Bill No. CS/HB 913, 2nd Eng.

Amendment No. ___ Barcode 951712

CHAMBER ACTION

Senate		House
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11 Senator Pruitt moved the following **amendment to amendment**
12 (913362):
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14 **Senate Amendment (with title amendment)**
15 On page 79, lines 14 - 17, delete those lines
16
17 and insert: subscriber to a contracted licensed
18 ophthalmologist.
19 Section 27. Effective July 1, 2002, section 627.6482,
20 Florida Statutes, is amended to read:
21 627.6482 Definitions.--As used in ss.
22 627.648-627.6498, the term:
23 (1) "Agent" means a person who is licensed to sell
24 health insurance in this state.
25 (2) "Association" means the Florida Comprehensive
26 Health Association created in s. 627.6488.
27 (3) "Case management" means the specific supervision
28 and management of the medical care provided or prescribed for
29 a specific individual, which may include the use of health
30 care providers designated by the plan case manager.
31 (4) "Plan case manager" means the person or persons

1 employed by the association to supervise and manage or
2 coordinate with the administrator the supervision and
3 management of the medical care provided or prescribed for a
4 specific individual.
5 (5) "Board" means the board of directors of the
6 association.
7 (6) "Health insurance" means any hospital and medical
8 expense incurred policy, minimum premium plan, stop-loss
9 coverage, health maintenance organization contract, prepaid
10 health clinic contract, multiple-employer welfare arrangement
11 contract, or fraternal benefit society health benefits
12 contract, whether sold as an individual or group policy or
13 contract. The term does not include any policy covering
14 medical payment coverage or personal injury protection
15 coverage in a motor vehicle policy, coverage issued as a
16 supplement to liability insurance, or workers' compensation.
17 (7) "Insurer" means any insurance company authorized
18 to transact health insurance in this state, any insurance
19 company authorized to transact health insurance or casualty
20 insurance in this state that is offering a minimum premium
21 plan or stop-loss coverage for any person or entity providing
22 health care benefits, health maintenance organization
23 authorized to transact business in this state pursuant to part
24 I of chapter 641, prepaid health clinic authorized to transact
25 business in this state pursuant to part II of chapter 641,
26 multiple-employer welfare arrangement authorized to transact
27 business in this state pursuant to ss. 624.436-624.45, or
28 fraternal benefit society providing health benefits to its
29 members as authorized pursuant to chapter 632.
30 (8) "Medicare" means coverage under both parts A and B
31 of Title XVIII of the Social Security Act, 42 U.S.C. ss. 1395

1 et seq., as amended.
2 (9) "Minimum premium plan" means an arrangement
3 whereby the expected amount of health care claims is
4 self-funded, but the insurance company assumes the risk that
5 claims will exceed that amount.
6 (10) "Physician" means a physician licensed under
7 chapter 458; an osteopathic physician licensed under chapter
8 459; a chiropractic physician licensed under chapter 460; a
9 podiatric physician licensed under chapter 461; or, for
10 purposes of oral surgery only, a dental surgeon licensed under
11 chapter 466.
12 (11) "Plan" means the comprehensive health insurance
13 plan adopted by the association or by rule of the Department
14 of Insurance.
15 (12) "Premium" means the entire cost of an insurance
16 plan, including the administrative fee, the risk assumption
17 charge, and, in the instance of a minimum premium plan or
18 stop-loss coverage, the incurred claims whether or not such
19 claims are paid directly by the insurer. "Premium" shall not
20 include a health maintenance organization's annual earned
21 premium revenue for Medicare and Medicaid contracts for any
22 assessment due for calendar years 1990 and 1991. For
23 assessments due for calendar year 1992 and subsequent years, a
24 health maintenance organization's annual earned premium
25 revenue for Medicare and Medicaid contracts is subject to
26 assessments unless the department determines that the health
27 maintenance organization has made a reasonable effort to amend
28 its Medicare or Medicaid government contract for 1992 and
29 subsequent years to provide reimbursement for any assessment
30 on Medicare or Medicaid premiums paid by the health
31 maintenance organization and the contract does not provide for

