A bill to be entitled

An act relating to health maintenance organizations; amending s. 641.51, F.S.; providing a licensure requirement for a physician who renders an adverse determination regarding services provided by another state-licensed physician; clarifying the authority of the Board of Medicine and the Board of Osteopathic Medicine; eliminating authority of certain out-of-state physicians to render such determinations; amending s. 627.736, F.S.; relating to required personal injury protection benefits; revising provisions relating to personal injury protection benefits; amending s. 627.410, F.S.; exempting group health insurance policies insuring groups of a certain size from rate filing requirements; providing alternative rate filing requirements for insurers with less than a specified number of nationwide policyholders or members; amending s. 627.411, F.S.; revising the grounds for the disapproval of insurance policy forms; amending s. 627.6515, F.S.; providing additional experience requirements and limitations for out-of-state groups; providing construction; amending s. 627.6699, F.S.; revising a definition; allowing carriers to separate the experience of small employer groups with fewer than two employees; revising the rating factors that may be used by small employer carriers; amending s. 627.9408, F.S.;

authorizing the department to adopt by rule certain provisions of the Long-Term Care Insurance Model Regulation, as adopted by the National Association of Insurance Commissioners; amending s. 641.31, F.S.; exempting contracts of group health maintenance organizations covering a specified number of persons from the requirements of filing with the department; providing alternative rate filing requirements for organizations with less than a specified number of subscribers; amending s. 641.3155, F.S.; specifying nonapplication of certain provisions to certain claims; providing for certain health flex plans; providing legislative intent; providing definitions; providing for a pilot program for health flex plans for certain uninsured persons; providing criteria; exempting approved health flex plans from certain licensing requirements; providing criteria for eligibility to enroll in a health flex plan; requiring health flex plan providers to maintain certain records; providing requirements for denial, nonrenewal, or cancellation of coverage; specifying that coverage under an approved health flex plan is not an entitlement; providing for civil actions against health plan entities by the Agency for Health Care Administration under certain circumstances; providing legislative findings; creating the Workgroup on Out of State Group

Policies; providing for membership; providing purposes; requiring recommendations for proposed legislation; providing an effective date.

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

Section 1. Subsection (4) of section 641.51, Florida Statutes, is amended to read:

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

(4) The organization shall ensure that only a physician with an active, unencumbered license ~~licensed~~ under chapter 458 or chapter 459~~, or an allopathic or osteopathic physician with an active, unencumbered license in another state with similar licensing requirements~~ may render an adverse determination regarding a service provided by a physician licensed in this state. The organization shall submit to the treating provider and the subscriber written notification regarding the organization's adverse determination within 2 working days after the subscriber or provider is notified of the adverse determination. The written notification must include the utilization review criteria or benefits provisions used in the adverse determination, identify the physician who rendered the adverse determination, and be signed by an authorized representative of the organization or the physician who rendered the adverse determination. The organization must include with the notification of an adverse determination information concerning the appeal process for adverse determinations.

Section 2. Paragraphs (b) and (f) of subsection (4), and paragraph (b) of subsection (5) and paragraph (a) of subsection (7) of section 627.736, Florida Statutes, are amended to read:

627.736 Required personal injury protection benefits; exclusions; priority; claims.--

(4) BENEFITS; WHEN DUE.--Benefits due from an insurer under ss. 627.730-627.7405 shall be primary, except that benefits received under any workers' compensation law shall be credited against the benefits provided by subsection (1) and shall be due and payable as loss accrues, upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are covered by the policy issued under ss. 627.730-627.7405. When the Agency for Health Care Administration provides, pays, or becomes liable for medical assistance under the Medicaid program related to injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle, benefits under ss. 627.730-627.7405 shall be subject to the provisions of the Medicaid program.

