SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/SB 1796

SPONSOR: Committee on Banking and Insurance and Senator Campbell

SUBJECT: Health Insurance

DATE: April 24, 2003 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Emrich	Deffenbaugh	BI	Favorable/CS
2.			HC	
3.			JU	
4.			AGG	
5.			AP	
6.				

I. Summary:

CS/SB 1796 makes substantial changes relating to health insurance coverage in Florida and provides for the following:

- Requires hospitals to have an Internet website that lists charges and codes and a description of services of the top 100 diagnosis-related groups discharged from the hospital for that year, and the top 100 outpatient procedures performed.
- Requires hospitals, upon request, to furnish a patient a reasonable estimate of charges.
- Requires hospitals to make available to a payor the records that are necessary to verify the accuracy of the patient's bill.
- Extends the term of the pilot project for health flex plans for an additional 4 years, from July 1, 2004, to July 1, 2008.
- Allows health insurers to transact reinsurance for the medical and lost wages benefits under a workers' compensation insurance policy.
- Prohibits mandatory arbitration clauses in life, health and disability insurance, managed care and prepaid contracts unless the same policy was offered and rejected without arbitration and that the binding arbitration provision was fully explained.
- Allows large group health insurance policies and HMO contracts covering a group of 51 or more persons to be exempt from any law that restricts deductibles, coinsurance, copayments, or annual or lifetime maximum benefits.
- Requires health insurance policies and HMO contracts that provide coverage to non-network providers which is less than the payment of the provider's billed charges, to provide benefits which are at least equal to the amount that would have been allowed had the insured used a network provider.

- Allows insurers issuing individual coverage on a guarantee-issue basis to HIPAA-eligible individuals whose most recent coverage was in another state, to impose a surcharge as would be permitted in that state.
- Requires HMOs to explain denial of coverage under individual contracts.
- Requires all lines of health coverage to utilize the same definition of eligible dependents, including adopted and foster children.
- Modifies individual carrier reinsurance pool practices and procedures.
- Provides consistent extension of benefit requirements such that the prior insurer is responsible for medical expenses for certain persons with ongoing treatment.
- Extends from 30 to 63 days the time for certain employees terminated from a group health plan to apply for continuation of coverage.
- Amends small group coverage provisions to tighten definitions of employee and employer; and modifies small group carrier modified community rating requirements and reinsurance pool practices and procedures.
- Requires small employers to annually provide information on at least three different health benefit plans for their employees
- Requires insurers and HMOs to offer coverage for speech, language, swallowing and hearing disorders.
- Modifies annual carrier reporting to include HMO's and provides for collection of information regarding various health market segments.
- Removes a limitation affecting nursing home benefit policies to allow insurers to offer "nursing home only" coverage for less than the current two-year minimum.
- Subjects HMOs to the same requirements as insurers when replacing coverage.

This bill substantially amends the following sections of the Florida Statutes: 395.301, 408.909, 624.406, 624.603, 627.410, 627.6044, 627.6415, 627.6475, 627.651, 627.6487, 627.6561, 627.662, 627.667, 627.6692, 627.6699, 627.911, 627.9175, 627.9403, 641.31, 641.3101, 641.2018, and 641.3107. The bill creates the following sections of the Florida Statutes: 627.6042, 641.31025, 641.31075, 627.6410, and 627.66912.

II. Present Situation:

Mandatory Arbitration Clauses

Arbitration is an alternative dispute resolution (ADR) technique that provides an alternative to litigation and is intended to be a more efficient and cost-effective method of resolving rate disputes than litigation. Mandatory arbitration clauses require one party to agree to another's pre-dispute arbitration provision. Arbitration is different from mediation in that mediation achieves an end to conflict through agreement of the parties while arbitration is the equivalent of a "judge for hire," with the difference being that the parties create the rules by which the "trial" or in this case, arbitration, will be carried out.

Some organizations are beginning to address consumer concerns relating to mandatory arbitration clauses. For example, recently the American Arbitration Association (AAA) implemented a cap on consumers' arbitration costs at $375, requiring businesses to pay the remainder. In addition, the AAA will no longer enforce pre-dispute arbitration clauses in health

insurance contracts. However, even with the AAA's prohibition, businesses can easily switch from using the AAA to other non-AAA arbitration providers.

Along with 34 other states, Florida has adopted the Uniform Arbitration Act, which is codified under Chapter 682, F.S., and cited as the Florida Arbitration Code (Code). Parties can stipulate in their written agreement or contract to submit to arbitrating any controversy existing between them. At the arbitration hearing, the parties may present evidence, be represented by counsel, and cross-examine witnesses. The majority of arbitrators may determine any question and render a final award. Upon application by a party to the arbitration, the court shall confirm the award. Agreements to arbitrate are generally favored by the courts; however, the jurisdiction of the courts cannot be invoked to compel arbitration unless an agreement to arbitrate complies with the Florida Arbitration Code. See, *Knight v. H. S. Equities, Inc.*, 280 So. 2d 456, 459 (Fla. 4th DCA 1973).

