By the Committee on Banking and Insurance; and Senator Campbell

311-2523-03

A bill to be entitled

An act relating to health insurance; amending s. 395.301, F.S.; requiring certain licensed facilities to make certain information public electronically; requiring notice; providing requirements; requiring health care providers and facilities to provide prospective patients with reasonable estimates of prospective charges; requiring certain licensed facilities to make available to payors certain records; providing that the facility may not charge for making records available but may charge a specified amount for providing copies; amending s. 408.909, F.S.; revising the definition of the term "health flex plans"; authorizing plans to limit the term of coverage; extending the expiration date for the program; amending s. 624.406, F.S.; providing for reinsurance under a workers' compensation insurance policy; amending s. 624.603, F.S.; providing an exception in which health insurance includes workers' compensation coverages; amending s. 627.410, F.S.; exempting individuals and certain groups from laws restricting or limiting coinsurance, copayments, or annual or lifetime maximum payments; creating s. 627.6042, F.S.; requiring policies of insurers offering coverage of dependent children to maintain such coverage until the child reaches age 25, under certain circumstances; providing application; creating s. 627.60425, F.S.;

providing for limitations to the requirement for binding arbitration; amending s. 627.6044, F.S.; providing for the payment of claims to non-network providers under specified conditions; requiring that the method used for determining payment of claims be included in filings; providing for disclosure; amending s. 627.6415, F.S.; deleting an age limitation on application of certain dependent coverage requirements; amending s. 627.6475, F.S.; revising risk-assuming carrier election requirements and procedures; revising certain criteria and limitations under the individual health reinsurance program; amending s. 627.651, F.S., relating to group contracts and plans; conforming a cross-reference to changes made by the act; amending s. 627.6487, F.S.; revising a definition of eligible individual for purposes of availability of individual health insurance coverage; authorizing insurers to impose certain surcharges or premium charges for creditable coverage earned in certain states; amending s. 627.6561, F.S.; requiring additional information in a certification relating to certain creditable coverage for purposes of eligibility for exclusion from preexisting condition requirements; amending s. 627.662, F.S.; revising a list of provisions applicable to group, blanket, or franchise health insurance to include use of specific methodology for payment of claims provisions;

amending s. 627.667, F.S.; deleting a limitation on application of certain extension of benefits provisions; amending s. 627.6692, F.S.; increasing a time period for payment of premium to continue coverage under a group health plan; amending s. 627.6699, F.S.; revising certain definitions; revising certain coverage enrollment eligibility criteria for small employers; revising small employer carrier election requirements and procedures; revising certain criteria and limitations under the small employer health reinsurance program; requiring small employers to provide certain health benefit plan information to employees; providing a limitation; revising certain rate adjustment criteria; authorizing separation of experience of certain small employer groups for certain purposes; amending ss. 627.911 and 627.9175, F.S.; applying certain information reporting requirements to health maintenance organizations; revising health insurance information requirements and criteria; authorizing the Financial Services Commission to adopt rules; deleting an annual report requirement; amending s. 627.9403, F.S.; exempting limited benefit policies relating to nursing home care from certain requirements for long-term care insurance; amending s. 641.31, F.S.; specifying nonapplication of certain health maintenance contract filing requirements to certain group health insurance policies,

with exceptions; requiring prepaid limited health service organizations and health maintenance organizations offering coverage of dependent children to maintain such coverage until the child reaches age 25, under certain circumstances; providing application; providing requirements for contract termination and denial of a claim related to limiting age attainment; amending s. 641.3101, F.S.; providing a compliance requirement for health maintenance contracts using a specific payment of claims methodology; creating s. 641.31025, F.S.; requiring that specific reasons for denial of coverage be provided; creating s. 641.31075, F.S.; imposing compliance requirements upon health maintenance organization replacements of other group health coverage with organization coverage; amending s. 641.3111, F.S.; deleting limitations on certain extension of benefits provisions upon group health maintenance contract termination; imposing additional extension of benefits requirements upon such termination; amending s. 641.2018 and 641.3107, F.S., relating to home health care coverage and contracts; conforming cross-references to changes made by the act; amending s. 641.513, F.S.; conforming a cross-reference to changes made by the act; creating s. 627.6410, F.S.; requiring insurers issuing individual health insurance policies to offer coverage for speech, language, swallowing

and hearing disorders; providing certain exceptions and authorizing certain conditions; creating s. 27.66912, F.S.; requiring group health insurers to offer such coverage; amending s. 641.31, F.S.; requiring health maintenance organizations to offer such coverage; providing an effective date.

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

Section 1. Subsection (7) is added to section 395.301, Florida Statutes, to read:

395.301 Itemized patient bill; form and content prescribed by the agency.--

(7)(a) Each licensed facility not operated by the state shall make available to the public on its Internet website or by other electronic means a list of charges and codes and a description of services of the top 100 diagnosis-related groups discharged from the hospital for that year using the CMS grouper applicable to that year and the top 100 outpatient occasions of diagnostic and therapeutic procedures performed using the Healthcare Common Procedure Coding System. For purposes of this paragraph, "CMS grouper" means a system of classification used by the Centers for Medicare and Medicaid Services to assign an inpatient discharge into a diagnosis-related group based on diagnosis codes, procedure codes, and demographic information. The facility shall place a notice in the reception areas that such information is available electronically. The facility's list of charges and codes and the description of services shall be consistent with federal electronic transmission uniform

standards under the Health Insurance Portability and Accountability Act (HIPAA). Changes to the data shall be posted and updated electronically at least 30 days prior to implementation.

