By Senator Posey

15-1072A-02

A bill to be entitled

An act relating to health care coverage; amending ss. 641.31072, 627.65615, 110.123, F.S.; providing for special enrollment periods for employees under specified circumstances relating to termination of contracts between an insurer and an employee's or dependent's primary care physician; providing for applicability; providing an effective date.

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

Section 1. Subsection (1) of section 641.31072, Florida Statutes, is amended to read:

641.31072 Special enrollment periods.--

(1) A health maintenance organization that issues a group health insurance policy shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the contract, or a dependent of such an employee if the dependent is eligible but not enrolled for coverage under such terms, to enroll for coverage under the terms of the contract if:

(a) Each of the following conditions is met:

1.~~(a)~~ The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent. For the purpose of this section, the terms "group health plan" and "health insurance coverage" have the same meaning ascribed in s. 2791 of the Public Health Service Act.

2.~~(b)~~ The employee stated in writing at such time that coverage under a group health plan or health insurance

coverage was the reason for declining enrollment, but only if the plan sponsor or health maintenance organization, if applicable, required such a statement at such time and provided the employee with notice of such requirement and the consequences of such requirement at such time.

3.~~(c)~~ The employee's or dependent's coverage described in subparagraph 1.~~paragraph (a)~~:

a.~~1.~~ Was under a COBRA continuation provision or continuation pursuant to s. 627.6692, and the coverage under such provision was exhausted; or

b.~~2.~~ Was not under such a provision and the coverage was terminated as a result of loss of eligibility for the coverage, including legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, or the coverage was terminated as a result of the termination of employer contributions toward such coverage.

4.~~(d)~~ Under the terms of the contract, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph (c)1., or termination of ~~or~~ employer contribution described in sub-subparagraph 3.b.; or ~~subparagraph (c)2.~~

(b) The employee's or enrollee's dependent's individual primary care physician's contract was terminated by the health maintenance organization before the renewal date of the group health plan; the employer or plan sponsor offers the choice of two or more group health plans to each employee at the time the employee's or dependent's individual primary care physician's contract was terminated; and, under the terms of the contract, the employee requests such enrollment not later

than 30 days after the date of termination of the employee's or dependent's individual primary care physician's contract.

Section 2. Subsection (1) of section 627.65615, Florida Statutes, is amended to read:

627.65615 Special enrollment periods.--

(1) An insurer that issues a group health insurance policy shall permit an employee who is eligible, but not enrolled, for coverage under the terms of the policy, or a dependent of such an employee if the dependent is eligible but not enrolled for coverage under such terms, to enroll for coverage under the terms of the policy if:

(a) Each of the following conditions is met:

1.~~(a)~~ The employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or dependent. For the purpose of this section, the terms "group health plan" and "health insurance coverage" have the same meaning ascribed in s. 2791 of the Public Health Service Act.

2.~~(b)~~ The employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or insurer, if applicable, required such a statement at such time and provided the employee with notice of such requirement and the consequences of such requirement at such time.

3.~~(c)~~ The employee's or dependent's coverage described in subparagraph 1.~~paragraph (a)~~:

a.~~1.~~ Was under a COBRA continuation provision or continuation pursuant to s. 627.6692, and the coverage under such provision was exhausted; or

b.~~2.~~ Was not under such a provision and the coverage was terminated as a result of loss of eligibility for the coverage, including legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, or the coverage was terminated as a result of the termination of employer contributions toward such coverage.

4.~~(d)~~ Under the terms of the plan, the employee requests such enrollment not later than 30 days after the date of exhaustion of coverage described in subparagraph (c)1., or termination of ~~or~~ employer contribution described in sub-subparagraph 3.b.; or ~~subparagraph (c)2.~~

(b) The employee's or enrollee's dependent's individual primary care physician's contract was terminated by the insurer before the renewal date of the group health plan; the employer or plan sponsor offers the choice of two or more group health plans to each employee at the time the employee's or dependent's individual primary care physician's contract was terminated; and, under the terms of the contract, the employee requests such enrollment not later than 30 days after the date of termination of the employee's or dependent's individual primary care physician's contract.

