By Senator Campbell

32-819-03 See HB 723

1 A bill to be entitled
2 An act relating to health insurance; amending
3 ss. 626.9541, 641.3903, and 641.441, F.S.;
4 specifying mandatory arbitration as an unfair
5 method of competition and unfair or deceptive
6 act or practice for certain insurers, managed
7 care providers, prepaid limited health service
8 organizations, or prepaid health clinics;
9 amending s. 627.4091, F.S.; including certain
10 additional contracts and plans under a
11 requirement to provide specific reasons for
12 denial of an application for insurance;
13 creating s. 627.4303, F.S.; requiring policies,
14 contracts, and plans providing benefits for
15 prescription drug coverage to cover all
16 federally approved drugs without a waiting
17 period; requiring prescription drug formularies
18 to be limited to three tiers of coverage;
19 creating s. 627.6042, F.S.; requiring policies
20 of insurers offering coverage of dependent
21 children to maintain such coverage until the
22 child reaches age 25, under certain
23 circumstances; providing application; amending
24 s. 627.6415, F.S.; deleting an age limitation
25 on application of certain dependent coverage
26 requirements; amending s. 627.6475, F.S.;
27 revising risk-assuming carrier election
28 requirements and procedures; revising certain
29 criteria and limitations under the individual
30 health reinsurance program; amending s.
31 627.6617, F.S.; increasing a minimum

1 reimbursement limitation amount for home health
2 care services; amending s. 627.662, F.S.;
3 revising a list of provisions applicable to
4 group, blanket, or franchise health insurance
5 to include use of specific methodology for
6 payment of claims provisions; amending s.
7 627.667, F.S.; deleting a limitation on
8 application of certain extension of benefits
9 provisions; amending s. 627.6692, F.S.;
10 increasing a time period for payment of premium
11 to continue coverage under a group health plan;
12 amending s. 627.6699, F.S.; revising certain
13 definitions; revising certain coverage
14 enrollment eligibility criteria for small
15 employers; deleting a premium rate restriction
16 on charging for certain rate adjustments;
17 revising small employer carrier election
18 requirements and procedures; revising certain
19 criteria and limitations under the small
20 employer health reinsurance program; amending
21 ss. 627.911 and 627.9175, F.S.; applying
22 certain information reporting requirements to
23 health maintenance organizations; revising
24 health insurance information requirements and
25 criteria; deleting an annual report
26 requirement; amending s. 627.9403, F.S.;
27 deleting an exemption for limited benefit
28 policies from a long-term care insurance
29 restriction relating to nursing home care;
30 amending ss. 636.016 and 641.31, F.S.;
31 requiring prepaid limited health service

1 organizations and health maintenance
2 organizations offering coverage of dependent
3 children to maintain such coverage until the
4 child reaches age 25, under certain
5 circumstances; providing application; providing
6 requirements for contract termination and
7 denial of a claim related to limiting age
8 attainment; amending s. 641.3101, F.S.;
9 providing a compliance requirement for health
10 maintenance contracts using a specific payment
11 of claims methodology; creating s. 641.31075,
12 F.S.; imposing compliance requirements upon
13 health maintenance organization replacements of
14 other group or individual health coverage with
15 organization coverage; amending s. 641.3111,
16 F.S.; deleting a limitation on certain
17 extension of benefits provisions upon group
18 health maintenance contract termination;
19 imposing additional extension of benefits
20 requirements upon such termination; amending
21 ss. 627.651, 641.2018, 641.3107, and 641.513,
22 F.S.; correcting cross-references; providing an
23 effective date.
24
25 Be It Enacted by the Legislature of the State of Florida:
26
27 Section 1. Paragraph (bb) is added to subsection (1)
28 of section 626.9541, Florida Statutes, to read:
29 626.9541 Unfair methods of competition and unfair or
30 deceptive acts or practices defined.--
31

1 (1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR
2 DECEPTIVE ACTS.--The following are defined as unfair methods
3 of competition and unfair or deceptive acts or practices:
4 (bb) Mandatory arbitration.--For a life insurer,
5 health insurer, or disability insurer, issuing a policy which
6 requires the submission of disputes between the parties to the
7 policy or contract to arbitration.
8 Section 2. Subsection (1) of section 627.4091, Florida
9 Statutes, is amended to read:
10 627.4091 Specific reasons for denial, cancellation, or
11 nonrenewal.--
12 (1) The denial of an application for an insurance
13 policy, health maintenance organization contract, or prepaid
14 limited health service organization plan must be accompanied
15 by the specific reasons for denial, including the specific
16 underwriting reasons, if applicable.
17 Section 3. Section 627.4303, Florida Statutes, is
18 created to read:
19 627.4303 Prescription drug
20 formularies.--Notwithstanding any other provision of law, any
21 individual, blanket, or group health insurance policy, health
22 maintenance organization contract, or prepaid limited health
23 organization plan, or any health insurance policy or
24 certificate delivered or issued for delivery to any person in
25 this state, including out-of-state group plans pursuant to s.
26 627.6515 covering residents of this state, that provides
27 benefits for prescription drug coverage shall cover all
28 prescription drugs approved by the United States Food and Drug
29 Administration without any waiting period. Prescription drug
30 formularies shall be limited to no more than three tiers of
31 coverage, including generic and nongeneric prescription drugs.

1 Section 4. Section 627.6042, Florida Statutes, is
2 created to read:
3 627.6042 Dependent coverage.--
4 (1) If an insurer offers coverage that insures
5 dependent children of the policyholder or certificateholder,
6 the policy must insure a dependent child of the policyholder
7 or certificateholder at least until the end of the calendar
8 year in which the child reaches the age of 25, if:
9 (a) The child is dependent upon the policyholder or
10 certificateholder for support.
11 (b) The child is living in the household of the
12 policyholder or certificateholder or the child is a full-time
13 or part-time student.
14 (2) Nothing in this section affects or preempts an
15 insurer's right to medically underwrite or charge the
16 appropriate premium.
17 Section 5. Subsections (1) and (4) of section
18 627.6415, Florida Statutes, are amended to read:
19 627.6415 Coverage for natural-born, adopted, and
20 foster children; children in insured's custodial care.--
21 (1) A health insurance policy that provides coverage
22 for a member of the family of the insured shall, as to the
23 family member's coverage, provide that the health insurance
24 benefits applicable to children of the insured also apply to
25 an adopted child or a foster child of the insured placed in
26 compliance with chapter 63~~, prior to the child's 18th~~
27 ~~birthday,~~ from the moment of placement in the residence of the
28 insured. Except in the case of a foster child, the policy may
29 not exclude coverage for any preexisting condition of the
30 child. In the case of a newborn child, coverage begins at the
31 moment of birth if a written agreement to adopt the child has

