Amendment No. (for drafter's use only)

CHAMBER ACTION

Senate	House
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Representative Llorente offered the following:

Amendment (with title amendment)

Between lines 618 and 619, insert:

Section 15. Section 627.6042, Florida Statutes, is created to read:

627.6042 Dependent coverage.--

(1) If an insurer offers coverage that insures dependent children of the policyholder or certificateholder, the policy must insure a dependent child of the policyholder or certificateholder at least until the end of the calendar year in which the child reaches the age of 25, if the child meets all of the following:

(a) The child is dependent upon the policyholder or certificateholder for support.

(b) The child is living in the household of the policyholder or certificateholder or the child is a full-time or part-time student.

(2) Nothing in this section affects or preempts an insurer's right to medically underwrite or charge the appropriate premium.

Section 16. Section 627.60425, Florida Statutes, is created to read:

627.60425 Binding arbitration requirement limitations.--Notwithstanding any other provision of law, except s. 624.155, an individual, blanket, group life, or group health insurance policy; health maintenance organization subscriber contract; prepaid limited health organization subscriber contract; or any life or health insurance policy or certificate delivered or issued for delivery, including out-of-state group plans pursuant to s. 627.5515 or s. 627.6515 covering residents of this state, to any resident of this state shall not require the submission of disputes between the parties to the policy, contract, or plan to binding arbitration unless the applicant has indicated that the same policy, contract, or plan was offered and rejected and that the binding arbitration provision was fully explained to the applicant and willingly accepted.

Section 17. Section 627.6044, Florida Statutes, is amended to read:

627.6044 Use of a specific methodology for payment of claims.--

(1) Each insurance policy that provides for payment of claims to nonnetwork providers that is less than the payment of

the provider's billed charges to the insured, excluding deductible, coinsurance, and copay amounts, shall:

(a) Provide benefits prior to deductible, coinsurance, and copay amounts for using a nonnetwork provider that are at least equal to the amount that would have been allowed had the insured used a network provider but are not in excess of the actual billed charges.

(b) Where there are multiple network providers in the geographical area in which the services were provided or, if none, the closest geographic area, the carrier may use an averaging method of the contracted amounts but not less than the 80th percentile of all network contracted amounts in the geographic area.

For purposes of this subsection, the term "network providers" means those providers for which an insured will not be responsible for any balance payment for services provided by such provider, excluding deductible, coinsurance, and copay amounts ~~based on a specific methodology, including, but not limited to, usual and customary charges, reasonable and customary charges, or charges based upon the prevailing rate in the community, shall specify the formula or criteria used by the insurer in determining the amount to be paid~~.

(2) Each insurer issuing a policy that provides for payment of claims based on a specific methodology shall provide to an insured, upon her or his written request, an estimate of the amount the insurer will pay for a particular medical procedure or service. The estimate may be in the form of a range of payments or an average payment and may specify that the

estimate is based on the assumption of a particular service code. ~~The insurer may require the insured to provide detailed information regarding the procedure or service to be performed, including the procedure or service code number provided by the health care provider and the health care provider's estimated charge.~~ An insurer that provides an insured with a good faith estimate is not bound by the estimate. However, a pattern of providing estimates that vary significantly from the ultimate insurance payment constitutes a violation of this code.

(3) The method used for determining the payment of claims shall be included in filings made pursuant to s. 627.410(6) and may not be changed unless such change is filed under s. 627.410(6).

(4) Any policy that provides that the insured is responsible for the balance of a claim amount, excluding deductible, coinsurance, and copay amounts, must disclose such feature on the face of the policy or certificate and such feature must be included in any outline of coverage provided to the insured.

