CHAMBER ACTION

Senate		House
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Representative Llorente offered the following:

Amendment to Amendment (637059) (with title amendment)

Remove everything after the enacting clause, and insert:

Section 1. Paragraph (e) of subsection (2), subsection (3), paragraph (c) of subsection (5), and subsection (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:

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

(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

28 areas of the state that have the highest number of uninsured
29 persons, as identified in the Florida Health Insurance Study
30 conducted by the agency and in Indian River County. A health
31 flex plan may limit or exclude benefits otherwise required by
32 law for insurers offering coverage in this state, may cap the
33 total amount of claims paid per year per enrollee, may limit the
34 number of enrollees <u>or the term of coverage</u>, or may take any
35 combination of those actions.

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

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

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

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

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

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

57 (5) ELIGIBILITY.--Eligibility to enroll in an approved
58 health flex plan is limited to residents of this state who:
59 (c) Are not covered by a private insurance policy and are
60 not eligible for coverage through a public health insurance
61 program, such as Medicare or Medicaid, or another public health
62 care program, such as KidCare, and have not been covered at any
63 time during the past 6 months, except that a small business
64 purchasing arrangement sponsored by a local government may limit
65 enrollment to residents of this state who have not been covered
66 at any time during the past 12 months; and
67 (10) EXPIRATION.--This section expires July 1, 2008 ~~2004~~.
68 Section 2. Section 627.6042, Florida Statutes, is created
69 to read:
70 627.6042 Dependent coverage.--
71 (1) If an insurer offers coverage that insures dependent
72 children of the policyholder or certificateholder, the policy
73 must insure a dependent child of the policyholder or
74 certificateholder at least until the end of the calendar year in
75 which the child reaches the age of 25, if the child meets all of
76 the following:
77 (a) The child is dependent upon the policyholder or
78 certificateholder for support.
79 (b) The child is living in the household of the
80 policyholder or certificateholder or the child is a full-time or
81 part-time student.
82 (2) Nothing in this section affects or preempts an
83 insurer's right to medically underwrite or charge the
84 appropriate premium.

85 Section 3. Section 627.60425, Florida Statutes, is created
86 to read:
87 627.60425 Binding arbitration requirement
88 limitations.--Notwithstanding any other provision of law, except
89 s. 624.155, an individual, blanket, group life, or group health
90 insurance policy; individual or group health maintenance
91 organization subscriber contract; prepaid limited health
92 organization subscriber contract; or any life or health
93 insurance policy or certificate delivered or issued for
94 delivery, including out-of-state group plans pursuant to s.
95 627.5515 or s. 627.6515 covering residents of this state, to any
96 resident of this state shall not require the submission of
97 disputes between the parties to the policy, contract, or plan to
98 binding arbitration unless the applicant has indicated that the
99 same policy, contract, or plan was offered and rejected without
100 arbitration and that the binding arbitration provision was fully
101 explained to the applicant and willingly accepted.
102 Section 4. Section 627.6044, Florida Statutes, is amended
103 to read:
104 627.6044 Use of a specific methodology for payment of
105 claims.--
106 (1) Each insurance policy that provides for payment of
107 claims to nonnetwork providers that is less than the payment of
108 the provider's billed charges to the insured, excluding
109 deductible, coinsurance, and copay amounts, shall:
110 (a) Provide benefits prior to deductible, coinsurance, and
111 copay amounts for using a nonnetwork provider that are at least
112 equal to the amount that would have been allowed had the insured

113 used a network provider but are not in excess of the actual
114 billed charges.
115 (b) Where there are multiple network providers in the
116 geographical area in which the services were provided or, if
117 none, the closest geographic area, the carrier may use an
118 averaging method of the contracted amounts but not less than the
119 80th percentile of all network contracted amounts in the
120 geographic area.
121
122 For purposes of this subsection, the term "network providers"
123 means those providers for which an insured will not be
124 responsible for any balance payment for services provided by
125 such provider, excluding deductible, coinsurance, and copay
126 amounts ~~based on a specific methodology, including, but not~~
127 ~~limited to, usual and customary charges, reasonable and~~
128 ~~customary charges, or charges based upon the prevailing rate in~~
129 ~~the community, shall specify the formula or criteria used by the~~
130 ~~insurer in determining the amount to be paid~~.
131 (2) Each insurer issuing a policy that provides for
132 payment of claims based on a specific methodology shall provide
133 to an insured, upon her or his written request, an estimate of
134 the amount the insurer will pay for a particular medical
135 procedure or service. The estimate may be in the form of a range
136 of payments or an average payment and may specify that the
137 estimate is based on the assumption of a particular service
138 code. ~~The insurer may require the insured to provide detailed~~
139 ~~information regarding the procedure or service to be performed,~~
140 ~~including the procedure or service code number provided by the~~
141 ~~health care provider and the health care provider's estimated~~

142 ~~charge.~~ An insurer that provides an insured with a good faith
143 estimate is not bound by the estimate. However, a pattern of
144 providing estimates that vary significantly from the ultimate
145 insurance payment constitutes a violation of this code.
146 (3) The method used for determining the payment of claims
147 shall be included in filings made pursuant to s. 627.410(6) and
148 may not be changed unless such change is filed under s.
149 627.410(6).
150 (4) Any policy that provides that the insured is
151 responsible for the balance of a claim amount, excluding
152 deductible, coinsurance, and copay amounts, must disclose such
153 feature on the face of the policy or certificate and such
154 feature must be included in any outline of coverage provided to
155 the insured.
156 Section 5. Subsections (1) and (4) of section 627.6415,
157 Florida Statutes, are amended to read:
158 627.6415 Coverage for natural-born, adopted, and foster
159 children; children in insured's custodial care.--
160 (1) A health insurance policy that provides coverage for a
161 member of the family of the insured shall, as to the family
162 member's coverage, provide that the health insurance benefits
163 applicable to children of the insured also apply to an adopted
164 child or a foster child of the insured placed in compliance with
165 chapter 63~~, prior to the child's 18th birthday,~~ from the moment
166 of placement in the residence of the insured. Except in the case
167 of a foster child, the policy may not exclude coverage for any
168 preexisting condition of the child. In the case of a newborn
169 child, coverage begins at the moment of birth if a written
170 agreement to adopt the child has been entered into by the

171 insured prior to the birth of the child, whether or not the
172 agreement is enforceable. This section does not require coverage
173 for an adopted child who is not ultimately placed in the
174 residence of the insured in compliance with chapter 63.
175 (4) In order to increase access to postnatal, infant, and
176 pediatric health care for all children placed in court-ordered
177 custody, including foster children, all health insurance
178 policies that provide coverage for a member of the family of the
179 insured shall, as to such family member's coverage, also provide
180 that the health insurance benefits applicable for children shall
181 be payable with respect to a foster child or other child in
182 court-ordered temporary or other custody of the insured~~, prior~~
183 ~~to the child's 18th birthday~~.
184 Section 6. Paragraph (a) of subsection (5), paragraph (c)
185 of subsection (6), and paragraphs (b), (c), and (e) of
186 subsection (7) of section 627.6475, Florida Statutes, are
187 amended to read:
188 627.6475 Individual reinsurance pool.--
189 (5) ISSUER'S ELECTION TO BECOME A RISK-ASSUMING CARRIER.--
190 (a) Each health insurance issuer that offers individual
191 health insurance must elect to become a risk-assuming carrier or
192 a reinsuring carrier for purposes of this section. Each such
193 issuer must make ~~an initial election, binding through December~~
194 ~~31, 1999. The issuer's initial election must be made no later~~
195 ~~than October 31, 1997. By October 31, 1997, all issuers must~~
196 ~~file a final election, which is binding for 2 years, from~~
197 ~~January 1, 1998, through December 31, 1999, after which~~ an
198 election <u>that</u> shall be binding <u>indefinitely or until modified or</u>
199 <u>withdrawn</u> ~~for a period of 5 years~~. The department may permit an