(b) Personal injury protection insurance benefits paid pursuant to this section shall be overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same. If such written notice is not furnished to the insurer as to the entire claim, any partial amount supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer. Any part or all of the remainder of the claim that is subsequently supported by written notice is overdue if not paid within 30 days after such written notice is furnished to the insurer. However, any

payment shall not be deemed overdue when the insurer has reasonable proof to establish that the insurer is not responsible for the payment that written notice has been furnished to the insurer. For the purpose of calculating the extent to which any benefits are overdue, payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope or, if not so posted, on the date of delivery. This paragraph does not preclude or limit the ability of the insurer to assert that the claim was unrelated, was not medically necessary, or was unreasonable or that the amount of the charge was in excess of that permitted under, or in violation of, subsection (5). Such assertion by the insurer may be made at any time, including after payment of the claim or after the 30-day time period for payment set forth in this paragraph.

~~(f) Medical payments insurance, if available in a policy of motor vehicle insurance, shall pay the portion of any claim for personal injury protection medical benefits which is otherwise covered but is not payable due to the coinsurance provision of paragraph (1)(a), regardless of whether the full amount of personal injury protection coverage has been exhausted. The benefits shall not be payable for the amount of any deductible which has been selected.~~

(5) CHARGES FOR TREATMENT OF INJURED PERSONS.--

(b) With respect to any treatment or service, other than medical services billed by a hospital or other provider for emergency services as defined in s. 395.002 or inpatient services rendered at a hospital-owned facility, the statement of charges must be furnished to the insurer by the provider and may not include, and the insurer is not required to pay,

charges for treatment or services rendered more than 35 ~~30~~ days before the postmark date of the statement, except for past due amounts previously billed on a timely basis under this paragraph, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 75 ~~60~~ days before the postmark date of the statement. The injured party is not liable for, and the provider shall not bill the injured party for, charges that are unpaid because of the provider's failure to comply with this paragraph. Any agreement requiring the injured person or insured to pay for such charges is unenforceable. If, however, the insured fails to furnish the provider with the correct name and address of the insured's personal injury protection insurer, the provider has 35 days from the date the provider obtains the correct information to furnish the insurer with a statement of the charges. The insurer is not required to pay for such charges, unless the provider includes with the statement documentary evidence that was provided by the insured during the 35-day period demonstrating that the provider reasonably relied on erroneous information from the insured and either:

1. A denial letter from the incorrect insurer; or

2. Proof of mailing, which may include an affidavit under penalty of perjury, reflecting timely mailing to the incorrect address or insurer.For emergency services and care as defined in s. 395.002 rendered in a hospital emergency department or for transport and treatment rendered by an ambulance provider licensed pursuant to part III of chapter 401, the provider is not required to furnish the statement of

charges within the time periods established by this paragraph; and the insurer shall not be considered to have been furnished with notice of the amount of covered loss for purposes of paragraph (4)(b) until it receives a statement complying with paragraph(e)~~(5)(d)~~, or copy thereof, which specifically identifies the place of service to be a hospital emergency department or an ambulance in accordance with billing standards recognized by the Health Care Finance Administration. Each notice of insured's rights under s. 627.7401 must include the following statement in type no smaller than 12 points:

BILLING REQUIREMENTS.--Florida Statutes provide that with respect to any treatment or services, other than certain hospital and emergency services, the statement of charges furnished to the insurer by the provider may not include, and the insurer and the injured party are not required to pay, charges for treatment or services rendered more than 35 ~~30~~ days before the postmark date of the statement, except for past due amounts previously billed on a timely basis, and except that, if the provider submits to the insurer a notice of initiation of treatment within 21 days after its first examination or treatment of the claimant, the statement may include charges for treatment or services rendered up to, but not more than, 75 ~~60~~ days before the postmark date of the statement.