Section 18. Subsections (1) and (4) of section 627.6415, Florida Statutes, are amended to read:

627.6415 Coverage for natural-born, adopted, and foster children; children in insured's custodial care.--

(1) A health insurance policy that provides coverage for a member of the family of the insured shall, as to the family member's coverage, provide that the health insurance benefits applicable to children of the insured also apply to an adopted child or a foster child of the insured placed in compliance with chapter 63~~, prior to the child's 18th birthday,~~ from the moment

of placement in the residence of the insured. Except in the case of a foster child, the policy may not exclude coverage for any preexisting condition of the child. In the case of a newborn child, coverage begins at the moment of birth if a written agreement to adopt the child has been entered into by the insured prior to the birth of the child, whether or not the agreement is enforceable. This section does not require coverage for an adopted child who is not ultimately placed in the residence of the insured in compliance with chapter 63.

(4) In order to increase access to postnatal, infant, and pediatric health care for all children placed in court-ordered custody, including foster children, all health insurance policies that provide coverage for a member of the family of the insured shall, as to such family member's coverage, also provide that the health insurance benefits applicable for children shall be payable with respect to a foster child or other child in court-ordered temporary or other custody of the insured~~, prior to the child's 18th birthday~~.

Section 19. Paragraph (a) of subsection (5), paragraph (c) of subsection (6), and paragraphs (b), (c), and (e) of subsection (7) of section 627.6475, Florida Statutes, are amended to read:

627.6475 Individual reinsurance pool.--

(5) ISSUER'S ELECTION TO BECOME A RISK-ASSUMING CARRIER.--

(a) Each health insurance issuer that offers individual health insurance must elect to become a risk-assuming carrier or a reinsuring carrier for purposes of this section. Each such issuer must make ~~an initial election, binding through December 31, 1999. The issuer's initial election must be made no later~~

~~than October 31, 1997. By October 31, 1997, all issuers must file a final election, which is binding for 2 years, from January 1, 1998, through December 31, 1999, after which~~ an election that shall be binding indefinitely or until modified or withdrawn ~~for a period of 5 years~~. The department may permit an issuer to modify its election at any time for good cause shown~~,~~ ~~after a hearing~~.

(6) ELECTION PROCESS TO BECOME A RISK-ASSUMING CARRIER.--

(c) The department shall provide public notice of an issuer's filing a designation of election under this subsection to become a risk-assuming carrier and shall provide at least a 21-day period for public comment upon receipt of such filing ~~prior to making a decision on the election~~. ~~The department shall hold a hearing on the election at the request of the issuer.~~

(7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.--

(b) A reinsuring carrier may reinsure with the program coverage of an eligible individual, subject to each of the following provisions:

1. A reinsuring carrier may reinsure an eligible individual within 90 ~~60~~ days after commencement of the coverage of the eligible individual.

2. The program may not reimburse a participating carrier with respect to the claims of a reinsured eligible individual until the carrier has paid incurred claims of an amount equal to the participating carrier's selected deductible level ~~at least $5,000~~ in a calendar year for benefits covered by the program. ~~In addition, the reinsuring carrier is responsible for 10 percent of the next $50,000 and 5 percent of the next $100,000~~

~~of incurred claims during a calendar year, and the program shall reinsure the remainder.~~

3. The board shall annually adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment may not be less than the annual change in the medical component of the "Commerce Price Index for All Urban Consumers" of the Bureau of Labor Statistics of the United States Department of Labor, unless the board proposes and the department approves a lower adjustment factor.

4. A reinsuring carrier may terminate reinsurance for all reinsured eligible individuals on any plan anniversary.

5. The premium rate charged for reinsurance by the program to a health maintenance organization that is approved by the Secretary of Health and Human Services as a federally qualified health maintenance organization pursuant to 42 U.S.C. s. 300e(c)(2)(A) and that, as such, is subject to requirements that limit the amount of risk that may be ceded to the program, which requirements are more restrictive than subparagraph 2., shall be reduced by an amount equal to that portion of the risk, if any, which exceeds the amount set forth in subparagraph 2., which may not be ceded to the program.

6. The board may consider adjustments to the premium rates charged for reinsurance by the program or carriers that use effective cost-containment measures, including high-cost case management, as defined by the board.