200 issuer to modify its election at any time for good cause shown, 201 after a hearing.
202 (6) ELECTION PROCESS TO BECOME A RISK-ASSUMING CARRIER.--
203 (c) The department shall provide public notice of an 204 issuer's filing a designation of election under this subsection 205 to become a risk-assuming carrier and shall provide at least a 206 21-day period for public comment upon receipt of such filing 207 prior to making a decision on the election. The department shall 208 hold a hearing on the election at the request of the issuer.
209 (7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.--
210 (b) A reinsuring carrier may reinsure with the program 211 coverage of an eligible individual, subject to each of the 212 following provisions:
213 1. A reinsuring carrier may reinsure an eligible 214 individual within 90 60 days after commencement of the coverage 215 of the eligible individual.
216 2. The program may not reimburse a participating carrier 217 with respect to the claims of a reinsured eligible individual 218 until the carrier has paid incurred claims of an amount equal to 219 the participating carrier's selected deductible level at least 220 $5,000 in a calendar year for benefits covered by the program. 221 In addition, the reinsuring carrier is responsible for 10 222 percent of the next $50,000 and 5 percent of the next $100,000 223 of incurred claims during a calendar year, and the program shall 224 reinsure the remainder.
225 3. The board shall annually adjust the initial level of 226 claims and the maximum limit to be retained by the carrier to 227 reflect increases in costs and utilization within the standard 228 market for health benefit plans within the state. The adjustment

229 may not be less than the annual change in the medical component
230 of the "Commerce Price Index for All Urban Consumers" of the
231 Bureau of Labor Statistics of the United States Department of
232 Labor, unless the board proposes and the department approves a
233 lower adjustment factor.
234 4. A reinsuring carrier may terminate reinsurance for all
235 reinsured eligible individuals on any plan anniversary.
236 5. The premium rate charged for reinsurance by the program
237 to a health maintenance organization that is approved by the
238 Secretary of Health and Human Services as a federally qualified
239 health maintenance organization pursuant to 42 U.S.C. s.
240 300e(c)(2)(A) and that, as such, is subject to requirements that
241 limit the amount of risk that may be ceded to the program, which
242 requirements are more restrictive than subparagraph 2., shall be
243 reduced by an amount equal to that portion of the risk, if any,
244 which exceeds the amount set forth in subparagraph 2., which may
245 not be ceded to the program.
246 6. The board may consider adjustments to the premium rates
247 charged for reinsurance by the program or carriers that use
248 effective cost-containment measures, including high-cost case
249 management, as defined by the board.
250 7. A reinsuring carrier shall apply its case-management
251 and claims-handling techniques, including, but not limited to,
252 utilization review, individual case management, preferred
253 provider provisions, other managed-care provisions, or methods
254 of operation consistently with both reinsured business and
255 nonreinsured business.
256 (c)1. The board, as part of the plan of operation, shall
257 establish a methodology for determining premium rates to be

258 charged by the program for reinsuring eligible individuals
259 pursuant to this section. The methodology must include a system
260 for classifying individuals which reflects the types of case
261 characteristics commonly used by carriers in this state. The
262 methodology must provide for the development of basic
263 reinsurance premium rates, which shall be multiplied by the
264 factors set for them in this paragraph to determine the premium
265 rates for the program. The basic reinsurance premium rates shall
266 be established by the board, subject to the approval of the
267 department, and shall be set at levels that reasonably
268 approximate gross premiums charged to eligible individuals for
269 individual health insurance by health insurance issuers. The
270 premium rates set by the board may vary by geographical area, as
271 determined under this section, to reflect differences in cost.
272 ~~An eligible individual may be reinsured for a rate that is five~~
273 ~~times the rate established by the board.~~

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

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

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

287 a. The operating losses of the program shall be assessed
288 in the following order subject to the specified limitations. The
289 first tier of assessments shall be made against reinsuring
290 carriers in an amount that may not exceed 5 percent of each
291 reinsuring carrier's premiums for individual health insurance.
292 If such assessments have been collected and additional moneys
293 are needed, the board shall make a second tier of assessments in
294 an amount that may not exceed 0.5 percent of each carrier's
295 health benefit plan premiums.
296 b. Except as provided in paragraph (f), risk-assuming
297 carriers are exempt from all assessments authorized pursuant to
298 this section. The amount paid by a reinsuring carrier for the
299 first tier of assessments shall be credited against any
300 additional assessments made.
301 c. The board shall equitably assess reinsuring carriers
302 for operating losses of the individual account based on market
303 share. The board shall annually assess each carrier a portion of
304 the operating losses of the individual account. The first tier
305 of assessments shall be determined by multiplying the operating
306 losses by a fraction, the numerator of which equals the
307 reinsuring carrier's earned premium pertaining to direct
308 writings of individual health insurance in the state during the
309 calendar year for which the assessment is levied, and the
310 denominator of which equals the total of all such premiums
311 earned by reinsuring carriers in the state during that calendar
312 year. The second tier of assessments shall be based on the
313 premiums that all carriers, except risk-assuming carriers,
314 earned on all health benefit plans written in this state. The
315 board may levy interim assessments against reinsuring carriers

316 to ensure the financial ability of the plan to cover claims
317 expenses and administrative expenses paid or estimated to be
318 paid in the operation of the plan for the calendar year prior to
319 the association's anticipated receipt of annual assessments for
320 that calendar year. Any interim assessment is due and payable
321 within 30 days after receipt by a carrier of the interim
322 assessment notice. Interim assessment payments shall be credited
323 against the carrier's annual assessment. Health benefit plan
324 premiums and benefits paid by a carrier that are less than an
325 amount determined by the board to justify the cost of collection
326 may not be considered for purposes of determining assessments.
327 d. Subject to the approval of the department, the board
328 shall adjust the assessment formula for reinsuring carriers that
329 are approved as federally qualified health maintenance
330 organizations by the Secretary of Health and Human Services
331 pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent, if any,
332 that restrictions are placed on them which are not imposed on
333 other carriers.
334 3. Before September ~~March~~ 1 of each year, the board shall
335 determine and file with the department an estimate of the
336 assessments needed to fund the losses incurred by the program in
337 the individual account for the previous calendar year.
338 4. If the board determines that the assessments needed to
339 fund the losses incurred by the program in the individual
340 account for the previous calendar year will exceed the amount
341 specified in subparagraph 2., the board shall evaluate the
342 operation of the program and report its findings and
343 recommendations to the department in the format established in

344 s. 627.6699(11) for the comparable report for the small employer
345 reinsurance program.
346 Section 7. Subsection (4) of section 627.651, Florida
347 Statutes, is amended to read:
348 627.651 Group contracts and plans of self-insurance must
349 meet group requirements.--
350 (4) This section does not apply to any plan which is
351 established or maintained by an individual employer in
352 accordance with the Employee Retirement Income Security Act of
353 1974, Pub. L. No. 93-406, or to a multiple-employer welfare
354 arrangement as defined in s. 624.437(1), except that a multiple-
355 employer welfare arrangement shall comply with ss. 627.419,
356 627.657, 627.6575, 627.6578, 627.6579, 627.6612, 627.66121,
357 627.66122, 627.6615, 627.6616, and 627.662<u>(8)</u>~~(7)~~. This
358 subsection does not allow an authorized insurer to issue a group
359 health insurance policy or certificate which does not comply
360 with this part.
361 Section 8. Section 627.662, Florida Statutes, is amended
362 to read:
363 627.662 Other provisions applicable.--The following
364 provisions apply to group health insurance, blanket health
365 insurance, and franchise health insurance:
366 (1) Section 627.569, relating to use of dividends,
367 refunds, rate reductions, commissions, and service fees.
368 (2) Section 627.602(1)(f) and (2), relating to
369 identification numbers and statement of deductible provisions.
370 <u>(3) Section 627.6044, relating to the use of specific</u>
371 <u>methodology for payment of claims.</u>
372 <u>(4)</u>~~(3)~~ Section 627.635, relating to excess insurance.