(b) A health care facility shall, upon request, furnish a patient, prior to provision of medical services, a reasonable estimate of charges for such services. Such estimate shall not preclude the health care provider or health care facility from exceeding the estimate or making additional charges based on changes in the patient's condition or treatment needs.

(c) A licensed facility not operated by the state must make available to a patient, or a payor acting on behalf of the patient, the records that are necessary to verify the accuracy of the patient's bill or payor's claim related to such patient's bill within a reasonable time after a request. The verification information must be made available in the facility's offices. Such records shall be available to the patient or payor prior to and after payment of the bill or claim. The facility may not charge the patient or payor for making such verification records available, except that the facility may charge its usual charge for providing copies of records as specified in s. 395.3025.

Section 2. Subsections (2), (3), and (10) of section 408.909, Florida Statutes, are amended to read:

408.909 Health flex plans.--

(2) DEFINITIONS.--As used in this section, the term:

(a) "Agency" means the Agency for Health Care Administration.

(b) "Department" means the Department of Insurance.

(c) "Enrollee" means an individual who has been determined to be eligible for and is receiving health care coverage under a health flex plan approved under this section.

(d) "Health care coverage" or "health flex plan coverage" means health care services that are covered as benefits under an approved health flex plan or that are otherwise provided, either directly or through arrangements with other persons, via a health flex plan on a prepaid per capita basis or on a prepaid aggregate fixed-sum basis.

(e) "Health flex plan" means a health plan approved under subsection (3) which guarantees payment for specified health care coverage provided to the enrollee <u>who purchases coverage directly from the plan or through a small business purchasing arrangement sponsored by a local government</u>.

(f) "Health flex plan entity" means a health insurer, health maintenance organization, health-care-provider-sponsored organization, local government, health care district, or other public or private community-based organization that develops and implements an approved health flex plan and is responsible for administering the health flex plan and paying all claims for health flex plan coverage by enrollees of the health flex plan.

(3) PILOT PROGRAM.--The agency and the department shall each approve or disapprove health flex plans that provide health care coverage for eligible participants who reside in the three areas of the state that have the highest number of uninsured persons, as identified in the Florida Health Insurance Study conducted by the agency and in Indian River County. A health flex plan may limit or exclude benefits otherwise required by law for insurers offering coverage in this state, may cap the total amount of claims paid per year

per enrollee, may limit the number of enrollees or the term of coverage, or may take any combination of those actions.

(a) The agency shall develop guidelines for the review of applications for health flex plans and shall disapprove or withdraw approval of plans that do not meet or no longer meet minimum standards for quality of care and access to care.

(b) The department shall develop guidelines for the review of health flex plan applications and shall disapprove or shall withdraw approval of plans that:

1. Contain any ambiguous, inconsistent, or misleading provisions or any exceptions or conditions that deceptively affect or limit the benefits purported to be assumed in the general coverage provided by the health flex plan;

2. Provide benefits that are unreasonable in relation to the premium charged or contain provisions that are unfair or inequitable or contrary to the public policy of this state, that encourage misrepresentation, or that result in unfair discrimination in sales practices; or

3. Cannot demonstrate that the health flex plan is financially sound and that the applicant is able to underwrite or finance the health care coverage provided.

(c) The agency and the department may adopt rules as needed to administer this section.

(10) EXPIRATION.--This section expires July 1, 2008 ~~2004~~.

Section 3. Subsection (4) of section 624.406, Florida Statutes, is amended to read:

624.406 Combinations of insuring powers, one insurer.--An insurer which otherwise qualifies therefor may be authorized to transact any one kind or combination of kinds of insurance as defined in part V except:

(1) A life insurer may also grant annuities, but shall not be authorized to transact any other kind of insurance except health insurance, disability income insurance, excess coverage for health maintenance organizations, or excess insurance, specific and aggregate, for self-insurers of a plan of health insurance and multiple-employer welfare arrangements.

(2) A reciprocal insurer shall not transact life insurance.

(3) Except as to domestic business trust title insurers as referred to in s. 624.404(6), so authorized prior to the effective date of this code, a title insurer shall be a stock insurer.

(4) A health insurer may also transact excess insurance, specific and aggregate, for self-insurers of a plan of health insurance and multiple-employer welfare arrangements and reinsurance for the medical and lost-wages benefits provided under a workers' compensation policy.

Section 4. Section 624.603, Florida Statutes, is amended to read:

624.603 "Health insurance" defined.--"Health insurance," also known as "disability insurance," is insurance of human beings against bodily injury, disablement, or death by accident or accidental means, or the expense thereof, or against disablement or expense resulting from sickness, and every insurance appertaining thereto. Health insurance does not include workers' compensation coverages, except as provided in s. 624.406.

