

1
2 An act relating to governmental agencies;
3 amending s. 20.41, F.S.; providing that area
4 agencies on aging are subject to ch. 119 and
5 ss. 286.011-286.012, F.S., as specified;
6 amending s. 408.05, F.S., relating to the State
7 Center for Health Statistics; requiring the
8 Agency for Health Care Administration to
9 publish health maintenance organization report
10 cards; amending s. 408.7056, F.S.; excluding
11 certain additional grievances from
12 consideration by a statewide provider and
13 subscriber assistance panel; revising the
14 membership of the panel; amending s. 627.6471,
15 F.S.; requiring preferred provider organization
16 policies which do not provide direct patient
17 access for dermatological services to conform
18 to certain requirements imposed on exclusive
19 provider organization contracts; amending s.
20 627.6645, F.S.; revising the notice
21 requirements for cancellation or nonrenewal of
22 a group health insurance policy; specifying
23 conditions under which the insurer may
24 retroactively cancel coverage due to nonpayment
25 of premium; amending s. 627.6675, F.S.;
26 revising the time limits for an employee or
27 group member to apply for an individual
28 converted policy when termination of group
29 coverage is due to failure of the employer to
30 pay the premium; revising the requirements for
31 the premium for the converted policy; allowing

1 a group insurer to contract with another
2 insurer to issue an individual converted policy
3 under certain conditions; amending s. 641.3108,
4 F.S.; revising the notice requirements for
5 cancellation or nonrenewal of a health
6 maintenance organization contract; specifying
7 conditions under which the organization may
8 retroactively cancel coverage due to nonpayment
9 of premium; amending s. 641.3922, F.S.;
10 revising the time limits for an employee or
11 group member to apply for a converted contract
12 from a health maintenance organization when
13 termination of group coverage is due to failure
14 of the employer to pay the premium; revising
15 the requirements for the premium for the
16 converted contract; amending s. 641.31, F.S.,
17 relating to health maintenance contracts;
18 providing for a point-of-service benefit rider
19 on a health maintenance contract; providing
20 requirements; providing restrictions;
21 authorizing reasonable copayment and annual
22 deductible; providing exceptions relating to
23 subscriber liability for services received;
24 amending s. 641.3155, F.S., relating to health
25 maintenance organization provider contracts and
26 payment of claims; requiring health maintenance
27 organizations to reconcile retroactive
28 reductions of payment to specific claims;
29 requiring providers to reconcile retroactive
30 demands for underpayment or nonpayment to
31 specific claims; providing an exception;

1 providing for the contract to specify the
2 look-back period; providing for an advisory
3 group established in the Agency for Health Care
4 Administration; requiring a report; amending s.
5 641.51, F.S.; requiring that health maintenance
6 organizations provide additional information to
7 the Agency for Health Care Administration
8 indicating quality of care; removing a
9 requirement that organizations conduct customer
10 satisfaction surveys; revising requirements for
11 preventive pediatric health care provided by
12 health maintenance organizations; amending s.
13 641.58, F.S.; providing for moneys in the
14 Health Care Trust Fund to be used for
15 additional purposes; amending s. 409.910, F.S.;
16 clarifying that the state may recover and
17 retain damages in excess of Medicaid payments
18 made under certain circumstances; providing for
19 retroactive application; amending s. 409.912,
20 F.S., relating to purchase of goods and
21 services for Medicaid recipients; requiring the
22 Agency for Health Care Administration to
23 develop certain programs and initiatives
24 relating to the prescribing, use, and
25 dispensing of drugs; providing for an advisory
26 panel on prescription practice patterns;
27 providing an appropriation; providing an
28 effective date.

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30 Be It Enacted by the Legislature of the State of Florida:
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1 Section 1. Paragraph (a) of subsection (5) of section
2 408.05, Florida Statutes, 1998 Supplement, is amended to read:

3 408.05 State Center for Health Statistics.--

4 (5) PUBLICATIONS; REPORTS; SPECIAL STUDIES.--The
5 center shall provide for the widespread dissemination of data
6 which it collects and analyzes. The center shall have the
7 following publication, reporting, and special study functions:

8 (a) The center shall publish and make available
9 periodically to agencies and individuals health statistics
10 publications of general interest, including HMO report cards;
11 publications providing health statistics on topical health
12 policy issues;~~7~~publications that ~~which~~ provide health status
13 profiles of the people in this state;~~7~~and other topical
14 health statistics publications.