(7) MENTAL AND PHYSICAL EXAMINATION OF INJURED PERSON; REPORTS.--

(a) Whenever the mental or physical condition of an injured person covered by personal injury protection is material to any claim that has been or may be made for past or future personal injury protection insurance benefits, such person shall, upon the request of an insurer, submit to mental or physical examination by a physician or physicians. The costs of any examinations requested by an insurer shall be borne entirely by the insurer. Such examination shall be conducted within the municipality where the insured is receiving treatment, or in a location reasonably accessible to the insured, which, for purposes of this paragraph, means any location within the municipality in which the insured resides, or any location within 10 miles by road of the insured's residence, provided such location is within the county in which the insured resides. If the examination is to be conducted in a location reasonably accessible to the insured, and if there is no qualified physician to conduct the examination in a location reasonably accessible to the insured, then such examination shall be conducted in an area of the closest proximity to the insured's residence. Personal protection insurers are authorized to include reasonable provisions in personal injury protection insurance policies for mental and physical examination of those claiming personal injury protection insurance benefits. An insurer may not withdraw payment of a treating physician without the consent of the injured person covered by the personal injury protection, unless the insurer first obtains a valid report by a physician licensed under the same chapter as the treating physician whose treatment authorization is sought to be withdrawn, stating that treatment was not reasonable, related, or necessary. A valid report is one prepared and signed by

the physician examining the injured person or reviewing the treatment records of the injured person and is factually supported by the examination or treatment records, if reviewed, and which has not been modified by anyone other than the physician. The physician preparing the report must be in active practice, unless the physician is physically disabled. Active practice means that during the 3 years immediately preceding the date of the physical examination or review of the treatment record, the physician devoted professional time to the active clinical practice of evaluation, diagnosis, or treatment of medical conditions; or the instruction of students in an accredited health professional school or accredited residency, or at a clinical research program or a clinical research program affiliated with an accredited health professional school or teaching hospital, or a clinical research program affiliated with an accredited health professional school or accredited residency, or clinical research program.

Section 3. Paragraph (a) of subsection (6) of section 627.410, Florida Statutes, is amended, and paragraph (f) is added to subsection (7) of said section, to read:

627.410 Filing, approval of forms.--

(6)(a) An insurer shall not deliver or issue for delivery or renew in this state any health insurance policy form until it has filed with the department a copy of every applicable rating manual, rating schedule, change in rating manual, and change in rating schedule; if rating manuals and rating schedules are not applicable, the insurer must file with the department applicable premium rates and any change in applicable premium rates. This paragraph does not apply to group health insurance policies insuring groups of 51 or more

persons, except for Medicare supplement insurance, long-term care insurance, and any coverage under which the increase in claims costs over the lifetime of the contract due to advancing age or duration is prefunded in the premium.

(7)

(f) Insurers with fewer than 1,000 nationwide policyholders or insured group members or subscribers covered under any form or pooled group of forms with health insurance coverage, as described in s. 627.6561(5)(a)2., excluding Medicare supplement insurance coverage under part VIII, at the time of a rate filing made pursuant to subparagraph (b)1., may file for an annual rate increase limited to medical trend as adopted by the department pursuant to s. 627.411(5). The filing is in lieu of the actuarial memorandum required for a rate filing prescribed by paragraph (6)(b). The filing must include forms adopted by the department and a certification by an officer of the company that the filing includes all similar forms.

Section 4. Paragraph (e) of subsection (1) of section 627.411, Florida Statutes, is amended to read:

627.411 Grounds for disapproval.--

(1) The department shall disapprove any form filed under s. 627.410, or withdraw any previous approval thereof, only if the form:

(e) Is for health insurance, and:

1. Provides benefits that ~~which~~ are unreasonable in relation to the premium charged;~~,~~

2. Contains provisions that ~~which~~ are unfair or inequitable or contrary to the public policy of this state or that ~~which~~ encourage misrepresentation;~~,~~ or

3. Contains provisions that ~~which~~ apply rating practices that ~~which result in premium escalations that are not viable for the policyholder market or~~ result in unfair discrimination pursuant to s. 626.9541(1)(g)2.;~~in sales practices~~.

Section 5. Subsection (9) is added to section 627.6515, Florida Statutes, to read:

627.6515 Out-of-state groups.--

(9) For purposes of this section, any insurer that issues any group health insurance policy or group certificate for health insurance to a resident of this state and requires individual underwriting to determine coverage eligibility or premium rates to be charged shall combine the experience of all association-based group policies or association-based group certificates which are substantially similar with respect to type and level of benefits and marketing method issued in this state after the policy form has been in force for a period of 5 years to calculate uniform percentage rate increases. For purposes of this section, policy forms that have different cost-sharing arrangements or different riders are considered to be different policy forms. Nothing in this subsection shall be construed to require uniform rates for policies or certificates after their fifth duration, it being the intent and purpose of this law to require uniform percentage rate increases for such policies or certificates. Furthermore, nothing in this subsection shall be construed to eliminate changes in rates by age for attained age policies or certificates. The provisions of this subsection shall apply to policies or certificates issued after July 1, 2001. For purposes of this subsection, a group health policy or group certificate for health insurance means any hospital or medical

policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract. The term does not include accident-only, specified disease, individual hospital indemnity, credit, dental-only, vision-only, Medicare supplement, long-term care, or disability income insurance; similar supplemental plans provided under a separate policy, certificate, or contract of insurance, which cannot duplicate coverage under an underlying health plan and are specifically designed to fill gaps in the underlying health plan, coinsurance, or deductibles; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical-payment insurance.

Section 6. Paragraph (n) of subsection (3) and paragraph (b) of subsection (6) of section 627.6699, Florida Statutes, are amended to read:

627.6699 Employee Health Care Access Act.--

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

(n) "Modified community rating" means a method used to develop carrier premiums which spreads financial risk across a large population; allows the use of separate rating factors for age, gender, family composition, tobacco usage, and geographic area as determined under paragraph (5)(j); and allows adjustments for: claims experience, health status, or duration of coverage as permitted under subparagraph (6)(b)5.; and administrative and acquisition expenses as permitted under subparagraph (6)(b)5. A carrier may separate the experience of small employer groups with less than 2 eligible employees from the experience of small employer groups with 2 through 50 eligible employees.

(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) and in which the premium may be adjusted as permitted by subparagraphs 6.~~5.~~and 7.~~6.~~

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. If the modified community rate is determined from two experience pools as authorized by paragraph (3)(n), the rate to be charged to small employer groups of less than 2 eligible employees may not exceed 150 percent of the rate determined for groups of 2 through 50 eligible employees; however, the carrier may charge excess losses of the less than 2 eligible employee experience pool to the experience pool of the 2 through 50 eligible employees so that all losses are allocated and the 150-percent rate limit on the less than 2 eligible employee experience pool is maintained.

4.~~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.

5.~~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.

6.~~5.~~ Any adjustments in rates for claims experience, health status, or duration of coverage may not be charged to

individual employees or dependents. For a small employer's policy, such adjustments may not result in a rate for the small employer which deviates more than 15 percent from the carrier's approved rate. Any such adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer. A small employer carrier may make an adjustment to a small employer's renewal premium, not to exceed 10 percent annually, due to the claims experience, health status, or duration of coverage of the employees or dependents of the small employer. Semiannually, small group carriers shall report information on forms adopted by rule by the department, to enable the department to monitor the relationship of aggregate adjusted premiums actually charged policyholders by each carrier to the premiums that would have been charged by application of the carrier's approved modified community rates. If the aggregate resulting from the application of such adjustment exceeds the premium that would have been charged by application of the approved modified community rate by 5 percent for the current reporting period, the carrier shall limit the application of such adjustments only to minus adjustments beginning not more than 60 days after the report is sent to the department. For any subsequent reporting period, if the total aggregate adjusted premium actually charged does not exceed the premium that would have been charged by application of the approved modified community rate by 5 percent, the carrier may apply both plus and minus adjustments. A small employer carrier may provide a credit to a small employer's premium based on administrative and acquisition expense differences resulting from the size of the group. Group size administrative and acquisition expense factors may be developed by each carrier to reflect the

carrier's experience and are subject to department review and approval.

7.~~6.~~ A small employer carrier rating methodology may include separate rating categories for one dependent child, for two dependent children, and for three or more dependent children for family coverage of employees having a spouse and dependent children or employees having dependent children only. A small employer carrier may have fewer, but not greater, numbers of categories for dependent children than those specified in this subparagraph.

8.~~7.~~ Small employer carriers may not use a composite rating methodology to rate a small employer with fewer than 10 employees. For the purposes of this subparagraph, a "composite rating methodology" means a rating methodology that averages the impact of the rating factors for age and gender in the premiums charged to all of the employees of a small employer.