Section 5. Paragraph (b) of subsection (6) of section 627.410, Florida Statutes, is amended to read:

627.410 Filing, approval of forms.--

(6)

(b) The department may establish by rule, for each type of health insurance form, procedures to be used in ascertaining the reasonableness of benefits in relation to premium rates and may, by rule, exempt from any requirement of paragraph (a) any health insurance policy form or type thereof (as specified in such rule) to which form or type such requirements may not be practically applied or to which form or type the application of such requirements is not desirable or necessary for the protection of the public. A law restricting or limiting deductibles, coinsurance, copayments, or annual or lifetime maximum payments shall not apply to any health plan policy offered or delivered to an individual or to a group of 51 or more persons which provides coverage as described in s. 627.6561(5)(a)2.With respect to any health insurance policy form or type thereof which is exempted by rule from any requirement of paragraph (a), premium rates filed pursuant to ss. 627.640 and 627.662 shall be for informational purposes.

Section 6. Section 627.6042, Florida Statutes, is created to read:

627.6042 Dependent coverage.--

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

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

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

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

Section 7. Section 627.60425, Florida Statutes, is created to read:

627.60425 Binding arbitration requirement limitations.--Notwithstanding any other provision of law except s. 624.155, an individual, blanket, or group life or group health insurance policy, individual or group health maintenance organization subscriber contract, prepaid limited health organization subscriber contract, or any life or health insurance policy or certificate delivered or issued for delivery, including out of state group plans pursuant to s. 627.5515 or 627.6515 covering residents of this state, to any resident of this state, shall not require the submission of disputes between the parties to the policy, contract, or plan to binding arbitration unless the applicant has indicated that the same policy, contract, or plan was offered and rejected without arbitration and that the binding arbitration provision was fully explained to the applicant and willingly accepted.

Section 8. Section 627.6044, Florida Statutes, is amended to read:

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

(1) Each insurance policy that provides for payment of claims to non-network providers which is less than the payment of the provider's billed charges to the insured, excluding deductible, coinsurance, and copay amounts, shall:

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

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

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

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

~~provided by the health care provider and the health care provider's estimated charge.~~ An insurer that provides an insured with a good faith estimate is not bound by the estimate. However, a pattern of providing estimates that vary significantly from the ultimate insurance payment constitutes a violation of this code.

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

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

Section 9. Subsections (1) and (4) of section 627.6415, Florida Statutes, are amended to read:

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

(1) A health insurance policy that provides coverage for a member of the family of the insured shall, as to the family member's coverage, provide that the health insurance benefits applicable to children of the insured also apply to an adopted child or a foster child of the insured placed in compliance with chapter 63~~, prior to the child's 18th birthday,~~ from the moment of placement in the residence of the insured. Except in the case of a foster child, the policy may not exclude coverage for any preexisting condition of the child. In the case of a newborn child, coverage begins at the moment of birth if a written agreement to adopt the child has

been entered into by the insured prior to the birth of the child, whether or not the agreement is enforceable. This section does not require coverage for an adopted child who is not ultimately placed in the residence of the insured in compliance with chapter 63.

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

Section 10. Paragraph (a) of subsection (5), paragraph (c) of subsection (6), and paragraphs (b), (c), and (e) of subsection (7) of section 627.6475, Florida Statutes, are amended to read:

627.6475 Individual reinsurance pool.--

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

(a) Each health insurance issuer that offers individual health insurance must elect to become a risk-assuming carrier or a reinsuring carrier for purposes of this section. Each such issuer must make ~~an initial election, binding through December 31, 1999. The issuer's initial election must be made no later than October 31, 1997. By October 31, 1997, all issuers must file a final election, which is binding for 2 years, from January 1, 1998, through December 31, 1999, after which~~ an election which shall be

binding indefinitely or until modified or withdrawn ~~for a period of 5 years~~. The department may permit an issuer to modify its election at any time for good cause shown~~, after a hearing~~.

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

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

(7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.--

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

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

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

3. The board shall annually adjust the initial level of claims and the maximum limit to be retained by the carrier

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

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

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

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

7. A reinsuring carrier shall apply its case-management and claims-handling techniques, including, but not limited to, utilization review, individual case management, preferred provider provisions, other managed-care provisions, or methods of operation consistently with both reinsured business and nonreinsured business.

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

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

(e)1. Before September ~~March~~ 1 of each calendar year, the board shall determine and report to the department the program net loss in the individual account for the previous year, including administrative expenses for that year and the incurred losses for that year, taking into account investment income and other appropriate gains and losses.

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

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

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

c. The board shall equitably assess reinsuring carriers for operating losses of the individual account based on market share. The board shall annually assess each carrier a portion of the operating losses of the individual account. The first tier of assessments shall be determined by multiplying the operating losses by a fraction, the numerator of which equals the reinsuring carrier's earned premium pertaining to direct writings of individual health insurance in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of all such premiums earned by reinsuring carriers in the state during that calendar year. The second tier of assessments shall be based on the premiums that all carriers, except risk-assuming carriers, earned on all health benefit plans written in this state. The board may levy interim assessments

against reinsuring carriers to ensure the financial ability of the plan to cover claims expenses and administrative expenses paid or estimated to be paid in the operation of the plan for the calendar year prior to the association's anticipated receipt of annual assessments for that calendar year. Any interim assessment is due and payable within 30 days after receipt by a carrier of the interim assessment notice. Interim assessment payments shall be credited against the carrier's annual assessment. Health benefit plan premiums and benefits paid by a carrier that are less than an amount determined by the board to justify the cost of collection may not be considered for purposes of determining assessments.