Concerns about Mandatory Arbitration Clauses

Typically, a consumer and an insurer do not have equal bargaining power when negotiating contract provisions. Consumers may not even be aware that they are subject to the mandatory arbitration provision until a dispute arises with their insurer. Objections to mandatory arbitration clauses include:

- Consumers are precluded from seeking a remedy against the insurer because the upfront cost of the arbitration process is too expensive, or consumers abandon the action due to unforeseen costs.

- Insurers are immunized from liability because consumers are deterred from bringing claims to arbitration due to the high costs.

- Written opinions of arbitration proceedings are rare so arbitrators are insulated from public scrutiny, as most clauses require that the arbitration proceedings be kept confidential. Subsequently, as no precedent is established, insurers have an advantage over consumers due to the fact such entities can often anticipate how certain issues will be decided given their historical experience in participating in arbitration.

- Decisions may only be overturned if there is an applicable contract defense, or "manifest disregard" of the law. This is a difficult standard to meet where there is no written opinion of the arbitration proceedings. To vacate a decision, typically, a party must show:

    - A serious conflict of interest on the part of neutral arbitrator.
    - The award wasn't "final."
    - The decision covered a subject outside the scope of the agreement. (or)
    - The decision provided an amount or kind of relief that the arbitrator was expressly precluded from awarding.

Advantages of Mandatory Arbitration Clauses

Typically, an arbitration hearing takes three to five months to schedule while civil litigation generally takes one to two years to complete. By avoiding the judicial system, many costs are eliminated. In addition, the advantages of arbitration typically include the following:

- The process is less expensive than litigation.
- Parties can choose their arbitrator, whereas they cannot choose their judge in litigation.
- Parties can set some of their own rules for the conduct of the hearing.
- Arbitration is faster than litigation in resolving disputes.
- Arbitration can be done at times more convenient to the parties.

Individual Health Insurance Reinsurance Pool

In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA), which requires insurers issuing individual health insurance policies to guarantee the issuance of coverage to persons who previously were covered for at least 18 months and met other eligibility criteria. HIPAA allows each state the option to enact and enforce the federal provisions or fall back to federal enforcement. The act also allows each state to craft alternative methods of guaranteeing availability of coverage.

In 1997, Florida enacted legislation to conform state law to HIPAA, which included an alternative mechanism that was deemed to be acceptable by the federal Health Care Finance Administration (HCFA).[1] To be eligible, an individual must have had prior creditable coverage for at least 18 months, without a break in coverage of more than 63 days, and not be eligible for any other group coverage, Medicare or Medicaid.

The Florida law provides two mechanisms for guaranteeing access to individual coverage to persons who lose their eligibility for prior coverage. One method requires the insurance company or health maintenance organization (HMO) that issued the group health plan to offer an individual conversion policy to persons who lose their eligibility for group coverage. At least two conversion policy options must be offered, one of which must be the standard benefit plan that Florida law requires small group carriers to offer small employers. Florida's second method of guaranteeing access to individual coverage is allowing eligible individuals to purchase an individual policy from any insurance company or HMO issuing individual coverage in the state. The policy must be offered on a guaranteed-issue basis, regardless of the health condition of the individual. The insurer or HMO must offer each of their two most popular policy forms, based on statewide premium volume. This method applies to eligible persons who are not entitled to a conversion policy under ss. 627.6675 or 641.3921, F.S.

Insurers and HMOs which are required to provide individual health insurance on a guarantee-issue basis to HIPPA-eligible individual may participate in a reinsurance pool established by s. 627.6475, F.S., to help subsidize the costs of high-risk individuals. The law requires such insurers to elect to become a risk–assuming carrier or a reinsuring carrier for the purposes of this section.[2] Such election must be made binding through December 31, 1999, and the initial election, must be made no later than October 31, 1997. By October 31, 1997, all issuers must file

[1] Chapter 97-179, L.O.F., creating s. 627.6487, F.S.
[2] Section 627.6475(5)(a), F.S.,

a final election which is binding for two years, from January 1, 1998 through December 31, 1999, after which an election shall be for five years, and the Office of Insurance Regulation[3] may permit an issuer to modify its election at any time for good cause shown, after a hearing.

Under s. 627.6475(6)(c), F.S., the department (now OIR) must provide public notice of an issuer's designation of election under this subsection and requires the department to provide at least a 21-day period for public comment before making a decision on the election. In addition, the department (OIR) is required to hold a hearing before permitting an issuer to modify its election. Under s. 627.6475(7)(b)1., F.S., it provides that a reinsuring carrier may reinsure an eligible individual within 60 days after the commencement of the coverage of the eligible individual.

Group, Blanket, and Franchise Health Insurance Policies

Under present law, individual health insurance policies that provide for payment of claims 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, must specify the formula or criteria used by the insurer in determining the amount to be paid.[4] In addition, individual health insurers issuing a policy that provides for the payment of claims based on a specific methodology must provide to in insured, upon written request, an estimate of the amount the insurer will pay for a particular medical procedure or service and specifies the criteria for such estimate.

Extension of Benefits

Section 627.667, F.S., requires that each group, blanket, and franchise health insurance policy provide for a specified timeframe for the extension of health insurance benefits for a person who is totally disabled at the date of discontinuance of the policy, regardless of whether replacement coverage is obtained. The law also provides that these requirements apply to holders of group certificates which are renewed, delivered, or issued for delivery to residents of this state under group policies effectuated or delivered outside this state, unless a succeeding carrier under a group policy has agreed to assume liability for the benefits.

