By Representative Bloom

A bill to be entitled

An act relating to health insurance policies, contracts, and coverage; creating s. 627.6474, F.S.; providing purposes; providing definitions; authorizing point of service coverage under arrangements between health insurers and health maintenance organizations; providing criteria; providing standards; providing requirements; providing procedures; providing applicability; providing rulemaking authority of the Department of Insurance; creating s. 627.64735, F.S.; prohibiting use of certain words under certain circumstances; amending s. 627.662, F.S.; providing for application of s. 627.64735, F.S., to certain insurance; creating s. 627.6693, F.S.; requiring certain group health insurance policies to comply with certain point of service requirements; creating s. 641.185, F.S.; establishing a subscriber's bill of rights to serve as standards for certain purposes; creating s. 641.2019, F.S.; prohibiting health maintenance organizations from excluding certain noncovered or covered services under certain circumstances; amending s. 641.30, F.S.; requiring certain health maintenance organization agreements to comply with certain point of service requirements; providing application; amending s. 641.31, F.S.; requiring the department to specify new rates or rate schedules for health maintenance

organizations under certain circumstances; providing for return of excessive premiums received; providing for continuation of care under certain circumstances; amending s. 641.3108, F.S.; requiring certain notice to group member subscribers prior to the effective date of cancellation or termination of a group health maintenance contract; amending s. 641.315, F.S.; requiring provider contracts to provide for notice to the department of any intent to cancel; creating s. 641.34, F.S.; prohibiting use of certain words under certain circumstances; amending s. 641.51, F.S.; extending the time required to be provided to subscribers for continued care by a terminating treating provider under certain circumstances; amending s. 641.511, F.S.; requiring a health maintenance organization respond to an initial complaint within a time certain; requiring grievance managers to provide written determinations of grievance panel review; providing grievance process requirements relating to subscribers; providing application; providing an effective date.

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

Section 1. Section 627.6474, Florida Statutes, is created to read:

627.6474 Point of service policies; purpose of part; definition; authority; standards, reporting; application of other laws.--

(1) PURPOSE.--It is the purpose of this section to encourage the issuance of coverage to persons that provides an option, at the time medical services are secured, of accessing benefits provided by a licensed health maintenance organization or accessing benefits provided by a licensed health insurer. By authorizing the issuance of that coverage, the Legislature intends to maximize health care options for consumers of health care policies.

(2) SCOPE.--Point of service coverage may be issued on an individual or group basis.

(3) DEFINITIONS.--As used in this section:

(a) "Point of service agreement" is the contractual means by which a health insurer and health maintenance organization offer point of service coverage.

(b) "Point of service policy" is a policy providing comprehensive health benefits under which an insured has:

1. Both a health insurance policy issued by an authorized health insurer in conjunction with a health maintenance contract issued by a licensed health maintenance organization whereby the insured may choose at each time of service whether to access indemnity benefits under the health insurance policy or benefits under the health maintenance contract, but not both; or

2. A single contract issued by a health maintenance organization or a single policy issued by a health insurer, pursuant to a point of service agreement between the health insurer and the health maintenance organization, whereby the insured may choose at each time of service whether to access

indemnity benefits under the health insurance portion of the policy or benefits under the health maintenance portion of the policy, but not both.

(c) "Insured" means the policyholder or subscriber of an individual point of service policy, or the subscriber or certificateholder under a group point of service policy.

(4) AUTHORITY TO ISSUE.--

(a) Subject to the requirements contained in this section, nothing in this code, including chapter 641, and rules adopted under the code and such chapter, shall be deemed to prohibit an authorized health insurer and a licensed health maintenance organization, in conjunction, from soliciting, offering, or providing point of service coverage either in a separate policy issued by the health insurer and a separate health maintenance contract issued by the health maintenance organization or in a single contract issued by the health maintenance organization or by a single policy by the health insurer.

(b) Except as provided in this section, no insurer or health maintenance organization shall solicit, offer, or provide a point of service policy.

(5) PROVISIONS OF POINT OF SERVICE POLICIES.--Each point of service policy shall contain the following provisions, in addition to all others required under this code, chapter 641, and rules adopted under the code and such chapter:

(a) A provision clearly identifying both the health insurer and the health maintenance organization and, in the instance of a group policy, a provision in the member handbook or certificate of coverage clearly identifying the health insurer and the health maintenance organization.

(b) A provision stating that an insured covered under a point of service policy must elect either indemnity benefits or health maintenance organization coverage for a given medical treatment.