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1 been entered into by the insured prior to the birth of the
2 child, whether or not the agreement is enforceable. This
3 section does not require coverage for an adopted child who is
4 not ultimately placed in the residence of the insured in
5 compliance with chapter 63.
6 (4) In order to increase access to postnatal, infant,
7 and pediatric health care for all children placed in
8 court-ordered custody, including foster children, all health
9 insurance policies that provide coverage for a member of the
10 family of the insured shall, as to such family member's
11 coverage, also provide that the health insurance benefits
12 applicable for children shall be payable with respect to a
13 foster child or other child in court-ordered temporary or
14 other custody of the insured~~, prior to the child's 18th~~
15 ~~birthday~~.
16 Section 6. Paragraph (a) of subsection (5), paragraph
17 (c) of subsection (6), and paragraphs (b), (c), and (e) of
18 subsection (7) of section 627.6475, Florida Statutes, are
19 amended to read:
20 627.6475 Individual reinsurance pool.--
21 (5) ISSUER'S ELECTION TO BECOME A RISK-ASSUMING
22 CARRIER.--
23 (a) Each health insurance issuer that offers
24 individual health insurance must elect to become a
25 risk-assuming carrier or a reinsuring carrier for purposes of
26 this section. Each such issuer must make ~~an initial election,~~
27 ~~binding through December 31, 1999. The issuer's initial~~
28 ~~election must be made no later than October 31, 1997. By~~
29 ~~October 31, 1997, all issuers must file a final election,~~
30 ~~which is binding for 2 years, from January 1, 1998, through~~
31 ~~December 31, 1999, after which~~ an election <u>which</u> 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

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1 to reflect increases in costs and utilization within the
2 standard market for health benefit plans within the state. The
3 adjustment may not be less than the annual change in the
4 medical component of the "Commerce Price Index for All Urban
5 Consumers" of the Bureau of Labor Statistics of the United
6 States Department of Labor, unless the board proposes and the
7 department approves a lower adjustment factor.
8 4. A reinsuring carrier may terminate reinsurance for
9 all reinsured eligible individuals on any plan anniversary.
10 5. The premium rate charged for reinsurance by the
11 program to a health maintenance organization that is approved
12 by the Secretary of Health and Human Services as a federally
13 qualified health maintenance organization pursuant to 42
14 U.S.C. s. 300e(c)(2)(A) and that, as such, is subject to
15 requirements that limit the amount of risk that may be ceded
16 to the program, which requirements are more restrictive than
17 subparagraph 2., shall be reduced by an amount equal to that
18 portion of the risk, if any, which exceeds the amount set
19 forth in subparagraph 2., which may not be ceded to the
20 program.
21 6. The board may consider adjustments to the premium
22 rates charged for reinsurance by the program or carriers that
23 use effective cost-containment measures, including high-cost
24 case management, as defined by the board.
25 7. A reinsuring carrier shall apply its
26 case-management and claims-handling techniques, including, but
27 not limited to, utilization review, individual case
28 management, preferred provider provisions, other managed-care
29 provisions, or methods of operation consistently with both
30 reinsured business and nonreinsured business.
31

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1 (c)1. The board, as part of the plan of operation,
2 shall establish a methodology for determining premium rates to
3 be charged by the program for reinsuring eligible individuals
4 pursuant to this section. The methodology must include a
5 system for classifying individuals which reflects the types of
6 case characteristics commonly used by carriers in this state.
7 The methodology must provide for the development of basic
8 reinsurance premium rates, which shall be multiplied by the
9 factors set for them in this paragraph to determine the
10 premium rates for the program. The basic reinsurance premium
11 rates shall be established by the board, subject to the
12 approval of the department, and shall be set at levels that
13 reasonably approximate gross premiums charged to eligible
14 individuals for individual health insurance by health
15 insurance issuers. The premium rates set by the board may vary
16 by geographical area, as determined under this section, to
17 reflect differences in cost. ~~An eligible individual may be~~
18 ~~reinsured for a rate that is five times the rate established~~
19 ~~by the board.~~
20 2. The board shall periodically review the methodology
21 established, including the system of classification and any
22 rating factors, to ensure that it reasonably reflects the
23 claims experience of the program. The board may propose
24 changes to the rates that are subject to the approval of the
25 department.
26 (e)1. Before <u>September</u> ~~March~~ 1 of each calendar year,
27 the board shall determine and report to the department the
28 program net loss in the individual account for the previous
29 year, including administrative expenses for that year and the
30 incurred losses for that year, taking into account investment
31 income and other appropriate gains and losses.

1 2. Any net loss in the individual account for the year
2 shall be recouped by assessing the carriers as follows:
3 a. The operating losses of the program shall be
4 assessed in the following order subject to the specified
5 limitations. The first tier of assessments shall be made
6 against reinsuring carriers in an amount that may not exceed 5
7 percent of each reinsuring carrier's premiums for individual
8 health insurance. If such assessments have been collected and
9 additional moneys are needed, the board shall make a second
10 tier of assessments in an amount that may not exceed 0.5
11 percent of each carrier' s health benefit plan premiums.
12 b. Except as provided in paragraph (f), risk-assuming
13 carriers are exempt from all assessments authorized pursuant
14 to this section. The amount paid by a reinsuring carrier for
15 the first tier of assessments shall be credited against any
16 additional assessments made.
17 c. The board shall equitably assess reinsuring
18 carriers for operating losses of the individual account based
19 on market share. The board shall annually assess each carrier
20 a portion of the operating losses of the individual account.
21 The first tier of assessments shall be determined by
22 multiplying the operating losses by a fraction, the numerator
23 of which equals the reinsuring carrier's earned premium
24 pertaining to direct writings of individual health insurance
25 in the state during the calendar year for which the assessment
26 is levied, and the denominator of which equals the total of
27 all such premiums earned by reinsuring carriers in the state
28 during that calendar year. The second tier of assessments
29 shall be based on the premiums that all carriers, except
30 risk-assuming carriers, earned on all health benefit plans
31 written in this state. The board may levy interim assessments

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1 against reinsuring carriers to ensure the financial ability of
2 the plan to cover claims expenses and administrative expenses
3 paid or estimated to be paid in the operation of the plan for
4 the calendar year prior to the association's anticipated
5 receipt of annual assessments for that calendar year. Any
6 interim assessment is due and payable within 30 days after
7 receipt by a carrier of the interim assessment notice. Interim
8 assessment payments shall be credited against the carrier's
9 annual assessment. Health benefit plan premiums and benefits
10 paid by a carrier that are less than an amount determined by
11 the board to justify the cost of collection may not be
12 considered for purposes of determining assessments.
13 d. Subject to the approval of the department, the
14 board shall adjust the assessment formula for reinsuring
15 carriers that are approved as federally qualified health
16 maintenance organizations by the Secretary of Health and Human
17 Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent,
18 if any, that restrictions are placed on them which are not
19 imposed on other carriers.
20 3. Before <u>September</u> ~~March~~ 1 of each year, the board
21 shall determine and file with the department an estimate of
22 the assessments needed to fund the losses incurred by the
23 program in the individual account for the previous calendar
24 year.
25 4. If the board determines that the assessments needed
26 to fund the losses incurred by the program in the individual
27 account for the previous calendar year will exceed the amount
28 specified in subparagraph 2., the board shall evaluate the
29 operation of the program and report its findings and
30 recommendations to the department in the format established in
31

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s. 627.6699(11) for the comparable report for the small employer reinsurance program.