Section 3. Paragraph (h) of subsection (3) of section 110.123, Florida Statutes, is amended to read:

110.123 State group insurance program.--

(3) STATE GROUP INSURANCE PROGRAM.--

(h)1. A person eligible to participate in the state group insurance program may be authorized by rules adopted by the department, in lieu of participating in the state group health insurance plan, to exercise an option to elect membership in a health maintenance organization plan which is

under contract with the state in accordance with criteria established by this section and by said rules. The offer of optional membership in a health maintenance organization plan permitted by this paragraph may be limited or conditioned by rule as may be necessary to meet the requirements of state and federal laws.

2. The department shall contract with health maintenance organizations seeking to participate in the state group insurance program through a request for proposal or other procurement process, as developed by the Department of Management Services and determined to be appropriate.

a. The department shall establish a schedule of minimum benefits for health maintenance organization coverage, and that schedule shall include: physician services; inpatient and outpatient hospital services; emergency medical services, including out-of-area emergency coverage; diagnostic laboratory and diagnostic and therapeutic radiologic services; mental health, alcohol, and chemical dependency treatment services meeting the minimum requirements of state and federal law; skilled nursing facilities and services; prescription drugs; and other benefits as may be required by the department. Additional services may be provided subject to the contract between the department and the HMO.

b. The department may establish uniform deductibles, copayments, or coinsurance schedules for all participating HMO plans.

c. The department may require detailed information from each health maintenance organization participating in the procurement process, including information pertaining to organizational status, experience in providing prepaid health benefits, accessibility of services, financial stability of

the plan, quality of management services, accreditation status, quality of medical services, network access and adequacy, performance measurement, ability to meet the department's reporting requirements, and the actuarial basis of the proposed rates and other data determined by the director to be necessary for the evaluation and selection of health maintenance organization plans and negotiation of appropriate rates for these plans. Upon receipt of proposals by health maintenance organization plans and the evaluation of those proposals, the department may enter into negotiations with all of the plans or a subset of the plans, as the department determines appropriate. Nothing shall preclude the department from negotiating regional or statewide contracts with health maintenance organization plans when this is cost-effective and when the department determines that the plan offers high value to enrollees.

d. The department may limit the number of HMOs that it contracts with in each service area based on the nature of the bids the department receives, the number of state employees in the service area, or any unique geographical characteristics of the service area. The department shall establish by rule service areas throughout the state.

e. All persons participating in the state group insurance program who are required to contribute towards a total state group health premium shall be subject to the same dollar contribution regardless of whether the enrollee enrolls in the state group health insurance plan or in an HMO plan.

3. The department is authorized to negotiate and to contract with specialty psychiatric hospitals for mental health benefits, on a regional basis, for alcohol, drug abuse, and mental and nervous disorders. The department may

establish, subject to the approval of the Legislature pursuant to subsection (5), any such regional plan upon completion of an actuarial study to determine any impact on plan benefits and premiums.

4. In addition to contracting pursuant to subparagraph 2., the department shall enter into contract with any HMO to participate in the state group insurance program which:

a. Serves greater than 5,000 recipients on a prepaid basis under the Medicaid program;

b. Does not currently meet the 25-percent non-Medicare/non-Medicaid enrollment composition requirement established by the Department of Health excluding participants enrolled in the state group insurance program;

c. Meets the minimum benefit package and copayments and deductibles contained in sub-subparagraphs 2.a. and b.;

d. Is willing to participate in the state group insurance program at a cost of premiums that is not greater than 95 percent of the cost of HMO premiums accepted by the department in each service area; and

e. Meets the minimum surplus requirements of s. 641.225.

The department is authorized to contract with HMOs that meet the requirements of sub-subparagraphs a.-d. prior to the open enrollment period for state employees. The department is not required to renew the contract with the HMOs as set forth in this paragraph more than twice. Thereafter, the HMOs shall be eligible to participate in the state group insurance program only through the request for proposal process described in subparagraph 2.