(c) A provision stating that whenever coverage has been paid or provided with respect to a given medical treatment by either the health insurer or the health maintenance organization pursuant to a filed and approved point of service policy, the provisions of s. 627.4235 shall not apply with respect to the point of service policy but shall apply as to other policies, plans, or contracts of the insured.

(d) A provision stating that 60 days prior to the termination of a point of service agreement, the terminating company must provide each insured who has a policy under the agreement notice in writing of the termination.

(e) A provision that, if a point of service agreement is terminated, the policyholder in an individual contract or the contract holder in a group contract may, within 60 days after receiving notice of the termination, elect to continue coverage with either the health maintenance organization or the health insurer that was a party to the point of service agreement for the remainder of the contract period.

(f) A provision that, if the insured is entitled to a conversion plan, for reasons set forth in s. 627.646, s. 627.6675, or s. 641.3922, the insured is entitled to a choice of either an indemnity plan from the health insurer or a health maintenance organization contract, without prejudice.

(6) FILING AND REPORTING REQUIREMENTS.--

(a) The following requirements apply to point of service policy forms and rate filings.

1. All point of service policy form and rate filings shall be made jointly, whether or not separate or combined forms are used.

2. The point of service policy form and rate filing shall include all forms and rates required by this section. However, if using forms and rates previously approved to satisfy the required separate health benefit policies and the conversion policies to be used in conjunction with this point of service policy, it shall be sufficient to identify the form number and date of approval of these forms and related rates.

3. The point of service policy form and rate filing shall contain certification from an officer of the health insurer and an officer of the health maintenance organization that each company agrees, as a condition precedent to termination of the point of service agreement, to provide the department with notice of its intention to terminate the point of service arrangement no less than 90 days prior to the effective date of termination. Further, each company agrees to notify the department within 48 hours in the event of a material breach by either company.

4. All point of service policy filings shall contain an authorization from the health insurer and the health maintenance organization, either as joint signatories or an original letter of authorization from each company to the other, to make the combined filing whenever a single policy will be used and that both parties will be responsible for the accuracy of the information contained in the combined filing.

5. All point of service policy forms and rates shall be filed and approved prior to use. All form and rate changes to said policy must be filed and approved prior to use.

6. The health insurer and the health maintenance organization shall each file and have approved a policy form and rate to be made available to the insured when the point of service agreement is terminated during an existing contract period. The filing shall:

a. Contain levels of indemnity benefits or other health benefit coverage no less than that provided under the point of service policy.

b. Comply in all respects with the requirements of the insurance code or chapter 641 as related to the product being filed.

c. Clearly identify in the filing that this policy is intended for use in conjunction with a point of service policy.

7. The health insurer and the health maintenance organization shall each have filed and approved a conversion policy, with corresponding rates, to be made available to the insured when the right to conversion is required.

8. The health insurer or the health maintenance organization shall make, at a minimum, an annual rate filing for each point of service policy form offered in this state. Annual periodic rate adjustments shall be made to reflect the actual premium split based on experience and compared with the assumed split at the beginning of the contract. Except as so described, no other experience adjustments shall be made on a retrospective basis without approval by the department.

9. All rate filings for a point of service policy shall contain the following terms and conditions, in addition to all others required under by law or rule:

a. The health insurer and the health maintenance organization shall each perform its own pricing on a net claim basis.

b. The health insurer and the health maintenance organization shall each calculate its own expenses and profit margins.

c. Expenses are to be itemized and shall clearly identify which entity is performing which duty relative to each expense item noted.

d. Minimum loss ratios, as defined in the code or in any applicable rule adopted under the code, shall be met by each company.

(b) The following requirements apply to point of service information reporting.--

1. The health insurer and the health maintenance organization shall each maintain separate records relating to any point of service policy. On each financial report made to the department, made on a form adopted by the department, each company shall provide the following information:

a. Total point of service earned premium.

b. Total number of point of service policyholders, certificateholders and subscribers by market, individual, small group, or large group.

c. Loss ratios for point of service policies.

d. Expenses.

e. Any other information required by the department in carrying out the department's duties under this section.

2. Each company shall disclose in the company's audited financial statement, at a minimum in a footnote to such report, the combined earned premium and total losses incurred, including expenses incurred but not reported for

this product. The annual actuarial certification shall also contain a specific actuarial certification that the rates charged for this product are not inadequate, excessive or discriminatory.

(7) APPLICABILITY.--

(a) Any health insurer entering into a point of service arrangement pursuant to this section, in addition to the requirements of this section, shall be subject to all provisions of the insurance code and other laws, and rules adopted under the code or such laws, applicable to health insurers generally.