Section 7. Subsection (2) of section 627.6617, Florida Statutes, is amended to read:

627.6617 Coverage for home health care services.--

(2) Carriers providing coverage pursuant to this section may establish a maximum length of care for any policy year, but in no event shall reimbursement be limited to an amount less than $15,000 ~~$1,000~~ per year.

Section 8. 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 9. Subsection (6) of section 627.667, Florida Statutes, is amended to read:

627.667 Extension of benefits.--

(6) This section also applies 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~~.

Section 10. Paragraph (e) of subsection (5) of section 627.6692, Florida Statutes, is amended to read:

627.6692 Florida Health Insurance Coverage Continuation Act.--

(5) CONTINUATION OF COVERAGE UNDER GROUP HEALTH PLANS.--

(e)1. A covered employee or other qualified beneficiary who wishes continuation of coverage must pay the initial premium and elect such continuation in writing to the insurance carrier issuing the employer's group health plan within 63 ~~30~~ days after receiving notice from the insurance carrier under paragraph (d). Subsequent premiums are due by the grace period expiration date. The insurance carrier or the insurance carrier's designee shall process all elections

1 promptly and provide coverage retroactively to the date
2 coverage would otherwise have terminated. The premium due
3 shall be for the period beginning on the date coverage would
4 have otherwise terminated due to the qualifying event. The
5 first premium payment must include the coverage paid to the
6 end of the month in which the first payment is made. After the
7 election, the insurance carrier must bill the qualified
8 beneficiary for premiums once each month, with a due date on
9 the first of the month of coverage and allowing a 30-day grace
10 period for payment.
11 2. Except as otherwise specified in an election, any
12 election by a qualified beneficiary shall be deemed to include
13 an election of continuation of coverage on behalf of any other
14 qualified beneficiary residing in the same household who would
15 lose coverage under the group health plan by reason of a
16 qualifying event. This subparagraph does not preclude a
17 qualified beneficiary from electing continuation of coverage
18 on behalf of any other qualified beneficiary.
19 Section 11. Paragraphs (h), (i), (n), and (u) of
20 subsection (3), paragraph (c) of subsection (5), paragraph (b)
21 of subsection (6), paragraph (a) of subsection (9), paragraph
22 (d) of subsection (10), and paragraphs (f), (g), (h), and (j)
23 of subsection (11) of section 627.6699, Florida Statutes, are
24 amended to read:
25 627.6699 Employee Health Care Access Act.--
26 (3) DEFINITIONS.--As used in this section, the term:
27 (h) "Eligible employee" means an employee who works
28 full time, having a normal workweek of 25 or more hours, who
29 is paid wages or a salary at least equal to the federal
30 minimum hourly wage applicable to such employee,and who has
31 met any applicable waiting-period requirements or other

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1 requirements of this act. The term includes a self-employed
2 individual, a sole proprietor, a partner of a partnership, or
3 an independent contractor, if the sole proprietor, partner, or
4 independent contractor is included as an employee under a
5 health benefit plan of a small employer, but does not include
6 a part-time, temporary, or substitute employee.
7 (i) "Established geographic area" means the county or
8 counties~~, or any portion of a county or counties,~~within which
9 the carrier provides or arranges for health care services to
10 be available to its insureds, members, or subscribers.
11 (n) "Modified community rating" means a method used to
12 develop carrier premiums which spreads financial risk across a
13 large population; allows the use of separate rating factors
14 for age, gender, family composition, tobacco usage, and
15 geographic area as determined under paragraph (5)(j); and
16 allows adjustments for~~: claims experience, health status, or~~
17 ~~duration of coverage as permitted under subparagraph (6)(b)5.;~~
18 ~~and~~ administrative and acquisition expenses as permitted under
19 subparagraph (6)(b)5.
20 (u) "Self-employed individual" means an individual or
21 sole proprietor who derives his or her income from a trade or
22 business carried on by the individual or sole proprietor which
23 <u>necessitates that the individual file with the Internal</u>
24 <u>Revenue Service for the most recent tax year federal income</u>
25 <u>tax forms with supporting schedules and accompanying income</u>
26 <u>reporting forms or federal income tax extensions of time to</u>
27 <u>file forms</u> ~~results in taxable income as indicated on IRS Form~~
28 ~~1040, schedule C or F, and which generated taxable income in~~
29 ~~one of the 2 previous years~~.
30 (5) AVAILABILITY OF COVERAGE.--
31

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1 (c) Every small employer carrier must, as a condition
2 of transacting business in this state:
3 1. Beginning July 1, 2000, offer and issue all small
4 employer health benefit plans on a guaranteed-issue basis to
5 every eligible small employer, with 2 to 50 eligible
6 employees, that elects to be covered under such plan, agrees
7 to make the required premium payments, and satisfies the other
8 provisions of the plan. A rider for additional or increased
9 benefits may be medically underwritten and may only be added
10 to the standard health benefit plan. The increased rate
11 charged for the additional or increased benefit must be rated
12 in accordance with this section.
13 2. Beginning July 1, 2000, and until July 31, 2001,
14 offer and issue basic and standard small employer health
15 benefit plans on a guaranteed-issue basis to every eligible
16 small employer which is eligible for guaranteed renewal, has
17 less than two eligible employees, is not formed primarily for
18 the purpose of buying health insurance, elects to be covered
19 under such plan, agrees to make the required premium payments,
20 and satisfies the other provisions of the plan. A rider for
21 additional or increased benefits may be medically underwritten
22 and may be added only to the standard benefit plan. The
23 increased rate charged for the additional or increased benefit
24 must be rated in accordance with this section. For purposes of
25 this subparagraph, a person, his or her spouse, and his or her
26 dependent children shall constitute a single eligible employee
27 if that person and spouse are employed by the same small
28 employer and either one has a normal work week of less than 25
29 hours.
30 3.<u>a.</u> Beginning August 1, 2001, offer and issue basic
31 and standard small employer health benefit plans on a

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guaranteed-issue basis, during a 31-day open enrollment period of August 1 through August 31 of each year, to every eligible small employer, with fewer than two eligible employees, which small employer is not formed primarily for the purpose of buying health insurance and which elects to be covered under such plan, agrees to make the required premium payments, and satisfies the other provisions of the plan. Coverage provided under this sub-subparagraph ~~subparagraph~~ shall begin on October 1 of the same year as the date of enrollment, unless the small employer carrier and the small employer agree to a different date. A rider for additional or increased benefits may be medically underwritten and may only be added to the standard health benefit plan. The increased rate charged for the additional or increased benefit must be rated in accordance with this section. For purposes of this sub-subparagraph ~~subparagraph~~, a person, his or her spouse, and his or her dependent children constitute a single eligible employee if that person and spouse are employed by the same small employer and either that person or his or her spouse has a normal work week of less than 25 hours.

b. Notwithstanding the restrictions set forth in sub-subparagraph a., when a small employer group is losing coverage because a carrier is exercising the provisions of s. 627.6571(3)(b) or s. 641.31074(3)(b), the eligible small employer, as defined in sub-subparagraph a., shall be entitled to enroll with another carrier offering small employer coverage within 63 days after the notice of termination or the termination date of the prior coverage, whichever is later. Coverage provided under this sub-subparagraph shall begin immediately upon enrollment unless the small employer carrier and the small employer agree to a different date.