373 (5)~~(4)~~ Section 627.638, relating to direct payment for
374 hospital or medical services.
375 (6)~~(5)~~ Section 627.640, relating to filing and
376 classification of rates.
377 (7)~~(6)~~ Section 627.613, relating to timely payment of
378 claims, or s. 627.6131, relating to payment of claims, whichever
379 is applicable.
380 (8)~~(7)~~ Section 627.645(1), relating to denial of claims.
381 (9)~~(8)~~ Section 627.6471, relating to preferred provider
382 organizations.
383 (10)~~(9)~~ Section 627.6472, relating to exclusive provider
384 organizations.
385 (11)~~(10)~~ Section 627.6473, relating to combined preferred
386 provider and exclusive provider policies.
387 (12)~~(11)~~ Section 627.6474, relating to provider contracts.
388 Section 9. Subsection (6) of section 627.667, Florida
389 Statutes, is amended to read:
390 627.667 Extension of benefits.--
391 (6) This section also applies to holders of group
392 certificates which are renewed, delivered, or issued for
393 delivery to residents of this state under group policies
394 effectuated or delivered outside this state~~, unless a succeeding~~
395 ~~carrier under a group policy has agreed to assume liability for~~
396 ~~the benefits~~.
397 Section 10. Paragraph (e) of subsection (5) of section
398 627.6692, Florida Statutes, is amended to read:
399 627.6692 Florida Health Insurance Coverage Continuation
400 Act.--
401 (5) CONTINUATION OF COVERAGE UNDER GROUP HEALTH PLANS.--

402 (e)1. A covered employee or other qualified beneficiary
403 who wishes continuation of coverage must pay the initial premium
404 and elect such continuation in writing to the insurance carrier
405 issuing the employer's group health plan within 63 ~~30~~ days after
406 receiving notice from the insurance carrier under paragraph (d).
407 Subsequent premiums are due by the grace period expiration date.
408 The insurance carrier or the insurance carrier's designee shall
409 process all elections promptly and provide coverage
410 retroactively to the date coverage would otherwise have
411 terminated. The premium due shall be for the period beginning on
412 the date coverage would have otherwise terminated due to the
413 qualifying event. The first premium payment must include the
414 coverage paid to the end of the month in which the first payment
415 is made. After the election, the insurance carrier must bill the
416 qualified beneficiary for premiums once each month, with a due
417 date on the first of the month of coverage and allowing a 30-day
418 grace period for payment.

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

427 Section 11. Paragraphs (g), (h), (i), and (u) of
428 subsection (3), paragraph (c) of subsection (5), paragraph (a)
429 of subsection (9), paragraph (d) of subsection (10), and

430 paragraphs (f), (g), (h), and (j) of subsection (11) of section
431 627.6699, Florida Statutes, are amended to read:
432 627.6699 Employee Health Care Access Act.--
433 (3) DEFINITIONS.--As used in this section, the term:
434 (g) "Dependent" means the spouse or child as described in
435 s. 627.6562 of an eligible employee, subject to the applicable
436 terms of the health benefit plan covering that employee.
437 (h) "Eligible employee" means an employee who works full
438 time, having a normal workweek of 25 or more hours, who is paid
439 wages or a salary at least equal to the federal minimum hourly
440 wage applicable to such employee, and who has met any applicable
441 waiting-period requirements or other requirements of this act.
442 The term includes a self-employed individual, a sole proprietor,
443 a partner of a partnership, or an independent contractor, if the
444 sole proprietor, partner, or independent contractor is included
445 as an employee under a health benefit plan of a small employer,
446 but does not include a part-time, temporary, or substitute
447 employee.
448 (i) "Established geographic area" means the county or
449 counties~~, or any portion of a county or counties,~~ within which
450 the carrier provides or arranges for health care services to be
451 available to its insureds, members, or subscribers.
452 (u) "Self-employed individual" means an individual or sole
453 proprietor who derives his or her income from a trade or
454 business carried on by the individual or sole proprietor which
455 necessitates that the individual file federal income tax forms
456 with supporting schedules and accompanying income reporting
457 forms or federal income tax extensions of time to file forms
458 with the Internal Revenue Service for the most recent tax year

459 ~~results in taxable income as indicated on IRS Form 1040,~~
460 ~~schedule C or F, and which generated taxable income in one of~~
461 ~~the 2 previous years~~.
462 (5) AVAILABILITY OF COVERAGE.--
463 (c) Every small employer carrier must, as a condition of
464 transacting business in this state:
465 1. Beginning July 1, 2000, offer and issue all small
466 employer health benefit plans on a guaranteed-issue basis to
467 every eligible small employer, with 2 to 50 eligible employees,
468 that elects to be covered under such plan, agrees to make the
469 required premium payments, and satisfies the other provisions of
470 the plan. A rider for additional or increased benefits may be
471 medically underwritten and may only be added to the standard
472 health benefit plan. The increased rate charged for the
473 additional or increased benefit must be rated in accordance with
474 this section.
475 2. Beginning July 1, 2000, and until July 31, 2001, offer
476 and issue basic and standard small employer health benefit plans
477 on a guaranteed-issue basis to every eligible small employer
478 which is eligible for guaranteed renewal, has less than two
479 eligible employees, is not formed primarily for the purpose of
480 buying health insurance, elects to be covered under such plan,
481 agrees to make the required premium payments, and satisfies the
482 other provisions of the plan. A rider for additional or
483 increased benefits may be medically underwritten and may be
484 added only to the standard benefit plan. The increased rate
485 charged for the additional or increased benefit must be rated in
486 accordance with this section. For purposes of this subparagraph,
487 a person, his or her spouse, and his or her dependent children

488 shall constitute a single eligible employee if that person and
489 spouse are employed by the same small employer and either one
490 has a normal work week of less than 25 hours.

491 3.a. Beginning August 1, 2001, offer and issue basic and
492 standard small employer health benefit plans on a guaranteed-
493 issue basis, during a 31-day open enrollment period of August 1
494 through August 31 of each year, to every eligible small
495 employer, with fewer than two eligible employees, which small
496 employer is not formed primarily for the purpose of buying
497 health insurance and which elects to be covered under such plan,
498 agrees to make the required premium payments, and satisfies the
499 other provisions of the plan. Coverage provided under this sub-
500 subparagraph ~~subparagraph~~ shall begin on October 1 of the same
501 year as the date of enrollment, unless the small employer
502 carrier and the small employer agree to a different date. A
503 rider for additional or increased benefits may be medically
504 underwritten and may only be added to the standard health
505 benefit plan. The increased rate charged for the additional or
506 increased benefit must be rated in accordance with this section.
507 For purposes of this sub-subparagraph ~~subparagraph~~, a person,
508 his or her spouse, and his or her dependent children constitute
509 a single eligible employee if that person and spouse are
510 employed by the same small employer and either that person or
511 his or her spouse has a normal work week of less than 25 hours.

512 b. Notwithstanding the restrictions set forth in sub-
513 subparagraph a., when a small employer group is losing coverage
514 because a carrier is exercising the provisions of s.
515 627.6571(3)(b) or s. 641.31074(3)(b), the eligible small
516 employer, as defined in sub-subparagraph a., shall be entitled

517 to enroll with another carrier offering small employer coverage
518 within 63 days after the notice of termination or the
519 termination date of the prior coverage, whichever is later.
520 Coverage provided under this sub-subparagraph shall begin
521 immediately upon enrollment unless the small employer carrier
522 and the small employer agree to a different date.

