By Senator Klein

28-1166-99

A bill to be entitled

An act relating to insurance; creating s. 627.64726, F.S.; authorizing point of service policies under arrangements between health insurers and health maintenance organizations; providing criteria; providing standards; creating s. 627.64727, F.S.; prohibiting the use of certain words; amending s. 627.662, F.S.; prohibiting the use of certain words; creating s. 627.6693, F.S.; mandating that group policies providing coverage pursuant to a point of service agreement shall comply with s. 627.64726, F.S.; creating s. 641.191, F.S.; establishing a subscriber's bill of rights to serve as standards for certain purposes; creating s. 641.2019, F.S.; prohibiting a health maintenance organization from excluding a covered service if the subscriber is receiving noncovered service in conjunction therewith; amending s. 641.30, F.S.; making the provisions of s. 627.64726, F.S., applicable to health maintenance organizations; amending s. 641.31, F.S.; providing for return of excessive premiums received; providing for continuation of care under certain circumstances; amending s. 641.3108, F.S.; prohibiting retroactive cancellation and requiring certain notice to group member subscribers prior to the effective date of cancellation; amending s. 641.315, F.S.; providing for notice to the department of cancellation of a provider contract; creating

s. 641.34, F.S.; prohibiting the use of certain words; amending s. 641.51, F.S.; extending the period in which a subscriber may receive covered services from a terminated provider; amending s. 641.511, F.S.; requiring a health maintenance organization to respond to an initial complaint within a specified time; requiring a grievance manager to provide written determination of grievance panel review; requiring that the grievance process permit subscribers to appear and be heard, bring representation, be accompanied by their provider, and be permitted to document the hearing by certain methods; providing an effective date.

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

Section 1. Section 627.64726, Florida Statutes, is created to read:

627.64726 Point of service policies; purpose; 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 which 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) DEFINITION.--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 and 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, buy not both.

(c) "Insured" is 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 the Florida Insurance Code including chapter 641, and rules adopted thereunder, shall 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 the Florida Insurance Code, chapter 641, and rules adopted thereunder:

(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 same.

(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 when 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 do not apply with respect to the point of service policy, but do 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, in the event a point of service agreement is terminated, the policyholder in an individual contract or the contractholder 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, in the event the insured is entitled to a conversion plan, for reasons provided 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) All point of service policy forms and rate filings must be made jointly by a health insurer and a health maintenance organization whether or not separate or combined forms are used.

(b) The point of service policy form and rate filing must include all forms and rates required by this section. If a health insurer and a health maintenance organization use 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 is sufficient to identify the form number and date of approval of these forms and related rates.

(c) The point of service policy form and rate filing must 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 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.

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

(e) All point of service policy forms and rates must be filed and approved prior to use. All form and rate changes to such policy must be filed and approved prior to use.

(f) 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:

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

2. Comply in all respects with the requirements of the Florida Insurance Code or chapter 641 as related to the product being filed; and

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

(g) 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.

(h) 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 must 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 may be made on a retrospective basis without approval by the department.

(i) All rate filings for a point of service policy must contain the following terms and conditions, in addition to all others required under statute or rule:

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

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

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

4. Minimum loss ratios, as defined in the Florida Insurance Code or in any applicable rule adopted thereunder, must be met by each company.

(j) 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, which must be made on a form adopted by the department, each company shall provide the following information:

1. Total point of service earned premium.

2. Total number of point of service policyholders, certificate holders, and subscribers by market (individual, small group, large group).

3. Loss ratios for point of service policies.

4. Expenses.

5. Any other information required by the department in carrying out its duties under this section.

(k) Each company shall disclose in its 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 must 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, is subject to all provisions of the Florida Insurance Code and other statutes and rules adopted thereunder applicable to health insurers generally.

(b) Any health maintenance organization entering into a point of service arrangement under this section, in addition to the requirements of this section, is subject to chapter 641 and rules adopted thereunder and to all other provisions of

the Florida Insurance Code and other statutes and rules adopted thereunder applicable to health maintenance organizations generally.

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

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

(8) RULEMAKING.--The department may adopt rules necessary to implement this section. In adopting these rules 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 documents related thereto 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 627.64727, Florida Statutes, is created to read:

627.64727 Use of certain words prohibited.--A health insurer or a health maintenance organization may not use in its contracts or literature, including any form of advertising, the phrase "point of service" or "POS" unless it relates to a policy that has been filed and approved by the department under s. 627.64726.

Section 3. Subsection (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 627.64727, relating to prohibition of the use of the term "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. 627.64726 must comply with the requirements of that section.

Section 5. Section 641.191, Florida Statutes, is created to read:

641.191 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 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 with which 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 has the right to simple, fair, timely, and impartial procedures for resolving coverage disputes.

(f) The subscriber has a right to a timely referral with payment preauthorization 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 to provide medically necessary care and treatment and to avoid unnecessary, inappropriate, or improper medical care or services.

(2) This section may 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 may 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 may not exclude coverage for a covered procedure if the subscriber elects to have a noncovered medically necessary procedure performed simultaneously or in conjunction with a covered procedure. The health maintenance organization must 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) Each health maintenance organization entering into a point of service agreement must comply with s. 627.64726.

Section 8. Paragraph (b) of subsection (3) of section 641.31, Florida Statutes, 1998 Supplement, is amended and subsection (36) is added to that 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 contractholder constituting the portion of the rate above that which was approved be returned to such contractholder in the form of a credit or refund.~~Use of the rating methodology must be discontinued immediately upon disapproval unless the health maintenance organization seeks administrative relief.~~ 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 ~~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 must include the provisions of s. 641.51(7).

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

641.3108 Notice of cancellation 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 that 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 its 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 may not use in its contracts or literature, including any form of advertising, the phrase "point of service" or "POS" unless it relates to a policy that has been filed and approved by the department pursuant to s. 627.64726.

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, not to 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 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 include as a minimum the following:

1. A hearing must be held at which the subscriber may appear, be heard, and submit documentation regarding the grievance;

2. The subscriber may be represented at the hearing by a person of his or her choice including legal counsel;

3. 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; and

4. The subscriber must 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 on October 1, 1999, and shall apply to policies and contracts issued or renewed on or after that date.

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SENATE SUMMARY

Authorizes point of service policies under arrangements between health insurers and health maintenance organizations. Provides criteria and standards. Establishes a subscriber's bill of rights. Prohibits health maintenance organizations from excluding a covered service if a subscriber is receiving a noncovered service in conjunction with the covered service. Provides for the return of excessive premiums and for continuation of care under certain circumstances. Prohibits retroactive cancellation and requires notice prior to cancellation. Requires that the Department of Insurance be given notice of the cancellation of a provider contract. Prohibits the use of certain words on forms, contracts, and advertising material. Extends time for receiving covered services from a terminated provider. Requires an HMO to respond to an initial complaint within 45 days. Specifies certain grievance procedures and rights. (See bill for details.)