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

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

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

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

Section 11. Subsection (4) of section 627.651, Florida Statutes, is amended to read:

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

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

Section 12. Paragraph (b) of subsection (3) of section 627.6487, Florida Statutes, is amended, and paragraph (c) is added to subsection (4) of that section, to read:

627.6487 Guaranteed availability of individual health insurance coverage to eligible individuals.--

(3) For the purposes of this section, the term "eligible individual" means an individual:

(b) Who is not eligible for coverage under:

1. A group health plan, as defined in s. 2791 of the Public Health Service Act;

2. A conversion policy or contract issued by an authorized insurer or health maintenance organization under s. 627.6675 or s. 641.3921, respectively, offered to an individual who is no longer eligible for coverage under either

an insured or self-insured group health ~~employer~~ plan or group health insurance policy;

3. Part A or part B of Title XVIII of the Social Security Act; or

4. A state plan under Title XIX of such act, or any successor program, and does not have other health insurance coverage;

(4)

(c) If the individual's most recent period of creditable coverage was earned in a state other than this state, an insurer issuing a policy that complies with paragraph (a) may impose a surcharge or charge a premium for such policy equal to that permitted in the state in which such creditable coverage was earned.

Section 13. Paragraph (c) of subsection (8) of section 627.6561, Florida Statutes, is amended to read:

627.6561 Preexisting conditions.--

(8)

(c) The certification described in this section is a written certification that must include:

1. The period of creditable coverage of the individual under the policy and the coverage, if any, under such COBRA continuation provision or continuation pursuant to s. 627.6692.~~;and~~

2. The waiting period, if any, imposed with respect to the individual for any coverage under such policy.

3. A statement that the creditable coverage was provided under a group health plan, a group or individual health insurance policy, or a health maintenance organization contract, the state in which such coverage was provided, and

whether or not such individual was eligible for a conversion policy under such coverage.

Section 14. 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 15. 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 16. 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 promptly and provide coverage retroactively to the date coverage would otherwise have terminated. The premium due shall be for the period beginning on the date coverage would have otherwise terminated due to the qualifying event. The first premium payment must include the coverage paid to the end of the month in which the first payment is made. After the election, the insurance carrier must bill the qualified beneficiary for premiums once each month, with a due date on

the first of the month of coverage and allowing a 30-day grace period for payment.

2. Except as otherwise specified in an election, any election by a qualified beneficiary shall be deemed to include an election of continuation of coverage on behalf of any other qualified beneficiary residing in the same household who would lose coverage under the group health plan by reason of a qualifying event. This subparagraph does not preclude a qualified beneficiary from electing continuation of coverage on behalf of any other qualified beneficiary.

Section 17. Paragraphs (g), (h), (i), and (u) of subsection (3), paragraph (c) of subsection (5), paragraph (b) of subsection (6), paragraph (a) of subsection (9), paragraph (d) of subsection (10), and paragraphs (f), (g), (h), and (j) of subsection (11) of section 627.6699, Florida Statutes, are amended, and paragraph (k) is added to subsection (5) of that section, to read:

627.6699 Employee Health Care Access Act.--

(3) DEFINITIONS.--As used in this section, the term:

(g) "Dependent" means the spouse or child <u>as described in s. 627.6512</u> of an eligible employee, subject to the applicable terms of the health benefit plan covering that employee.

(h) "Eligible employee" means an employee who works full time, having a normal workweek of 25 or more hours, <u>who is paid wages or a salary at least equal to the federal minimum hourly wage applicable to such employee,</u>and who has met any applicable waiting-period requirements or other requirements of this act. The term includes a self-employed individual, a sole proprietor, a partner of a partnership, or an independent contractor, if the sole proprietor, partner, or

independent contractor is included as an employee under a health benefit plan of a small employer, but does not include a part-time, temporary, or substitute employee.

(i) "Established geographic area" means the county or counties~~, or any portion of a county or counties,~~within which the carrier provides or arranges for health care services to be available to its insureds, members, or subscribers.

(u) "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 that the individual file with the Internal Revenue Service for the most recent tax year federal income tax forms with supporting schedules and accompanying income reporting forms or federal income tax extensions of time to file forms ~~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~~.

(5) AVAILABILITY OF COVERAGE.--

(c) Every small employer carrier must, as a condition of transacting business in this state:

1. Beginning July 1, 2000, offer and issue all small employer health benefit plans on a guaranteed-issue basis to every eligible small employer, with 2 to 50 eligible employees, that elects to be covered under such plan, agrees to make the required premium payments, and satisfies the other provisions of the plan. 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.