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

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

529 (a) A small employer carrier must elect to become either a
530 risk-assuming carrier or a reinsuring carrier. ~~Each small~~
531 ~~employer carrier must make an initial election, binding through~~
532 ~~January 1, 1994. The carrier's initial election must be made no~~
533 ~~later than October 31, 1992. By October 31, 1993, all small~~
534 ~~employer carriers must file a final election, which is binding~~
535 ~~for 2 years, from January 1, 1994, through December 31, 1995,~~
536 ~~after which an election shall be binding for a period of 5~~
537 ~~years.~~ Any carrier that is not a small employer carrier on
538 October 31, 1992, and intends to become a small employer carrier
539 after October 31, 1992, must file its designation when it files
540 the forms and rates it intends to use for small employer group
541 health insurance; such designation shall be binding indefinitely
542 or until modified or withdrawn ~~for 2 years after the date of~~
543 ~~approval of the forms and rates, and any subsequent designation~~
544 ~~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.

573 4. Issue reinsurance policies, in accordance with the
574 requirements of this act.
575 5. Establish rules, conditions, and procedures for
576 reinsurance risks under the program participation.
577 6. Establish actuarial functions as appropriate for the
578 operation of the program.
579 7. Assess participating carriers in accordance with
580 paragraph (j), and make advance interim assessments as may be
581 reasonable and necessary for organizational and interim
582 operating expenses. Interim assessments shall be credited as
583 offsets against any regular assessments due following the close
584 of the calendar year.
585 8. Appoint appropriate legal, actuarial, and other
586 committees as necessary to provide technical assistance in the
587 operation of the program, and in any other function within the
588 authority of the program.
589 9. Borrow money to effect the purposes of the program. Any
590 notes or other evidences of indebtedness of the program which
591 are not in default constitute legal investments for carriers and
592 may be carried as admitted assets.
593 10. To the extent necessary, increase the $5,000
594 deductible reinsurance requirement to adjust for the effects of
595 inflation. The program may evaluate the desirability of
596 establishing different levels of deductibles. If different
597 levels of deductibles are established, such levels and the
598 resulting premiums shall be approved by the department.
599 (g) A reinsuring carrier may reinsure with the program
600 coverage of an eligible employee of a small employer, or any

601 dependent of such an employee, subject to each of the following
602 provisions:
603 1. With respect to a standard and basic health care plan,
604 the program may ~~must~~ reinsure the level of coverage provided;
605 and, with respect to any other plan, the program may ~~must~~
606 reinsure the coverage up to, but not exceeding, the level of
607 coverage provided under the standard and basic health care plan.
608 As an alternative to reinsuring the level of coverage provided
609 under the standard and basic health care plan, the program may
610 develop alternate levels of reinsurance designed to coordinate
611 with a reinsuring carrier's existing reinsurance. The levels of
612 reinsurance and resulting premiums must be approved by the
613 department.
614 2. Except in the case of a late enrollee, a reinsuring
615 carrier may reinsure an eligible employee or dependent within 60
616 days after the commencement of the coverage of the small
617 employer. A newly employed eligible employee or dependent of a
618 small employer may be reinsured within 60 days after the
619 commencement of his or her coverage.
620 3. A small employer carrier may reinsure an entire
621 employer group within 60 days after the commencement of the
622 group's coverage under the plan. The carrier may choose to
623 reinsure newly eligible employees and dependents of the
624 reinsured group pursuant to subparagraph 1.
625 4. The program may evaluate the option of allowing a small
626 employer carrier to reinsure an entire employer group or an
627 eligible employee at the first or subsequent renewal date. Any
628 such option and the resulting premium must be approved by the
629 department.

630 5.~~4.~~ The program may not reimburse a participating carrier
631 with respect to the claims of a reinsured employee or dependent
632 until the carrier has paid incurred claims of an amount equal to
633 the participating carrier's selected deductible level ~~at least~~
634 ~~$5,000~~ in a calendar year for benefits covered by the program.
635 ~~In addition, the reinsuring carrier shall be responsible for 10~~
636 ~~percent of the next $50,000 and 5 percent of the next $100,000~~
637 ~~of incurred claims during a calendar year and the program shall~~
638 ~~reinsure the remainder.~~

639 6.~~5.~~ The board annually shall adjust the initial level of
640 claims and the maximum limit to be retained by the carrier to
641 reflect increases in costs and utilization within the standard
642 market for health benefit plans within the state. The adjustment
643 shall not be less than the annual change in the medical
644 component of the "Consumer Price Index for All Urban Consumers"
645 of the Bureau of Labor Statistics of the Department of Labor,
646 unless the board proposes and the department approves a lower
647 adjustment factor.

648 7.~~6.~~ A small employer carrier may terminate reinsurance
649 for all reinsured employees or dependents on any plan
650 anniversary.

651 8.~~7.~~ The premium rate charged for reinsurance by the
652 program to a health maintenance organization that is approved by
653 the Secretary of Health and Human Services as a federally
654 qualified health maintenance organization pursuant to 42 U.S.C.
655 s. 300e(c)(2)(A) and that, as such, is subject to requirements
656 that limit the amount of risk that may be ceded to the program,
657 which requirements are more restrictive than subparagraph 5. ~~4.~~,
658 shall be reduced by an amount equal to that portion of the risk,

659 if any, which exceeds the amount set forth in subparagraph 5. 4.
660 which may not be ceded to the program.

661 9.8. The board may consider adjustments to the premium
662 rates charged for reinsurance by the program for carriers that
663 use effective cost containment measures, including high-cost
664 case management, as defined by the board.

665 10.9. A reinsuring carrier shall apply its case-management
666 and claims-handling techniques, including, but not limited to,
667 utilization review, individual case management, preferred
668 provider provisions, other managed care provisions or methods of
669 operation, consistently with both reinsured business and
670 nonreinsured business.

671 (h)1. The board, as part of the plan of operation, shall
672 establish a methodology for determining premium rates to be
673 charged by the program for reinsuring small employers and
674 individuals pursuant to this section. The methodology shall
675 include a system for classification of small employers that
676 reflects the types of case characteristics commonly used by
677 small employer carriers in the state. The methodology shall
678 provide for the development of basic reinsurance premium rates,
679 which shall be multiplied by the factors set for them in this
680 paragraph to determine the premium rates for the program. The
681 basic reinsurance premium rates shall be established by the
682 board, subject to the approval of the department, and shall be
683 set at levels which reasonably approximate gross premiums
684 charged to small employers by small employer carriers for health
685 benefit plans with benefits similar to the standard and basic
686 health benefit plan. The premium rates set by the board may vary
687 by geographical area, as determined under this section, to

688 reflect differences in cost. ~~The multiplying factors must be~~
689 ~~established as follows:~~
690 ~~a. The entire group may be reinsured for a rate that is~~
691 ~~1.5 times the rate established by the board.~~
692 ~~b. An eligible employee or dependent may be reinsured for~~
693 ~~a rate that is 5 times the rate established by the board.~~
694 2. The board periodically shall review the methodology
695 established, including the system of classification and any
696 rating factors, to assure that it reasonably reflects the claims
697 experience of the program. The board may propose changes to the
698 rates which shall be subject to the approval of the department.
699 (j)1. Before <u>September</u> ~~March~~ 1 of each calendar year, the
700 board shall determine and report to the department the program
701 net loss for the previous year, including administrative
702 expenses for that year, and the incurred losses for the year,
703 taking into account investment income and other appropriate
704 gains and losses.
705 2. Any net loss for the year shall be recouped by
706 assessment of the carriers, as follows:
707 a. The operating losses of the program shall be assessed
708 in the following order subject to the specified limitations. The
709 first tier of assessments shall be made against reinsuring
710 carriers in an amount which shall not exceed 5 percent of each
711 reinsuring carrier's premiums from health benefit plans covering
712 small employers. If such assessments have been collected and
713 additional moneys are needed, the board shall make a second tier
714 of assessments in an amount which shall not exceed 0.5 percent
715 of each carrier's health benefit plan premiums. Except as
716 provided in paragraph (n), risk-assuming carriers are exempt

