By the Committee on Health Care Services and Representatives Farkas, Bloom, Goodlette, C. Green, Kelly, Jones, Rayson, Goode, Bitner, Ogles, Bilirakis, Gottlieb, Ritter, Wasserman Schultz, Greenstein, Eggelletion and Morroni

A bill to be entitled

An act relating to small employer health alliances; amending s. 408.7056, F.S.; providing additional definitions for the Statewide Provider and Subscriber Assistance Program; amending s. 627.654, F.S.; providing for insuring small employers under policies issued to small employer health alliances; providing requirements for participation; providing limitations; providing for insuring spouses and dependent children; allowing a single master policy to include alternative health plans; amending s. 627.6571, F.S.; including small employer health alliances within policy nonrenewal or discontinuance, coverage modification, and application provisions; amending s. 627.6699, F.S.; revising restrictions relating to premium rates to authorize small employer carriers to modify rates under certain circumstances and to authorize carriers to issue group health insurance policies to small employer health alliances under certain circumstances; requiring carriers issuing a policy to an alliance to allow appointed agents to sell such a policy; amending ss. 240.2995, 240.2996, 240.512, 381.0406, 395.3035, and 627.4301, F.S.; conforming cross references; defining the term "managed care"; repealing ss. 408.70(3), 408.701, 408.702, 408.703, 408.704, 408.7041, 408.7042, 408.7045, 408.7055, and 408.706,

F.S., relating to community health purchasing alliances; providing an effective date.

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

Section 1. Subsection (1) of section 408.7056, Florida Statutes, is amended to read:

408.7056 Statewide Provider and Subscriber Assistance Program.--

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

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

(b) "Department" means the Department of Insurance.

(c) "Grievance procedure" means an established set of rules that specify a process for appeal of an organizational decision.

(d) "Health care provider" or "provider" means a state-licensed or state-authorized facility, a facility principally supported by a local government or by funds from a charitable organization that holds a current exemption from federal income tax under s. 501(c)(3) of the Internal Revenue Code, a licensed practitioner, a county health department established under part I of chapter 154, a prescribed pediatric extended care center defined in s. 400.902, a federally supported primary care program such as a migrant health center or a community health center authorized under s. 329 or s. 330 of the United States Public Health Services Act that delivers health care services to individuals, or a community facility that receives funds from the state under the Community Alcohol, Drug Abuse, and Mental Health Services Act and provides mental health services to individuals.

(e)~~(a)~~ "Managed care entity" means a health maintenance organization or a prepaid health clinic certified under chapter 641, a prepaid health plan authorized under s. 409.912, or an exclusive provider organization certified under s. 627.6472.

(f)~~(b)~~ "Panel" means a statewide provider and subscriber assistance panel selected as provided in subsection (11).

Section 2. Section 627.654, Florida Statutes, is amended to read:

627.654 Labor union, ~~and~~ association, and small employer health alliance groups.--

(1)(a) A group of individuals may be insured under a policy issued to an association, including a labor union, which association has a constitution and bylaws and not less than 25 individual members and which has been organized and has been maintained in good faith for a period of 1 year for purposes other than that of obtaining insurance, or to the trustees of a fund established by such an association, which association or trustees shall be deemed the policyholder, insuring at least 15 individual members of the association for the benefit of persons other than the officers of the association, the association or trustees.

(b) A small employer, as defined in s. 627.6699 and including the employer's eligible employees and the spouses and dependents of such employees, may be insured under a policy issued to a small employer health alliance by a carrier as defined in s. 627.6699. A small employer health alliance must be organized as a not-for-profit corporation under chapter 617. Notwithstanding any other law, if a small employer member of an alliance loses eligibility to purchase

health care through the alliance solely because the business of the small employer member expands to more than 50 and fewer than 75 eligible employees, the small employer member may, at its next renewal date, purchase coverage through the alliance for not more than 1 additional year. A small employer health alliance shall establish conditions of participation in the alliance by a small employer, including, but not limited to:

1. Assurance that the small employer is not formed for the purpose of securing health benefit coverage.

2. Assurance that the employees of a small employer have not been added for the purpose of securing health benefit coverage.

(2) No such policy of insurance as defined in subsection (1) may be issued to any such association or alliance, unless all individual members of such association, or all small employer members of an alliance,or all of any class or classes thereof, are declared eligible and acceptable to the insurer at the time of issuance of the policy.

(3) Any such policy issued under paragraph (1)(a)may insure the spouse or dependent children with or without the member being insured.