2. Beginning July 1, 2000, and until July 31, 2001, offer and issue basic and standard small employer health benefit plans on a guaranteed-issue basis to every eligible small employer which is eligible for guaranteed renewal, has less than two eligible employees, is not formed primarily for the purpose of buying health insurance, elects to be covered under such plan, agrees to make the required premium payments, and satisfies the other provisions of the plan. A rider for additional or increased benefits may be medically underwritten and may be added only to the standard benefit plan. The increased rate charged for the additional or increased benefit must be rated in accordance with this section. For purposes of this subparagraph, a person, his or her spouse, and his or her dependent children shall constitute a single eligible employee if that person and spouse are employed by the same small employer and either one has a normal work week of less than 25 hours.

3.a. Beginning August 1, 2001, offer and issue basic and standard small employer health benefit plans on a 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.

4. This paragraph does not limit a carrier's ability to offer other health benefit plans to small employers if the standard and basic health benefit plans are offered and rejected.

(k) Beginning January 1, 2004, every small employer shall provide, on an annual basis, information on at least three different health benefit plans for employees. Nothing in this paragraph shall be construed as requiring a small employer to provide the health benefit plan or contribute to the cost of such plan.

(6) RESTRICTIONS RELATING TO PREMIUM RATES.--

(b) For all small employer health benefit plans that are subject to this section and are issued by small employer carriers on or after January 1, 1994, premium rates for health benefit plans subject to this section are subject to the following:

1. Small employer carriers must use a modified community rating methodology in which the premium for each small employer must be determined solely on the basis of the eligible employee's and eligible dependent's gender, age, family composition, tobacco use, or geographic area as determined under paragraph (5)(j) and in which the premium may be adjusted as permitted by this paragraph.

2. Rating factors related to age, gender, family composition, tobacco use, or geographic location may be developed by each carrier to reflect the carrier's experience. The factors used by carriers are subject to department review and approval.

3. Small employer carriers may not modify the rate for a small employer for 12 months from the initial issue date or renewal date, unless the composition of the group changes or benefits are changed. However, a small employer carrier may modify the rate one time prior to 12 months after the initial issue date for a small employer who enrolls under a previously issued group policy that has a common anniversary date for all employers covered under the policy if:

a. The carrier discloses to the employer in a clear and conspicuous manner the date of the first renewal and the fact that the premium may increase on or after that date.

b. The insurer demonstrates to the department that efficiencies in administration are achieved and reflected in the rates charged to small employers covered under the policy.

4. A carrier may issue a group health insurance policy to a small employer health alliance or other group association with rates that reflect a premium credit for expense savings attributable to administrative activities being performed by the alliance or group association if such expense savings are specifically documented in the insurer's rate filing and are approved by the department. Any such credit may not be based on different morbidity assumptions or on any other factor related to the health status or claims experience of any person covered under the policy. Nothing in this subparagraph exempts an alliance or group association from licensure for any activities that require licensure under the insurance code. A carrier issuing a group health insurance policy to a small employer health alliance or other group association shall allow any properly licensed and appointed agent of that carrier to market and sell the small employer health alliance or other group association policy. Such agent shall be paid the usual and customary commission paid to any agent selling the policy.

5. Any adjustments in rates for claims experience, health status, or duration of coverage may not be charged to individual employees or dependents. For a small employer's policy, such adjustments may not result in a rate for the small employer which deviates more than 15 percent from the 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 3 ~~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 3 ~~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, for two dependent children, and for three or more dependent children for family coverage of employees having a spouse and dependent children or employees having dependent children only. A small employer carrier may have fewer, but not greater, numbers of categories for dependent children than those specified in this subparagraph.

7. Small employer carriers may not use a composite rating methodology to rate a small employer with fewer than 10 employees. For the purposes of this subparagraph, a "composite rating methodology" means a rating methodology that averages the impact of the rating factors for age and gender in the premiums charged to all of the employees of a small employer.

8.a. A carrier may separate the experience of small employer groups with less than 2 eligible employees from the experience of small employer groups with 2-50 eligible employees for purposes of determining an alternative modified community rating.

b. If a carrier separates the experience of small employer groups as provided in sub-subparagraph a., the rate to be charged to small employer groups of less than 2 eligible employees may not exceed 150 percent of the rate determined for small employer groups of 2-50 eligible employees. However, the carrier may charge excess losses of the experience pool consisting of small employer groups with less than 2 eligible employees to the experience pool consisting of small employer groups with 2-50 eligible employees so that all losses are allocated and the 150-percent rate limit on the experience pool consisting of small employer groups with less than 2 eligible employees is maintained. Notwithstanding s. 627.411(1), the rate to be charged to a small employer group 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. In addition to the separation allowed under sub-subparagraph 8.a., a carrier may also separate the experience of small employer groups of 1-50 eligible employees

using a health reimbursement arrangement, as defined in Internal Revenue Service Notice 2002-45, 2002-28 Internal Revenue Bulletin 93, and Revenue Ruling 2002-41, 2002-28 Internal Revenue Bulletin 75, from the experience of small employer groups of 1-50 eligible employees not using such a health reimbursement arrangement for purposes of determining an alternative modified community rating.