717 from all assessments authorized pursuant to this section. The
718 amount paid by a reinsuring carrier for the first tier of
719 assessments shall be credited against any additional assessments
720 made.
721 b. The board shall equitably assess carriers for operating
722 losses of the plan based on market share. The board shall
723 annually assess each carrier a portion of the operating losses
724 of the plan. The first tier of assessments shall be determined
725 by multiplying the operating losses by a fraction, the numerator
726 of which equals the reinsuring carrier's earned premium
727 pertaining to direct writings of small employer health benefit
728 plans in the state during the calendar year for which the
729 assessment is levied, and the denominator of which equals the
730 total of all such premiums earned by reinsuring carriers in the
731 state during that calendar year. The second tier of assessments
732 shall be based on the premiums that all carriers, except risk-
733 assuming carriers, earned on all health benefit plans written in
734 this state. The board may levy interim assessments against
735 carriers to ensure the financial ability of the plan to cover
736 claims expenses and administrative expenses paid or estimated to
737 be paid in the operation of the plan for the calendar year prior
738 to the association's anticipated receipt of annual assessments
739 for that calendar year. Any interim assessment is due and
740 payable within 30 days after receipt by a carrier of the interim
741 assessment notice. Interim assessment payments shall be credited
742 against the carrier's annual assessment. Health benefit plan
743 premiums and benefits paid by a carrier that are less than an
744 amount determined by the board to justify the cost of collection
745 may not be considered for purposes of determining assessments.

746 c. Subject to the approval of the department, the board
747 shall make an adjustment to the assessment formula for
748 reinsuring carriers that are approved as federally qualified
749 health maintenance organizations by the Secretary of Health and
750 Human Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the
751 extent, if any, that restrictions are placed on them that are
752 not imposed on other small employer carriers.

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

757 4. If the board determines that the assessments needed to
758 fund the losses incurred by the program in the previous calendar
759 year will exceed the amount specified in subparagraph 2., the
760 board shall evaluate the operation of the program and report its
761 findings, including any recommendations for changes to the plan
762 of operation, to the department within <u>240</u> ~~90~~ days following the
763 end of the calendar year in which the losses were incurred. The
764 evaluation shall include an estimate of future assessments, the
765 administrative costs of the program, the appropriateness of the
766 premiums charged and the level of carrier retention under the
767 program, and the costs of coverage for small employers. If the
768 board fails to file a report with the department within <u>240</u> ~~90~~
769 days following the end of the applicable calendar year, the
770 department may evaluate the operations of the program and
771 implement such amendments to the plan of operation the
772 department deems necessary to reduce future losses and
773 assessments.

774 5. If assessments exceed the amount of the actual losses
775 and administrative expenses of the program, the excess shall be
776 held as interest and used by the board to offset future losses
777 or to reduce program premiums. As used in this paragraph, the
778 term "future losses" includes reserves for incurred but not
779 reported claims.
780 6. Each carrier's proportion of the assessment shall be
781 determined annually by the board, based on annual statements and
782 other reports considered necessary by the board and filed by the
783 carriers with the board.
784 7. Provision shall be made in the plan of operation for
785 the imposition of an interest penalty for late payment of an
786 assessment.
787 8. A carrier may seek, from the commissioner, a deferment,
788 in whole or in part, from any assessment made by the board. The
789 department may defer, in whole or in part, the assessment of a
790 carrier if, in the opinion of the department, the payment of the
791 assessment would place the carrier in a financially impaired
792 condition. If an assessment against a carrier is deferred, in
793 whole or in part, the amount by which the assessment is deferred
794 may be assessed against the other carriers in a manner
795 consistent with the basis for assessment set forth in this
796 section. The carrier receiving such deferment remains liable to
797 the program for the amount deferred and is prohibited from
798 reinsuring any individuals or groups in the program if it fails
799 to pay assessments.
800 Section 12. Section 627.911, Florida Statutes, is amended
801 to read:

802 627.911 Scope of this part.--Any insurer or health
803 maintenance organization transacting insurance in this state
804 shall report information as required by this part.
805 Section 13. Section 627.9175, Florida Statutes, is amended
806 to read:
807 627.9175 Reports of information on health insurance.--
808 (1) Each authorized health insurer or health maintenance
809 organization shall submit annually to the office, on or before
810 March 1 of each year, information concerning ~~department as to~~
811 ~~policies of individual~~ health insurance coverage being issued or
812 currently in force in this state. The information shall include
813 information related to premium, number of policies, and covered
814 lives for such policies and other information necessary to
815 analyze trends in enrollment, premiums, and claim costs.
816 (2) The required information shall be broken down by
817 market segment, to include:
818 (a) Health insurance issuer, company, contact person, or
819 agent.
820 (b) All health insurance products issued or in force,
821 including, but not limited to:
822 1. Direct premiums earned.
823 2. Direct losses incurred.
824 3. Direct premiums earned for new business issued during
825 the year.
826 4. Number of policies.
827 5. Number of certificates.
828 6. Number of total covered lives.
829 ~~(a) A summary of typical benefits, exclusions, and~~
830 ~~limitations for each type of individual policy form currently~~

831 ~~being issued in the state. The summary shall include, as~~
832 ~~appropriate:~~
833 ~~1. The deductible amount;~~
834 ~~2. The coinsurance percentage;~~
835 ~~3. The out-of-pocket maximum;~~
836 ~~4. Outpatient benefits;~~
837 ~~5. Inpatient benefits; and~~
838 ~~6. Any exclusions for preexisting conditions.~~
839
840 ~~The department shall determine other appropriate benefits,~~
841 ~~exclusions, and limitations to be reported for inclusion in the~~
842 ~~consumer's guide published pursuant to this section.~~
843 ~~(b) A schedule of rates for each type of individual policy~~
844 ~~form reflecting typical variations by age, sex, region of the~~
845 ~~state, or any other applicable factor which is in use and is~~
846 ~~determined to be appropriate for inclusion by the department.~~
847
848 ~~The department shall provide by rule a uniform format for the~~
849 ~~submission of this information in order to allow for meaningful~~
850 ~~comparisons of premiums charged for comparable benefits.~~
851 (3) The department may adopt rules to administer this
852 section, including, but not limited to, rules governing
853 compliance and provisions implementing electronic methodologies
854 for use in furnishing such records or documents. The commission
855 may by rule specify a uniform format for the submission of this
856 information in order to allow for meaningful comparisons ~~shall~~
857 ~~publish annually a consumer's guide which summarizes and~~
858 ~~compares the information required to be reported under this~~
859 ~~subsection~~.

860 ~~(2)(a) Every insurer transacting health insurance in this~~
861 ~~state shall report annually to the department, not later than~~
862 ~~April 1, information relating to any measure the insurer has~~
863 ~~implemented or proposes to implement during the next calendar~~
864 ~~year for the purpose of containing health insurance costs or~~
865 ~~cost increases. The reports shall identify each measure and the~~
866 ~~forms to which the measure is applied, shall provide an~~
867 ~~explanation as to how the measure is used, and shall provide an~~
868 ~~estimate of the cost effect of the measure.~~
869 ~~(b) The department shall promulgate forms to be used by~~
870 ~~insurers in reporting information pursuant to this subsection~~
871 ~~and shall utilize such forms to analyze the effects of health~~
872 ~~care cost containment programs used by health insurers in this~~
873 ~~state.~~
874 ~~(c) The department shall analyze the data reported under~~
875 ~~this subsection and shall annually make available to the public~~
876 ~~a summary of its findings as to the types of cost containment~~
877 ~~measures reported and the estimated effect of these measures.~~
878 Section 14. Section 627.9403, Florida Statutes, is amended
879 to read:
880 627.9403 Scope.--The provisions of this part shall apply
881 to long-term care insurance policies delivered or issued for
882 delivery in this state, and to policies delivered or issued for
883 delivery outside this state to the extent provided in s.
884 627.9406, by an insurer, a fraternal benefit society as defined
885 in s. 632.601, a health maintenance organization as defined in
886 s. 641.19, a prepaid health clinic as defined in s. 641.402, or
887 a multiple-employer welfare arrangement as defined in s.
888 624.437. A policy which is advertised, marketed, or offered as a