(b) Any health maintenance organization entering into a point of service arrangement pursuant to this section, in addition to the requirements of this section, shall be subject to all provisions of chapter 641 and rules adopted under such chapter, and to all other provisions of this code and other laws and rules adopted under such code and laws, applicable to health maintenance organizations generally.

(c) The health insurance portion of a point of service arrangement policy shall be subject to the provisions of part III of chapter 631. The health maintenance portion of a point of service arrangement shall be subject to part IV of chapter 631.

(d) Any health maintenance organization entering into a point of service arrangement pursuant to this section shall not be subject to part VII of chapter 626 when administering a point of service policy.

(8) RULEMAKING.--The department may adopt any rule necessary to implement the intent and provisions of this section. In adopting such rule, the department shall consider requirements to assure that experience adjustments and other

adjustments are reasonable, fair, and equitable; that point of service policies, advertisements, solicitation materials, and other statements or related documents are clear and understandable; that point of service policies are provided to the insurance buying public in a fashion that meets the purposes of this section and are provided in a fair and equitable fashion; and that point of service policies provide for a proper triggering of the conversion plan policies.

Section 2. Section 627.64735, Florida Statutes, is created to read:

627.64735 Use of certain words prohibited.--A health insurer or a health maintenance organization shall not use in its contracts or literature or in any form of advertising the phrase "point of service," or its abbreviation "POS," unless the phrase or abbreviation relates to a policy which has been filed and approved by the department pursuant to s. 627.6474.

Section 3. Section 11 is added to section 627.662, Florida Statutes, to read:

627.662 Other provisions applicable.--The following provisions apply to group health insurance, blanket health insurance, and franchise health insurance:

(11) Section 627.64735, relating to prohibiting use of the phrase "point of service."

Section 4. Section 627.6693, Florida Statutes, is created to read:

627.6693 Point of service.--Any group health insurance policy that provides coverage to a resident of this state pursuant to a point of service agreement as defined in s. 627.6474 shall comply with all requirements set forth in s. 627.6474.

Section 5. Section 641.185, Florida Statutes, is created to read:

641.185 Health maintenance organization subscriber's bill of rights.--

(1) With respect to the provisions of this part, and consistent with the scope of covered conditions and treatments under the contract, the principles expressed in the following statements shall serve as standards to be followed by the department and the agency in exercising their powers and duties, in exercising administrative discretion, in dispensing administrative interpretations of the law, in enforcing the law, and in adopting rules:

(a) A subscriber has the right to receive quality, medically necessary and appropriate health care services that are available and accessible in a timely manner.

(b) A subscriber has the right to the provision of medical care by the health maintenance organization with the goal of maintaining the subscriber's good health in a cost-effective fashion and to treat the subscriber's medical conditions as may be necessary and appropriate.

(c) A subscriber has the right to accurate and easily understood information to make informed decisions about health plans, professionals, and facilities.

(d) A subscriber has the right to compassionate, sympathetic, and respectful care from all health maintenance organization providers and employees.

(e) A subscriber shall have access to simple, fair, timely, and impartial procedures for resolving coverage disputes.

(f) A subscriber has a right to a timely referral with payment pre-authorization for covered treatment outside the

health maintenance organization's provider network when a health maintenance organization does not have a provider specializing in or experienced with respect to the medical care or course of treatment appropriate to the subscriber's medical condition.

(g) A subscriber has a right to expedited treatment of any covered condition that would jeopardize the life or health of a subscriber or would jeopardize the subscriber's ability to regain maximum function.

(h) A subscriber has a right to a quality assurance program with respect to health maintenance organization providers so as to provide medically necessary care and treatment and to avoid unnecessary, inappropriate, or improper medical care or services.

(2) This section shall not be construed as creating a civil cause of action by any subscriber against any health maintenance organization.

Section 6. Section 641.2019, Florida Statutes, is created to read:

641.2019 Simultaneous delivery of covered and noncovered medical treatment.--A health maintenance organization shall not prohibit a subscriber from receiving noncovered medically necessary treatment simultaneously with covered treatment if a provider determines the simultaneous treatment is not contrary to the best interests of the subscriber. A health maintenance organization shall not exclude coverage for a covered procedure if the subscriber elects to have a noncovered medically necessary procedure performed simultaneously or in conjunction with the covered procedure. The health maintenance organization shall not reduce the level of reimbursement to the provider performing

the covered service in conjunction with the noncovered service.