7. A reinsuring carrier shall apply its case-management and claims-handling techniques, including, but not limited to,

utilization review, individual case management, preferred provider provisions, other managed-care provisions, or methods of operation consistently with both reinsured business and nonreinsured business.

(c)1. The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring eligible individuals pursuant to this section. The methodology must include a system for classifying individuals which reflects the types of case characteristics commonly used by carriers in this state. The methodology must provide for the development of basic reinsurance premium rates, which shall be multiplied by the factors set for them in this paragraph to determine the premium rates for the program. The basic reinsurance premium rates shall be established by the board, subject to the approval of the department, and shall be set at levels that reasonably approximate gross premiums charged to eligible individuals for individual health insurance by health insurance issuers. The premium rates set by the board may vary by geographical area, as determined under this section, to reflect differences in cost. ~~An eligible individual may be reinsured for a rate that is five times the rate established by the board.~~

2. The board shall periodically review the methodology established, including the system of classification and any rating factors, to ensure that it reasonably reflects the claims experience of the program. The board may propose changes to the rates that are subject to the approval of the department.

(e)1. Before September ~~March~~ 1 of each calendar year, the board shall determine and report to the department the program

net loss in the individual account for the previous year, including administrative expenses for that year and the incurred losses for that year, taking into account investment income and other appropriate gains and losses.

2. Any net loss in the individual account for the year shall be recouped by assessing the carriers as follows:

a. The operating losses of the program shall be assessed in the following order subject to the specified limitations. The first tier of assessments shall be made against reinsuring carriers in an amount that may not exceed 5 percent of each reinsuring carrier's premiums for individual health insurance. If such assessments have been collected and additional moneys are needed, the board shall make a second tier of assessments in an amount that may not exceed 0.5 percent of each carrier's health benefit plan premiums.

b. Except as provided in paragraph (f), risk-assuming carriers are exempt from all assessments authorized pursuant to this section. The amount paid by a reinsuring carrier for the first tier of assessments shall be credited against any additional assessments made.

c. The board shall equitably assess reinsuring carriers for operating losses of the individual account based on market share. The board shall annually assess each carrier a portion of the operating losses of the individual account. The first tier of assessments shall be determined by multiplying the operating losses by a fraction, the numerator of which equals the reinsuring carrier's earned premium pertaining to direct writings of individual health insurance in the state during the calendar year for which the assessment is levied, and the

denominator of which equals the total of all such premiums earned by reinsuring carriers in the state during that calendar year. The second tier of assessments shall be based on the premiums that all carriers, except risk-assuming carriers, earned on all health benefit plans written in this state. The board may levy interim assessments against reinsuring carriers to ensure the financial ability of the plan to cover claims expenses and administrative expenses paid or estimated to be paid in the operation of the plan for the calendar year prior to the association's anticipated receipt of annual assessments for that calendar year. Any interim assessment is due and payable within 30 days after receipt by a carrier of the interim assessment notice. Interim assessment payments shall be credited against the carrier's annual assessment. Health benefit plan premiums and benefits paid by a carrier that are less than an amount determined by the board to justify the cost of collection may not be considered for purposes of determining assessments.

d. Subject to the approval of the department, the board shall adjust the assessment formula for reinsuring carriers that are approved as federally qualified health maintenance organizations by the Secretary of Health and Human Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent, if any, that restrictions are placed on them which are not imposed on other carriers.

3. Before <u>September</u> ~~March~~ 1 of each year, the board shall determine and file with the department an estimate of the assessments needed to fund the losses incurred by the program in the individual account for the previous calendar year.

4. If the board determines that the assessments needed to fund the losses incurred by the program in the individual account for the previous calendar year will exceed the amount specified in subparagraph 2., the board shall evaluate the operation of the program and report its findings and recommendations to the department in the format established in s. 627.6699(11) for the comparable report for the small employer reinsurance program.