889 long-term care policy and as a Medicare supplement policy shall
890 meet the requirements of this part and the requirements of ss.
891 627.671-627.675 and, to the extent of a conflict, be subject to
892 the requirement that is more favorable to the policyholder or
893 certificateholder. The provisions of this part shall not apply
894 to a continuing care contract issued pursuant to chapter 651 and
895 shall not apply to guaranteed renewable policies issued prior to
896 October 1, 1988. Any limited benefit policy that limits coverage
897 to care in a nursing home or to one or more lower levels of care
898 required or authorized to be provided by this part or by
899 department rule must meet all requirements of this part that
900 apply to long-term care insurance policies, except ss.
901 627.9407(3)(c) <u>and (d)</u>, (9), (10)(f), and (12) and 627.94073(2).
902 ~~If the limited benefit policy does not provide coverage for care~~
903 ~~in a nursing home, but does provide coverage for one or more~~
904 ~~lower levels of care, the policy shall also be exempt from the~~
905 ~~requirements of s. 627.9407(3)(d).~~

906 Section 15. Paragraph (b) of subsection (1) of section
907 641.185, Florida Statutes, is amended to read:

908 641.185 Health maintenance organization subscriber
909 protections.--

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

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

922 Section 16. Paragraph (d) of subsection (3) and
923 subsections (9) through (17) of section 641.31, Florida
924 Statutes, are amended to read:

925 641.31 Health maintenance contracts.--

926 (3)

927 (d) Any change in rates charged for the contract must be
928 filed with the department not less than 30 days in advance of
929 the effective date. At the expiration of such 30 days, the rate
930 filing shall be deemed approved unless prior to such time the
931 filing has been affirmatively approved or disapproved by order
932 of the department. The approval of the filing by the department
933 constitutes a waiver of any unexpired portion of such waiting
934 period. The department may extend by not more than an additional
935 15 days the period within which it may so affirmatively approve
936 or disapprove any such filing, by giving notice of such
937 extension before expiration of the initial 30-day period. At the
938 expiration of any such period as so extended, and in the absence
939 of such prior affirmative approval or disapproval, any such
940 filing shall be deemed approved. This paragraph does not apply
941 to group health maintenance organization contracts effectuated
942 and delivered in this state insuring groups of 51 or more
943 persons.

944 (9)(a)1. If a health maintenance organization offers
945 coverage for dependent children of the subscriber, the contract

946 must cover a dependent child of the subscriber at least until
947 the end of the calendar year in which the child reaches the age
948 of 23, if the child meets all of the following:
949 a. The child is dependent upon the subscriber for support.
950 b. The child is living in the household of the subscriber,
951 or the child is a full-time or part-time student.
952 2. Nothing in this paragraph affects or preempts a health
953 maintenance organization's right to medically underwrite or
954 charge the appropriate premium.
955 (b)1. A contract that provides coverage for a family
956 member of the subscriber shall, as to such family member's
957 coverage, provide that benefits applicable to children of the
958 subscriber also apply to an adopted child or a foster child of
959 the subscriber placed in compliance with chapter 63 from the
960 moment of placement in the residence of the subscriber. Except
961 in the case of a foster child, the contract may not exclude
962 coverage for any preexisting condition of the child. In the case
963 of a newborn child, coverage begins at the moment of birth if a
964 written agreement to adopt such child has been entered into by
965 the subscriber prior to the birth of the child, whether or not
966 the agreement is enforceable. This section does not require
967 coverage for an adopted child who is not ultimately placed in
968 the residence of the subscriber in compliance with chapter 63.
969 2. A contract may require the subscriber to notify the
970 health maintenance organization of the birth or placement of an
971 adopted child within a specified time period of not less than 30
972 days after the birth or placement in the residence of a child
973 adopted by the subscriber. If timely notice is given, the health
974 maintenance organization may not charge an additional premium

975 for coverage of the child for the duration of the notice period.
976 If timely notice is not given, the health maintenance
977 organization may charge an additional premium from the date of
978 birth or placement. If notice is given within 60 days after the
979 birth or placement of the child, the health maintenance
980 organization may not deny coverage for the child due to the
981 failure of the subscriber to timely notify the health
982 maintenance organization of the birth or placement of the child.
983 3. If the contract does not require the subscriber to
984 notify the health maintenance organization of the birth or
985 placement of an adopted child within a specified time period,
986 the health maintenance organization may not deny coverage for
987 such child or retroactively charge the subscriber an additional
988 premium for such child. However, the health maintenance
989 organization may prospectively charge the subscriber an
990 additional premium for the child if the health maintenance
991 organization provides at least 45 days' notice of the additional
992 premium required.
993 4. In order to increase access to postnatal, infant, and
994 pediatric health care for all children placed in court-ordered
995 custody, including foster children, all health maintenance
996 organization contracts that provide coverage for a family member
997 of the subscriber shall, as to such family member's coverage,
998 provide that benefits applicable for children shall be payable
999 with respect to a foster child or other child in court-ordered,
1000 temporary, or other custody of the subscriber.
1001 (10) A contract that provides that coverage of a dependent
1002 child shall terminate upon attainment of the limiting age for
1003 dependent children specified in the contract shall also provide

1004 in substance that attainment of the limiting age does not
1005 terminate the coverage of the child while the child continues to
1006 be:
1007 (a) Incapable of self-sustaining employment by reason of
1008 mental retardation or physical handicap.
1009 (b) Chiefly dependent upon the subscriber for support and
1010 maintenance.
1011
1012 If a claim is denied under a contract for the stated reason that
1013 the child has attained the limiting age for dependent children
1014 specified in the contract, the notice of denial must state that
1015 the subscriber has the burden of establishing that the child
1016 continues to meet the criteria specified in paragraphs (a) and
1017 (b). ~~All health maintenance contracts that provide coverage,~~
1018 ~~benefits, or services for a member of the family of the~~
1019 ~~subscriber must, as to such family member's coverage, benefits,~~
1020 ~~or services, provide also that the coverage, benefits, or~~
1021 ~~services applicable for children must be provided with respect~~
1022 ~~to a newborn child of the subscriber, or covered family member~~
1023 ~~of the subscriber, from the moment of birth. However, with~~
1024 ~~respect to a newborn child of a covered family member other than~~
1025 ~~the spouse of the insured or subscriber, the coverage for the~~
1026 ~~newborn child terminates 18 months after the birth of the~~
1027 ~~newborn child. The coverage, benefits, or services for newborn~~
1028 ~~children must consist of coverage for injury or sickness,~~
1029 ~~including the necessary care or treatment of medically diagnosed~~
1030 ~~congenital defects, birth abnormalities, or prematurity, and~~
1031 ~~transportation costs of the newborn to and from the nearest~~
1032 ~~appropriate facility appropriately staffed and equipped to treat~~