15 Section 2. Subsections (2) and (11) of section
16 408.7056, Florida Statutes, 1998 Supplement, are amended to
17 read:

18 408.7056 Statewide Provider and Subscriber Assistance
19 Program.--

20 (2) The agency shall adopt and implement a program to
21 provide assistance to subscribers and providers, including
22 those whose grievances are not resolved by the managed care
23 entity to the satisfaction of the subscriber or provider. The
24 program shall consist of one or more panels that meet as often
25 as necessary to timely review, consider, and hear grievances
26 and recommend to the agency or the department any actions that
27 should be taken concerning individual cases heard by the
28 panel. The panel shall hear every grievance filed by
29 subscribers and providers on behalf of subscribers, unless the
30 grievance:

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- 1 (a) Relates to a managed care entity's refusal to
2 accept a provider into its network of providers;
- 3 (b) Is part of an internal grievance in a Medicare
4 managed care entity or a reconsideration appeal through the
5 Medicare appeals process which does not involve a quality of
6 care issue;
- 7 (c) Is related to a health plan not regulated by the
8 state such as an administrative services organization,
9 third-party administrator, or federal employee health benefit
10 program;
- 11 (d) Is related to appeals by in-plan suppliers and
12 providers, unless related to quality of care provided by the
13 plan;
- 14 (e) Is part of a Medicaid fair hearing pursued under
15 42 C.F.R. ss. 431.220 et seq.;
- 16 (f) Is the basis for an action pending in state or
17 federal court;
- 18 (g) Is related to an appeal by nonparticipating
19 providers, unless related to the quality of care provided to a
20 subscriber by the managed care entity and the provider is
21 involved in the care provided to the subscriber;
- 22 (h) Was filed before the subscriber or provider
23 completed the entire internal grievance procedure of the
24 managed care entity, the managed care entity has complied with
25 its timeframes for completing the internal grievance
26 procedure, and the circumstances described in subsection (6)
27 do not apply;
- 28 (i) Has been resolved to the satisfaction of the
29 subscriber or provider who filed the grievance, unless the
30 managed care entity's initial action is egregious or may be
31 indicative of a pattern of inappropriate behavior;

1 (j) Is limited to seeking damages for pain and
2 suffering, lost wages, or other incidental expenses, including
3 accrued interest on unpaid balances, court costs, and
4 transportation costs associated with a grievance procedure;

5 (k) Is limited to issues involving conduct of a health
6 care provider or facility, staff member, or employee of a
7 managed care entity which constitute grounds for disciplinary
8 action by the appropriate professional licensing board and is
9 not indicative of a pattern of inappropriate behavior, and the
10 agency or department has reported these grievances to the
11 appropriate professional licensing board or to the health
12 facility regulation section of the agency for possible
13 investigation; or

14 (l) Is withdrawn by the subscriber or provider.
15 Failure of the subscriber or the provider to attend the
16 hearing shall be considered a withdrawal of the grievance.

17 (11) The panel shall consist of members employed by
18 the agency and members employed by the department, chosen by
19 their respective agencies; a consumer appointed by the
20 Governor; a physician appointed by the Governor, as a standing
21 member; and physicians who have expertise relevant to the case
22 to be heard, on a rotating basis. The agency may contract with
23 a medical director and a primary care physician who shall
24 provide additional technical expertise to the panel. The
25 medical director shall be selected from a health maintenance
26 organization with a current certificate of authority to
27 operate in Florida.

28 Section 3. Present subsection (5) of section 627.6471,
29 Florida Statutes, is redesignated as subsection (6) and a new
30 subsection (5) is added to that section to read:

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1 627.6471 Contracts for reduced rates of payment;
2 limitations; coinsurance and deductibles.--

3 (5) Any policy issued under this section which does
4 not provide direct patient access to a dermatologist must
5 conform to the requirements of s. 627.6472(16). This
6 subsection shall not be construed to affect the amount the
7 insured or patient must pay as a deductible or coinsurance
8 amount authorized under this section.

9 Section 4. Subsection (36) is added to section 641.31,
10 Florida Statutes, 1998 Supplement, to read:

11 641.31 Health maintenance contracts.--

12 (36)(a) Notwithstanding any other provision of this
13 part, a health maintenance organization that meets the
14 requirements of paragraph (b) may, through a point-of-service
15 rider to its contract providing comprehensive health care
16 services, include a point-of-service benefit. Under such a
17 rider, a subscriber or other covered person of the health
18 maintenance organization may choose, at the time of covered
19 service, a provider with whom the health maintenance
20 organization does not have a health maintenance organization
21 provider contract. The rider may not require a referral from
22 the health maintenance organization for the point-of-service
23 benefits.

24 (b) A health maintenance organization offering a
25 point-of-service rider under this subsection must have a valid
26 certificate of authority issued under the provisions of the
27 chapter, must have been licensed under this chapter for a
28 minimum of 3 years, and must at all times that it has riders
29 in effect maintain a minimum surplus of \$5 million.

30 (c) Premiums paid in for the point-of-service riders
31 may not exceed 15 percent of total premiums for all health

1 plan products sold by the health maintenance organization
2 offering the rider. If the premiums paid for point-of-service
3 riders exceed 15 percent, the health maintenance organization
4 must notify the department and, once this fact is known, must
5 immediately cease offering such a rider until it is in
6 compliance with the rider premium cap.

7 (d) Notwithstanding the limitations of deductibles and
8 copayment provisions in this part, a point-of-service rider
9 may require the subscriber to pay a reasonable copayment for
10 each visit for services provided by a noncontracted provider
11 chosen at the time of the service. The copayment by the
12 subscriber may either be a specific dollar amount or a
13 percentage of the reimbursable provider charges covered by the
14 contract and must be paid by the subscriber to the
15 noncontracted provider upon receipt of covered services. The
16 point-of-service rider may require that a reasonable annual
17 deductible for the expenses associated with the
18 point-of-service rider be met and may include a lifetime
19 maximum benefit amount. The rider must include the language
20 required by s. 627.6044 and must comply with copayment limits
21 described in s. 627.6471. Section 641.315(2) and (3) does not
22 apply to a point-of-service rider authorized under this
23 subsection.