Section 20. Subsection (4) of section 627.651, Florida Statutes, is amended to read:

627.651 Group contracts and plans of self-insurance must meet group requirements.--

(4) This section does not apply to any plan which is established or maintained by an individual employer in accordance with the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, or to a multiple-employer welfare arrangement as defined in s. 624.437(1), except that a multiple-employer welfare arrangement shall comply with ss. 627.419, 627.657, 627.6575, 627.6578, 627.6579, 627.6612, 627.66121, 627.66122, 627.6615, 627.6616, and 627.662(8)~~(7)~~. This subsection does not allow an authorized insurer to issue a group health insurance policy or certificate which does not comply with this part.

Section 21. Section 627.662, Florida Statutes, is amended to read:

627.662 Other provisions applicable.--The following provisions apply to group health insurance, blanket health insurance, and franchise health insurance:

(1) Section 627.569, relating to use of dividends, refunds, rate reductions, commissions, and service fees.

(2) Section 627.602(1)(f) and (2), relating to identification numbers and statement of deductible provisions.

(3) Section 627.6044, relating to the use of specific methodology for payment of claims.

(4)~~(3)~~ Section 627.635, relating to excess insurance.

(5)~~(4)~~ Section 627.638, relating to direct payment for hospital or medical services.

(6)~~(5)~~ Section 627.640, relating to filing and classification of rates.

(7)~~(6)~~ Section 627.613, relating to timely payment of claims, or s. 627.6131, relating to payment of claims, whichever is applicable.

(8)~~(7)~~ Section 627.645(1), relating to denial of claims.

(9)~~(8)~~ Section 627.6471, relating to preferred provider organizations.

(10)~~(9)~~ Section 627.6472, relating to exclusive provider organizations.

(11)~~(10)~~ Section 627.6473, relating to combined preferred provider and exclusive provider policies.

(12)~~(11)~~ Section 627.6474, relating to provider contracts.

Section 22. Section 627.911, Florida Statutes, is amended to read:

627.911 Scope of this part.--Any insurer or health maintenance organization transacting insurance in this state shall report information as required by this part.

Section 23. Section 627.9175, Florida Statutes, is amended to read:

627.9175 Reports of information on health insurance.--

(1) Each authorized health insurer or health maintenance organization shall submit annually to the department information concerning ~~as to policies of individual~~ health insurance coverage being issued or currently in force in this state. The information shall include information related to premium, number of policies, and covered lives for such policies and other information necessary to analyze trends in enrollment, premiums, and claim costs.

(2) The required information shall be broken down by market segment, to include:

(a) Health insurance issuer, company, contact person, or agent.

(b) All health insurance products issued or in force, including, but not limited to:

1. Direct premiums earned.

2. Direct losses incurred.

3. Direct premiums earned for new business issued during the year.

4. Number of policies.

5. Number of certificates.

6. Number of total covered lives.

~~(a) A summary of typical benefits, exclusions, and limitations for each type of individual policy form currently being issued in the state. The summary shall include, as appropriate:~~

~~1. The deductible amount;~~

~~2. The coinsurance percentage;~~

~~3. The out-of-pocket maximum;~~

~~4. Outpatient benefits;~~
~~5. Inpatient benefits; and~~
~~6. Any exclusions for preexisting conditions.~~

~~The department shall determine other appropriate benefits, exclusions, and limitations to be reported for inclusion in the consumer's guide published pursuant to this section.~~

~~(b) A schedule of rates for each type of individual policy form reflecting typical variations by age, sex, region of the state, or any other applicable factor which is in use and is determined to be appropriate for inclusion by the department.~~

~~The department shall provide by rule a uniform format for the submission of this information in order to allow for meaningful comparisons of premiums charged for comparable benefits.~~

(3) The department may adopt rules to administer this section, including, but not limited to, rules governing compliance and provisions implementing electronic methodologies for use in furnishing such records or documents. The commission may by rule specify a uniform format for the submission of this information in order to allow for meaningful comparisons ~~shall publish annually a consumer's guide which summarizes and compares the information required to be reported under this subsection~~.