Section 7. Subsection (6) is added to section 641.30, Florida Statutes, to read:

641.30 Construction and relationship to other laws.--

(6) Every health maintenance organization entering into an arrangement to provide point of service coverage shall comply with s. 627.6474.

Section 8. Paragraph (b) of subsection (3) of section 641.31, Florida Statutes, 1998 Supplement, is amended, and subsection (36) is added to said section, to read:

641.31 Health maintenance contracts.--

(3)

(b) The department shall disapprove any form filed under this subsection, or withdraw any previous approval thereof, if the form:

1. Is in any respect in violation of, or does not comply with, any provision of this part or rule adopted thereunder.

2. Contains or incorporates by reference, where such incorporation is otherwise permissible, any inconsistent, ambiguous, or misleading clauses or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract.

3. Has any title, heading, or other indication of its provisions which is misleading.

4. Is printed or otherwise reproduced in such a manner as to render any material provision of the form substantially illegible.

5. Contains provisions which are unfair, inequitable, or contrary to the public policy of this state or which encourage misrepresentation.

6. Charges rates that are determined by the department to be inadequate, excessive, or unfairly discriminatory, or the rating methodology followed by the health maintenance organization is determined by the department to be inconsistent, indeterminate, ambiguous, or encouraging misrepresentation or misunderstanding. When the department finds that a rate or rate change is excessive, inadequate, or unfairly discriminatory, the department shall, in addition to disapproving the form, specify that a new rate or rate schedule, which responds to the findings of the department, be filed by the health maintenance organization. The department shall further require that premiums charged each contract holder, constituting the portion of the rate above that which was approved, be returned to such contract holder in the form of a credit or refund. The refund or credit amount due shall be calculated from the date of the original disapproval. When the department finds that a health maintenance organization's rate or rate change is inadequate, the new rate or rate schedule filed with the department in response to such a finding ~~Use of the rating methodology must be discontinued immediately upon disapproval unless the health maintenance organization seeks administrative relief. If a new rating methodology is filed with the department, the premiums determined by such newly filed rating methodology~~ may apply prospectively only to new or renewal business written on or after the effective date of the responsive filing made by the health maintenance organization.

7. Excludes coverage for human immunodeficiency virus infection or acquired immune deficiency syndrome or contains limitations in the benefits payable, or in the terms or conditions of such contract, for human immunodeficiency virus infection or acquired immune deficiency syndrome which are different than those which apply to any other sickness or medical condition.

(36) A health maintenance organization contract shall include the provisions of s. 641.51(7).

Section 9. Section 641.3108, Florida Statutes, is amended to read:

641.3108 Notice of cancellation or nonrenewal of contract.--

(1) Except for nonpayment of premium or termination of eligibility, no health maintenance organization may cancel or otherwise terminate or fail to renew a health maintenance contract without giving each ~~the~~ subscriber covered by the contract at least 45 days' notice in writing of the cancellation, termination, or nonrenewal of the contract. The written notice shall state the reason or reasons for the cancellation, termination, or nonrenewal. All health maintenance contracts shall contain a clause which requires that this notice be given. ~~In the case of a health maintenance contract issued to an employer or person holding the contract on behalf of the subscriber group, the health maintenance organization may make the notification through the employer or group contract holder, and, if the health maintenance organization elects to take this action through the employer or group contract holder, the organization shall be deemed to have complied with the provisions of this section upon notifying the employer or group contract holder of the~~

~~requirements of this section and requesting the employer or group contract holder to forward to all subscribers the notice required herein.~~

(2) No health maintenance organization may cancel or otherwise terminate or fail to renew a group health maintenance contract for nonpayment of premium or termination of eligibility without giving each subscriber covered by the contract at least 30 days' notice in writing of the cancellation, termination, or nonrenewal of the contract. The written notice shall state the reason or reasons for the cancellation, termination, or nonrenewal. All group health maintenance contracts shall contain a clause which requires that this notice be given.

Section 10. Subsection (6) of section 641.315, Florida Statutes, is amended to read:

641.315 Provider contracts.--

(6)(a) For all provider contracts executed after October 1, 1999 ~~1991, and within 180 days after October 1, 1991, for contracts in existence as of October 1, 1991~~:

1. The contracts must provide that the provider shall provide 60 days' advance written notice to the health maintenance organization ~~and the department~~ before canceling the contract with the health maintenance organization for any reason; ~~and~~

2. The contract must also provide that nonpayment for goods or services rendered by the provider to the health maintenance organization shall not be a valid reason for avoiding the 60-day advance notice of cancellation; and~~.~~

3. The contract must also provide that the health maintenance organization shall, within 72 hours after receipt of the notice required in subparagraph 1., notify the

department of the provider's intent to cancel the contract with the health maintenance organization.