Florida Health Insurance Coverage Continuation Act

Federal law requires that all groups with 20 or more employees must allow individuals who lose coverage as a result of a qualifying event to continue as an insured member of the group for 18 to 36 months. Employers are responsible for notifying their employees or their dependents of this right. This coverage is referred to as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under COBRA, an eligible employee has 63 days after notification to make a written election to continue health care coverage.

[3] Effective January 7, 2003, the Department of Insurance was transferred to the Department of Financial Services and to the Office of Insurance Regulation (ch. 2002-404, L.O.F.). This session, CS/CS/SB 1712 makes conforming changes to the Florida Statutes.
[4] Section 627.6044, F.S.

Current Florida law (s. 627.6692, F.S.) extends similar protection to groups with *less* than 20 employees under the Florida Health Insurance Coverage Continuation Act ("Mini-COBRA"). Under this provision, an eligible employee has 30 days after notification to make a written election to continue health care coverage.

Small Employee Health Care Access Act

In 1992, as a result of a lack of access to health care coverage for small employers and their employees, the Florida Legislature enacted a series of laws entitled the Employers Health Care Access Act (Act).[5] The purpose and intent of the act was to promote the availability of health insurance coverage to small employers regardless of their claims experience or their employees' health status.

"Eligible employee"

The Act (s. 627.6699(3)(h), F.S.) provides a definition of "eligible employee" as an employee who works full time, having a normal workweek of 25 or more hours, and who has met any applicable waiting-period requirements or other requirements of the Act. The definition specifically identifies certain types of business entities. In June 2002, Florida Treasurer and Insurance Commissioner Tom Gallagher assembled a Small Employer Benefit Plan Committee (committee). The committee was comprised of representatives of carriers, agents, employers, and employees. Their task was to re-design the Standard and Basic health insurance plans to better meet market needs, to explore options, and to offer recommendations making health plans available to small businesses to be more accessible and affordable. Among the committee recommendations included a provision that the statutory definition of a small group employee be modified to include the phrase an employee, other than owner, who works full time, having a normal workweek of 25 or more hours and is "paid wages or a salary at least equal to federal minimum hourly wage applicable to such employee."

"Modified community rating"

Community Rating is a method of developing health insurance rates taking into account the medical and hospital costs in the entire community or area to be covered. Individual characteristics of the insured employer are *not* considered. Modified community rating is a variation on community rating in that under modified community rating, small employer carriers are permitted to use the separate rating factors for age, gender, family composition, tobacco usage, and geographic location in developing their premiums.

Section 627.6699(3)(n), F.S, defines "modified community rating" to allow insurers to separate the experience of small employer groups with fewer than two employees (i.e., one-life cases) from the experience of small employer groups with 2-50 eligible employees for the purpose of determining an alternative modified community rating. Adjustments are permitted for: claims experience, health status, or duration of coverage pursuant to subparagraph (6)(b)5., F.S., and administrative and acquisition expenses as permitted under subparagraph (6)(b)5., F.S.

[5] Section 627.6699, F.S.

“Self-employed individual”

Section 627.6699(3)(u), F.S., defines “self-employed individual” to mean an individual or sole proprietor who derives his or her income from a trade or business which results in taxable income as indicated on IRS form 1040, schedule C or F, and which generated taxable income in one of the 2 previous years. A recognized problem in the small employer group market is that there is some abuse of the availability of guaranteed issue policies, especially by one-life groups. Individuals who are unable to obtain coverage elsewhere are alleged to claim (illegitimately) to be a sole proprietor. As a means of ensuring the legitimacy of these groups as employers, the statute indicates that the business must result in taxable income “as indicated on Internal Revenue Form (IRS) Form 1040 schedule C [non-farm income] or F [farm income], and which has generated taxable income in one of the 2 previous years." However, Schedule C and F do not use the words "taxable income." Schedule C uses "gross receipts or sales" to describe total operating revenues and "gross income" to mean gross receipts plus other income minus cost of goods sold; while, schedule F uses "gross income" to mean all revenue.

As a result of the above, the committee recommended the revision of the definition to read: “self-employed individual" means an individual or sole proprietor who derives his or her income from a trade or business carried on by the individual or sole proprietor which necessitates the filing of (1) Federal Income Tax Forms, with supporting schedules and accompanying income reporting forms or (2) Federal Income Tax Extensions of Time To File Forms with the Internal IRS for the most recent tax year.

Availability of Coverage for One-Life Groups

Employers with 2-50 employees are entitled to guaranteed-issuance of coverage on a year-round basis. However, “one-life groups” (employers with one employee, sole proprietors, and self-employed individuals) are limited to a one-month open enrollment period in August of each year, with coverage beginning on October 1. Such one-life groups are not entitled to guaranteed-issuance of a small group policy at any other time, such as when coverage under a current small group policy is lost due to a carrier or health maintenance organization exercising the provisions of s. 627.6571(3)(b), or s. 641.31074(3)(b), F.S., by discontinuing offering all health insurance or health coverage in the small-group market or the large group market, or both. However, such an individual may be entitled to an individual conversion policy or to guaranteed issuance of an individual policy as a HIPAA eligible individual.