(4) A single master policy issued to an association, labor union, or small employer health alliance may include more than one health plan from the same insurer or affiliated insurer group as alternatives for an employer, employee, or member to select.

Section 3. Paragraph (f) of subsection (2), paragraph (b) of subsection (4), and subsection (6) of section 627.6571, Florida Statutes, are amended to read:

627.6571 Guaranteed renewability of coverage.--

(2) An insurer may nonrenew or discontinue a group health insurance policy based only on one or more of the following conditions:

(f) In the case of health insurance coverage that is made available only through one or more bona fide associations as defined in subsection (5) or through one or more small employer health alliances as described in s. 627.654(1)(b), the membership of an employer in the association or in the small employer health alliance, on the basis of which the coverage is provided, ceases, but only if such coverage is terminated under this paragraph uniformly without regard to any health-status-related factor that relates to any covered individuals.

(4) At the time of coverage renewal, an insurer may modify the health insurance coverage for a product offered:

(b) In the small-group market if, for coverage that is available in such market other than only through one or more bona fide associations as defined in subsection (5) or through one or more small employer health alliances as described in s. 627.654(1)(b), such modification is consistent with s. 627.6699 and effective on a uniform basis among group health plans with that product.

(6) In applying this section in the case of health insurance coverage that is made available by an insurer in the small-group market or large-group market to employers only through one or more associations or through one or more small employer health alliances as described in s. 627.654(1)(b), a reference to "policyholder" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

Section 4. Paragraph (h) of subsection (5), paragraph (b) of subsection (6), and paragraph (a) of subsection (12) of section 627.6699, Florida Statutes, are amended to read:

627.6699 Employee Health Care Access Act.--

(5) AVAILABILITY OF COVERAGE.--

(h) All health benefit plans issued under this section must comply with the following conditions:

1. For employers who have fewer than two employees, a late enrollee may be excluded from coverage for no longer than 24 months if he or she was not covered by creditable coverage continually to a date not more than 63 days before the effective date of his or her new coverage.

2. Any requirement used by a small employer carrier in determining whether to provide coverage to a small employer group, including requirements for minimum participation of eligible employees and minimum employer contributions, must be applied uniformly among all small employer groups having the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier, except that a small employer carrier that participates in, administers, or issues health benefits pursuant to s. 381.0406 which do not include a preexisting condition exclusion may require as a condition of offering such benefits that the employer has had no health insurance coverage for its employees for a period of at least 6 months. A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

3. In applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider as an eligible employee employees or dependents

who have qualifying existing coverage in an employer-based group insurance plan or an ERISA qualified self-insurance plan in determining whether the applicable percentage of participation is met. However, a small employer carrier may count eligible employees and dependents who have coverage under another health plan that is sponsored by that employer ~~except if such plan is offered pursuant to s. 408.706~~.

4. A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage, unless the employer size has changed, in which case the small employer carrier may apply the requirements that are applicable to the new group size.

5. If a small employer carrier offers coverage to a small employer, it must offer coverage to all the small employer's eligible employees and their dependents. A small employer carrier may not offer coverage limited to certain persons in a group or to part of a group, except with respect to late enrollees.

6. A small employer carrier may not modify any health benefit plan issued to a small employer with respect to a small employer or any eligible employee or dependent through riders, endorsements, or otherwise to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

7. An initial enrollment period of at least 30 days must be provided. An annual 30-day open enrollment period must be offered to each small employer's eligible employees and their dependents. A small employer carrier must provide special enrollment periods as required by s. 627.65615.

(6) RESTRICTIONS RELATING TO PREMIUM RATES.--

(b) For all small employer health benefit plans that are subject to this section and are issued by small employer carriers on or after January 1, 1994, premium rates for health benefit plans subject to this section are subject to the following:

1. Small employer carriers must use a modified community rating methodology in which the premium for each small employer must be determined solely on the basis of the eligible employee's and eligible dependent's gender, age, family composition, tobacco use, or geographic area as determined under paragraph (5)(j).

2. Rating factors related to age, gender, family composition, tobacco use, or geographic location may be developed by each carrier to reflect the carrier's experience. The factors used by carriers are subject to department review and approval.

3. Small employer carriers may not modify the rate for a small employer for 12 months from the initial issue date or renewal date, unless the composition of the group changes or benefits are changed. However, a small employer carrier may modify the rate one time prior to 12 months after the initial issue date for a small employer who enrolls under a previously issued group policy that has a common anniversary date for all employers covered under the policy if:

a. The carrier discloses to the employer in a clear and conspicuous manner the date of the first renewal and the fact that the premium may increase on or after that date.

b. The insurer demonstrates to the department that efficiencies in administration are achieved and reflected in the rates charged to small employers covered under the policy.