(b) For all provider contracts executed after October 1, 1999 ~~1996, and within 180 days after October 1, 1996~~, for contracts in existence as of October 1, 1996, the contracts must provide that the health maintenance organization will provide 60 days' advance written notice to the provider and the department before canceling, without cause, the contract with the provider, except in a case in which a patient's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action by the Board of Medicine or other governmental agency.

Section 11. Section 641.34, Florida Statutes, is created to read:

641.34 Use of certain words prohibited.--A health maintenance organization shall not use in its contracts or literature or in any form of advertising the phrase "point of service," or its abbreviation "POS," unless the phrase or abbreviation relates to a policy which has been filed and approved by the department pursuant to s. 627.6474.

Section 12. Subsection (7) of section 641.51, Florida Statutes, is amended to read:

641.51 Quality assurance program; second medical opinion requirement.--

(7) Each organization shall allow subscribers to continue care for 90 ~~60~~ days with a terminated treating provider when medically necessary, provided the subscriber has a life-threatening condition or a disabling and degenerative condition. Each organization shall allow a subscriber who is in the third trimester of pregnancy to continue care with a terminated treating provider until completion of postpartum

care. The organization and the provider shall continue to be bound by the terms of the contract for such continued care. This subsection shall not apply to treating providers who have been terminated by the organization for cause.

Section 13. Subsections (2) and (4) of section 641.511, Florida Statutes, 1998 Supplement, are amended to read:

641.511 Subscriber grievance reporting and resolution requirements.--

(2) When an organization receives an initial complaint from a subscriber, the organization must respond to the complaint within a reasonable time after its submission but not exceed 15 days. At the time of receipt of the initial complaint, the organization shall inform the subscriber that the subscriber has a right to file a written grievance at any time and that assistance in preparing the written grievance shall be provided by the organization.

(4)(a) With respect to a grievance concerning an adverse determination, an organization shall make available to the subscriber a review of the grievance by an internal review panel.~~:~~ Such review shall ~~must~~ be requested within 30 days after the organization's transmittal of the final decision, in writing, by the grievance manager, pursuant to paragraph (3)(f)~~determination notice of an adverse determination~~. A majority of the panel shall be persons who previously were not involved in the initial adverse determination. A person who previously was involved in the adverse determination may appear before the panel to present information or answer questions. The panel shall have the authority to bind the organization to the panel's decision.

(b) An organization shall ensure that a majority of the persons reviewing a grievance involving an adverse determination are providers who have appropriate expertise. An organization shall issue a copy of the written decision of the review panel to the subscriber and to the provider, if any, who submits a grievance on behalf of a subscriber. In cases where there has been a denial of coverage of service, the reviewing provider shall not be a provider previously involved with the adverse determination.

(c) An organization shall establish written procedures for a review of an adverse determination. Review procedures shall be available to the subscriber and to a provider acting on behalf of a subscriber.

(d) Each organization's grievance procedures for the review panel, as required under this subsection, must provide at a minimum:

1. For a hearing at which the subscriber may appear, be heard, and submit documentation regarding the grievance.

2. That the subscriber is entitled to be represented at the hearing by a person of his or her choice, including legal counsel.

3. That the subscriber may be accompanied by the provider who ordered the disputed treatment or service, who shall be allowed to speak on the subscriber's behalf.

4. That the subscriber be allowed to document the hearing by transcription or by video or audio recording.

(e)~~(d)~~ In any case when the review process does not resolve a difference of opinion between the organization and the subscriber or the provider acting on behalf of the subscriber, the subscriber or the provider acting on behalf of

the subscriber may submit a written grievance to the Statewide Provider and Subscriber Assistance Program.

Section 14. This act shall take effect October 1, 1999, and shall apply to policies and contracts issued or renewed on or after such date.

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HOUSE SUMMARY

Authorizes licensed health insurers and health maintenance organizations to issue optional point of service coverage for indemnity benefits under a health insurance policy or benefits under a health maintenance contract. Provides a bill of rights for health maintenance organization subscribers. Provides for simultaneous treatment of covered and noncovered services. Provides for continued treatment for terminal illnesses, pregnancies, or institutional care under terminated policies. Requires health maintenance organizations to provide notice prior to canceling or terminating, or failing to renew health maintenance contracts. Specifies additional requirements for grievance procedures of health maintenance organizations.