24 (e) The term "point of service" may not be used by a
25 health maintenance organization except with riders permitted
26 under this section or with forms approved by the department in
27 which a point-of-service product is offered with an indemnity
28 carrier.

29 (f) A point-of-service rider must be filed and
30 approved under ss. 627.410 and 627.411.

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1 Section 5. Subsection (4) is added to section
2 641.3155, Florida Statutes, 1998 Supplement, to read:

3 641.3155 Provider contracts; payment of claims.--

4 (4) Any retroactive reductions of payments or demands
5 for refund of previous overpayments which are due to
6 retroactive review-of-coverage decisions or payment levels
7 must be reconciled to specific claims unless the parties agree
8 to other reconciliation methods and terms. Any retroactive
9 demands by providers for payment due to underpayments or
10 nonpayments for covered services must be reconciled to
11 specific claims unless the parties agree to other
12 reconciliation methods and terms. The look-back period may be
13 specified by the terms of the contract.

14 Section 6. The Director of the Agency for Health Care
15 Administration shall establish an advisory group composed of
16 eight members, with three members from health maintenance
17 organizations licensed in Florida, one representative from a
18 not-for-profit hospital, one representative from a for-profit
19 hospital, one representative who is a licensed physician, one
20 representative from the Office of the Insurance Commissioner,
21 and one representative from the Agency for Health Care
22 Administration. The advisory group shall study and make
23 recommendations concerning:

24 (1) Trends and issues relating to legislative,
25 regulatory, or private-sector solutions for timely and
26 accurate submission and payment of health claims.

27 (2) Development of electronic billing and claims
28 processing for providers and health care facilities that
29 provide for electronic processing of eligibility requests;
30 benefit verification; authorizations; precertifications;
31 business expensing of assets, including software, used for

1 electronic billing and claims processing; and claims status,
2 including use of models such as those compatible with federal
3 billing systems.

4 (3) The form and content of claims.

5 (4) Measures to reduce fraud and abuse relating to the
6 submission and payment of claims.

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8 The advisory group shall be appointed and convened by July 1,
9 1999, and shall meet in Tallahassee. Members of the advisory
10 group shall not receive per diem or travel reimbursement. The
11 advisory group shall submit its recommendations in a report,
12 by January 1, 2000, to the President of the Senate and the
13 Speaker of the House of Representatives.

14 Section 7. Subsections (8), (9), and (10) of section
15 641.51, Florida Statutes, are amended to read:

16 641.51 Quality assurance program; second medical
17 opinion requirement.--

18 (8) Each organization shall release to the agency data
19 that ~~which~~ are indicators of access and quality of care. The
20 agency shall develop rules specifying data-reporting
21 requirements for these indicators. The indicators shall
22 include the following characteristics:

23 (a) They must relate to access and quality of care
24 measures.

25 (b) They must be consistent with data collected
26 pursuant to accreditation activities and standards.

27 (c) They must be consistent with frequency
28 requirements under the accreditation process.

29 (d) They must include measures of the management of
30 chronic diseases.

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1 (e) They must include preventive health care for
2 adults and children.

3 (f) They must include measures of prenatal care.

4 (g) They must include measures of health checkups for
5 children.

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7 The agency shall develop by rule a uniform format for
8 publication of the data for the public which shall contain
9 explanations of the data collected and the relevance of such
10 data. The agency shall publish such data no less frequently
11 than every 2 years.

12 ~~(9) Each organization shall conduct a standardized~~
13 ~~customer satisfaction survey, as developed by the agency by~~
14 ~~rule, of its membership at intervals specified by the agency.~~
15 ~~The survey shall be consistent with surveys required by~~
16 ~~accrediting organizations and may contain up to 10 additional~~
17 ~~questions based on concerns specific to Florida. Survey data~~
18 ~~shall be submitted to the agency, which shall make comparative~~
19 ~~findings available to the public.~~

20 (9)(10) Each organization shall adopt recommendations
21 for preventive pediatric health care which are consistent with
22 the early periodic screening, diagnosis, and treatment
23 requirements for health checkups for children developed for
24 the Medicaid program. Each organization shall establish goals
25 to achieve 80-percent compliance by July 1, 1998, and
26 90-percent compliance by July 1, 1999, for their enrolled
27 pediatric population.

28 Section 8. Subsection (4) of section 641.58, Florida
29 Statutes, is amended to read:

30 641.58 Regulatory assessment; levy and amount; use of
31 funds; tax returns; penalty for failure to pay.--

1 (4) The moneys ~~so~~ received and deposited into the
2 Health Care Trust Fund shall be used to defray the expenses of
3 the agency in the discharge of its administrative and
4 regulatory powers and duties under this part, including
5 conducting an annual survey of the satisfaction of members of
6 health maintenance organizations; contracting with physician
7 consultants for the Statewide Provider and Subscriber
8 Assistance Panel;~~the~~ maintaining ~~of~~ offices and necessary
9 supplies, essential equipment, and other materials, salaries
10 and expenses of required personnel; and discharging all other
11 ~~legitimate expenses relating to the discharge of the~~
12 administrative and regulatory powers and duties imposed under
13 this ~~such~~ part.