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1 4. This paragraph does not limit a carrier's ability
2 to offer other health benefit plans to small employers if the
3 standard and basic health benefit plans are offered and
4 rejected.
5 (6) RESTRICTIONS RELATING TO PREMIUM RATES.--
6 (b) For all small employer health benefit plans that
7 are subject to this section and are issued by small employer
8 carriers on or after January 1, 1994, premium rates for health
9 benefit plans subject to this section are subject to the
10 following:
11 1. Small employer carriers must use a modified
12 community rating methodology in which the premium for each
13 small employer must be determined solely on the basis of the
14 eligible employee's and eligible dependent' s gender, age,
15 family composition, tobacco use, or geographic area as
16 determined under paragraph (5)(j) and in which the premium may
17 be adjusted as permitted by this paragraph.
18 2. Rating factors related to age, gender, family
19 composition, tobacco use, or geographic location may be
20 developed by each carrier to reflect the carrier's experience.
21 The factors used by carriers are subject to department review
22 and approval.
23 3. Small employer carriers may not modify the rate for
24 a small employer for 12 months from the initial issue date or
25 renewal date, unless the composition of the group changes or
26 benefits are changed. However, a small employer carrier may
27 modify the rate one time prior to 12 months after the initial
28 issue date for a small employer who enrolls under a previously
29 issued group policy that has a common anniversary date for all
30 employers covered under the policy if:
31

1 a. The carrier discloses to the employer in a clear
2 and conspicuous manner the date of the first renewal and the
3 fact that the premium may increase on or after that date.
4 b. The insurer demonstrates to the department that
5 efficiencies in administration are achieved and reflected in
6 the rates charged to small employers covered under the policy.
7 4. A carrier may issue a group health insurance policy
8 to a small employer health alliance or other group association
9 with rates that reflect a premium credit for expense savings
10 attributable to administrative activities being performed by
11 the alliance or group association if such expense savings are
12 specifically documented in the insurer's rate filing and are
13 approved by the department. Any such credit may not be based
14 on different morbidity assumptions or on any other factor
15 related to the health status or claims experience of any
16 person covered under the policy. Nothing in this subparagraph
17 exempts an alliance or group association from licensure for
18 any activities that require licensure under the insurance
19 code. A carrier issuing a group health insurance policy to a
20 small employer health alliance or other group association
21 shall allow any properly licensed and appointed agent of that
22 carrier to market and sell the small employer health alliance
23 or other group association policy. Such agent shall be paid
24 the usual and customary commission paid to any agent selling
25 the policy.
26 5. ~~Any adjustments in rates for claims experience,~~
27 ~~health status, or duration of coverage may not be charged to~~
28 ~~individual employees or dependents. For a small employer's~~
29 ~~policy, such adjustments may not result in a rate for the~~
30 ~~small employer which deviates more than 15 percent from the~~
31 ~~carrier's approved rate. Any such adjustment must be applied~~

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

6. A small employer carrier rating methodology may include separate rating categories for one dependent child,

1 for two dependent children, and for three or more dependent
2 children for family coverage of employees having a spouse and
3 dependent children or employees having dependent children
4 only. A small employer carrier may have fewer, but not
5 greater, numbers of categories for dependent children than
6 those specified in this subparagraph.
7 7. Small employer carriers may not use a composite
8 rating methodology to rate a small employer with fewer than 10
9 employees. For the purposes of this subparagraph, a "composite
10 rating methodology" means a rating methodology that averages
11 the impact of the rating factors for age and gender in the
12 premiums charged to all of the employees of a small employer.
13 8.a. A carrier may separate the experience of small
14 employer groups with less than 2 eligible employees from the
15 experience of small employer groups with 2-50 eligible
16 employees for purposes of determining an alternative modified
17 community rating.
18 b. If a carrier separates the experience of small
19 employer groups as provided in sub-subparagraph a., the rate
20 to be charged to small employer groups of less than 2 eligible
21 employees may not exceed 150 percent of the rate determined
22 for small employer groups of 2-50 eligible employees. However,
23 the carrier may charge excess losses of the experience pool
24 consisting of small employer groups with less than 2 eligible
25 employees to the experience pool consisting of small employer
26 groups with 2-50 eligible employees so that all losses are
27 allocated and the 150-percent rate limit on the experience
28 pool consisting of small employer groups with less than 2
29 eligible employees is maintained. Notwithstanding s.
30 627.411(1), the rate to be charged to a small employer group
31 of fewer than 2 eligible employees, insured as of July 1,

2002, may be up to 125 percent of the rate determined for small employer groups of 2-50 eligible employees for the first annual renewal and 150 percent for subsequent annual renewals.

(9) SMALL EMPLOYER CARRIER'S ELECTION TO BECOME A RISK-ASSUMING CARRIER OR A REINSURING CARRIER.--

(a) A small employer carrier must elect to become either a risk-assuming carrier or a reinsuring carrier. ~~Each small employer carrier must make an initial election, binding through January 1, 1994. The carrier's initial election must be made no later than October 31, 1992. By October 31, 1993, all small employer carriers must file a final election, which is binding for 2 years, from January 1, 1994, through December 31, 1995, after which an election shall be binding for a period of 5 years.~~Any carrier that is not a small employer carrier on October 31, 1992, and intends to become a small employer carrier after October 31, 1992, must file its designation when it files the forms and rates it intends to use for small employer group health insurance; such designation shall be binding indefinitely or until modified or withdrawn ~~for 2 years after the date of approval of the forms and rates, and any subsequent designation is binding for 5 years~~. The department may permit a carrier to modify its election at any time for good cause shown~~, after a hearing~~.