Section 7. Section 627.9408, Florida Statutes, is amended to read:

627.9408 Rules.--

(1) The department may ~~has authority to~~ adopt rules pursuant to ss. 120.536(1) and 120.54 to administer ~~implement the provisions of~~ this part.

(2) The department may adopt by rule the provisions of the Long-Term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners in the second quarter of the year 2000 which are not in conflict with the Florida Insurance Code.

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

641.31 Health maintenance contracts.--

(3)

(b) Any change in the rate is subject to paragraph (d) and requires at least 30 days' advance written notice to the subscriber. In the case of a group member, there may be a contractual agreement with the health maintenance organization to have the employer provide the required notice to the individual members of the group. This paragraph does not apply to a group contract covering 51 or more persons unless the rate is for any coverage under which the increase in claim costs over the lifetime of the contract due to advancing age or duration is prefunded in the premium.

(f) A health maintenance organization with fewer than 1,000 covered subscribers under all individual or group contracts, at the time of a rate filing, may file for an annual rate increase limited to annual medical trend, as adopted by the department. The filing is in lieu of the actuarial memorandum otherwise required for the rate filing. The filing must include forms adopted by the department and a certification by an officer of the company that the filing includes all similar forms.

Section 9. Paragraphs (a) and (b) of subsection (1) of section 641.3155, Florida Statutes, are amended to read:

641.3155 Payment of claims.--

(1)(a) As used in this section, the term "clean claim" for a noninstitutional provider means a claim submitted on a HCFA 1500 form which has no defect or impropriety, including lack of required substantiating documentation for noncontracted providers and suppliers, or particular circumstances requiring special treatment which prevent timely payment from being made on the claim. A claim may not be considered not clean solely because a health maintenance

organization refers the claim to a medical specialist within the health maintenance organization for examination. If additional substantiating documentation, such as the medical record or encounter data, is required from a source outside the health maintenance organization, the claim is considered not clean. This paragraph does not apply to claims which include potential coordination of benefits for third-party liability or subrogation, as evidenced by the information provided on the claim form related to coordination of benefits.This definition of "clean claim" is repealed on the effective date of rules adopted by the department which define the term "clean claim."

(b) Absent a written definition that is agreed upon through contract, the term "clean claim" for an institutional claim is a properly and accurately completed paper or electronic billing instrument that consists of the UB-92 data set or its successor with entries stated as mandatory by the National Uniform Billing Committee. This paragraph does not apply to claims which include potential coordination of benefits for third-party liability or subrogation, as evidenced by the information provided on the claim form related to coordination of benefits.

Section 10. Health flex plans.--

(1) INTENT.--The Legislature finds that a significant portion of the residents of this state are not able to obtain affordable health insurance coverage. Therefore, it is the intent of the Legislature to expand the availability of health care options for lower income uninsured state residents by encouraging health insurers, health maintenance organizations, health care provider sponsored organizations, local governments, health care districts, or other public or private

community-based organizations to develop alternative approaches to traditional health insurance which emphasize coverage for basic and preventive health care services. To the maximum extent possible, such options should be coordinated with existing governmental or community-based health services programs in a manner that is consistent with the objectives and requirements of such programs.

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

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

(b) "Approved plan" means a health flex plan approved under subsection (3) which guarantees payment by the health plan entity for specified health care services provided to the enrollee.

(c) "Enrollee" means an individual who has been determined eligible for and is receiving health benefits under a health flex plan approved under this section.

(d) "Health care coverage" means payment for health care services covered as benefits under an approved plan or that otherwise provides, either directly or through arrangements with other persons, covered health care services on a prepaid per-capita basis or on a prepaid aggregate fixed-sum basis.

(e) "Health plan entity" means a health insurer, health maintenance organization, health care provider sponsored organization, local government, health care districts, or other public or private community-based organization that develops and implements an approved plan and is responsible for financing and paying all claims by enrollees of the plan.