14 Section 9. Subsections (4) and (7) of section 409.910,
15 Florida Statutes, 1998 Supplement, are amended to read:

16 409.910 Responsibility for payments on behalf of
17 Medicaid-eligible persons when other parties are liable.--

18 (4) After the department has provided medical
19 assistance under the Medicaid program, it shall seek recovery
20 of reimbursement from third-party benefits to the limit of
21 legal liability and for the full amount of third-party
22 benefits, but not in excess of the amount of medical
23 assistance paid by Medicaid, as to:

24 (a) Claims for which the department has a waiver
25 pursuant to federal law; or

26 (b) Situations in which the department learns of the
27 existence of a liable third party or in which third-party
28 benefits are discovered or become available after medical
29 assistance has been provided by Medicaid.

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1 (7) The department shall recover the full amount of
2 all medical assistance provided by Medicaid on behalf of the
3 recipient to the full extent of third-party benefits.

4 (a) Recovery of such benefits shall be collected
5 directly from:

6 1. Any third party;

7 2. The recipient or legal representative, if he or she
8 has received third-party benefits;

9 3. The provider of a recipient's medical services if
10 third-party benefits have been recovered by the provider;
11 notwithstanding any provision of this section, to the
12 contrary, however, no provider shall be required to refund or
13 pay to the department any amount in excess of the actual
14 third-party benefits received by the provider from a
15 third-party payor for medical services provided to the
16 recipient; or

17 4. Any person who has received the third-party
18 benefits.

19 (b) Upon receipt of any recovery or other collection
20 pursuant to this section, the department shall distribute the
21 amount collected as follows:

22 1. To itself, an amount equal to the state Medicaid
23 expenditures for the recipient plus any incentive payment made
24 in accordance with paragraph (14)(a).

25 2. To the Federal Government, the federal share of the
26 state Medicaid expenditures minus any incentive payment made
27 in accordance with paragraph (14)(a) and federal law, and
28 minus any other amount permitted by federal law to be
29 deducted.

30 3. To the recipient, after deducting any known amounts
31 owed to the department for any related medical assistance or

1 to health care providers, any remaining amount. This amount
2 shall be treated as income or resources in determining
3 eligibility for Medicaid.

4
5 The provisions of this subsection do not apply to any proceeds
6 received by the state, or any agency thereof, pursuant to a
7 final order, judgment, or settlement agreement, in any matter
8 in which the state asserts claims brought on its own behalf,
9 and not as a subrogee of a recipient, or under other theories
10 of liability. The provisions of this subsection do not apply
11 to any proceeds received by the state, or an agency thereof,
12 pursuant to a final order, judgment, or settlement agreement,
13 in any matter in which the state asserted both claims as a
14 subrogee and additional claims, except as to those sums
15 specifically identified in the final order, judgment, or
16 settlement agreement as reimbursements to the recipient as
17 expenditures for the named recipient on the subrogation claim.

18 Section 10. The amendments to section 409.910, Florida
19 Statutes, 1998 Supplement, made by this act are intended to
20 clarify existing law and are remedial in nature. As such,
21 they are specifically made retroactive to October 1, 1990, and
22 shall apply to all causes of action arising on or after
23 October 1, 1990.

24 Section 11. Subsection (1) of section 627.6645,
25 Florida Statutes, is amended and subsection (5) is added to
26 that section to read:

27 627.6645 Notification of cancellation, expiration,
28 nonrenewal, or change in rates.--

29 (1) Every insurer delivering or issuing for delivery a
30 group health insurance policy under the provisions of this
31 part shall give the policyholder at least 45 days' advance

1 notice of cancellation, expiration, nonrenewal, or a change in
2 rates. Such notice shall be mailed to the policyholder's last
3 address as shown by the records of the insurer. However, if
4 cancellation is for nonpayment of premium, only the
5 requirements of subsection (5)~~this section shall not~~ apply.
6 Upon receipt of such notice, the policyholder shall forward,
7 as soon as practicable, the notice of expiration,
8 cancellation, or nonrenewal to each certificateholder covered
9 under the policy.

10 (5) If cancellation is due to nonpayment of premium,
11 the insurer may not retroactively cancel the policy to a date
12 prior to the date that notice of cancellation was provided to
13 the policyholder unless the insurer mails notice of
14 cancellation to the policyholder prior to 45 days after the
15 date the premium was due. Such notice must be mailed to the
16 policyholder's last address as shown by the records of the
17 insurer and may provide for a retroactive date of cancellation
18 no earlier than midnight of the date that the premium was due.