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

(d) The department shall provide public notice of a small employer carrier's filing a designation of election under subsection (9) 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~~

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1 ~~election~~. ~~The department shall hold a hearing on the election~~
2 ~~at the request of the carrier.~~
3 (11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.--
4 (f) The program has the general powers and authority
5 granted under the laws of this state to insurance companies
6 and health maintenance organizations licensed to transact
7 business, except the power to issue health benefit plans
8 directly to groups or individuals. In addition thereto, the
9 program has specific authority to:
10 1. Enter into contracts as necessary or proper to
11 carry out the provisions and purposes of this act, including
12 the authority to enter into contracts with similar programs of
13 other states for the joint performance of common functions or
14 with persons or other organizations for the performance of
15 administrative functions.
16 2. Sue or be sued, including taking any legal action
17 necessary or proper for recovering any assessments and
18 penalties for, on behalf of, or against the program or any
19 carrier.
20 3. Take any legal action necessary to avoid the
21 payment of improper claims against the program.
22 4. Issue reinsurance policies, in accordance with the
23 requirements of this act.
24 5. Establish rules, conditions, and procedures for
25 reinsurance risks under the program participation.
26 6. Establish actuarial functions as appropriate for
27 the operation of the program.
28 7. Assess participating carriers in accordance with
29 paragraph (j), and make advance interim assessments as may be
30 reasonable and necessary for organizational and interim
31 operating expenses. Interim assessments shall be credited as

offsets against any regular assessments due following the close of the calendar year.

8. Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the program, and in any other function within the authority of the program.

9. Borrow money to effect the purposes of the program. Any notes or other evidences of indebtedness of the program which are not in default constitute legal investments for carriers and may be carried as admitted assets.

10. To the extent necessary, increase the $5,000 deductible reinsurance requirement to adjust for the effects of inflation. The program may evaluate the desirability of establishing different levels of deductibles. If different levels of deductibles are established, such levels and the resulting premiums shall be approved by the department.

(g) A reinsuring carrier may reinsure with the program coverage of an eligible employee of a small employer, or any dependent of such an employee, subject to each of the following provisions:

1. With respect to a standard and basic health care plan, the program may ~~must~~ reinsure the level of coverage provided; and, with respect to any other plan, the program may ~~must~~ reinsure the coverage up to, but not exceeding, the level of coverage provided under the standard and basic health care plan. As an alternative to reinsuring the level of coverage provided under the standard and basic health care plan, the program may develop alternate levels of reinsurance designed to coordinate with a reinsuring carrier's existing reinsurance. The levels of reinsurance and resulting premiums must be approved by the department.

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2. Except in the case of a late enrollee, a reinsuring carrier may reinsure an eligible employee or dependent within 60 days after the commencement of the coverage of the small employer. A newly employed eligible employee or dependent of a small employer may be reinsured within 60 days after the commencement of his or her coverage.

3. A small employer carrier may reinsure an entire employer group within 60 days after the commencement of the group's coverage under the plan. The carrier may choose to reinsure newly eligible employees and dependents of the reinsured group pursuant to subparagraph 1.

4. The program may 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. Any such option and the resulting premium must be approved by the department.

5.~~4.~~ The program may not reimburse a participating carrier with respect to the 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 level ~~at least $5,000~~ in a calendar year for benefits covered by the program. ~~In addition, the reinsuring carrier shall be 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.~~

6.~~5.~~ The board annually shall 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 shall not be less than the annual change in the

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medical component of the "Consumer Price Index for All Urban Consumers" of the Bureau of Labor Statistics of the Department of Labor, unless the board proposes and the department approves a lower adjustment factor.

7.~~6.~~ A small employer carrier may terminate reinsurance for all reinsured employees or dependents on any plan anniversary.

8.~~7.~~ 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 5.~~4.~~, shall be reduced by an amount equal to that portion of the risk, if any, which exceeds the amount set forth in subparagraph 5.~~4.~~which may not be ceded to the program.

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

10.~~9.~~ 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.

(h)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 small employers and

individuals pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall 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 which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard and basic health benefit plan. The premium rates set by the board may vary by geographical area, as determined under this section, to reflect differences in cost. ~~The multiplying factors must be established as follows:~~

~~a. The entire group may be reinsured for a rate that is 1.5 times the rate established by the board.~~

~~b. An eligible employee or dependent may be reinsured for a rate that is 5 times the rate established by the board.~~

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

(j)1. Before September ~~March~~ 1 of each calendar year, the board shall determine and report to the department the program net loss for the previous year, including administrative expenses for that year, and the incurred losses

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1 for the year, taking into account investment income and other
2 appropriate gains and losses.
3 2. Any net loss for the year shall be recouped by
4 assessment of the carriers, as follows:
5 a. The operating losses of the program shall be
6 assessed in the following order subject to the specified
7 limitations. The first tier of assessments shall be made
8 against reinsuring carriers in an amount which shall not
9 exceed 5 percent of each reinsuring carrier's premiums from
10 health benefit plans covering small employers. If such
11 assessments have been collected and additional moneys are
12 needed, the board shall make a second tier of assessments in
13 an amount which shall not exceed 0.5 percent of each carrier's
14 health benefit plan premiums. Except as provided in paragraph
15 (n), risk-assuming carriers are exempt from all assessments
16 authorized pursuant to this section. The amount paid by a
17 reinsuring carrier for the first tier of assessments shall be
18 credited against any additional assessments made.
19 b. The board shall equitably assess carriers for
20 operating losses of the plan based on market share. The board
21 shall annually assess each carrier a portion of the operating
22 losses of the plan. The first tier of assessments shall be
23 determined by multiplying the operating losses by a fraction,
24 the numerator of which equals the reinsuring carrier's earned
25 premium pertaining to direct writings of small employer health
26 benefit plans in the state during the calendar year for which
27 the assessment is levied, and the denominator of which equals
28 the total of all such premiums earned by reinsuring carriers
29 in the state during that calendar year. The second tier of
30 assessments shall be based on the premiums that all carriers,
31 except risk-assuming carriers, earned on all health benefit

plans written in this state. The board may levy interim assessments against 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.

c. Subject to the approval of the department, the board shall make an adjustment to 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 that are not imposed on other small employer carriers.