5. All enrollees in the state group health insurance plan or any health maintenance organization plan shall have the option of changing to any other health plan which is offered by the state within any open enrollment period designated by the department. Open enrollment shall be held at least once each calendar year. In addition to other events that constitute an open enrollment period, the enrollee shall be granted a special open enrollment period if the enrollee's or the enrollee's dependent's individual primary care physician's contract is terminated by the health maintenance organization.

6. When a contract between a treating provider and the state-contracted health maintenance organization is terminated for any reason other than for cause, each party shall allow any enrollee for whom treatment was active to continue coverage and care when medically necessary, through completion of treatment of a condition for which the enrollee was receiving care at the time of the termination, until the enrollee selects another treating provider, or until the next open enrollment period offered, whichever is longer, but no longer than 6 months after termination of the contract. Each party to the terminated contract shall allow an enrollee who has initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care and coverage until completion of postpartum care. This does not prevent a provider from refusing to continue to provide care to an enrollee who is abusive, noncompliant, or in arrears in payments for services provided. For care continued under this subparagraph, the program and the provider shall continue to be bound by the terms of the terminated contract. Changes made

within 30 days before termination of a contract are effective only if agreed to by both parties.

7. Any HMO participating in the state group insurance program shall submit health care utilization and cost data to the department, in such form and in such manner as the department shall require, as a condition of participating in the program. The department shall enter into negotiations with its contracting HMOs to determine the nature and scope of the data submission and the final requirements, format, penalties associated with noncompliance, and timetables for submission. These determinations shall be adopted by rule.

8. The department may establish and direct, with respect to collective bargaining issues, a comprehensive package of insurance benefits that may include supplemental health and life coverage, dental care, long-term care, vision care, and other benefits it determines necessary to enable state employees to select from among benefit options that best suit their individual and family needs.

a. Based upon a desired benefit package, the department shall issue a request for proposal for health insurance providers interested in participating in the state group insurance program, and the department shall issue a request for proposal for insurance providers interested in participating in the non-health-related components of the state group insurance program. Upon receipt of all proposals, the department may enter into contract negotiations with insurance providers submitting bids or negotiate a specially designed benefit package. Insurance providers offering or providing supplemental coverage as of May 30, 1991, which qualify for pretax benefit treatment pursuant to s. 125 of the Internal Revenue Code of 1986, with 5,500 or more state

employees currently enrolled may be included by the department in the supplemental insurance benefit plan established by the department without participating in a request for proposal, submitting bids, negotiating contracts, or negotiating a specially designed benefit package. These contracts shall provide state employees with the most cost-effective and comprehensive coverage available; however, no state or agency funds shall be contributed toward the cost of any part of the premium of such supplemental benefit plans. With respect to dental coverage, the division shall include in any solicitation or contract for any state group dental program made after July 1, 2001, a comprehensive indemnity dental plan option which offers enrollees a completely unrestricted choice of dentists. If a dental plan is endorsed, or in some manner recognized as the preferred product, such plan shall include a comprehensive indemnity dental plan option which provides enrollees with a completely unrestricted choice of dentists.

b. Pursuant to the applicable provisions of s. 110.161, and s. 125 of the Internal Revenue Code of 1986, the department shall enroll in the pretax benefit program those state employees who voluntarily elect coverage in any of the supplemental insurance benefit plans as provided by sub-subparagraph a.

c. Nothing herein contained shall be construed to prohibit insurance providers from continuing to provide or offer supplemental benefit coverage to state employees as provided under existing agency plans.

Section 4. This act shall take effect July 1, 2002, and apply to insurance and managed care contracts issued, renewed, or amended on or after October 1, 2002.

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SENATE SUMMARY

Requires a health maintenance organization, a group health insurer, and the state to offer an open enrollment period to an enrollee if the enrollee or enrollee's dependent's primary care physician's contract with the provider has been terminated.