

Amendment No. (for drafter's use only)

CHAMBER ACTION

Senate

House

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Representative Llorente offered the following:

Amendment to Amendment (637059) (with directory and title amendments)

Between lines 13 and 14, 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.

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27 (3) PILOT PROGRAM.--The agency and the department shall
28 each approve or disapprove health flex plans that provide health
29 care coverage for eligible participants who reside in the three
30 areas of the state that have the highest number of uninsured
31 persons, as identified in the Florida Health Insurance Study
32 conducted by the agency and in Indian River County. A health
33 flex plan may limit or exclude benefits otherwise required by
34 law for insurers offering coverage in this state, may cap the
35 total amount of claims paid per year per enrollee, may limit the
36 number of enrollees or the term of coverage, or may take any
37 combination of those actions.

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

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

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

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

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

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

59 (5) ELIGIBILITY.--Eligibility to enroll in an approved
60 health flex plan is limited to residents of this state who:

61 (c) Are not covered by a private insurance policy and are
62 not eligible for coverage through a public health insurance
63 program, such as Medicare or Medicaid, or another public health
64 care program, such as KidCare, and have not been covered at any
65 time during the past 6 months, except that a small business
66 purchasing arrangement sponsored by a local government may limit
67 enrollment to residents of this state who have not been covered
68 at any time during the past 12 months; and

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

70 Section 2. Section 627.6042, Florida Statutes, is created
71 to read:

72 627.6042 Dependent coverage.--

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

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

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

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

87 Section 3. Section 627.60425, Florida Statutes, is created
88 to read:

89 627.60425 Binding arbitration requirement
90 limitations.--Notwithstanding any other provision of law, except
91 s. 624.155, an individual, blanket, group life, or group health
92 insurance policy; individual or group health maintenance
93 organization subscriber contract; prepaid limited health
94 organization subscriber contract; or any life or health
95 insurance policy or certificate delivered or issued for
96 delivery, including out-of-state group plans pursuant to s.
97 627.5515 or s. 627.6515 covering residents of this state, to any
98 resident of this state shall not require the submission of
99 disputes between the parties to the policy, contract, or plan to
100 binding arbitration unless the applicant has indicated that the
101 same policy, contract, or plan was offered and rejected without
102 arbitration and that the binding arbitration provision was fully
103 explained to the applicant and willingly accepted.

104 Section 4. Section 627.6044, Florida Statutes, is amended
105 to read:

106 627.6044 Use of a specific methodology for payment of
107 claims.--

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

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

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

117 (b) Where there are multiple network providers in the
118 geographical area in which the services were provided or, if
119 none, the closest geographic area, the carrier may use an
120 averaging method of the contracted amounts but not less than the
121 80th percentile of all network contracted amounts in the
122 geographic area.

123
124 For purposes of this subsection, the term "network providers"
125 means those providers for which an insured will not be
126 responsible for any balance payment for services provided by
127 such provider, excluding deductible, coinsurance, and copay
128 amounts based on a specific methodology, including, but not
129 limited to, usual and customary charges, reasonable and
130 customary charges, or charges based upon the prevailing rate in
131 the community, shall specify the formula or criteria used by the
132 insurer in determining the amount to be paid.

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

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

148 (3) The method used for determining the payment of claims
149 shall be included in filings made pursuant to s. 627.410(6) and
150 may not be changed unless such change is filed under s.
151 627.410(6).

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

158 Section 5. Subsections (1) and (4) of section 627.6415,
159 Florida Statutes, are amended to read:

160 627.6415 Coverage for natural-born, adopted, and foster
161 children; children in insured's custodial care.--

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

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

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

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

190 627.6475 Individual reinsurance pool.--

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

192 (a) Each health insurance issuer that offers individual
193 health insurance must elect to become a risk-assuming carrier or
194 a reinsuring carrier for purposes of this section. Each such
195 issuer must make ~~an initial election, binding through December~~
196 ~~31, 1999. The issuer's initial election must be made no later~~