3. Before September ~~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 previous calendar year.

4. 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 in subparagraph 2., the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the department within 240 ~~90~~ days following the end of the calendar year in which the losses

1 were incurred. The evaluation shall include an estimate of
2 future assessments, the administrative costs of the program,
3 the appropriateness of the premiums charged and the level of
4 carrier retention under the program, and the costs of coverage
5 for small employers. If the board fails to file a report with
6 the department within <u>240</u> ~~90~~ days following the end of the
7 applicable calendar year, the department may evaluate the
8 operations of the program and implement such amendments to the
9 plan of operation the department deems necessary to reduce
10 future losses and assessments.
11 5. If assessments exceed the amount of the actual
12 losses and administrative expenses of the program, the excess
13 shall be held as interest and used by the board to offset
14 future losses or to reduce program premiums. As used in this
15 paragraph, the term "future losses" includes reserves for
16 incurred but not reported claims.
17 6. Each carrier's proportion of the assessment shall
18 be determined annually by the board, based on annual
19 statements and other reports considered necessary by the board
20 and filed by the carriers with the board.
21 7. Provision shall be made in the plan of operation
22 for the imposition of an interest penalty for late payment of
23 an assessment.
24 8. A carrier may seek, from the commissioner, a
25 deferment, in whole or in part, from any assessment made by
26 the board. The department may defer, in whole or in part, the
27 assessment of a carrier if, in the opinion of the department,
28 the payment of the assessment would place the carrier in a
29 financially impaired condition. If an assessment against a
30 carrier is deferred, in whole or in part, the amount by which
31 the assessment is deferred may be assessed against the other

1 carriers in a manner consistent with the basis for assessment
2 set forth in this section. The carrier receiving such
3 deferment remains liable to the program for the amount
4 deferred and is prohibited from reinsuring any individuals or
5 groups in the program if it fails to pay assessments.
6 Section 12. Section 627.911, Florida Statutes, is
7 amended to read:
8 627.911 Scope of this part.--Any insurer or health
9 maintenance organization transacting insurance in this state
10 shall report information as required by this part.
11 Section 13. Section 627.9175, Florida Statutes, is
12 amended to read:
13 627.9175 Reports of information on health insurance.--
14 (1) Each authorized health insurer or health
15 maintenance organization shall submit annually to the
16 department information concerning ~~as to policies of individual~~
17 health insurance coverage being issued or currently in force
18 in this state. The information shall include information
19 related to premium, number of policies, and covered lives for
20 such policies and other information necessary to analyze
21 trends in enrollment, premiums, and claim costs.
22 (2) The required information shall be broken down by
23 market segment, to include:
24 (a) Health insurance issuer, company, or contact
25 person or agent.
26 (b) All health insurance products issued or in force,
27 including, but not limited to:
28 1. Direct premiums earned.
29 2. Direct losses incurred.
30 3. Direct premiums earned for new business issued
31 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 shall publish annually a consumer's guide ~~which summarizes and compares the information required to be reported under this subsection~~.

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~~(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.~~

(4)~~(c)~~ The department shall analyze the data reported under ~~this~~ subsection (2) 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 14. 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

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1 supplement policy shall meet the requirements of this part and
2 the requirements of ss. 627.671-627.675 and, to the extent of
3 a conflict, be subject to the requirement that is more
4 favorable to the policyholder or certificateholder. The
5 provisions of this part shall not apply to a continuing care
6 contract issued pursuant to chapter 651 and shall not apply to
7 guaranteed renewable policies issued prior to October 1, 1988.
8 Any limited benefit policy that limits coverage to care in a
9 nursing home or to one or more lower levels of care required
10 or authorized to be provided by this part or by department
11 rule must meet all requirements of this part that apply to
12 long-term care insurance policies, except ss. 627.9407(3)(c),
13 (9), (10)(f), and (12) and 627.94073(2). If the limited
14 benefit policy does not provide coverage for care in a nursing
15 home, but does provide coverage for one or more lower levels
16 of care, the policy shall also be exempt from the requirements
17 of s. 627.9407(3)(d).
18 Section 15. Subsection (5) of section 636.016, Florida
19 Statutes, is amended to read:
20 636.016 Prepaid limited health service contracts.--For
21 any entity licensed prior to October 1, 1993, all subscriber
22 contracts in force at such time shall be in compliance with
23 this section upon renewal of such contract.
24 (5)(a)1. If a prepaid limited health service
25 organization offers coverage for dependent children of the
26 contract holder, the policy must insure a dependent child of
27 the contract holder at least until the end of the calendar
28 year in which the child reaches the age of 25, if:
29 a. The child is dependent upon the contract holder for
30 support.
31

1 b. The child is living in the household of the
2 contract holder or the child is a full-time or part-time
3 student.
4 2. Nothing in this section affects or preempts a
5 prepaid limited health service organization's right to
6 medically underwrite or charge the appropriate premium.
7 (b)1. A contract that provides coverage for a family
8 member of the contract holder shall, as to such family
9 member's coverage, provide that benefits applicable to
10 children of the contract holder also apply to an adopted child
11 or a foster child of the contract holder placed in compliance
12 with chapter 63 from the moment of placement in the residence
13 of the contract holder. Except in the case of a foster child,
14 the policy may not exclude coverage for any preexisting
15 condition of the child. In the case of a newborn child,
16 coverage begins at the moment of birth if a written agreement
17 to adopt such child has been entered into by the contract
18 holder prior to the birth of the child, whether or not the
19 agreement is enforceable. This section does not require
20 coverage for an adopted child who is not ultimately placed in
21 the residence of the contract holder in compliance with
22 chapter 63.
23 2. A contract may require the contract holder to
24 notify the insurer of the birth or placement of an adopted
25 child within a specified time period of not less than 30 days
26 after the birth or placement in the residence of a child
27 adopted by the contract holder. If timely notice is given, the
28 insurer may not charge an additional premium for coverage of
29 the child for the duration of the notice period. If timely
30 notice is not given, the insurer may charge an additional
31 premium from the date of birth or placement. If notice is

1 given within 60 days after the birth or placement of the
2 child, the insurer may not deny coverage for the child due to
3 the failure of the contract holder to timely notify the
4 insurer of the birth or placement of the child.
5 3. If the policy does not require the contract holder
6 to notify the insurer of the birth or placement of an adopted
7 child within a specified time period, the insurer may not deny
8 coverage for such child or retroactively charge the contract
9 holder an additional premium for such child. However, the
10 insurer may prospectively charge the contract holder an
11 additional premium for the child if the insurer provides at
12 least 45 days' notice of the additional premium required.
13 4. In order to increase access to postnatal, infant,
14 and pediatric health care for all children placed in
15 court-ordered custody, including foster children, all health
16 insurance policies that provide coverage for a family member
17 of the contract holder shall, as to such family member's
18 coverage, provide that benefits applicable for children shall
19 be payable with respect to a foster child or other child in
20 court-ordered temporary or other custody of the contract
21 holder.
22 (c) A contract that provides that coverage of a
23 dependent child shall terminate upon attainment of the
24 limiting age for dependent children specified in the contract
25 shall also provide in substance that attainment of the
26 limiting age does not terminate the coverage of the child
27 while the child continues to be:
28 1. Incapable of self-sustaining employment by reason
29 of mental retardation or physical handicap.
30 2. Chiefly dependent upon the contract holder or
31 subscriber for support and maintenance.