1 such reimbursement.
2 (13) "Resident" means a person who is legally
3 domiciled in this state.
4 (14) "Stop-loss coverage" means an arrangement whereby
5 an insurer insures against the risk that any one claim will
6 exceed a specific dollar amount or that an entire
7 self-insurance plan's loss will exceed a specific amount.
8 Section 28. Effective July 1, 2002, section 627.6486,
9 Florida Statutes, is amended to read:
10 627.6486 Eligibility.--
11 (1) Except as provided in subsection (2), any resident
12 of this state shall be eligible for coverage under the plan,
13 including:
14 (a) The insured's spouse.
15 (b) Any dependent unmarried child of the insured, from
16 the moment of birth. Subject to the provisions of s.
17 627.6041, such coverage shall terminate at the end of the
18 premium period in which the child marries, ceases to be a
19 dependent of the insured, or attains the age of 19, whichever
20 occurs first. However, if the child is a full-time student at
21 an accredited institution of higher learning, the coverage may
22 continue while the child remains unmarried and a full-time
23 student, but not beyond the premium period in which the child
24 reaches age 23.
25 (c) The former spouse of the insured whose coverage
26 would otherwise terminate because of annulment or dissolution
27 of marriage, if the former spouse is dependent upon the
28 insured for financial support. The former spouse shall have
29 continued coverage and shall not be subject to waiting periods
30 because of the change in policyholder status.
31 (2)(a) The board or administrator shall require

1 verification of residency and shall require any additional
2 information or documentation, or statements under oath, when
3 necessary to determine residency upon initial application and
4 for the entire term of the policy.
5 (b) No person who is currently eligible for health
6 care benefits under Florida's Medicaid program is eligible for
7 coverage under the plan unless:
8 1. He or she has an illness or disease which requires
9 supplies or medication which are covered by the association
10 but are not included in the benefits provided under Florida's
11 Medicaid program in any form or manner; and
12 2. He or she is not receiving health care benefits or
13 coverage under Florida's Medicaid program.
14 (c) No person who is covered under the plan and
15 terminates the coverage is again eligible for coverage.
16 (d) No person on whose behalf the plan has paid out
17 $500,000 in covered benefits is eligible for coverage under
18 the plan.
19 (e) The coverage of any person who ceases to meet the
20 eligibility requirements of this section may be terminated
21 immediately. If such person again becomes eligible for
22 subsequent coverage under the plan, any previous claims
23 payments shall be applied towards the $500,000 lifetime
24 maximum benefit and any limitation relating to preexisting
25 conditions in effect at the time such person again becomes
26 eligible shall apply to such person. However, no such person
27 may again become eligible for coverage after June 30, 1991.
28 (f) No person is eligible for coverage under the plan
29 unless such person has been rejected by two insurers for
30 coverage substantially similar to the plan coverage and no
31 insurer has been found through the market assistance plan

1 pursuant to s. 627.6484 that is willing to accept the
2 application. As used in this paragraph, "rejection" includes
3 an offer of coverage with a material underwriting restriction
4 or an offer of coverage at a rate greater than the association
5 plan rate.
6 (g) No person is eligible for coverage under the plan
7 if such person has, on the date of issue of coverage under the
8 plan, substantially similar coverage under another contract or
9 policy, unless such coverage is provided pursuant to the
10 Consolidated Omnibus Budget Reconciliation Act of 1985, Pub.
11 L. No. 99-272, 100 Stat. 82 (1986) (COBRA), as amended, and
12 scheduled to end at a time certain and the person meets all
13 other requirements of eligibility. Coverage provided by the
14 association shall be secondary to any coverage provided by an
15 insurer pursuant to COBRA.
16 (h) All eligible persons who are classified as
17 high-risk individuals pursuant to s. 627.6498(4)(a)4. shall,
18 upon application or renewal, agree to be placed in a case
19 management system when it is determined by the board and the
20 plan case manager that such system will be cost-effective and
21 provide quality care to the individual.
22 Section 29. Effective July 1, 2002, subsection (3) of
23 section 627.6487, Florida Statutes, is amended to read:
24 627.6487 Guaranteed availability of individual health
25 insurance coverage to eligible individuals.--
26 (3) For the purposes of this section, the term
27 "eligible individual" means an individual:
28 (a)1. For whom, as of the date on which the individual
29 seeks coverage under this section, the aggregate of the
30 periods of creditable coverage, as defined in s. 627.6561(5)
31 and (6), is 18 or more months; and