Adjustment of Rating Factors

Section 627.6699(6)(b)5., F.S., authorizes small group carriers to adjust a small employer’s rate by plus or minus 15 percent, based on health status, claims experience, or duration of coverage. The renewal premium can be adjusted up to 10 percent annually (up to the total 15 percent limit) of the carrier’s approved rate, based on these additional factors.

Small Employer Health Reinsurance Program

The Florida Health Reinsurance Program (program) was established in 1992 as a part of small group insurance reform. Its purpose was to provide a mechanism for small group carriers, who

are required to provide coverage on a guaranteed issue basis, to transfer selected risks to a pool comprised of other small group carriers. Participation in the program is voluntary. The submitting carrier pays a significant extra premium beyond that collected from the employer. Section 627.6699(11)(f)10., F.S., provides that the program has the general powers and authority as other insurance companies and health maintenance organizations licensed to transact business, except for the power to issue health benefit plans to groups or individuals. In addition to other authority granted the program, the program has the authority to increase the $5,000 deductible reinsurance requirement to adjust for the effects of inflation.

Current law also requires that, with respect to a standard and basic health care plan, the program must reinsure the level of coverage provided and with respect to any other plan must reinsure the coverage up to, but not exceeding, the level of coverage provided under the standard and basic health plan.

Current law also prohibits the Florida Health Reinsurance Program from reimbursing a participating carrier with respect to the claims of a reinsured employee or dependent until the carrier has paid incurred claims of 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 must reinsure the remainder.

Present law directs the board, as part of the plan of operation, to establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology must provide for the development of basic reinsurance premium rates, which must be multiplied by the factors set for them to determine the premium rates for the program. The multiplying factors must be established as follows: the entire group may be reinsured for a rate that is 1.5 times the rate established by the board; and an eligible employee or dependent may be reinsured for a rate that is 5 times the rate established by the board.

Current law requires that before March 1 of each calendar year, the board must determine and report to the OIR the program net loss for the previous year, including administrative expenses for that year, and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. Also, current law requires that before March 1 of each year, the board must determine and file with the department an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.

Current law requires that if the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified by statute, the board must evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the OIR within 90 days following the end of the calendar year in which the losses were incurred; and provides that if the board should fail to submit the report within the 90 days, the OIR may evaluate the operation and implement such amendments to the plan of operation as the OIR deems is necessary.

Small Employer Carrier's Election to Become a Risk-Assuming Carrier or a Reinsuring Carrier

Section 627.6699(9)(a), F.S., requires each small employer carrier to elect to become either a risk-assuming carrier or a reinsuring carrier by no later than October 31, 1992; and that such election is binding through January 1, 1994. In addition, such carriers are required to file, by October 31, 1993, a final election, which is binding for two years, from January 1, 1994, through December 31, 1995, after which the election is binding for a period of five years. In addition, subsequent elections are binding for two years after the date of approval of the forms and rates, and any subsequent designation is binding for five years. However, the OIR may permit a carrier to modify its election at any time for good cause shown, after a hearing.

Section 627.6699(10)(d), F.S., requires that the OIR provide a public notice of a small employer carrier's designation of election to become a risk-assuming carrier and must provide a 21-day period for public comment prior to making a decision on the election. The OIR is also required to hold a hearing on the election at the request of the carrier.

Reports of Information on Health Insurance

Section 627.9175, F.S., requires specified information to be contained in reports submitted by the insurers to the OIR on an annual basis. In addition, the subsection:

- Authorizes the Commission[6] to determine other appropriate benefits, exclusions, and limitations to be reported for inclusion in the consumer's guide published pursuant to this section;
- Requires submission by the carriers of schedule of rates subject to specific criteria; and
- Grants the Commission specific rulemaking authority.

Long-Term Care Insurance Policies

Section 627.9403, F.S., regulates long-term care insurance policies. In part, the current law provides an exemption for limited benefit policies which do not provide coverage for care in a nursing home, but does provide coverage for one or more levels of care.

Extension of Benefits

Section 641.3111, F.S., provides that every group health maintenance contract must provide that termination of the contract without prejudice to any continuous loss which commenced while the contract was in force, but that any extension of benefits beyond the period the contract was in force may be predicated upon the continuous total disability of the subscriber and may be limited to payment for the treatment of a specific accident or illness incurred while the subscriber was a member.

Health Flex Plan Pilot Program

The Health Flex Plan pilot program was created by the Florida Legislature during the 2002 Session. The pilot program permits entities to develop alternative health care coverage plans,

[6] Refers to the Financial Services Commission.

referred to as health flex plans, for uninsured persons who have a family income equal to or less than 200 percent of the federal poverty level. The goal of the program is to improve the affordability and availability of heath care coverage for low-income Floridians who are unable to obtain health coverage, by encouraging the development of alternative approaches to traditional health insurance that still provide basic and preventative health care services.

A health flex plan is permitted to take measures that are impermissible for regular providers of health care coverage. The health flex plan may limit or exclude benefits that are otherwise required by law for insurers offering coverage in Florida (s. 408.909(3), F.S.). The plan may also cap the total amount of claims paid per year per enrollee, and may limit the number of enrollees (s. 408.909(3), F.S.).