If a claim is denied under a contract for the stated reason that the child has attained the limiting age for dependent children specified in the contract, the notice of denial must state that the contract holder has the burden of establishing that the child continues to meet the criteria specified in subparagraphs 1. and 2.~~All prepaid limited health service coverage, benefits, or services for a member of the family of the subscriber must, as to such family member's coverage, benefits, or services, provide also that the coverage, benefits, or services applicable for children will be provided with respect to a preenrolled newborn child of the subscriber, or covered family member of the subscriber, from the moment of birth, or adoption pursuant to chapter 63.~~

Section 16. Subsections (9) through (17) of section 641.31, Florida Statutes, are amended to read:

641.31 Health maintenance contracts.--

(9)(a)1. If a health maintenance organization offers coverage for dependent children of the subscriber, the policy must cover a dependent child of the subscriber at least until the end of the calendar year in which the child reaches the age of 25, if:

a. The child is dependent upon the subscriber for support.

b. The child is living in the household of the subscriber, or the child is a full-time or part-time student.

2. Nothing in this paragraph affects or preempts a health maintenance organization's right to medically underwrite or charge the appropriate premium.

(b)1. A contract that provides coverage for a family member of the subscriber shall, as to such family member's

1 coverage, provide that benefits applicable to children of the
2 subscriber also apply to an adopted child or a foster child of
3 the subscriber placed in compliance with chapter 63 from the
4 moment of placement in the residence of the subscriber. Except
5 in the case of a foster child, the policy may not exclude
6 coverage for any preexisting condition of the child. In the
7 case of a newborn child, coverage begins at the moment of
8 birth if a written agreement to adopt such child has been
9 entered into by the subscriber prior to the birth of the
10 child, whether or not the agreement is enforceable. This
11 section does not require coverage for an adopted child who is
12 not ultimately placed in the residence of the subscriber in
13 compliance with chapter 63.
14 2. A contract may require the subscriber to notify the
15 health maintenance organization of the birth or placement of
16 an adopted child within a specified time period of not less
17 than 30 days after the birth or placement in the residence of
18 a child adopted by the subscriber. If timely notice is given,
19 the health maintenance organization may not charge an
20 additional premium for coverage of the child for the duration
21 of the notice period. If timely notice is not given, the
22 health maintenance organization may charge an additional
23 premium from the date of birth or placement. If notice is
24 given within 60 days after the birth or placement of the
25 child, the health maintenance organization may not deny
26 coverage for the child due to the failure of the subscriber to
27 timely notify the health maintenance organization of the birth
28 or placement of the child.
29 3. If the policy does not require the subscriber to
30 notify the health maintenance organization of the birth or
31 placement of an adopted child within a specified time period,

1 the health maintenance organization may not deny coverage for
2 such child or retroactively charge the subscriber an
3 additional premium for such child. However, the health
4 maintenance organization may prospectively charge the
5 subscriber an additional premium for the child if the health
6 maintenance organization provides at least 45 days' notice of
7 the additional premium required.
8 4. In order to increase access to postnatal, infant,
9 and pediatric health care for all children placed in
10 court-ordered custody, including foster children, all health
11 insurance policies that provide coverage for a family member
12 of the subscriber shall, as to such family member's coverage,
13 provide that benefits applicable for children shall be payable
14 with respect to a foster child or other child in court-ordered
15 temporary or other custody of the subscriber.
16 (10) A contract that provides that coverage of a
17 dependent child shall terminate upon attainment of the
18 limiting age for dependent children specified in the contract
19 shall also provide in substance that attainment of the
20 limiting age does not terminate the coverage of the child
21 while the child continues to be:
22 (a) Incapable of self-sustaining employment by reason
23 of mental retardation or physical handicap.
24 (b) Chiefly dependent upon the subscriber for support
25 and maintenance.
26
27 If a claim is denied under a contract for the stated reason
28 that the child has attained the limiting age for dependent
29 children specified in the contract, the notice of denial must
30 state that the subscriber has the burden of establishing that
31 the child continues to meet the criteria specified in

paragraphs (a) and (b).~~All health maintenance contracts that provide coverage, benefits, or services for a member of the family of the subscriber must, as to such family member's coverage, benefits, or services, provide also that the coverage, benefits, or services applicable for children must be provided with respect to a newborn child of the subscriber, or covered family member of the subscriber, from the moment of birth. However, with respect to a newborn child of a covered family member other than the spouse of the insured or subscriber, the coverage for the newborn child terminates 18 months after the birth of the newborn child. The coverage, benefits, or services for newborn children must consist of coverage for injury or sickness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, and transportation costs of the newborn to and from the nearest appropriate facility appropriately staffed and equipped to treat the newborn's condition, when such transportation is certified by the attending physician as medically necessary to protect the health and safety of the newborn child.~~

~~(a) A contract may require the subscriber to notify the plan of the birth of a child within a time period, as specified in the contract, of not less than 30 days after the birth, or a contract may require the preenrollment of a newborn prior to birth. However, if timely notice is given, a plan may not charge an additional premium for additional coverage of the newborn child for not less than 30 days after the birth of the child. If timely notice is not given, the plan may charge an additional premium from the date of birth. If notice is given within 60 days of the birth of the child, the contract may not deny coverage of the child due to failure~~

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~~of the subscriber to timely notify the plan of the birth of the child or to preenroll the child.~~

~~(b) If the contract does not require the subscriber to notify the plan of the birth of a child within a specified time period, the plan may not deny coverage of the child nor may it retroactively charge the subscriber an additional premium for the child; however, the contract may prospectively charge the member an additional premium for the child if the plan provides at least 45 days' notice of the additional charge.~~

(11)~~(10)~~ No alteration of any written application for any health maintenance contract shall be made by any person other than the applicant without his or her written consent, except that insertions may be made by the health maintenance organization, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

(12)~~(11)~~ No contract shall contain any waiver of rights or benefits provided to or available to subscribers under the provisions of any law or rule applicable to health maintenance organizations.

(13)~~(12)~~ Each health maintenance contract, certificate, or member handbook shall state that emergency services and care shall be provided to subscribers in emergency situations not permitting treatment through the health maintenance organization's providers, without prior notification to and approval of the organization. Not less than 75 percent of the reasonable charges for covered services and supplies shall be paid by the organization, up to the subscriber contract benefit limits. Payment also may be subject to additional applicable copayment provisions, not to

exceed $100 per claim. The health maintenance contract, certificate, or member handbook shall contain the definitions of "emergency services and care" and "emergency medical condition" as specified in s. 641.19(7) and (8), shall describe procedures for determination by the health maintenance organization of whether the services qualify for reimbursement as emergency services and care, and shall contain specific examples of what does constitute an emergency. In providing for emergency services and care as a covered service, a health maintenance organization shall be governed by s. 641.513.