(3) PILOT PROGRAM.--The agency and the Department of Insurance shall jointly approve or disapprove health flex plans which provide health care coverage for eligible participants residing in the three areas of the state having the highest number of uninsured residents as determined by the agency. A plan may limit or exclude benefits otherwise required by law for insurers offering coverage in this state, cap the total amount of claims paid in 1 year per enrollee, or limit the number of enrollees covered. The agency and the Department of Insurance shall not approve or shall withdraw approval of a plan which:

(a) Contains any ambiguous, inconsistent, or misleading provisions, or exceptions or conditions that deceptively affect or limit the benefits purported to be assumed in the general coverage provided by the plan;

(b) Provides benefits that are unreasonable in relation to the premium charged, contains provisions that are unfair or inequitable or contrary to the public policy of this state or that encourage misrepresentation, or result in unfair discrimination in sales practices; or

(c) Cannot demonstrate that the plan is financially sound and the applicant has the ability to underwrite or finance the benefits provided.

(4) LICENSE NOT REQUIRED.--A health flex plan approved under this section shall not be subject to the licensing requirements of the Florida Insurance Code or chapter 641, Florida Statutes, relating to health maintenance organizations, unless expressly made applicable. However, for the purposes of prohibiting unfair trade practices, health flex plans shall be considered insurance subject to the

applicable provisions of part IX of chapter 626, Florida Statutes, except as otherwise provided in this section.

(5) ELIGIBILITY.--Eligibility to enroll in an approved health flex plan is limited to residents of this state who:

(a) Are 64 years of age or younger;

(b) Have a family income equal to or less than 200 percent of the federal poverty level;

(c) Are not covered by a private insurance policy and are not eligible for coverage through a public health insurance program such as Medicare or Medicaid, or other public health care program, including, but not limited to, Kidcare, and have not been covered at any time during the past 6 months; and

(d) Have applied for health care benefits through an approved health flex plan and agree to make any payments required for participation, including, but not limited to, periodic payments and payments due at the time health care services are provided.

(6) RECORDS.--Every health flex plan provider shall maintain reasonable records of its loss, expense, and claims experience and shall make such records reasonably available to enable the agency and the Department of Insurance to monitor and determine the financial viability of the plan, as necessary.

(7) NOTICE.--The denial of coverage by the health plan entity shall be accompanied by the specific reasons for denial, nonrenewal, or cancellation. Notice of nonrenewal or cancellation shall be provided at least 45 days in advance of such nonrenewal or cancellation except that 10 days' written notice shall be given for cancellation due to nonpayment of premiums. If the health plan entity fails to give the

required notice, the plan shall remain in effect until notice is appropriately given.

(8) NONENTITLEMENT.--Coverage under an approved health flex plan is not an entitlement and no cause of action shall arise against the state, local governmental entity, or other political subdivision of this state or the agency for failure to make coverage available to eligible persons under this section.

(9) CIVIL ACTIONS.--In addition to an administrative action initiated under subsection (4), the agency may seek any remedy provided by law, including, but not limited to, the remedies provided in s. 812.035, Florida Statutes, if the agency finds that a health plan entity has engaged in any act resulting in injury to an enrollee covered by a plan approved under this section.

Section 11. The Legislature finds that the affordability and availability of health insurance is one of the most important and complex issues in this state and that coverage issued to a state resident under group health insurance policies issued outside the state is an important factor in meeting the needs of the citizens of this state. The Legislature also finds that it is important to ensure that those policies are adequately regulated in order to maintain the quality of the coverage offered to citizens of this state. Therefore, the Workgroup on Out of State Group Policies is hereby created to study the regulatory environment in which these policies are now offered and recommend any statutory changes that may be necessary to maintain the quality of the insurance offered in this state. There shall be four members from the House of Representatives appointed by the Speaker of the House of Representatives and four members from the Senate

appointed by the President of the Senate. The group shall begin its meetings by July 1, 2001, and complete its meetings by November 15, 2001. Recommendations for suggested legislation shall be delivered to the Speaker of the House of Representatives and the President of the Senate by December 15, 2001. At its first meeting, the group shall elect a chair from among its members.

Section 12. This act shall take effect July 1, 2001. This provision does not create authority for the Board of Medicine or the Board of Osteopathic Medicine to regulate the organization; however, the Board of Medicine and the Board of Osteopathic Medicine continue to have jurisdiction over licensees of their respective boards.

Section 13. This act shall take effect January 1, 2002.