~~(2)(a) Every insurer transacting health insurance in this state shall report annually to the department, not later than April 1, information relating to any measure the insurer has implemented or proposes to implement during the next calendar year for the purpose of containing health insurance costs or~~

~~cost increases. The reports shall identify each measure and the forms to which the measure is applied, shall provide an explanation as to how the measure is used, and shall provide an estimate of the cost effect of the measure.~~

~~(b) The department shall promulgate forms to be used by insurers in reporting information pursuant to this subsection and shall utilize such forms to analyze the effects of health care cost containment programs used by health insurers in this state.~~

~~(c) The department shall analyze the data reported under this subsection and shall annually make available to the public a summary of its findings as to the types of cost containment measures reported and the estimated effect of these measures.~~

Section 24. Section 627.9403, Florida Statutes, is amended to read:

627.9403 Scope.--The provisions of this part shall apply to long-term care insurance policies delivered or issued for delivery in this state, and to policies delivered or issued for delivery outside this state to the extent provided in s. 627.9406, by an insurer, a fraternal benefit society as defined in s. 632.601, a health maintenance organization as defined in s. 641.19, a prepaid health clinic as defined in s. 641.402, or a multiple-employer welfare arrangement as defined in s. 624.437. A policy which is advertised, marketed, or offered as a long-term care policy and as a Medicare supplement policy shall meet the requirements of this part and the requirements of ss. 627.671-627.675 and, to the extent of a conflict, be subject to the requirement that is more favorable to the policyholder or certificateholder. The provisions of this part shall not apply

to a continuing care contract issued pursuant to chapter 651 and shall not apply to guaranteed renewable policies issued prior to October 1, 1988. Any limited benefit policy that limits coverage to care in a nursing home or to one or more lower levels of care required or authorized to be provided by this part or by department rule must meet all requirements of this part that apply to long-term care insurance policies, except ss. 627.9407(3)(c) and (d), (9), (10)(f), and (12) and 627.94073(2). ~~If the limited benefit policy does not provide coverage for care in a nursing home, but does provide coverage for one or more lower levels of care, the policy shall also be exempt from the requirements of s. 627.9407(3)(d).~~

Section 25. Paragraph (b) of subsection (1) of section 641.185, Florida Statutes, is amended to read:

641.185 Health maintenance organization subscriber protections.--

(1) With respect to the provisions of this part and part III, the principles expressed in the following statements shall serve as standards to be followed by the Department of Insurance and the Agency for Health Care Administration in exercising their powers and duties, in exercising administrative discretion, in administrative interpretations of the law, in enforcing its provisions, and in adopting rules:

(b) A health maintenance organization subscriber should receive quality health care from a broad panel of providers, including referrals, preventive care pursuant to s. 641.402(1), emergency screening and services pursuant to ss. 641.31(13)~~(12)~~ and 641.513, and second opinions pursuant to s. 641.51.

Section 26. Section 641.3101, Florida Statutes, is amended to read:

641.3101 Additional contract contents.--

(1) A health maintenance contract may contain additional provisions not inconsistent with this part which are:

(a)~~(1)~~ Necessary, on account of the manner in which the organization is constituted or operated, in order to state the rights and obligations of the parties to the contract; or

(b)~~(2)~~ Desired by the organization and neither prohibited by law nor in conflict with any provisions required to be included therein.

(2) A health maintenance contract that uses a specific methodology for payment of claims shall comply with s. 627.6044.

Section 27. Section 641.31025, Florida Statutes, is created to read:

641.31025 Specific reasons for denial of coverage.--The denial of an application for a health maintenance organization contract must be accompanied by the specific reasons for the denial, including, but not limited to, the specific underwriting reasons, if applicable.

Section 28. Subsection (4) of section 627.651, Florida Statutes, is amended to read:

627.651 Group contracts and plans of self-insurance must meet group requirements.--

(4) This section does not apply to any plan which is established or maintained by an individual employer in accordance with the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, or to a multiple-employer welfare arrangement as defined in s. 624.437(1), except that a multiple-

employer welfare arrangement shall comply with ss. 627.419, 627.657, 627.6575, 627.6578, 627.6579, 627.6612, 627.66121, 627.66122, 627.6615, 627.6616, and 627.662(8)~~(7)~~. This subsection does not allow an authorized insurer to issue a group health insurance policy or certificate which does not comply with this part.