4. A carrier may issue a group health insurance policy to a small employer health alliance or other group association with rates that reflect a premium credit for expense savings attributable to administrative activities being performed by the alliance or group association if such expense savings are specifically documented in the insurer's rate filing and are approved by the department. Any such credit may not be based on different morbidity assumptions or on any other factor related to the health status or claims experience of any person covered under the policy. Nothing in this subparagraph exempts an alliance or group association from licensure for any activities that require licensure under the Insurance Code. A carrier issuing a group health insurance policy to a small employer health alliance or other group association shall allow any properly licensed and appointed agent of that carrier to market and sell the small employer health alliance or other group association policy. Such agent shall be paid the usual and customary commission paid to any agent selling the policy.~~Carriers participating in the alliance program, in accordance with ss. 408.70-408.706, may apply a different community rate to business written in that program.~~

(12) STANDARD, BASIC, AND LIMITED HEALTH BENEFIT PLANS.--

(a)1. By May 15, 1993, the commissioner shall appoint a health benefit plan committee composed of four representatives of carriers which shall include at least two representatives of HMOs, at least one of which is a staff model HMO, two representatives of agents, four representatives of small employers, and one employee of a small employer. The carrier members shall be selected from a list of individuals recommended by the board. The commissioner may require the

board to submit additional recommendations of individuals for appointment. ~~As alliances are established under s. 408.702, each alliance shall also appoint an additional member to the committee.~~

2. The committee shall develop changes to the form and level of coverages for the standard health benefit plan and the basic health benefit plan, and shall submit the forms, and levels of coverages to the department by September 30, 1993. The department must approve such forms and levels of coverages by November 30, 1993, and may return the submissions to the committee for modification on a schedule that allows the department to grant final approval by November 30, 1993.

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

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

5. After approval of the revised health benefit plans, if the department determines that modifications to a plan might be appropriate, the commissioner shall appoint a new health benefit plan committee in the manner provided in subparagraph 1. to submit recommended modifications to the department for approval.

Section 5. Subsection (1) of section 240.2995, Florida Statutes, is amended to read:

240.2995 University health services support organizations.--

(1) Each state university is authorized to establish university health services support organizations which shall have the ability to enter into, for the benefit of the university academic health sciences center, arrangements with

other entities as providers ~~for accountable health partnerships, as defined in s. 408.701, and providers~~ in other integrated health care systems or similar entities. To the extent required by law or rule, university health services support organizations shall become licensed as insurance companies, pursuant to chapter 624, or be certified as health maintenance organizations, pursuant to chapter 641. University health services support organizations shall have sole responsibility for the acts, debts, liabilities, and obligations of the organization. In no case shall the state or university have any responsibility for such acts, debts, liabilities, and obligations incurred or assumed by university health services support organizations.

Section 6. Paragraph (a) of subsection (2) of section 240.2996, Florida Statutes, is amended to read:

240.2996 University health services support organization; confidentiality of information.--

(2) The following university health services support organization's records and information are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution:

(a) Contracts for managed care arrangements~~, as managed care is defined in s. 408.701,~~ under which the university health services support organization provides health care services, including preferred provider organization contracts, health maintenance organization contracts, alliance network arrangements, and exclusive provider organization contracts, and any documents directly relating to the negotiation, performance, and implementation of any such contracts for managed care arrangements or alliance network arrangements. As used in this paragraph, the

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

The exemptions in this subsection are subject to the Open Government Sunset Review Act of 1995 in accordance with s. 119.15 and shall stand repealed on October 2, 2001, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 7. Paragraph (b) of subsection (8) of section 240.512, Florida Statutes, is amended to read:

240.512 H. Lee Moffitt Cancer Center and Research Institute.--There is established the H. Lee Moffitt Cancer Center and Research Institute at the University of South Florida.