1 2.a. Whose most recent prior creditable coverage was
2 under a group health plan, governmental plan, or church plan,
3 or health insurance coverage offered in connection with any
4 such plan; or
5 b. Whose most recent prior creditable coverage was
6 under an individual plan issued in this state by a health
7 insurer or health maintenance organization, which coverage is
8 terminated due to the insurer or health maintenance
9 organization becoming insolvent or discontinuing the offering
10 of all individual coverage in the State of Florida, or due to
11 the insured no longer living in the service area in the State
12 of Florida of the insurer or health maintenance organization
13 that provides coverage through a network plan in the State of
14 Florida;
15 (b) Who is not eligible for coverage under:
16 1. A group health plan, as defined in s. 2791 of the
17 Public Health Service Act;
18 2. A conversion policy or contract issued by an
19 authorized insurer or health maintenance organization under s.
20 627.6675 or s. 641.3921, respectively, offered to an
21 individual who is no longer eligible for coverage under either
22 an insured or self-insured employer plan;
23 3. Part A or part B of Title XVIII of the Social
24 Security Act; or
25 4. A state plan under Title XIX of such act, or any
26 successor program, and does not have other health insurance
27 coverage;
28 (c) With respect to whom the most recent coverage
29 within the coverage period described in paragraph (a) was not
30 terminated based on a factor described in s. 627.6571(2)(a) or
31 (b), relating to nonpayment of premiums or fraud, unless such

1 nonpayment of premiums or fraud was due to acts of an employer
2 or person other than the individual;
3 (d) Who, having been offered the option of
4 continuation coverage under a COBRA continuation provision or
5 under s. 627.6692, elected such coverage; and
6 (e) Who, if the individual elected such continuation
7 provision, has exhausted such continuation coverage under such
8 provision or program.
9 Section 30. Effective July 1, 2002, section 627.6488,
10 Florida Statutes, is amended to read:
11 627.6488 Florida Comprehensive Health Association.--
12 (1) There is created a nonprofit legal entity to be
13 known as the "Florida Comprehensive Health Association." All
14 insurers, as a condition of doing business, shall be members
15 of the association.
16 (2)(a) The association shall operate subject to the
17 supervision and approval of a three-member board of directors.
18 The board of directors shall be appointed by the Insurance
19 Commissioner as follows:
20 1. The chair of the board shall be the Insurance
21 Commissioner or his or her designee.
22 2. One representative of policyholders who is not
23 associated with the medical profession, a hospital, or an
24 insurer.
25 3. One representative of insurers.
26
27 The administrator or his or her affiliate shall not be a
28 member of the board. Any board member appointed by the
29 commissioner may be removed and replaced by him or her at any
30 time without cause.
31 (b) All board members, including the chair, shall be

1 appointed to serve for staggered 3-year terms beginning on a
2 date as established in the plan of operation.
3 (c) The board of directors shall have the power to
4 employ or retain such persons as are necessary to perform the
5 administrative and financial transactions and responsibilities
6 of the association and to perform other necessary and proper
7 functions not prohibited by law.
8 (d) Board members may be reimbursed from moneys of the
9 association for actual and necessary expenses incurred by them
10 as members, but may not otherwise be compensated for their
11 services.
12 (e) There shall be no liability on the part of, and no
13 cause of action of any nature shall arise against, any member
14 insurer, or its agents or employees, agents or employees of
15 the association, members of the board of directors of the
16 association, or the departmental representatives for any act
17 or omission taken by them in the performance of their powers
18 and duties under this act, unless such act or omission by such
19 person is in intentional disregard of the rights of the
20 claimant.
21 (f) Meetings of the board are subject to s. 286.011.
22 (3) The association shall adopt a plan pursuant to
23 this act and submit its articles, bylaws, and operating rules
24 to the department for approval. If the association fails to
25 adopt such plan and suitable articles, bylaws, and operating
26 rules within 180 days after the appointment of the board, the
27 department shall adopt rules to effectuate the provisions of
28 this act; and such rules shall remain in effect until
29 superseded by a plan and articles, bylaws, and operating rules
30 submitted by the association and approved by the department.
31 (4) The association shall:

1 (a) Establish administrative and accounting procedures
2 for the operation of the association.
3 (b) Establish procedures under which applicants and
4 participants in the plan may have grievances reviewed by an
5 impartial body and reported to the board.
6 (c) Select an administrator in accordance with s.
7 627.649.
8 (d) Collect assessments from all insurers to provide
9 for operating losses incurred or estimated to be incurred
10 during the period for which the assessment is made. The level
11 of payments shall be established by the board, as formulated
12 in s. 627.6492(1). Annual assessment of the insurers for each
13 calendar year shall occur as soon thereafter as the operating
14 results of the plan for the calendar year and the earned
15 premiums of insurers being assessed for that year are known.
16 Annual assessments are due and payable within 30 days of
17 receipt of the assessment notice by the insurer.
18 (e) Require that all policy forms issued by the
19 association conform to standard forms developed by the
20 association. The forms shall be approved by the department.
21 (f) Develop and implement a program to publicize the
22 existence of the plan, the eligibility requirements for the
23 plan, and the procedures for enrollment in the plan and to
24 maintain public awareness of the plan.
25 (g) Design and employ cost containment measures and
26 requirements which may include preadmission certification,
27 home health care, hospice care, negotiated purchase of medical
28 and pharmaceutical supplies, and individual case management.
29 (h) Contract with preferred provider organizations and
30 health maintenance organizations giving due consideration to
31 the preferred provider organizations and health maintenance

1 organizations which have contracted with the state group
2 health insurance program pursuant to s. 110.123. If
3 cost-effective and available in the county where the
4 policyholder resides, the board, upon application or renewal
5 of a policy, shall place a high-risk individual, as
6 established under s. 627.6498(4)(a)4., with the plan case
7 manager who shall determine the most cost-effective quality
8 care system or health care provider and shall place the
9 individual in such system or with such health care provider.
10 If cost-effective and available in the county where the
11 policyholder resides, the board, with the consent of the
12 policyholder, may place a low-risk or medium-risk individual,
13 as established under s. 627.6498(4)(a)4., with the plan case
14 manager who may determine the most cost-effective quality care
15 system or health care provider and shall place the individual
16 in such system or with such health care provider. Prior to and
17 during the implementation of case management, the plan case
18 manager shall obtain input from the policyholder, parent, or
19 guardian.
20 (i) Make a report to the Governor, the President of
21 the Senate, the Speaker of the House of Representatives, and
22 the Minority Leaders of the Senate and the House of
23 Representatives not later than October 1 of each year. The
24 report shall summarize the activities of the plan for the
25 12-month period ending July 1 of that year, including
26 then-current data and estimates as to net written and earned
27 premiums, the expense of administration, and the paid and
28 incurred losses for the year. The report shall also include
29 analysis and recommendations for legislative changes regarding
30 utilization review, quality assurance, an evaluation of the
31 administrator of the plan, access to cost-effective health

1 care, and cost containment/case management policy and
2 recommendations concerning the opening of enrollment to new
3 entrants as of July 1, 1992.
4 (j) Make a report to the Governor, the Insurance
5 Commissioner, the President of the Senate, the Speaker of the
6 House of Representatives, and the Minority Leaders of the
7 Senate and House of Representatives, not later than 45 days
8 after the close of each calendar quarter, which includes, for
9 the prior quarter, current data and estimates of net written
10 and earned premiums, the expenses of administration, and the
11 paid and incurred losses. The report shall identify any
12 statutorily mandated program that has not been fully
13 implemented by the board.
14 (k) To facilitate preparation of assessments and for
15 other purposes, the board shall direct preparation of annual
16 audited financial statements for each calendar year as soon as
17 feasible following the conclusion of that calendar year, and
18 shall, within 30 days after rendition of such statements, file
19 with the department the annual report containing such
20 information as required by the department to be filed on March
21 1 of each year.
22 (l) Employ a plan case manager or managers to
23 supervise and manage the medical care or coordinate the
24 supervision and management of the medical care, with the
25 administrator, of specified individuals. The plan case
26 manager, with the approval of the board, shall have final
27 approval over the case management for any specific individual.
28 (5) The association may:
29 (a) Exercise powers granted to insurers under the laws
30 of this state.
31 (b) Sue or be sued.