19 Section 12. Section 627.6675, Florida Statutes, 1998
20 Supplement, is amended to read:

21 627.6675 Conversion on termination of
22 eligibility.--Subject to all of the provisions of this
23 section, a group policy delivered or issued for delivery in
24 this state by an insurer or nonprofit health care services
25 plan that provides, on an expense-incurred basis, hospital,
26 surgical, or major medical expense insurance, or any
27 combination of these coverages, shall provide that an employee
28 or member whose insurance under the group policy has been
29 terminated for any reason, including discontinuance of the
30 group policy in its entirety or with respect to an insured
31 class, and who has been continuously insured under the group

1 policy, and under any group policy providing similar benefits
2 that the terminated group policy replaced, for at least 3
3 months immediately prior to termination, shall be entitled to
4 have issued to him or her by the insurer a policy or
5 certificate of health insurance, referred to in this section
6 as a "converted policy." A group insurer may meet the
7 requirements of this section by contracting with another
8 insurer, authorized in this state, to issue an individual
9 converted policy, which policy has been approved by the
10 department under s. 627.410. An employee or member shall not
11 be entitled to a converted policy if termination of his or her
12 insurance under the group policy occurred because he or she
13 failed to pay any required contribution, or because any
14 discontinued group coverage was replaced by similar group
15 coverage within 31 days after discontinuance.

16 (1) TIME LIMIT.--Written application for the converted
17 policy shall be made and the first premium must be paid to the
18 insurer, not later than 63 days after termination of the group
19 policy. However, if termination was the result of failure to
20 pay any required premium or contribution and such nonpayment
21 of premium was due to acts of an employer or policyholder
22 other than the employee or certificateholder, written
23 application for the converted policy must be made and the
24 first premium must be paid to the insurer not later than 63
25 days after notice of termination is mailed by the insurer or
26 the employer, whichever is earlier, to the employee's or
27 certificateholder's last address as shown by the record of the
28 insurer or the employer, whichever is applicable. In such case
29 of termination due to nonpayment of premium by the employer or
30 policyholder, the premium for the converted policy may not
31 exceed the rate for the prior group coverage for the period of

1 coverage under the converted policy prior to the date notice
2 of termination is mailed to the employee or certificateholder.
3 For the period of coverage after such date, the premium for
4 the converted policy is subject to the requirements of
5 subsection (3).

6 (2) EVIDENCE OF INSURABILITY.--The converted policy
7 shall be issued without evidence of insurability.

8 (3) CONVERSION PREMIUM; EFFECT ON PREMIUM RATES FOR
9 GROUP COVERAGE.--

10 (a) The premium for the converted policy shall be
11 determined in accordance with premium rates applicable to the
12 age and class of risk of each person to be covered under the
13 converted policy and to the type and amount of insurance
14 provided. However, the premium for the converted policy may
15 not exceed 200 percent of the standard risk rate as
16 established by the department, pursuant to this subsection.

17 (b) Actual or expected experience under converted
18 policies may be combined with such experience under group
19 policies for the purposes of determining premium and loss
20 experience and establishing premium rate levels for group
21 coverage.

22 (c) The department shall annually determine standard
23 risk rates, using reasonable actuarial techniques and
24 standards adopted by the department by rule. The standard risk
25 rates must be determined as follows:

26 1. Standard risk rates for individual coverage must be
27 determined separately for indemnity policies, preferred
28 provider/exclusive provider policies, and health maintenance
29 organization contracts.

30 2. The department shall survey insurers and health
31 maintenance organizations representing at least an 80 percent

1 market share, based on premiums earned in the state for the
2 most recent calendar year, for each of the categories
3 specified in subparagraph 1.

4 3. Standard risk rate schedules must be determined,
5 computed as the average rates charged by the carriers
6 surveyed, giving appropriate weight to each carrier's
7 statewide market share of earned premiums.

8 4. The rate schedule shall be determined from analysis
9 of the one county with the largest market share in the state
10 of all such carriers.

11 5. The rate for other counties must be determined by
12 using the weighted average of each carrier's county factor
13 relationship to the county determined in subparagraph 4.

14 6. The rate schedule must be determined for different
15 age brackets and family size brackets.

16 (4) EFFECTIVE DATE OF COVERAGE.--The effective date of
17 the converted policy shall be the day following the
18 termination of insurance under the group policy.

19 (5) SCOPE OF COVERAGE.--The converted policy shall
20 cover the employee or member and his or her dependents who
21 were covered by the group policy on the date of termination of
22 insurance. At the option of the insurer, a separate converted
23 policy may be issued to cover any dependent.

24 (6) OPTIONAL COVERAGE.--The insurer shall not be
25 required to issue a converted policy covering any person who
26 is or could be covered by Medicare. The insurer shall not be
27 required to issue a converted policy covering a person if
28 paragraphs (a) and (b) apply to the person:

29 (a) If any of the following apply to the person:

30 1. The person is covered for similar benefits by
31 another hospital, surgical, medical, or major medical expense

1 insurance policy or hospital or medical service subscriber
2 contract or medical practice or other prepayment plan, or by
3 any other plan or program.

4 2. The person is eligible for similar benefits,
5 whether or not actually provided coverage, under any
6 arrangement of coverage for individuals in a group, whether on
7 an insured or uninsured basis.

8 3. Similar benefits are provided for or are available
9 to the person under any state or federal law.