(14)~~(13)~~ In addition to the requirements of this section, with respect to a person who is entitled to have payments for health care costs made under Medicare, Title XVIII of the Social Security Act ("Medicare"), parts A and/or B:

(a) The health maintenance organization shall mail or deliver notification to the Medicare beneficiary of the date of enrollment in the health maintenance organization within 10 days after receiving notification of enrollment approval from the United States Department of Health and Human Services, Health Care Financing Administration. When a Medicare beneficiary who is a subscriber of the health maintenance organization requests disenrollment from the organization, the organization shall mail or deliver to the beneficiary notice of the effective date of the disenrollment within 10 days after receipt of the written disenrollment request. The health maintenance organization shall forward the disenrollment request to the United States Department of Health and Human Services, Health Care Financing Administration, in a timely

1 manner so as to effectuate the next available disenrollment
2 date, as prescribed by such federal agency.
3 (b) The health maintenance contract, certificate, or
4 member handbook shall be delivered to the subscriber no later
5 than the earlier of 10 working days after the health
6 maintenance organization and the Health Care Financing
7 Administration of the United States Department of Health and
8 Human Services approve the subscriber's enrollment application
9 or the effective date of coverage of the subscriber under the
10 health maintenance contract. However, if notice from the
11 Health Care Financing Administration of its approval of the
12 subscriber's enrollment application is received by the health
13 maintenance organization after the effective coverage date
14 prescribed by the Health Care Financing Administration, the
15 health maintenance organization shall deliver the contract,
16 certificate, or member handbook to the subscriber within 10
17 days after receiving such notice. When a Medicare recipient is
18 enrolled in a health maintenance organization program, the
19 contract, certificate, or member handbook shall be accompanied
20 by a health maintenance organization identification sticker
21 with instruction to the Medicare beneficiary to place the
22 sticker on the Medicare identification card.
23 (15)~~(14)~~ Whenever a subscriber of a health maintenance
24 organization is also a Medicaid recipient, the health
25 maintenance organization's coverage shall be primary to the
26 recipient's Medicaid benefits and the organization shall be a
27 third party subject to the provisions of s. 409.910(4).
28 (16)~~(15)~~(a) All health maintenance contracts,
29 certificates, and member handbooks shall contain the following
30 provision:
31

"Grace Period: This contract has a (insert a number not less than 10) day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the following grace period. During the grace period, the contract will stay in force."

(b) The required provision of paragraph (a) shall not apply to certificates or member handbooks delivered to individual subscribers under a group health maintenance contract when the employer or other person who will hold the contract on behalf of the subscriber group pays the entire premium for the individual subscribers. However, such required provision shall apply to the group health maintenance contract.

(17)~~(16)~~ The contracts must clearly disclose the intent of the health maintenance organization as to the applicability or nonapplicability of coverage to preexisting conditions. If coverage of the contract is not to be applicable to preexisting conditions, the contract shall specify, in substance, that coverage pertains solely to accidental bodily injuries resulting from accidents occurring after the effective date of coverage and that sicknesses are limited to those which first manifest themselves subsequent to the effective date of coverage.

~~(17) All health maintenance contracts that provide coverage for a member of the family of the subscriber, shall, as to such family member's coverage, provide that coverage, benefits, or services applicable for children shall be provided with respect to an adopted child of the subscriber, which child is placed in compliance with chapter 63, from the moment of placement in the residence of the subscriber. Such~~

1 ~~contracts may not exclude coverage for any preexisting~~
2 ~~condition of the child. In the case of a newborn child,~~
3 ~~coverage shall begin from the moment of birth if a written~~
4 ~~agreement to adopt such child has been entered into by the~~
5 ~~subscriber prior to the birth of the child, whether or not~~
6 ~~such agreement is enforceable. However, coverage for such~~
7 ~~child shall not be required in the event that the child is not~~
8 ~~ultimately placed in the residence of the subscriber in~~
9 ~~compliance with chapter 63.~~
10 Section 17. Section 641.3101, Florida Statutes, is
11 amended to read:
12 641.3101 Additional contract contents.--
13 (1) A health maintenance contract may contain
14 additional provisions not inconsistent with this part which
15 are:
16 (a)~~(1)~~ Necessary, on account of the manner in which
17 the organization is constituted or operated, in order to state
18 the rights and obligations of the parties to the contract; or
19 (b)~~(2)~~ Desired by the organization and neither
20 prohibited by law nor in conflict with any provisions required
21 to be included therein.
22 (2) A health maintenance contract that uses a specific
23 methodology for payment of claims shall comply with s.
24 627.6044.
25 Section 18. Section 641.31075, Florida Statutes, is
26 created to read:
27 641.31075 Replacement.--
28 (1) Any health maintenance organization that is
29 replacing any other group health coverage with its group
30 health maintenance coverage shall comply with s. 627.666.
31

CODING:Words ~~stricken~~ are deletions; words underlined are additions.

(2) Any health maintenance organization that is replacing any other individual health coverage with its individual health maintenance coverage shall comply with s. 627.6045.

Section 19. Subsection (1) of section 641.3111, Florida Statutes, is amended to read:

641.3111 Extension of benefits.--

(1) Every group health maintenance contract shall provide that termination of the contract shall be without prejudice to any continuous loss which commenced while the contract was in force, but 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~~. The extension is required regardless of whether the group contract holder or other entity secures replacement coverage from a new insurer or health maintenance organization or foregoes the provision of coverage. The required provision must provide for continuation of contract benefits in connection with the treatment of a specific accident or illness incurred while the contract was in effect.Such extension of benefits may be limited to the occurrence of the earliest of the following events:

(a) The expiration of 12 months.

(b) Such time as the member is no longer totally disabled.

(c) A succeeding carrier elects to provide replacement coverage without limitation as to the disability condition.

(d) The maximum benefits payable under the contract have been paid.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

1 Section 20. Subsection (15) is added to section
2 641.3903, Florida Statutes, to read:
3 641.3903 Unfair methods of competition and unfair or
4 deceptive acts or practices defined.--The following are
5 defined as unfair methods of competition and unfair or
6 deceptive acts or practices:
7 (15) MANDATORY ARBITRATION.--For a managed care
8 provider or prepaid limited health service organization,
9 issuing a contract or service agreement which requires the
10 submission of disputes between the parties to the contract or
11 service agreement to arbitration.
12 Section 21. Subsection (9) is added to section
13 641.441, Florida Statutes, to read:
14 641.441 Unfair methods of competition and unfair or
15 deceptive acts or practices defined.--The following are
16 defined as unfair methods of competition and unfair or
17 deceptive acts or practices:
18 (9) MANDATORY ARBITRATION.--For a prepaid health
19 clinic, issuing a policy or a contract which requires the
20 submission of disputes between the parties to the policy or
21 contract to arbitration.
22 Section 22. Subsection (4) of section 627.651, Florida
23 Statutes, is amended to read:
24 627.651 Group contracts and plans of self-insurance
25 must meet group requirements.--
26 (4) This section does not apply to any plan which is
27 established or maintained by an individual employer in
28 accordance with the Employee Retirement Income Security Act of
29 1974, Pub. L. No. 93-406, or to a multiple-employer welfare
30 arrangement as defined in s. 624.437(1), except that a
31 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 23. 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 24. 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 25. 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.

Such reimbursement shall be net of any applicable copayment authorized pursuant to this subsection.

Section 26. This act shall take effect upon becoming a law.

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