1 (c) In addition to imposing annual assessments under
2 paragraph (4)(d), levy interim assessments against insurers to
3 ensure the financial ability of the plan to cover claims
4 expenses and administrative expenses paid or estimated to be
5 paid in the operation of the plan for a calendar year prior to
6 the association's anticipated receipt of annual assessments
7 for that calendar year. Any interim assessment shall be due
8 and payable within 30 days of receipt by an insurer of an
9 interim assessment notice. Interim assessment payments shall
10 be credited against the insurer's annual assessment.
11 (d) Prepare or contract for a performance audit of the
12 administrator of the association.
13 (6) The department shall examine and investigate the
14 association in the manner provided in part II of chapter 624.
15 Section 31. Effective July 1, 2002, paragraph (b) of
16 subsection (3) of section 627.649, Florida Statutes, is
17 amended to read:
18 627.649 Administrator.--
19 (3) The administrator shall:
20 (b) Pay an agent's referral fee as established by the
21 board to each insurance agent who refers an applicant to the
22 plan, if the applicant's application is accepted. The selling
23 or marketing of plans shall not be limited to the
24 administrator or its agents. The referral fees shall be paid
25 by the administrator from moneys received as premiums for the
26 plan.
27 Section 32. Effective July 1, 2002, section 627.6492,
28 Florida Statutes, is amended to read:
29 627.6492 Participation of insurers.--
30 (1)(a) As a condition of doing business in this state
31 an insurer shall pay an assessment to the board, in the amount

1 prescribed by this section. For operating losses incurred on
2 July 1, 1991, and thereafter, each insurer shall annually be
3 assessed by the board in the following calendar year a portion
4 of such incurred operating losses of the plan; such portion
5 shall be determined by multiplying such operating losses by a
6 fraction, the numerator of which equals the insurer's earned
7 premium pertaining to direct writings of health insurance in
8 the state during the calendar year preceding that for which
9 the assessment is levied, and the denominator of which equals
10 the total of all such premiums earned by participating
11 insurers in the state during such calendar year.
12 (b) For operating losses incurred from July 1, 1991,
13 through December 31, 1991, the total of all assessments upon a
14 participating insurer shall not exceed .375 percent of such
15 insurer's health insurance premiums earned in this state
16 during 1990. For operating losses incurred in 1992 and
17 thereafter, the total of all assessments upon a participating
18 insurer shall not exceed 1 percent of such insurer's health
19 insurance premium earned in this state during the calendar
20 year preceding the year for which the assessments were levied.
21 (c) For operating losses incurred from October 1,
22 1990, through June 30, 1991, the board shall assess each
23 insurer in the amount and manner prescribed by chapter 90-334,
24 Laws of Florida. The maximum assessment against an insurer, as
25 provided in such act, shall apply separately to the claims
26 incurred in 1990 (October 1 through December 31) and the
27 claims incurred in 1991 (January 1 through June 30). For
28 operating losses incurred on January 1, 1991, through June 30,
29 1991, the maximum assessment against an insurer shall be
30 one-half of the amount of the maximum assessment specified for
31 such insurer in former s. 627.6492(1)(b), 1990 Supplement, as