1033 ~~the newborn's condition, when such transportation is certified~~
1034 ~~by the attending physician as medically necessary to protect the~~
1035 ~~health and safety of the newborn child.~~
1036 ~~(a) A contract may require the subscriber to notify the~~
1037 ~~plan of the birth of a child within a time period, as specified~~
1038 ~~in the contract, of not less than 30 days after the birth, or a~~
1039 ~~contract may require the preenrollment of a newborn prior to~~
1040 ~~birth. However, if timely notice is given, a plan may not charge~~
1041 ~~an additional premium for additional coverage of the newborn~~
1042 ~~child for not less than 30 days after the birth of the child. If~~
1043 ~~timely notice is not given, the plan may charge an additional~~
1044 ~~premium from the date of birth. If notice is given within 60~~
1045 ~~days of the birth of the child, the contract may not deny~~
1046 ~~coverage of the child due to failure of the subscriber to timely~~
1047 ~~notify the plan of the birth of the child or to preenroll the~~
1048 ~~child.~~
1049 ~~(b) If the contract does not require the subscriber to~~
1050 ~~notify the plan of the birth of a child within a specified time~~
1051 ~~period, the plan may not deny coverage of the child nor may it~~
1052 ~~retroactively charge the subscriber an additional premium for~~
1053 ~~the child; however, the contract may prospectively charge the~~
1054 ~~member an additional premium for the child if the plan provides~~
1055 ~~at least 45 days' notice of the additional charge.~~
1056 (11)~~(10)~~ No alteration of any written application for any
1057 health maintenance contract shall be made by any person other
1058 than the applicant without his or her written consent, except
1059 that insertions may be made by the health maintenance
1060 organization, for administrative purposes only, in such manner

1061 as to indicate clearly that such insertions are not to be
1062 ascribed to the applicant.
1063 (12)~~(11)~~ No contract shall contain any waiver of rights or
1064 benefits provided to or available to subscribers under the
1065 provisions of any law or rule applicable to health maintenance
1066 organizations.
1067 (13)~~(12)~~ Each health maintenance contract, certificate, or
1068 member handbook shall state that emergency services and care
1069 shall be provided to subscribers in emergency situations not
1070 permitting treatment through the health maintenance
1071 organization's providers, without prior notification to and
1072 approval of the organization. Not less than 75 percent of the
1073 reasonable charges for covered services and supplies shall be
1074 paid by the organization, up to the subscriber contract benefit
1075 limits. Payment also may be subject to additional applicable
1076 copayment provisions, not to exceed $100 per claim. The health
1077 maintenance contract, certificate, or member handbook shall
1078 contain the definitions of "emergency services and care" and
1079 "emergency medical condition" as specified in s. 641.19(7) and
1080 (8), shall describe procedures for determination by the health
1081 maintenance organization of whether the services qualify for
1082 reimbursement as emergency services and care, and shall contain
1083 specific examples of what does constitute an emergency. In
1084 providing for emergency services and care as a covered service,
1085 a health maintenance organization shall be governed by s.
1086 641.513.
1087 (14)~~(13)~~ In addition to the requirements of this section,
1088 with respect to a person who is entitled to have payments for

1089 health care costs made under Medicare, Title XVIII of the Social
1090 Security Act ("Medicare"), parts A and/or B:
1091 (a) The health maintenance organization shall mail or
1092 deliver notification to the Medicare beneficiary of the date of
1093 enrollment in the health maintenance organization within 10 days
1094 after receiving notification of enrollment approval from the
1095 United States Department of Health and Human Services, Health
1096 Care Financing Administration. When a Medicare beneficiary who
1097 is a subscriber of the health maintenance organization requests
1098 disenrollment from the organization, the organization shall mail
1099 or deliver to the beneficiary notice of the effective date of
1100 the disenrollment within 10 days after receipt of the written
1101 disenrollment request. The health maintenance organization shall
1102 forward the disenrollment request to the United States
1103 Department of Health and Human Services, Health Care Financing
1104 Administration, in a timely manner so as to effectuate the next
1105 available disenrollment date, as prescribed by such federal
1106 agency.
1107 (b) The health maintenance contract, certificate, or
1108 member handbook shall be delivered to the subscriber no later
1109 than the earlier of 10 working days after the health maintenance
1110 organization and the Health Care Financing Administration of the
1111 United States Department of Health and Human Services approve
1112 the subscriber's enrollment application or the effective date of
1113 coverage of the subscriber under the health maintenance
1114 contract. However, if notice from the Health Care Financing
1115 Administration of its approval of the subscriber's enrollment
1116 application is received by the health maintenance organization
1117 after the effective coverage date prescribed by the Health Care

1118 Financing Administration, the health maintenance organization
1119 shall deliver the contract, certificate, or member handbook to
1120 the subscriber within 10 days after receiving such notice. When
1121 a Medicare recipient is enrolled in a health maintenance
1122 organization program, the contract, certificate, or member
1123 handbook shall be accompanied by a health maintenance
1124 organization identification sticker with instruction to the
1125 Medicare beneficiary to place the sticker on the Medicare
1126 identification card.

1127 (15)~~(14)~~ Whenever a subscriber of a health maintenance
1128 organization is also a Medicaid recipient, the health
1129 maintenance organization's coverage shall be primary to the
1130 recipient's Medicaid benefits and the organization shall be a
1131 third party subject to the provisions of s. 409.910(4).

1132 (16)~~(15)~~(a) All health maintenance contracts,
1133 certificates, and member handbooks shall contain the following
1134 provision:

1135

1136 "Grace Period: This contract has a (insert a number not less
1137 than 10) day grace period. This provision means that if any
1138 required premium is not paid on or before the date it is due, it
1139 may be paid during the following grace period. During the grace
1140 period, the contract will stay in force."

1141

1142 (b) The required provision of paragraph (a) shall not
1143 apply to certificates or member handbooks delivered to
1144 individual subscribers under a group health maintenance contract
1145 when the employer or other person who will hold the contract on
1146 behalf of the subscriber group pays the entire premium for the

1147 individual subscribers. However, such required provision shall
1148 apply to the group health maintenance contract.
1149 (17)~~(16)~~ The contracts must clearly disclose the intent of
1150 the health maintenance organization as to the applicability or
1151 nonapplicability of coverage to preexisting conditions. If
1152 coverage of the contract is not to be applicable to preexisting
1153 conditions, the contract shall specify, in substance, that
1154 coverage pertains solely to accidental bodily injuries resulting
1155 from accidents occurring after the effective date of coverage
1156 and that sicknesses are limited to those which first manifest
1157 themselves subsequent to the effective date of coverage.
1158 ~~(17) All health maintenance contracts that provide~~
1159 ~~coverage for a member of the family of the subscriber, shall, as~~
1160 ~~to such family member's coverage, provide that coverage,~~
1161 ~~benefits, or services applicable for children shall be provided~~
1162 ~~with respect to an adopted child of the subscriber, which child~~
1163 ~~is placed in compliance with chapter 63, from the moment of~~
1164 ~~placement in the residence of the subscriber. Such contracts may~~
1165 ~~not exclude coverage for any preexisting condition of the child.~~
1166 ~~In the case of a newborn child, coverage shall begin from the~~
1167 ~~moment of birth if a written agreement to adopt such child has~~
1168 ~~been entered into by the subscriber prior to the birth of the~~
1169 ~~child, whether or not such agreement is enforceable. However,~~
1170 ~~coverage for such child shall not be required in the event that~~
1171 ~~the child is not ultimately placed in the residence of the~~
1172 ~~subscriber in compliance with chapter 63.~~
1173 Section 17. Section 641.31025, Florida Statutes, is
1174 created to read:

1175 641.31025 Specific reasons for denial of coverage.--The
1176 denial of an application for a health maintenance organization
1177 contract must be accompanied by the specific reasons for the
1178 denial, including, but not limited to, the specific underwriting
1179 reasons, if applicable.

1180 Section 18. Section 641.31075, Florida Statutes, is
1181 created to read:

1182 641.31075 Replacement.--Any health maintenance
1183 organization that is replacing any other group health coverage
1184 with its group health maintenance coverage shall comply with s.
1185 627.666.