(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 election~~. ~~The department shall hold a hearing on the election at the request of the carrier.~~

(11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.--

(f) The program has the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to groups or individuals. In addition thereto, the program has specific authority to:

1. Enter into contracts as necessary or proper to carry out the provisions and purposes of this act, including the authority to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions.

2. Sue or be sued, including taking any legal action necessary or proper for recovering any assessments and penalties for, on behalf of, or against the program or any carrier.

3. Take any legal action necessary to avoid the payment of improper claims against the program.

4. Issue reinsurance policies, in accordance with the requirements of this act.

5. Establish rules, conditions, and procedures for reinsurance risks under the program participation.

6. Establish actuarial functions as appropriate for the operation of the program.

7. Assess participating carriers in accordance with paragraph (j), and make advance interim assessments as may be reasonable and necessary for organizational and interim 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 office.

(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 office.

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 office.

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 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 for the year, taking into account investment income and other appropriate gains and losses.

2. Any net loss for the year shall be recouped by assessment of the carriers, as follows:

a. The operating losses of the program shall be assessed in the following order subject to the specified limitations. The first tier of assessments shall be made against reinsuring carriers in an amount which shall not exceed 5 percent of each reinsuring carrier's premiums from health benefit plans covering small employers. If such assessments have been collected and additional moneys are needed, the board shall make a second tier of assessments in an amount which shall not exceed 0.5 percent of each carrier's health benefit plan premiums. Except as provided in paragraph (n), risk-assuming carriers are exempt from all assessments authorized pursuant to this section. The amount paid by a reinsuring carrier for the first tier of assessments shall be credited against any additional assessments made.

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

the total of all such premiums earned by reinsuring carriers in the state during that calendar year. The second tier of assessments shall be based on the premiums that all carriers, except risk-assuming carriers, earned on all health benefit plans written in this state. The board may levy interim assessments against 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 <u>September</u> ~~March~~ 1 of each year, the board shall determine and file with the department an estimate of the assessments needed to fund the losses incurred by the program in the 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 were incurred. The evaluation shall include an estimate of future assessments, the administrative costs of the program, the appropriateness of the premiums charged and the level of carrier retention under the program, and the costs of coverage for small employers. If the board fails to file a report with the department within 240 ~~90~~ days following the end of the applicable calendar year, the department may evaluate the operations of the program and implement such amendments to the plan of operation the department deems necessary to reduce future losses and assessments.

5. If assessments exceed the amount of the actual losses and administrative expenses of the program, the excess shall be held as interest and used by the board to offset future losses or to reduce program premiums. As used in this paragraph, the term "future losses" includes reserves for incurred but not reported claims.

6. Each carrier's proportion of the assessment shall be determined annually by the board, based on annual statements and other reports considered necessary by the board and filed by the carriers with the board.

7. Provision shall be made in the plan of operation for the imposition of an interest penalty for late payment of an assessment.

8. A carrier may seek, from the commissioner, a deferment, in whole or in part, from any assessment made by the board. The department may defer, in whole or in part, the assessment of a carrier if, in the opinion of the department,

the payment of the assessment would place the carrier in a financially impaired condition. If an assessment against a carrier is deferred, in whole or in part, the amount by which the assessment is deferred may be assessed against the other carriers in a manner consistent with the basis for assessment set forth in this section. The carrier receiving such deferment remains liable to the program for the amount deferred and is prohibited from reinsuring any individuals or groups in the program if it fails to pay assessments.

Section 18. Section 627.911, Florida Statutes, is amended to read:

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

Section 19. Section 627.9175, Florida Statutes, is amended to read:

627.9175 Reports of information on health insurance.--

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

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

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

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

1. Direct premiums earned.

2. Direct losses incurred.

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

4. Number of policies.

5. Number of certificates.

6. Number of total covered lives.

(3) The commission may adopt rules to administer this section, including rules governing compliance and provisions implementing electronic methodologies for use in furnishing such records or documents. The commission may by rule specify a uniform format for the submission of this information in order to allow for meaningful comparisons.

~~(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. The department shall publish annually a consumer's guide which summarizes and compares the information required to be reported under this subsection.~~

~~(2)(a) Every insurer transacting health insurance in this state shall report annually to the department, not later than April 1, information relating to any measure the insurer has implemented or proposes to implement during the next calendar year for the purpose of containing health insurance costs or cost increases. The reports shall identify each measure and the forms to which the measure is applied, shall provide an explanation as to how the measure is used, and shall provide an estimate of the cost effect of the measure.~~

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

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

Section 20. Section 627.9403, Florida Statutes, is amended to read:

627.9403 Scope.--The provisions of this part shall apply to long-term care insurance policies delivered or issued for delivery in this state, and to policies delivered or issued for delivery outside this state to the extent provided in s. 627.9406, by an insurer, a fraternal benefit society as defined in s. 632.601, a health maintenance organization as defined in s. 641.19, a prepaid health clinic as defined in s. 641.402, or a multiple-employer welfare arrangement as defined in s. 624.437. A policy which is advertised, marketed, or offered as a long-term care policy and as a Medicare supplement policy shall meet the requirements of this part and the requirements of ss. 627.671-627.675 and, to the extent of a conflict, be subject to the requirement that is more favorable to the policyholder or certificateholder. The provisions of this part shall not apply to a continuing care contract issued pursuant to chapter 651 and shall not apply to guaranteed renewable policies issued prior to October 1, 1988. Any limited benefit policy that limits coverage to care in a nursing home or to one or more lower levels of care required or authorized to be provided by this part or by department rule must meet all requirements of this part that apply to long-term care insurance policies, except ss. 627.9407(3)(c) and (d), (9), (10)(f), and (12) and 627.94073(2). If the limited benefit policy does not provide coverage for care in a nursing home, but does provide coverage for one or more lower levels of care, the policy shall also be exempt from the requirements of s. 627.9407(3)(d).