10 (b) If the benefits provided under the sources
11 referred to in subparagraph (a)1. or the benefits provided or
12 available under the sources referred to in subparagraphs (a)2.
13 and 3., together with the benefits provided by the converted
14 policy, would result in overinsurance according to the
15 insurer's standards. The insurer's standards must bear some
16 reasonable relationship to actual health care costs in the
17 area in which the insured lives at the time of conversion and
18 must be filed with the department prior to their use in
19 denying coverage.

20 (7) INFORMATION REQUESTED BY INSURER.--

21 (a) A converted policy may include a provision under
22 which the insurer may request information, in advance of any
23 premium due date, of any person covered thereunder as to
24 whether:

25 1. The person is covered for similar benefits by
26 another hospital, surgical, medical, or major medical expense
27 insurance policy or hospital or medical service subscriber
28 contract or medical practice or other prepayment plan or by
29 any other plan or program.

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1 2. The person is covered for similar benefits under
2 any arrangement of coverage for individuals in a group,
3 whether on an insured or uninsured basis.

4 3. Similar benefits are provided for or are available
5 to the person under any state or federal law.

6 (b) The converted policy may provide that the insurer
7 may refuse to renew the policy or the coverage of any person
8 only for one or more of the following reasons:

9 1. Either the benefits provided under the sources
10 referred to in subparagraphs (a)1. and 2. for the person or
11 the benefits provided or available under the sources referred
12 to in subparagraph (a)3. for the person, together with the
13 benefits provided by the converted policy, would result in
14 overinsurance according to the insurer's standards on file
15 with the department.

16 2. The converted policyholder fails to provide the
17 information requested pursuant to paragraph (a).

18 3. Fraud or intentional misrepresentation in applying
19 for any benefits under the converted policy.

20 4. Other reasons approved by the department.

21 (8) BENEFITS OFFERED.--

22 (a) An insurer shall not be required to issue a
23 converted policy that provides benefits in excess of those
24 provided under the group policy from which conversion is made.

25 (b) An insurer shall offer the benefits specified in
26 s. 627.668 and the benefits specified in s. 627.669 if those
27 benefits were provided in the group plan.

28 (c) An insurer shall offer maternity benefits and
29 dental benefits if those benefits were provided in the group
30 plan.

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1 (9) PREEXISTING CONDITION PROVISION.--The converted
2 policy shall not exclude a preexisting condition not excluded
3 by the group policy. However, the converted policy may provide
4 that any hospital, surgical, or medical benefits payable under
5 the converted policy may be reduced by the amount of any such
6 benefits payable under the group policy after the termination
7 of covered under the group policy. The converted policy may
8 also provide that during the first policy year the benefits
9 payable under the converted policy, together with the benefits
10 payable under the group policy, shall not exceed those that
11 would have been payable had the individual's insurance under
12 the group policy remained in force.

13 (10) REQUIRED OPTION FOR MAJOR MEDICAL
14 COVERAGE.--Subject to the provisions and conditions of this
15 part, the employee or member shall be entitled to obtain a
16 converted policy providing major medical coverage under a plan
17 meeting the following requirements:

18 (a) A maximum benefit equal to the lesser of the
19 policy limit of the group policy from which the individual
20 converted or \$500,000 per covered person for all covered
21 medical expenses incurred during the covered person's
22 lifetime.

23 (b) Payment of benefits at the rate of 80 percent of
24 covered medical expenses which are in excess of the
25 deductible, until 20 percent of such expenses in a benefit
26 period reaches \$2,000, after which benefits will be paid at
27 the rate of 90 percent during the remainder of the contract
28 year unless the insured is in the insurer's case management
29 program, in which case benefits shall be paid at the rate of
30 100 percent during the remainder of the contract year. For
31 the purposes of this paragraph, "case management program"

1 means the specific supervision and management of the medical
2 care provided or prescribed for a specific individual, which
3 may include the use of health care providers designated by the
4 insurer. Payment of benefits for outpatient treatment of
5 mental illness, if provided in the converted policy, may be at
6 a lesser rate but not less than 50 percent.

7 (c) A deductible for each calendar year that must be
8 \$500, \$1,000, or \$2,000, at the option of the policyholder.

9 (d) The term "covered medical expenses," as used in
10 this subsection, shall be consistent with those customarily
11 offered by the insurer under group or individual health
12 insurance policies but is not required to be identical to the
13 covered medical expenses provided in the group policy from
14 which the individual converted.

15 (11) ALTERNATIVE PLANS.--The insurer shall, in
16 addition to the option required by subsection (10), offer the
17 standard health benefit plan, as established pursuant to s.
18 627.6699(12). The insurer may, at its option, also offer
19 alternative plans for group health conversion in addition to
20 the plans required by this section.

21 (12) RETIREMENT COVERAGE.--If coverage would be
22 continued under the group policy on an employee following the
23 employee's retirement prior to the time he or she is or could
24 be covered by Medicare, the employee may elect, instead of
25 such continuation of group insurance, to have the same
26 conversion rights as would apply had his or her insurance
27 terminated at retirement by reason or termination of
28 employment or membership.