Section 29. Subsection (1) of section 641.2018, Florida Statutes, is amended to read:

641.2018 Limited coverage for home health care authorized.--

(1) Notwithstanding other provisions of this chapter, a health maintenance organization may issue a contract that limits coverage to home health care services only. The organization and the contract shall be subject to all of the requirements of this part that do not require or otherwise apply to specific benefits other than home care services. To this extent, all of the requirements of this part apply to any organization or contract that limits coverage to home care services, except the requirements for providing comprehensive health care services as provided in ss. 641.19(4), (12), and (13), and 641.31(1), except ss. 641.31~~(9),~~ (13)~~(12)~~, ~~(17),~~ (18), (19), (20), (21), and (24) and 641.31095.

Section 30. Section 641.3107, Florida Statutes, is amended to read:

641.3107 Delivery of contract.--Unless delivered upon execution or issuance, a health maintenance contract, certificate of coverage, or member handbook shall be mailed or delivered to the subscriber or, in the case of a group health maintenance contract, to the employer or other person who will

hold the contract on behalf of the subscriber group within 10 working days from approval of the enrollment form by the health maintenance organization or by the effective date of coverage, whichever occurs first. However, if the employer or other person who will hold the contract on behalf of the subscriber group requires retroactive enrollment of a subscriber, the organization shall deliver the contract, certificate, or member handbook to the subscriber within 10 days after receiving notice from the employer of the retroactive enrollment. This section does not apply to the delivery of those contracts specified in s. 641.31(14)~~(13)~~.

Section 31. Subsection (4) of section 641.513, Florida Statutes, is amended to read:

641.513 Requirements for providing emergency services and care.--

(4) A subscriber may be charged a reasonable copayment, as provided in s. 641.31(13)~~(12)~~, for the use of an emergency room.

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

Remove line(s) 66, and insert:

to subscribers; creating s. 627.6042, F.S.; requiring policies of insurers offering coverage of dependent children to maintain such coverage until a child reaches age 25, under certain circumstances; providing application; creating s. 627.60425, F.S.; providing limitations on certain binding arbitration requirements; amending s. 627.6044, F.S.; providing for payment of claims to nonnetwork providers under specified conditions; providing a definition; requiring the method used for

543 determining payment of claims to be included in filings;
544 providing for disclosure; amending s. 627.6415, F.S.; deleting
545 an 18th birthday age limitation on application of certain
546 dependent coverage requirements; amending s. 627.6475, F.S.;
547 revising risk-assuming carrier election requirements and
548 procedures; revising certain criteria and limitations under the
549 individual health reinsurance program; amending s. 627.651,
550 F.S.; correcting a cross reference; amending s. 627.662, F.S.;
551 revising a list of provisions applicable to group, blanket, or
552 franchise health insurance to include use of specific
553 methodology for payment of claims provisions; amending ss.
554 627.911 and 627.9175, F.S.; applying certain information
555 reporting requirements to health maintenance organizations;
556 revising health insurance information requirements and criteria;
557 authorizing the department to adopt rules; deleting an annual
558 report requirement; amending s. 627.9403, F.S.; deleting an
559 exemption for limited benefit policies from a long-term care
560 insurance restriction relating to nursing home care; amending s.
561 641.185, F.S.; correcting a cross reference; amending s.
562 641.3101, F.S.; providing a compliance requirement for health
563 maintenance contracts using a specific payment of claims
564 methodology; creating s. 641.31025, F.S.; requiring specific
565 reasons for denial of coverage under a health maintenance
566 organization contract; amending ss. 627.651, 641.2018, 641.3107,
567 and 641.513, F.S.; correcting cross references; providing
568 severability; providing an
569