Section 21. Subsection (2), paragraph (d) of subsection (3), and subsections (9) through (17) of section 641.31, Florida Statutes, are amended to read:

641.31 Health maintenance contracts.--

(2) The rates charged by any health maintenance organization to its subscribers shall not be excessive, inadequate, or unfairly discriminatory or follow a rating methodology that is inconsistent, indeterminate, or ambiguous or encourages misrepresentation or misunderstanding. A law restricting or limiting deductibles, coinsurance, copayments, or annual or lifetime maximum payments shall not apply to any health maintenance organization contract offered or delivered to an individual or a group of 51 or more persons which provides coverage as described in s. 641.31071(5)(a)2.The department, in accordance with generally accepted actuarial practice as applied to health maintenance organizations, may define by rule what constitutes excessive, inadequate, or unfairly discriminatory rates and may require whatever information it deems necessary to determine that a rate or proposed rate meets the requirements of this subsection.

(3)

(d) Any change in rates charged for the contract must be filed with the department not less than 30 days in advance of the effective date. At the expiration of such 30 days, the rate filing shall be deemed approved unless prior to such time the filing has been affirmatively approved or disapproved by order of the department. The approval of the filing by the department constitutes a waiver of any unexpired portion of such waiting period. The department may extend by not more than an additional 15 days the period within which it may so affirmatively approve or disapprove any such filing, by giving notice of such extension before expiration of the initial 30-day period. At the expiration of any such period as so extended, and in the absence of such prior affirmative approval or disapproval, any such filing shall be deemed

approved. This paragraph does not apply to group contracts effectuated and delivered in this state insuring groups of 51 or more persons, except for Medicare supplement insurance, long-term care insurance, and any coverage under which the increase in claims costs over the lifetime of the contract due to advancing age or duration is refunded in the premium.

(9)(a)1. If a health maintenance organization offers coverage for dependent children of the subscriber, the contract 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 the child meets all of the following:

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 coverage, provide that benefits applicable to children of the subscriber also apply to an adopted child or a foster child of the subscriber placed in compliance with chapter 63 from the moment of placement in the residence of the subscriber. Except in the case of a foster child, the contract may not exclude coverage for any preexisting condition of the child. In the case of a newborn child, coverage begins at the moment of birth if a written agreement to adopt such child has been entered into by the subscriber prior to the birth of the child, whether or not the agreement is enforceable. This

section does not require coverage for an adopted child who is not ultimately placed in the residence of the subscriber in compliance with chapter 63.

2. A contract may require the subscriber to notify the health maintenance organization 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. If timely notice is given, the health maintenance organization may not charge an additional premium for coverage of the child for the duration of the notice period. If timely notice is not given, the health maintenance organization may charge an additional premium from the date of birth or placement. If notice is given within 60 days after the birth or placement of the child, the health maintenance organization may not deny coverage for the child due to the failure of the subscriber to timely notify the health maintenance organization of the birth or placement of the child.

3. If the contract does not require the subscriber to notify the health maintenance organization of the birth or placement of an adopted child within a specified time period, the health maintenance organization may not deny coverage for such child or retroactively charge the subscriber an additional premium for such child. However, the health maintenance organization may prospectively charge the subscriber an additional premium for the child if the health maintenance organization provides at least 45 days' notice of the additional premium required.

4. In order to increase access to postnatal, infant, and pediatric health care for all children placed in court-ordered custody, including foster children, all health

maintenance organization contracts that provide coverage for a family member of the subscriber shall, as to such family member's coverage, provide that benefits applicable for children shall be payable with respect to a foster child or other child in court-ordered temporary or other custody of the subscriber.

(10) A contract that provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the contract shall also provide in substance that attainment of the limiting age does not terminate the coverage of the child while the child continues to be:

(a) Incapable of self-sustaining employment by reason of mental retardation or physical handicap.

(b) Chiefly dependent upon the 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 subscriber has the burden of establishing that 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 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 manner so as to effectuate the next available disenrollment date, as prescribed by such federal agency.