29 (13) REDUCTION OF COVERAGE DUE TO MEDICARE.--The
30 converted policy may provide for reduction of coverage on any
31 person upon his or her eligibility for coverage under Medicare

1 or under any other state or federal law providing for benefits
2 similar to those provided by the converted policy.

3 (14) CONVERSION PRIVILEGE ALLOWED.--The conversion
4 privilege shall also be available to any of the following:

5 (a) The surviving spouse, if any, at the death of the
6 employee or member, with respect to the spouse and the
7 children whose coverages under the group policy terminate by
8 reason of the death, otherwise to each surviving child whose
9 coverage under the group policy terminates by reason of such
10 death, or, if the group policy provides for continuation of
11 dependents' coverages following the employee's or member's
12 death, at the end of such continuation.

13 (b) The former spouse whose coverage would otherwise
14 terminate because of annulment or dissolution of marriage, if
15 the former spouse is dependent for financial support.

16 (c) The spouse of the employee or member upon
17 termination of coverage of the spouse, while the employee or
18 member remains insured under the group policy, by reason of
19 ceasing to be a qualified family member under the group
20 policy, with respect to the spouse and the children whose
21 coverages under the group policy terminate at the same time.

22 (d) A child solely with respect to himself or herself
23 upon termination of his or her coverage by reason of ceasing
24 to be a qualified family member under the group policy, if a
25 conversion privilege is not otherwise provided in this
26 subsection with respect to such termination.

27 (15) BENEFIT LEVELS.--If the benefit levels required
28 in subsection (10) exceed the benefit levels provided under
29 the group policy, the conversion policy may offer benefits
30 which are substantially similar to those provided under the
31 group policy in lieu of those required in subsection (10).

1 (16) GROUP COVERAGE INSTEAD OF INDIVIDUAL
2 COVERAGE.--The insurer may elect to provide group insurance
3 coverage instead of issuing a converted individual policy.

4 (17) NOTIFICATION.--A notification of the conversion
5 privilege shall be included in each certificate of coverage.
6 The insurer shall mail an election and premium notice form,
7 including an outline of coverage, on a form approved by the
8 department, within 14 days after an individual who is eligible
9 for a converted policy gives notice to the insurer that the
10 individual is considering applying for the converted policy or
11 otherwise requests such information. The outline of coverage
12 must contain a description of the principal benefits and
13 coverage provided by the policy and its principal exclusions
14 and limitations, including, but not limited to, deductibles
15 and coinsurance.

16 (18) OUTSIDE CONVERSIONS.--A converted policy that is
17 delivered outside of this state must be on a form that could
18 be delivered in the other jurisdiction as a converted policy
19 had the group policy been issued in that jurisdiction.

20 (19) APPLICABILITY.--This section does not require
21 conversion on termination of eligibility for a policy or
22 contract that provides benefits for specified diseases, or for
23 accidental injuries only, disability income, Medicare
24 supplement, hospital indemnity, limited benefit,
25 nonconventional, or excess policies.

26 (20) Nothing in this section or in the incorporation
27 of it into insurance policies shall be construed to require
28 insurers to provide benefits equal to those provided in the
29 group policy from which the individual converted, provided,
30 however, that comprehensive benefits are offered which shall
31 be subject to approval by the Insurance Commissioner.

1 Section 13. Section 641.3108, Florida Statutes, is
2 amended to read:

3 641.3108 Notice of cancellation of contract.--

4 (1) Except for nonpayment of premium or termination of
5 eligibility, no health maintenance organization may cancel or
6 otherwise terminate or fail to renew a health maintenance
7 contract without giving the subscriber at least 45 days'
8 notice in writing of the cancellation, termination, or
9 nonrenewal of the contract. The written notice shall state the
10 reason or reasons for the cancellation, termination, or
11 nonrenewal. All health maintenance contracts shall contain a
12 clause which requires that this notice be given.

13 (2) If cancellation is due to nonpayment of premium,
14 the health maintenance organization may not retroactively
15 cancel the contract to a date prior to the date that notice of
16 cancellation was provided to the subscriber unless the
17 organization mails notice of cancellation to the subscriber
18 prior to 45 days after the date the premium was due. Such
19 notice must be mailed to the subscriber's last address as
20 shown by the records of the organization and may provide for a
21 retroactive date of cancellation no earlier than midnight of
22 the date that the premium was due.

23 (3) In the case of a health maintenance contract
24 issued to an employer or person holding the contract on behalf
25 of the subscriber group, the health maintenance organization
26 may make the notification through the employer or group
27 contract holder, and, if the health maintenance organization
28 elects to take this action through the employer or group
29 contract holder, the organization shall be deemed to have
30 complied with the provisions of this section upon notifying
31 the employer or group contract holder of the requirements of

1 this section and requesting the employer or group contract
2 holder to forward to all subscribers the notice required
3 herein.