1 amended by chapter 90-334, Laws of Florida.
2 (d) All rights, title, and interest in the assessment
3 funds collected shall vest in this state. However, all of
4 such funds and interest earned shall be used by the
5 association to pay claims and administrative expenses.
6 (2) If assessments and other receipts by the
7 association, board, or administrator exceed the actual losses
8 and administrative expenses of the plan, the excess shall be
9 held at interest and used by the board to offset future
10 losses. As used in this subsection, the term "future losses"
11 includes reserves for claims incurred but not reported.
12 (3) Each insurer's assessment shall be determined
13 annually by the association based on annual statements and
14 other reports deemed necessary by the association and filed
15 with it by the insurer. Any deficit incurred under the plan
16 shall be recouped by assessments against participating
17 insurers by the board in the manner provided in subsection
18 (1); and the insurers may recover the assessment in the normal
19 course of their respective businesses without time limitation.
20 Section 33. Effective July 1, 2002, section 627.6498,
21 Florida Statutes, is amended to read:
22 627.6498 Minimum benefits coverage; exclusions;
23 premiums; deductibles.--
24 (1) COVERAGE OFFERED.--
25 (a) The plan shall offer in a semiannually renewable
26 policy the coverage specified in this section for each
27 eligible person. For applications accepted on or after June 7,
28 1991, but before July 1, 1991, coverage shall be effective on
29 July 1, 1991, and shall be renewable on January 1, 1992, and
30 every 6 months thereafter. Policies in existence on June 7,
31 1991, shall, upon renewal, be for a term of less than 6 months

1 that terminates and becomes subject to subsequent renewal on
2 the next succeeding January 1 or July 1, whichever is sooner.
3 (b) If an eligible person is also eligible for
4 Medicare coverage, the plan shall not pay or reimburse any
5 person for expenses paid by Medicare.
6 (c) Any person whose health insurance coverage is
7 involuntarily terminated for any reason other than nonpayment
8 of premium may apply for coverage under the plan. If such
9 coverage is applied for within 60 days after the involuntary
10 termination and if premiums are paid for the entire period of
11 coverage, the effective date of the coverage shall be the date
12 of termination of the previous coverage.
13 (d) The plan shall provide that, upon the death or
14 divorce of the individual in whose name the contract was
15 issued, every other person then covered in the contract may
16 elect within 60 days to continue under the same or a different
17 contract.
18 (e) No coverage provided to a person who is eligible
19 for Medicare benefits shall be issued as a Medicare supplement
20 policy as defined in s. 627.672.
21 (2) BENEFITS.--
22 (a) The plan shall offer major medical expense
23 coverage similar to that provided by the state group health
24 insurance program as defined in s. 110.123 except as specified
25 in subsection (3) to every eligible person who is not eligible
26 for Medicare. Major medical expense coverage offered under the
27 plan shall pay an eligible person's covered expenses, subject
28 to limits on the deductible and coinsurance payments
29 authorized under subsection (4), up to a lifetime limit of
30 $500,000 per covered individual. The maximum limit under this
31 paragraph shall not be altered by the board, and no

1 actuarially equivalent benefit may be substituted by the
2 board.
3 (b) The plan shall provide that any policy issued to a
4 person eligible for Medicare shall be separately rated to
5 reflect differences in experience reasonably expected to occur
6 as a result of Medicare payments.
7 (3) COVERED EXPENSES.--The coverage to be issued by
8 the association shall be patterned after the state group
9 health insurance program as defined in s. 110.123, including
10 its benefits, exclusions, and other limitations, except as
11 otherwise provided in this act. The plan may cover the cost
12 of experimental drugs which have been approved for use by the
13 Food and Drug Administration on an experimental basis if the
14 cost is less than the usual and customary treatment. Such
15 coverage shall only apply to those insureds who are in the
16 case management system upon the approval of the insured, the
17 case manager, and the board.
18 (4) PREMIUMS, DEDUCTIBLES, AND COINSURANCE.--
19 (a) The plan shall provide for annual deductibles for
20 major medical expense coverage in the amount of $1,000 or any
21 higher amounts proposed by the board and approved by the
22 department, plus the benefits payable under any other type of
23 insurance coverage or workers' compensation. The schedule of
24 premiums and deductibles shall be established by the
25 association. With regard to any preferred provider arrangement
26 utilized by the association, the deductibles provided in this
27 paragraph shall be the minimum deductibles applicable to the
28 preferred providers and higher deductibles, as approved by the
29 department, may be applied to providers who are not preferred
30 providers.
31 1. Separate schedules of premium rates based on age