A health flex plan may be developed and implemented by health insurers, HMOs, health care provider-sponsored organizations, local governments, heath care districts, or other community-based organizations (s. 408.909(2), F.S.). Current law specifies that the Agency for Health Care Administration must develop guidelines for reviewing health flex plan applications and must disapprove or withdraw approval of plans that do not meet minimum standards for quality of care and access to care. The Department of Insurance[7] must also develop guidelines for reviewing health flex plan applications and must disapprove or withdraw approval of plans that:

- Contain 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;
- Provide benefits that are unreasonable in relation to the premium charged, contain 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
- Cannot demonstrate that the health flex plan is financially sound and that the applicant has the ability to underwrite or finance the benefits provided. (s. 408.909(3), F.S.)

The statute attempts to target the pilot programs in areas of the state that have the greatest number of the uninsured poor. The statute authorizes the Agency for Health Care Administration and the Department of Insurance to approve health flex plans in the three areas of the state having the highest number of uninsured persons (s. 408.909(3), F.S.). These areas are District 1 (Bay, Escambia, Gadsden, Leon, Okaloosa, and Santa Rosa Counties), District 16 (Broward County), and District 17 (Dade County). The statute also authorizes the issuance of health flex plans in Indian River County.

Eligibility to enroll in a health flex plan is limited to Florida residents who are under 65 years of age and have a family income equal to or less than 200 percent of the federal poverty level. (s. 408.909(5), F.S.). The enrollee must not be covered by a private insurance policy, must not be eligible for coverage through a public health insurance program such as Medicare, Medicaid, or Kidcare, and must not have been covered at any time during the past 6 months. The enrollee

[7] Legislation in 2002 (ch. 2004-404, L.O.F.), effective January 7, 2003, transferred the Department of Insurance to the Department of Financial Services and to the Financial Services Commission and its Office of Insurance Regulation. Conforming changes to the statutes have not yet been enacted, which are addressed in CS/SB 1712 by the Committee on Banking and Insurance.

must also have applied for health care coverage through an approved plan and agree to make any payments required for participation, including periodic payments or payments due at the time health care services are provided.

The AHCA must evaluate the pilot program and its effects on the entities that seek approval as health flex plans, as well as the number of enrollees and the scope of the coverage afforded. (s. 408.909(9), F.S.). The AHCA and the Department of Insurance are mandated to assess the health flex plans and their potential applicability in other settings. By January 1, 2004, the AHCA and the department are to submit their findings in a report to the Governor, President of the Senate, and the Speaker of the House of Representatives. Each approved health flex plan is required to maintain records of enrollment, finances, and claims experience to enable the agency and the department to monitor the plan (s. 408.909(7), F.S.). The statute authorizing the creating of the health flex pilot program expires on July 1, 2004.

The Agency for Health Care Administration reports that to date, only one health flex plan has been approved, in Dade County. The agency has received only one additional application from Dade County. No other applications have been received by the agency, and no health flex programs have been created other than the one currently in existence in Dade County.

Other applicable current law provisions are noted under the appropriate sections below.

III. Effect of Proposed Changes:

Section 1. Amends. s. 395.301, F.S., as follows:

- Requires hospitals not operated by the state to have an Internet website that lists charges and codes and a description of services of the top 100 diagnosis-related groups discharged from the hospital for that year, and the top 100 outpatient procedures performed.
- Requires hospitals, upon request, to furnish a patient a reasonable estimate of charges.
- Requires hospitals not operated by the state to make available to a payor the records that are necessary to verify the accuracy of the patient's bill. The hospital may not charge for making such records available, but may charge its usual charge for copying.

Section 2. Amends. s. 408.909, F.S., to extend the term of the pilot project for health flex plans for an additional 4 years, from July 1, 2004, to July 1, 2008. It also amends the definition of health flex plans to make the plans available to an enrollee "who purchases the coverage directly from the plan or through a small business purchasing arrangement sponsored by a local government." The modified definition clarifies the ways in which a person can purchase health flex plan benefits by explicitly stating that coverage can be purchased via a small business purchasing arrangement.

The bill clarifies that the term of coverage may be limited under a health flex plan. Health care insurance plans generally last for only a limited period of time, and the Agency for Health Care Administration states that it is currently permitting health flex plans to last for a limited term.

Section 3. Amends s. 624.406, F.S., to allow health insurers to transact reinsurance for the medical and lost wages benefits under a workers' compensation insurance policy.

Section 4. Amends s. 624.603, F.S., to change the definition of health insurance, which currently is defined as not including workers' compensation insurance. As amended, the term health insurance would include workers' compensation to the extent provided in s. 624.406, F.S., as amended by Section 3 of the bill.

Section 5. Amends s. 627.410, F.S., to allow large group health insurance policies covering a group of 51 or more persons to be exempt from any law that restricts deductibles, coinsurance, copayments, or annual or lifetime maximum benefits. A similar exemption was enacted in 2002 for small employer policies issued to employers with 1 to 51 employees (s. 627.6699(15), F.S.; ch. 2002-396, L.O.F.). This would now appear to cover all group health insurance policies, to effectively supercede any mandatory benefit law that would require a particular benefit to be exempt from a deductible or copayment requirement, or which would require a specific lifetime or annual maximum benefit for any particular benefit. The bill also applies this to large group HMO contracts in Section 21.