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

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

205 (c) The department shall provide public notice of an
206 issuer's filing a designation of election under this subsection
207 to become a risk-assuming carrier and shall provide at least a
208 21-day period for public comment upon receipt of such filing
209 ~~prior to making a decision on the election. The department shall~~
210 ~~hold a hearing on the election at the request of the issuer.~~

211 (7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.--

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

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

218 2. The program may not reimburse a participating carrier
219 with respect to the claims of a reinsured eligible individual
220 until the carrier has paid incurred claims of an amount equal to
221 the participating carrier's selected deductible level ~~at least~~
222 ~~\$5,000~~ in a calendar year for benefits covered by the program.
223 ~~In addition, the reinsuring carrier is responsible for 10~~
224 ~~percent of the next \$50,000 and 5 percent of the next \$100,000~~

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

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

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

238 5. The premium rate charged for reinsurance by the program
239 to a health maintenance organization that is approved by the
240 Secretary of Health and Human Services as a federally qualified
241 health maintenance organization pursuant to 42 U.S.C. s.
242 300e(c)(2)(A) and that, as such, is subject to requirements that
243 limit the amount of risk that may be ceded to the program, which
244 requirements are more restrictive than subparagraph 2., shall be
245 reduced by an amount equal to that portion of the risk, if any,
246 which exceeds the amount set forth in subparagraph 2., which may
247 not be ceded to the program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

348 Section 7. Subsection (4) of section 627.651, Florida
349 Statutes, is amended to read:

350 627.651 Group contracts and plans of self-insurance must
351 meet group requirements.--

352 (4) This section does not apply to any plan which is
353 established or maintained by an individual employer in
354 accordance with the Employee Retirement Income Security Act of
355 1974, Pub. L. No. 93-406, or to a multiple-employer welfare
356 arrangement as defined in s. 624.437(1), except that a multiple-
357 employer welfare arrangement shall comply with ss. 627.419,
358 627.657, 627.6575, 627.6578, 627.6579, 627.6612, 627.66121,
359 627.66122, 627.6615, 627.6616, and 627.662(8)~~(7)~~. This
360 subsection does not allow an authorized insurer to issue a group
361 health insurance policy or certificate which does not comply
362 with this part.

363 Section 8. Section 627.662, Florida Statutes, is amended
364 to read:

365 627.662 Other provisions applicable.--The following
366 provisions apply to group health insurance, blanket health
367 insurance, and franchise health insurance:

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

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

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

374 (4)(3) Section 627.635, relating to excess insurance.

375 (5)(4) Section 627.638, relating to direct payment for
376 hospital or medical services.

377 (6)(5) Section 627.640, relating to filing and
378 classification of rates.

379 (7)(6) Section 627.613, relating to timely payment of
380 claims, or s. 627.6131, relating to payment of claims, whichever
381 is applicable.

382 (8)(7) Section 627.645(1), relating to denial of claims.

383 (9)(8) Section 627.6471, relating to preferred provider
384 organizations.

385 (10)(9) Section 627.6472, relating to exclusive provider
386 organizations.

387 (11)(10) Section 627.6473, relating to combined preferred
388 provider and exclusive provider policies.

389 (12)(11) Section 627.6474, relating to provider contracts.

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

392 627.667 Extension of benefits.--

393 (6) This section also applies to holders of group
394 certificates which are renewed, delivered, or issued for
395 delivery to residents of this state under group policies
396 effectuated or delivered outside this state, ~~unless a succeeding~~

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397 ~~carrier under a group policy has agreed to assume liability for~~
398 ~~the benefits.~~

399 Section 10. Paragraph (e) of subsection (5) of section
400 627.6692, Florida Statutes, is amended to read:

401 627.6692 Florida Health Insurance Coverage Continuation
402 Act.--

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

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

421 2. Except as otherwise specified in an election, any
422 election by a qualified beneficiary shall be deemed to include
423 an election of continuation of coverage on behalf of any other
424 qualified beneficiary residing in the same household who would
425 lose coverage under the group health plan by reason of a

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426 qualifying event. This subparagraph does not preclude a
427 qualified beneficiary from electing continuation of coverage on
428 behalf of any other qualified beneficiary.