1 may apply for individual risks.
2 2. Rates are subject to approval by the department.
3 3. Standard risk rates for coverages issued by the
4 association shall be established by the department, pursuant
5 to s. 627.6675(3).
6 4. The board shall establish separate premium
7 schedules for low-risk individuals, medium-risk individuals,
8 and high-risk individuals and shall revise premium schedules
9 annually beginning January 1999. No rate shall exceed 200
10 percent of the standard risk rate for low-risk individuals,
11 225 percent of the standard risk rate for medium-risk
12 individuals, or 250 percent of the standard risk rate for
13 high-risk individuals. For the purpose of determining what
14 constitutes a low-risk individual, medium-risk individual, or
15 high-risk individual, the board shall consider the anticipated
16 claims payment for individuals based upon an individual's
17 health condition.
18 (b) If the covered costs incurred by the eligible
19 person exceed the deductible for major medical expense
20 coverage selected by the person in a policy year, the plan
21 shall pay in the following manner:
22 1. For individuals placed under case management, the
23 plan shall pay 90 percent of the additional covered costs
24 incurred by the person during the policy year for the first
25 $10,000, after which the plan shall pay 100 percent of the
26 covered costs incurred by the person during the policy year.
27 2. For individuals utilizing the preferred provider
28 network, the plan shall pay 80 percent of the additional
29 covered costs incurred by the person during the policy year
30 for the first $10,000, after which the plan shall pay 90
31 percent of covered costs incurred by the person during the

1 policy year.
2 3. If the person does not utilize either the case
3 management system or the preferred provider network, the plan
4 shall pay 60 percent of the additional covered costs incurred
5 by the person for the first $10,000, after which the plan
6 shall pay 70 percent of the additional covered costs incurred
7 by the person during the policy year.
8 (5) PREEXISTING CONDITIONS.--An association policy may
9 contain provisions under which coverage is excluded during a
10 period of 12 months following the effective date of coverage
11 with respect to a given covered individual for any preexisting
12 condition, as long as:
13 (a) The condition manifested itself within a period of
14 6 months before the effective date of coverage; or
15 (b) Medical advice or treatment was recommended or
16 received within a period of 6 months before the effective date
17 of coverage.
18 (6) OTHER SOURCES PRIMARY.--
19 (a) No amounts paid or payable by Medicare or any
20 other governmental program or any other insurance, or
21 self-insurance maintained in lieu of otherwise statutorily
22 required insurance, may be made or recognized as claims under
23 such policy or be recognized as or towards satisfaction of
24 applicable deductibles or out-of-pocket maximums or to reduce
25 the limits of benefits available.
26 (b) The association has a cause of action against a
27 participant for any benefits paid to the participant which
28 should not have been claimed or recognized as claims because
29 of the provisions of this subsection or because otherwise not
30 covered.
31 Section 34. The Legislature finds that the provisions

of this act fulfill an important state interest.

Section 35. ~~The amendments in this act to section 627.6487, Florida Statutes, shall not take effect unless the Health Care Financing Administration of the U.S. Department of Health and Human Services approves this act as providing an acceptable alternative mechanism, as provided in the Public Health Service Act.~~

Section 36. Section 627.6484, Florida Statutes, is not repealed on January 1, 2003, but is reenacted and shall remain in effect as it appeared in the 2001 Florida Statutes.

Section 37. Except as otherwise provided in this act, this act shall take effect October 1, 2002, and shall apply to claims for services rendered after such date.

================ T I T L E A M E N D M E N T ===============

And the title is amended as follows:

On page 85, line 26, after the semicolon

insert:

amending ss. 627.6482, 627.6486, 627.6487, 627.6488, 627.649, 627.6492, 627.6498, 627.6484, 627.6487, F.S.; reenacting such sections as they appeared in Florida Statutes 2001; abrogating the repeal of s. 627.6484, F.S.;