Section 6. Creates s. 627.6042, F.S., to require individual health insurance policies that cover dependent children, to cover such dependent children until age 25, if the child is living at the home of the policyholder or is a full-time or part-time student. This is the same requirement that currently applies to group health insurance policies in s. 627.6562, F.S..

Section 7. Creates s. 627.60425, F.S., to prohibit all health, life, and HMO policies and contract s from requiring the submission of disputes to binding arbitration unless the applicant has indicated that the same policy was offered and rejected without arbitration and that the binding arbitration provision was fully explained and willingly accepted.

Section 8. Amends. s. 627.6044, F.S., to require individual health insurance policies that provide coverage to non-network providers which is less than the payment of the provider's billed charges, to provide benefits which are at least equal to the amount that would have been allowed had the insured used a network provider. If there are multiple network providers, the carrier may use an averaging method of the contracted amounts, but not less the 80th percentile of all network contracted amounts. "Network providers" means those providers for which an insured is not responsible for any balance payment for services.

The method used for determining the payment of claims must be included in health insurance rate filings and may not be changed unless pursuant to a rate filing. Any policy that provides that the insured is responsible for the balance of a claim, must disclose such feature on the face of the policy or certificate and in any outline of coverage.

Section 9. Amends. s. 627.6415, F.S., to provide that the current law requiring group health insurance policies to cover adopted or foster children, if the policy covers any family member, would no longer be limited to a child that is placed prior to the child's 18th birthday.

Section 10. Amends s. 627.6475, F.S., relating to the individual reinsurance pool that is established as an option for insurers issuing individual coverage on a guarantee-issue basis to

HIPAA-eligible individuals. The bill deletes the out-of-date timeframes and requires all issuers to make an election which is binding indefinitely or until modified or withdrawn instead of the current law provision of 5 years. It deletes the requirement of the OIR to hold a hearing before allowing an insurer to modify its election.

The bill provides that upon the issuer's filing a designation of election, the OIR must provide a 21-day period for comment upon receipt of the filing. It deletes the requirement for the department to hold a hearing on the election at the request of the issuer.

Currently, the law provides that a reinsuring carrier may reinsure an eligible individual within 60 days after the commencement of the coverage of the eligible individual. The bill expands this time to 90 days. Under s. 627.6475(7)(b)2., F.S., the current law provides that the Individual Health Reinsurance Program (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 at least $5,000 in a calendar year and, 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, with the program reinsuring the remainder. The bill changes the reimbursement level to "an amount equal to the participating carrier's selected deductible level." In addition, the bill deletes the requirement for the reinsuring carrier to be responsible for 10 percent of the next $50,000 and 5 percent of the next $100,000 requirement.

Section 11. Amends s. 627.651, F.S., to correct a cross-reference.

Section 12. Amends. s. 627.6487, F.S., to allow insurers issuing individual coverage on a guarantee-issue basis to HIPAA-eligible individuals whose most recent period of creditable coverage was earned in another state, to impose a surcharge or charge a premium equal to that permitted in the state in which such creditable coverage was earned.

This would require the Office of Insurance Regulation to know what rate would be allowed under every other state's rating laws. Also, this allowance for a higher rate under another state's law would apparently apply to the Florida resident no matter how long the person resides in Florida, and such person's rates continue to be surcharged as allowed by another state's law. If such other state's law is amended after the policy is issued in Florida, it is not clear if the other state's amended law would then have to be applied to the Florida premium. (Also see Sec. 13, below, which is linked to Section 12.)

Section 13. Amends s. 627.6561, F.S., to change the information that must be included in the written certificate of creditable coverage that group health insurers must provide to persons who cease to be covered under the group plan, or under an extended COBRA period or under an individual conversion policy. As amended, the certificate must include a statement that the coverage was provided under a group health plan, a group or individual policy, or an HMO contract, the state in which such coverage was provided, and whether or not such individual was eligible for a conversion policy under such coverage.

The current Florida law was modeled on the federal HIPAA law. The changes are not likely to be required by other states. Since Florida law applies only to insurers issuing coverage in Florida, it may not be enforceable for certificates of coverage issued by insurers in another state. If such

certificates do not contain the required information, it may provide an "excuse" for an individual insurer in Florida to not issue a policy to a HIPAA-eligible individual.

Section 14. Amends s. 627.662, F.S., to require group policies to be subject to the requirement of s. 627.6044, F.S., that applies to individual health insurance policies regarding use of specific methodology for payment of claims, which is amended by Section 8 of the bill.

Section 15. Amends s. 627.667, F.S., relating to extension of benefits. The bill deletes the exception for out-of-state group policies, which currently provides that such policies are not required to extend benefits for persons who are totally disabled at the time of discontinuance of the policy, if replacement coverage is obtained.

Section 16. Amends. s. 627.6692, F.S., relating to continuation of coverage ("mini COBRA"), for employees whose group coverage terminates, for employer plans with fewer than 20 employees. The bill extends the time period from 30 days to 63 days for the employee to elect continuation of coverage.