(8)

(b) Proprietary confidential business information is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution. However, the Auditor General and Board of Regents, pursuant to their oversight and auditing functions, must be given access to all proprietary confidential business information upon request and

without subpoena and must maintain the confidentiality of information so received. As used in this paragraph, the term "proprietary confidential business information" means information, regardless of its form or characteristics, which is owned or controlled by the not-for-profit corporation or its subsidiaries; is intended to be and is treated by the not-for-profit corporation or its subsidiaries as private and the disclosure of which would harm the business operations of the not-for-profit corporation or its subsidiaries; has not been intentionally disclosed by the corporation or its subsidiaries unless pursuant to law, an order of a court or administrative body, a legislative proceeding pursuant to s. 5, Art. III of the State Constitution, or a private agreement that provides that the information may be released to the public; and which is information concerning:

1. Internal auditing controls and reports of internal auditors;

2. Matters reasonably encompassed in privileged attorney-client communications;

3. Contracts for managed-care arrangements, ~~as managed care is defined in s. 408.701,~~ including preferred provider organization contracts, health maintenance organization contracts, and exclusive provider organization contracts, and any documents directly relating to the negotiation, performance, and implementation of any such contracts for managed-care arrangements;

4. Bids or other contractual data, banking records, and credit agreements the disclosure of which would impair the efforts of the not-for-profit corporation or its subsidiaries to contract for goods or services on favorable terms;

5. Information relating to private contractual data, the disclosure of which would impair the competitive interest of the provider of the information;

6. Corporate officer and employee personnel information;

7. Information relating to the proceedings and records of credentialing panels and committees and of the governing board of the not-for-profit corporation or its subsidiaries relating to credentialing;

8. Minutes of meetings of the governing board of the not-for-profit corporation and its subsidiaries, except minutes of meetings open to the public pursuant to subsection (9);

9. Information that reveals plans for marketing services that the corporation or its subsidiaries reasonably expect to be provided by competitors;

10. Trade secrets as defined in s. 688.002, including reimbursement methodologies or rates; or

11. The identity of donors or prospective donors of property who wish to remain anonymous or any information identifying such donors or prospective donors. The anonymity of these donors or prospective donors must be maintained in the auditor's report.

As used in this paragraph, the term "managed care" means systems or techniques generally used by third-party payors or their agents to affect access to and control payment for health care services. Managed-care techniques most often include one or more of the following: prior, concurrent, and retrospective review of the medical necessity and appropriateness of services or site of services; contracts

with selected health care providers; financial incentives or disincentives related to the use of specific providers, services, or service sites; controlled access to and coordination of services by a case manager; and payor efforts to identify treatment alternatives and modify benefit restrictions for high-cost patient care.

Section 8. Subsection (14) of section 381.0406, Florida Statutes, is amended to read:

381.0406 Rural health networks.--

(14) NETWORK FINANCING.--Networks may use all sources of public and private funds to support network activities. Nothing in this section prohibits networks from becoming managed care providers~~, or accountable health partnerships, provided they meet the requirements for an accountable health partnership as specified in s. 408.706~~.

Section 9. Paragraph (a) of subsection (2) of section 395.3035, Florida Statutes, is amended to read:

395.3035 Confidentiality of hospital records and meetings.--

(2) The following records and information of any hospital that is subject to chapter 119 and s. 24(a), Art. I of the State Constitution are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution:

(a) Contracts for managed care arrangements, as managed care is defined in s. 408.701, under which the public hospital provides health care services, including preferred provider organization contracts, health maintenance organization contracts, exclusive provider organization contracts, and alliance network arrangements, and any documents directly relating to the negotiation, performance,

and implementation of any such contracts for managed care or alliance network arrangements. As used in this paragraph, the term "managed care" means systems or techniques generally used by third-party payors or their agents to affect access to and control payment for health care services. Managed-care techniques most often include one or more of the following: prior, concurrent, and retrospective review of the medical necessity and appropriateness of services or site of services; contracts with selected health care providers; financial incentives or disincentives related to the use of specific providers, services, or service sites; controlled access to and coordination of services by a case manager; and payor efforts to identify treatment alternatives and modify benefit restrictions for high-cost patient care.

Section 10. Paragraph (b) of subsection (1) of section 627.4301, Florida Statutes, is amended to read:

627.4301 Genetic information for insurance purposes.--

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

(b) "Health insurer" means an authorized insurer offering health insurance as defined in s. 624.603, a self-insured plan as defined in s. 624.031, a multiple-employer welfare arrangement as defined in s. 624.437, a prepaid limited health service organization as defined in s. 636.003, a health maintenance organization as defined in s. 641.19, a prepaid health clinic as defined in s. 641.402, a fraternal benefit society as defined in s. 632.601, ~~an accountable health partnership as defined in s. 408.701,~~ or any health care arrangement whereby risk is assumed.

Section 11. Subsection (3) of section 408.70, and sections 408.701, 408.702, 408.703, 408.704, 408.7041,

408.7042, 408.7045, 408.7055, and 408.706, Florida Statutes, are repealed.

Section 12. This act shall take effect October 1, 2000.