1186 Section 19. Subsections (1) and (3) of section 641.3111,
1187 Florida Statutes, are amended to read:

1188 641.3111 Extension of benefits.--

1189 (1) Every group health maintenance contract shall provide
1190 that termination of the contract shall be without prejudice to
1191 any continuous loss which commenced while the contract was in
1192 force, but any extension of benefits beyond the period the
1193 contract was in force may be predicated upon the continuous
1194 total disability of the subscriber ~~and may be limited to payment~~
1195 ~~for the treatment of a specific accident or illness incurred~~
1196 ~~while the subscriber was a member~~. The extension is required
1197 regardless of whether the group contract holder or other entity
1198 secures replacement coverage from a new insurer or health
1199 maintenance organization or foregoes the provision of coverage.
1200 The required provision must provide for continuation of contract
1201 benefits in connection with the treatment of a specific accident
1202 or illness incurred while the contract was in effect. Such

1203 extension of benefits may be limited to the occurrence of the
1204 earliest of the following events:
1205 (a) The expiration of 12 months.
1206 (b) Such time as the member is no longer totally disabled.
1207 ~~(c) A succeeding carrier elects to provide replacement~~
1208 ~~coverage without limitation as to the disability condition.~~
1209 <u>(c)</u>~~(d)~~ The maximum benefits payable under the contract
1210 have been paid.
1211 (3) In the case of maternity coverage, ~~when not covered by~~
1212 ~~the succeeding carrier,~~ a reasonable extension of benefits or
1213 accrued liability provision is required, which provision
1214 provides for continuation of the contract benefits in connection
1215 with maternity expenses for a pregnancy that commenced while the
1216 policy was in effect. The extension shall be for the period of
1217 that pregnancy and shall not be based upon total disability.
1218 Section 20. Subsection (4) of section 627.651, Florida
1219 Statutes, is amended to read:
1220 627.651 Group contracts and plans of self-insurance must
1221 meet group requirements.--
1222 (4) This section does not apply to any plan which is
1223 established or maintained by an individual employer in
1224 accordance with the Employee Retirement Income Security Act of
1225 1974, Pub. L. No. 93-406, or to a multiple-employer welfare
1226 arrangement as defined in s. 624.437(1), except that a multiple-
1227 employer welfare arrangement shall comply with ss. 627.419,
1228 627.657, 627.6575, 627.6578, 627.6579, 627.6612, 627.66121,
1229 627.66122, 627.6615, 627.6616, and 627.662<u>(8)</u>~~(7)~~. This
1230 subsection does not allow an authorized insurer to issue a group

1231 health insurance policy or certificate which does not comply
1232 with this part.
1233 Section 21. Subsection (1) of section 641.2018, Florida
1234 Statutes, is amended to read:
1235 641.2018 Limited coverage for home health care
1236 authorized.--
1237 (1) Notwithstanding other provisions of this chapter, a
1238 health maintenance organization may issue a contract that limits
1239 coverage to home health care services only. The organization and
1240 the contract shall be subject to all of the requirements of this
1241 part that do not require or otherwise apply to specific benefits
1242 other than home care services. To this extent, all of the
1243 requirements of this part apply to any organization or contract
1244 that limits coverage to home care services, except the
1245 requirements for providing comprehensive health care services as
1246 provided in ss. 641.19(4), (12), and (13), and 641.31(1), except
1247 ss. 641.31~~(9),~~ (13)~~(12)~~, ~~(17),~~ (18), (19), (20), (21), and (24)
1248 and 641.31095.
1249 Section 22. Section 641.3107, Florida Statutes, is amended
1250 to read:
1251 641.3107 Delivery of contract.--Unless delivered upon
1252 execution or issuance, a health maintenance contract,
1253 certificate of coverage, or member handbook shall be mailed or
1254 delivered to the subscriber or, in the case of a group health
1255 maintenance contract, to the employer or other person who will
1256 hold the contract on behalf of the subscriber group within 10
1257 working days from approval of the enrollment form by the health
1258 maintenance organization or by the effective date of coverage,
1259 whichever occurs first. However, if the employer or other person

1260 who will hold the contract on behalf of the subscriber group
1261 requires retroactive enrollment of a subscriber, the
1262 organization shall deliver the contract, certificate, or member
1263 handbook to the subscriber within 10 days after receiving notice
1264 from the employer of the retroactive enrollment. This section
1265 does not apply to the delivery of those contracts specified in
1266 s. 641.31(14)~~(13)~~.
1267 Section 23. Subsection (4) of section 641.513, Florida
1268 Statutes, is amended to read:
1269 641.513 Requirements for providing emergency services and
1270 care.--
1271 (4) A subscriber may be charged a reasonable copayment, as
1272 provided in s. 641.31(13)~~(12)~~, for the use of an emergency room.
1273 Section 24. This act shall take effect upon becoming a
1274 law.
1275
1276 ================ T I T L E A M E N D M E N T ================
1277 Remove the entire title, and insert:
1278 A bill to be entitled
1279 An act relating to health insurance; amending s. 408.909,
1280 F.S.; revising a definition; authorizing health flex plans
1281 to limit coverage under certain circumstances; authorizing
1282 a small business purchasing arrangement to limit
1283 enrollment to certain residents; extending an expiration
1284 date; creating s. 627.6042, F.S.; requiring policies of
1285 insurers offering coverage of dependent children to
1286 maintain such coverage until a child reaches age 25, under
1287 certain circumstances; providing application; creating s.
1288 627.60425, F.S.; providing limitations on certain binding

1289 arbitration requirements; amending s. 627.6044, F.S.;
1290 providing for payment of claims to nonnetwork providers
1291 under specified conditions; providing a definition;
1292 requiring the method used for determining payment of
1293 claims to be included in filings; providing for
1294 disclosure; amending s. 627.6415, F.S.; deleting an 18th
1295 birthday age limitation on application of certain
1296 dependent coverage requirements; amending s. 627.6475,
1297 F.S.; revising risk-assuming carrier election requirements
1298 and procedures; revising certain criteria and limitations
1299 under the individual health reinsurance program; amending
1300 s. 627.651, F.S.; correcting a cross reference; amending
1301 s. 627.662, F.S.; revising a list of provisions applicable
1302 to group, blanket, or franchise health insurance to
1303 include use of specific methodology for payment of claims
1304 provisions; amending s. 627.667, F.S.; deleting a
1305 limitation on application of certain extension of benefits
1306 provisions; amending s. 627.6692, F.S.; increasing a time
1307 period for payment of premium to continue coverage under a
1308 group health plan; amending s. 627.6699, F.S.; revising
1309 definitions; revising coverage enrollment eligibility
1310 criteria for small employers; revising small employer
1311 carrier election requirements and procedures; revising
1312 certain criteria and limitations under the small employer
1313 health reinsurance program; amending ss. 627.911 and
1314 627.9175, F.S.; applying certain information reporting
1315 requirements to health maintenance organizations; revising
1316 health insurance information requirements and criteria;
1317 authorizing the department to adopt rules; deleting an

1318 annual report requirement; amending s. 627.9403, F.S.;
1319 deleting an exemption for limited benefit policies from a
1320 long-term care insurance restriction relating to nursing
1321 home care; amending s. 641.185, F.S.; correcting a cross
1322 reference; amending s. 641.31, F.S.; specifying
1323 nonapplication to certain contracts; requiring health
1324 maintenance organizations offering coverage of dependent
1325 children to maintain such coverage until a child reaches
1326 age 25, under certain circumstances; providing
1327 application; providing requirements for contract
1328 termination and denial of a claim related to limiting age
1329 attainment; creating s. 641.31025, F.S.; requiring
1330 specific reasons for denial of coverage under a health
1331 maintenance organization contract; creating s. 641.31075,
1332 F.S.; imposing compliance requirements upon health
1333 maintenance organization replacements of other group
1334 health coverage with organization coverage; amending s.
1335 641.3111, F.S.; deleting a limitation on certain extension
1336 of benefits provisions upon group health maintenance
1337 contract termination; imposing additional extension of
1338 benefits requirements upon such termination; amending ss.
1339 627.651, 641.2018, 641.3107, and 641.513, F.S.; correcting
1340 cross references; providing an effective date.
1341