicators shall include, but not be limited to: return on assets, return on equity, total margin, and debt service coverage.

(42) ~~(43)~~ "Rural hospital" means an acute care hospital licensed under chapter 395, having 100 or fewer licensed beds and an emergency room, and which is:

(a) The sole provider within a county with a population density of no greater than 100 persons per square mile;

(b) An acute care hospital, in a county with a population density of no greater than 100 persons per square mile, which is

at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from another acute care hospital within the same county;

(c) A hospital supported by a tax district or subdistrict whose boundaries encompass a population of 100 persons or fewer per square mile;

(d) A hospital with a service area that has a population of 100 persons or fewer per square mile. As used in this paragraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Policy Analysis at the Agency for Health Care Administration; or

(e) A critical access hospital.

Population densities used in this subsection must be based upon the most recently completed United States census. A hospital that received funds under s. 409.9116 for a quarter beginning no later than July 1, 2002, is deemed to have been and shall continue to be a rural hospital from that date through June 30, 2015, if the hospital continues to have 100 or fewer licensed beds and an emergency room, or meets the criteria of s. 395.602(2)(e)4. An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of this subsection shall be granted such designation upon application, including supporting documentation, to the Agency for Health Care Administration.

(43) ~~(44)~~ "Special study" means a nonrecurring data-gathering and analysis effort designed to aid the agency in meeting its responsibilities pursuant to this chapter.

(44) ~~(45)~~ "Teaching hospital" means any Florida hospital officially affiliated with an accredited Florida medical school which exhibits activity in the area of graduate medical education as reflected by at least seven different graduate medical education programs accredited by the Accreditation Council for Graduate Medical Education or the Council on Postdoctoral Training of the American Osteopathic Association and the presence of 100 or more full-time equivalent resident physicians. The Director of the Agency for Health Care Administration shall be responsible for determining which hospitals meet this definition.

Section 6. Subsection (10) 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 Secretary of Corrections 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 of Corrections' health care delivery system, and by assuring that adequate standards of physical and mental health care for inmates are maintained at all Department of Corrections institutions. For this purpose, the authority has the authority to:

~~(10) Coordinate the development of prospective payment arrangements as described in s. 408.50 when appropriate for the acquisition of inmate health care services.~~

Section 7. Sub-subsection (c) of subsection (3) of section 1001.706, Florida Statutes, is amended to read:

(3) POWERS AND DUTIES RELATING TO ORGANIZATION AND OPERATION OF STATE UNIVERSITIES.—

(a) The Board of Governors, or the board's designee, shall develop guidelines and procedures related to data and technology, including information systems, communications systems, computer hardware and software, and networks.

(b) The Board of Governors shall develop guidelines relating to divisions of sponsored research, pursuant to the provisions of s. 1004.22, to serve the function of administration and promotion of the programs of research.

(c) The Board of Governors shall prescribe conditions for direct-support organizations ~~and university health services support organizations~~ to be certified and to use university property and services. Conditions relating to certification must provide for audit review and oversight by the Board of Governors.

(d) The Board of Governors shall develop guidelines for supervising faculty practice plans for the academic health science centers.

(e) The Board of Governors shall ensure that students at state universities have access to general education courses as provided in the statewide articulation agreement, pursuant to s. 1007.23.

(f) The Board of Governors shall approve baccalaureate degree programs that require more than 120 semester credit hours of coursework prior to such programs being offered by a state university. At least half of the required coursework for any baccalaureate degree must be offered at the lower-division level, except in program areas approved by the Board of Governors.

(g) The Board of Governors, or the board's designee, shall adopt a written antihazing policy, appropriate penalties for violations of such policy, and a program for enforcing such policy.

(h) The Board of Governors, or the board's designee, may establish a uniform code of conduct and appropriate penalties for violations of its regulations by students and student organizations, including regulations governing student academic honesty. Such penalties, unless otherwise provided by law, may include reasonable fines, the withholding of diplomas or transcripts pending compliance with regulations or payment of fines, and the imposition of probation, suspension, or dismissal.

Section 8. This act shall take effect July 1, 2011.