(b) The health maintenance contract, certificate, or member handbook shall be delivered to the subscriber no later than the earlier of 10 working days after the health maintenance organization and the Health Care Financing Administration of the United States Department of Health and Human Services approve the subscriber's enrollment application or the effective date of coverage of the subscriber under the

health maintenance contract. However, if notice from the Health Care Financing Administration of its approval of the subscriber's enrollment application is received by the health maintenance organization after the effective coverage date prescribed by the Health Care Financing Administration, the health maintenance organization shall deliver the contract, certificate, or member handbook to the subscriber within 10 days after receiving such notice. When a Medicare recipient is enrolled in a health maintenance organization program, the contract, certificate, or member handbook shall be accompanied by a health maintenance organization identification sticker with instruction to the Medicare beneficiary to place the sticker on the Medicare identification card.

(15)~~(14)~~ Whenever a subscriber of a health maintenance organization is also a Medicaid recipient, the health maintenance organization's coverage shall be primary to the recipient's Medicaid benefits and the organization shall be a third party subject to the provisions of s. 409.910(4).

(16)~~(15)~~(a) All health maintenance contracts, certificates, and member handbooks shall contain the following provision:

"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 contracts may not exclude coverage for any preexisting condition of the child. In the case of a newborn child, coverage shall begin from 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 such agreement is enforceable. However, coverage for such child shall not be required in the event that the child is not ultimately placed in the residence of the subscriber in compliance with chapter 63.~~

Section 22. Section 641.3101, Florida Statutes, is amended to read:

641.3101 Additional contract contents.--

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

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

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

(2) A health maintenance contract that uses a specific methodology for payment of claims shall comply with s. 627.6044. The method used for determining the payment of claims shall be included in filings made pursuant to s. 641.31(3), and may not be changed unless such change is filed under s. 641.31(3).

Section 23. Section 641.31025, Florida Statutes, is created to read:

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

Section 24. Section 641.31075, Florida Statutes, is created to read:

641.31075 Replacement.--Any health maintenance organization that is replacing any other group health coverage with its group health maintenance coverage shall comply with s. 627.666.

Section 25. Subsections (1) and (3) of section 641.3111, Florida Statutes, are 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.~~

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

(3) In the case of maternity coverage, ~~when not covered by the succeeding carrier,~~a reasonable extension of benefits or accrued liability provision is required, which provision provides for continuation of the contract benefits

in connection with maternity expenses for a pregnancy that commenced while the policy was in effect. The extension shall be for the period of that pregnancy and shall not be based upon total disability.

Section 26. 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 27. 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 28. 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.

Section 29. Section 627.6410, Florida Statutes, is created to read:

627.6410 Optional coverage for speech, language, swallowing, and hearing disorders.--

(1) Insurers issuing individual health insurance policies in this state shall make available to the policyholder as part of the application for any such policy of insurance, 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 a hearing aid and earmolds benefit at the level of benefits specified in the January 2001 Florida Medicaid Hearing Services Handbook.

(2) This section does not apply to specified-accident, specified-disease, hospital indemnity, limited benefit, disability income, or long-term care insurance policies.

(3) Such optional coverage is not required to be offered when substantially similar benefits are included in the policy of insurance issued to the policyholder.

(4) This section does not require or prohibit the use of a provider network.

(5) This section does not prohibit an insurer from requiring prior authorization for the benefits under this section.

Section 30. Section 627.66912, Florida Statutes, is created to read:

627.66912 Optional coverage for speech, language, swallowing, and hearing disorders.--

(1) Insurers issuing group health insurance policies in this state shall make available to the policyholder as part of the application for any such policy of insurance, 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 a hearing aid and earmolds benefit at the level of benefits specified in the January 2001 Florida Medicaid Hearing Services Handbook.

(2) This section does not apply to specified-accident, specified-disease, hospital indemnity, limited benefit, disability income, or long-term care insurance policies.

(3) Such optional coverage is not required to be offered when substantially similar benefits are included in the policy of insurance issued to the policyholder.

(4) This section does not require or prohibit the use of a provider network.

(5) This section does not prohibit an insurer from requiring prior authorization for the benefits under this section.

Section 31. Subsection (40) is added to section 641.31, Florida Statutes, to read:

641.31 Health maintenance contracts.--

(40) Health maintenance organizations shall make available to the contract holder as part of the application for any such contract, 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 a hearing aid and earmolds benefit at the level of benefits specified in the January 2001 Florida Medicaid Hearing Services Handbook.

(a) Such optional coverage is not required to be offered when substantially similar benefits are included in the contract issued to the subscriber.

(b) This section does not require or prohibit the use of a provider network.

(c) This section does not prohibit an organization from requiring prior authorization for the benefits under this subsection.

(d) This subsection does not apply to health maintenance organizations issuing individual coverage to fewer than 50,000 members.

Section 32. This act shall take effect July 1, 2003.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR
Senate Bill 1796

The committee substitute does the following:

- Requires hospitals to have an Internet web site that lists charges and codes for certain procedures, to furnish a patient a reasonable estimate of charges, and to make available 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.
- Allows health insurers to transact reinsurance for the medical and lost wages benefits under a workers' compensation insurance policy.
- Revises the prohibition on mandatory arbitration clauses in life, health, and disability insurance.
- 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 to provide certain payments.
- 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 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.
- Deletes provisions of the bill relating to prescription drug benefits and home health services.
- Reinserts the current law allowing small group carriers to adjust rates by plus or minus 15 percent based on health status or claims experience.