Section 17. Amends s. 627.6699, F.S., the Employee Health Care Access Act (Small group law). It amends definitions to include an "eligible employee," as an employee who is paid wages at least equal to the federal minimum hourly wage; the "established geographical area," to delete the term "portions of a county or counties;" and a "self-employed individual," to require the individual to file with the IRS federal income tax forms verifying status as being self-employed.

Provides that notwithstanding the limitation of the one-month (August) open-enrollment period for one-life groups, when a small employer group is losing coverage due to the insurer or HMO discontinuing offering health insurance or health coverage, the eligible small employer is entitled to enroll with another carrier within 63 days after the termination of the prior coverage, whichever is later. The coverage will begin immediately upon enrollment, unless the small employer carrier and the small employer agree to a different date.

Provides that beginning Jan. 1, 2004, small employers are required to annually provide information on at least three different health benefit plans for their employees and specifies that employers are not required to provide the plan or contribute to the cost of the plan.

Revises the modified community rating provisions that currently allow carriers to adjust rates by plus or minus 15 percent based on health status or claims experience. The bill lowers from 5 percent to 3 percent the total aggregate adjusted premium that a carrier may have for all of its policies during a reporting period. If the carrier exceeds this amount, it must limit its application of adjustment only to minus adjustments until the 3 percent variance is reached.

Allows small group carriers to separate the experience of small employer groups using a health reimbursement arrangement, as defined in specified notices and bulletins published by the Internal Revenue Service.

Revises the optional reinsurance program for small group carriers, as follows:

- Deletes obsolete language related to carriers electing to be risk-assuming or reinsuring carriers and requires that the election by carriers is binding indefinitely or until modified

or withdrawn. Deletes the requirement for the Office of Insurance Regulation (OIR) to hold a hearing, if requested by the carrier, prior to making a decision on the election.

- Permits the small employer health reinsurance program (program) to evaluate the desirability of establishing different levels of deductibles, and in the event that such deductibles are established, such levels and resulting premiums must be approved by the OIR. With respect to a standard and basic health care plan, the bill makes permissive the provision relating to the program reinsuring the level of coverage provided. Authorizes the program to develop alternative levels of reinsurance (provided under the standard and basic health plan) which is designed to coordinate with a reinsuring carrier's existing reinsurance; however, such reinsurance and resulting premiums must be approved by the OIR. Authorizes the program to evaluate the option of allowing a small employer carrier to reinsure an entire employer group or an eligible employee at the first or subsequent renewal date; however, any such option and the resulting premium must be approved by the OIR.
- Provides that the program may not reimburse a participating carrier relating to claims of a reinsured employee or dependent until the carrier has paid incurred claims of an amount equal to the participating carrier's selected deductible as opposed to paying $5,000 for benefits. Deletes the criteria relating to the multiplying factors as to premium rates and changes the date for specified reports to be submitted by the program board to OIR from March 1 to September 1.

Section 18. Amends. s. 627.911, F.S., to require HMOs to report market information annually to the Office of Insurance Regulation as required for health insurers in the following section.

Section 19. Amends s. 627.9175, F.S., relating to reports of information on health insurance. The bill substantially rewrites this section and expands the requirements to include health maintenance organizations. The bill requires authorized health insurers and health maintenance organizations to submit to the OIR, on an annual basis, information concerning coverage being issued or currently in force in the state. The information must 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. The bill provides a list of specific required information that must be provided by both insurers and health maintenance organizations. The OIR will continue to publish an annual consumer's guide and to analyze the data reported under subsection (2) and must make a summary of its findings as to the types of cost containment measure reported and the estimated effect of these measures available to the public on an annual basis.

Section 20. Amends s. 627.9403, F.S., relating to long-term care insurance policies to exempt all limited benefit policies from the 24-month nursing home coverage requirement, so that a nursing home only policy could be sold that provides coverage for less than 24 months.

Section 21. Amends. s. 641.31, F.S., relating to HMO contracts, as follows:

- Provides that a law restricting deductibles, coinsurance, copayments, or lifetime payments shall not apply to any HMO contract offered to an individual or a group of 51 or more persons;