4 Section 14. Subsection (1) of section 641.3922,
5 Florida Statutes, 1998 Supplement, is amended to read:

6 641.3922 Conversion contracts; conditions.--Issuance
7 of a converted contract shall be subject to the following
8 conditions:

9 (1) TIME LIMIT.--Written application for the converted
10 contract shall be made and the first premium paid to the
11 health maintenance organization not later than 63 days after
12 such termination. However, if termination was the result of
13 failure to pay any required premium or contribution and such
14 nonpayment of premium was due to acts of an employer or group
15 contract holder other than the employee or individual
16 subscriber, written application for the contract must be made
17 and the first premium must be paid not later than 63 days
18 after notice of termination is mailed by the organization or
19 the employer, whichever is earlier, to the employee's or
20 individual's last address as shown by the record of the
21 organization or the employer, whichever is applicable. In such
22 case of termination due to non-payment of premium by the
23 employer or group contract holder, the premium for the
24 converted contract may not exceed the rate for the prior group
25 coverage for the period of coverage under the converted
26 contract prior to the date notice of termination is mailed to
27 the employee or individual subscriber. For the period of
28 coverage after such date, the premium for the converted
29 contract is subject to the requirements of subsection (3).

30 Section 15. Subsection (9) is added to section 20.41,
31 Florida Statutes, to read:

1 20.41 Department of Elderly Affairs.--There is created
2 a Department of Elderly Affairs.

3 (9) Area agencies on aging are subject to chapter 119,
4 relating to public records, and, when considering any
5 contracts requiring the expenditure of funds, are subject to
6 ss. 286.011-286.012, relating to public meetings.

7 Section 16. Subsection (13) of section 409.912,
8 Florida Statutes, 1998 Supplement, is amended to read:

9 409.912 Cost-effective purchasing of health care.--The
10 agency shall purchase goods and services for Medicaid
11 recipients in the most cost-effective manner consistent with
12 the delivery of quality medical care. The agency shall
13 maximize the use of prepaid per capita and prepaid aggregate
14 fixed-sum basis services when appropriate and other
15 alternative service delivery and reimbursement methodologies,
16 including competitive bidding pursuant to s. 287.057, designed
17 to facilitate the cost-effective purchase of a case-managed
18 continuum of care. The agency shall also require providers to
19 minimize the exposure of recipients to the need for acute
20 inpatient, custodial, and other institutional care and the
21 inappropriate or unnecessary use of high-cost services.

22 (13)(a) The agency shall identify health care
23 utilization and price patterns within the Medicaid program
24 which are not cost-effective or medically appropriate and
25 assess the effectiveness of new or alternate methods of
26 providing and monitoring service, and may implement such
27 methods as it considers appropriate. Such methods may include
28 disease management initiatives, an integrated and systematic
29 approach for managing the health care needs of recipients who
30 are at risk of or diagnosed with a specific disease by using
31 best practices, prevention strategies, clinical-practice

1 improvement, clinical interventions and protocols, outcomes
2 research, information technology, and other tools and
3 resources to reduce overall costs and improve measurable
4 outcomes.

5 (b) The responsibility of the agency under this
6 subsection shall include the development of capabilities to
7 identify actual and optimal practice patterns; patient and
8 provider educational initiatives; methods for determining
9 patient compliance with prescribed treatments; fraud, waste,
10 and abuse prevention and detection programs; and beneficiary
11 case management programs.

12 1. The practice pattern identification program shall
13 evaluate practitioner prescribing patterns based on national
14 and regional practice guidelines, comparing practitioners to
15 their peer groups. The agency and its Drug Utilization Review
16 Board shall consult with a panel of practicing health care
17 professionals consisting of the following: the Speaker of the
18 House of Representatives and the President of the Senate shall
19 each appoint three physicians licensed under ch. 458 or ch.
20 459; and the Governor shall appoint two pharmacists licensed
21 under ch. 465 and one dentist licensed under ch. 466 who is an
22 oral surgeon. Terms of the panel members shall expire at the
23 discretion of the appointing official. The panel shall begin
24 its work by August 1, 1999, regardless of the number of
25 appointments made by that date. The advisory panel shall be
26 responsible for evaluating treatment guidelines and
27 recommending ways to incorporate their use in the practice
28 pattern identification program. Practitioners who are
29 prescribing inappropriately or inefficiently, as determined by
30 the agency, may have their prescribing of certain drugs
31 subject to prior authorization.

1 2. The agency shall also develop educational
2 interventions designed to promote the proper use of
3 medications by providers and beneficiaries.
4 3. The agency shall implement a pharmacy fraud, waste,
5 and abuse initiative that may include a surety bond or letter
6 of credit requirement for participating pharmacies, enhanced
7 provider auditing practices, the use of additional fraud and
8 abuse software, recipient management programs for
9 beneficiaries inappropriately using their benefits, and other
10 steps that will eliminate provider and recipient fraud, waste,
11 and abuse. The initiative shall address enforcement efforts to
12 reduce the number and use of counterfeit prescriptions.
13 4. The agency may apply for any federal waivers needed
14 to implement this paragraph.
15 Section 17. There is appropriated to the Agency for
16 Health Care Administration for fiscal year 1999-2000
17 \$1,439,000 from the Health Care Trust Fund for 12 months of
18 funding for the purpose of implementing this act.
19 Section 18. This act shall take effect upon becoming a
20 law.
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