- Provides that changes in rates charged for HMO contracts would no longer have to be filed for approval with OIR for group health contracts effectuated and delivered in this state insuring groups of 51 or more persons, except for Medicare supplement insurance, long-term care insurance, and other specified coverage;
- Provides that if an HMO offers coverage for dependent children of the subscriber, it must cover the child until the end of the calendar year in which the child reaches the age of 25, if the child is dependent upon the subscriber for support and the child is either living in the household of the subscriber or the child is a full-time or part-time student.
- Provides that if an HMO contract provides coverage for a family member of the subscriber, it must provide that benefits applicable to children also apply to an adopted child or a foster child. Provides that except in the case of the foster child, the contract is prohibited from excluding 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 such child has been entered into by the subscriber prior to the birth of the child, whether or not the agreement is enforceable. However, there is no requirement for coverage for an adopted child who is not ultimately placed in the residence of the subscriber. The contract may require the subscriber to notify the HMO of the birth or placement of an adopted child within a specified time period of not less than 30 days after the birth or placement in the residence of a child adopted by the subscriber and provides criteria for charging additional premiums in the event of an untimely notice. If the contract does not require the subscriber to notify the HMO within a specified time period, the HMO may not deny coverage or charge an additional premium. However, the HMO may prospectively charge the subscriber an additional premium for the child if the HMO provides at least 45 days' notice of the additional premium required.
- Provides that HMO family member coverage is applicable for all children placed in court-ordered custody, including foster children, and that benefits are applicable with respect to a foster child or other children in court-ordered temporary or other custody of the subscriber and provides that coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in the contract and that the contract specify that attainment of the limiting age does not terminate the coverage of the child while the child continues to be: incapable of self-sustaining employment by reason of mental retardation or physical handicap; and chiefly dependent upon the subscribe for support or maintenance.
- Requires that if a claim is denied under the contract for the stated reason that the child has attained the limiting age for dependent children specified, the notice of denial must state that the subscriber has the burden of establishing that the child continues to meet the criteria specified.

Section 22. Amends s. 641.3101, F.S., relating to additional contract contents to provide that an HMO contract that provides for payment of claims based on a specific methodology must comply with the requirements of s. 627.6044, F.S., that apply to health insurers (in Section 8, above). The method used for determining the claims payments must be included in the HMO's rate filings.

Section 23. Creates s. 641.31025, F.S., to provide that denial of an application for an HMO contract must be accompanied by specific reasons for the denial.

Section 24. Creates s. 641.31075, F.S., to provide that when an HMO replaces any other group health coverage with its group health maintenance coverage that it must comply with provisions pertaining to replacement coverage for group, blanket, or franchise health insurance policies. Specifically, the section provides that each person who was covered by prior coverage must be covered by the succeeding coverage and that the prior coverage is subject to certain extension of benefits. In addition, requirements related to succeeding insurers in applying deductibles, out-of-pocket limitations, or waiting periods is specified; as is criteria relating to determination of prior benefits. In addition, the requirements of this section are applicable to a group whose benefits had previously been self-insured or to a self-insurer providing coverage to a group that had been previously covered by an insurer or another self-insurer.

Section 25. Amends. s. 641.3111, F.S., to provide additional requirements for extension of benefits under group HMO contracts in that such extension is required regardless of whether the group contract holder or other entity secures replacement coverage from a new insurer or HMO or foregoes the provision of coverage; and that the provision of coverage must provide for the continuation of contract benefits in connection with the treatment of a specific accident or illness that incurred while the contract was in effect.

Section 26. Amends. s. 641.2018, F.S., to correct a cross-reference related to limited coverage for home health care.

Section 27. Amends. s. 641.3107, F.S., to correct a cross-reference pertaining to delivery of contracts.

Section 28. Amends. 641.513, F.S., to correct a cross-reference relating to emergency services.

Section 29. Creates s. 627.6410, F.S., relating to optional coverage for speech, language, swallowing and hearing disorders. Requires that insurers issuing individual health insurance policies must make available, for an appropriate additional premium, the benefits or levels of benefits specified in the December 1999 Florida Medicaid Therapy Services Handbook for genetic or congenital disorders or conditions involving speech, language, swallowing, and hearing and hearing aid and earmolds benefit, at the level of benefits specified in the January 2001 Florida Medicaid Hearing Services Handbook. It excludes specified-accident, specified-disease, hospital indemnity, limited benefit, disability income, or long-term care insurance policies. Such coverage is not required to be offered when substantially the same benefits are included in a policy of insurance; that these provisions do not require or prohibit the use of a provider network; and these provisions do not prohibit an insurer from requiring prior authorization for the benefits offered.

Section 30. Creates s. 627.66912, F.S., to require insurers issuing group health insurance policies to make available coverage for speech, language, swallowing and hearing disorders under the same benefits and level as provided under section 29.

Section 31. Amends s. 641.31, F.S., to require HMOs to make available to the contract holder as part of the application for any contract coverage for speech, language, swallowing and hearing

disorders, at the same level as required under section 29. Further provides that these provisions do not apply to HMOs issuing individual coverage to fewer than 50,000 members.

Section 31. Provides that the act takes effect July 1. 2003.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Hospitals would be subject to the costs of the increased disclosure requirements. Such disclosures may provide greater information about charges to patients and insurers to allow for a greater degree of "price shopping."

Large group health insurance policies and HMO contracts would have greater freedom to have large deductibles and copayments, or lower lifetime or annual maximum benefits. This may allow for policies with lower premiums and lower benefits.

Policyholders and HMO subscribers should be provided greater benefits and consistency regarding coverage of dependents and extension of benefits.

Greater flexibility for the individual reinsurance pool and the small group reinsurance pool may allow those programs to provide a more viable option for insurers to help subsidize the costs of high-risk insureds.

The prohibition of mandatory arbitration for disputes could result in increased litigation and contribute to increased costs of health coverage plans. The expanded definitions for dependent coverage may also contribute to increased costs to health coverage plans by keeping young, healthy people out of the insurance pool.

C. Government Sector Impact:

The Office of Insurance Regulation reports that any additional costs will be handled within existing resources.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.