429 Section 11. Paragraphs (g), (h), (i), and (u) of
430 subsection (3), paragraph (c) of subsection (5), paragraph (a)
431 of subsection (9), paragraph (d) of subsection (10), and
432 paragraphs (f), (g), (h), and (j) of subsection (11) of section
433 627.6699, Florida Statutes, are amended to read:

434 627.6699 Employee Health Care Access Act.--

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

436 (g) "Dependent" means the spouse or child as described in
437 s. 627.6562 of an eligible employee, subject to the applicable
438 terms of the health benefit plan covering that employee.

439 (h) "Eligible employee" means an employee who works full
440 time, having a normal workweek of 25 or more hours, who is paid
441 wages or a salary at least equal to the federal minimum hourly
442 wage applicable to such employee, and who has met any applicable
443 waiting-period requirements or other requirements of this act.
444 The term includes a self-employed individual, a sole proprietor,
445 a partner of a partnership, or an independent contractor, if the
446 sole proprietor, partner, or independent contractor is included
447 as an employee under a health benefit plan of a small employer,
448 but does not include a part-time, temporary, or substitute
449 employee.

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

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454 (u) "Self-employed individual" means an individual or sole
455 proprietor who derives his or her income from a trade or
456 business carried on by the individual or sole proprietor which
457 necessitates that the individual file federal income tax forms
458 with supporting schedules and accompanying income reporting
459 forms or federal income tax extensions of time to file forms
460 with the Internal Revenue Service for the most recent tax year
461 ~~results in taxable income as indicated on IRS Form 1040,~~
462 ~~schedule C or F, and which generated taxable income in one of~~
463 ~~the 2 previous years.~~

464 (5) AVAILABILITY OF COVERAGE.--

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

467 1. Beginning July 1, 2000, offer and issue all small
468 employer health benefit plans on a guaranteed-issue basis to
469 every eligible small employer, with 2 to 50 eligible employees,
470 that elects to be covered under such plan, agrees to make the
471 required premium payments, and satisfies the other provisions of
472 the plan. A rider for additional or increased benefits may be
473 medically underwritten and may only be added to the standard
474 health benefit plan. The increased rate charged for the
475 additional or increased benefit must be rated in accordance with
476 this section.

477 2. Beginning July 1, 2000, and until July 31, 2001, offer
478 and issue basic and standard small employer health benefit plans
479 on a guaranteed-issue basis to every eligible small employer
480 which is eligible for guaranteed renewal, has less than two
481 eligible employees, is not formed primarily for the purpose of
482 buying health insurance, elects to be covered under such plan,

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483 agrees to make the required premium payments, and satisfies the
484 other provisions of the plan. A rider for additional or
485 increased benefits may be medically underwritten and may be
486 added only to the standard benefit plan. The increased rate
487 charged for the additional or increased benefit must be rated in
488 accordance with this section. For purposes of this subparagraph,
489 a person, his or her spouse, and his or her dependent children
490 shall constitute a single eligible employee if that person and
491 spouse are employed by the same small employer and either one
492 has a normal work week of less than 25 hours.

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

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512 employed by the same small employer and either that person or
513 his or her spouse has a normal work week of less than 25 hours.

514 b. Notwithstanding the restrictions set forth in sub-
515 subparagraph a., when a small employer group is losing coverage
516 because a carrier is exercising the provisions of s.

517 627.6571(3)(b) or s. 641.31074(3)(b), the eligible small
518 employer, as defined in sub-subparagraph a., shall be entitled
519 to enroll with another carrier offering small employer coverage
520 within 63 days after the notice of termination or the
521 termination date of the prior coverage, whichever is later.

522 Coverage provided under this sub-subparagraph shall begin
523 immediately upon enrollment unless the small employer carrier
524 and the small employer agree to a different date.

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

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

531 (a) A small employer carrier must elect to become either a
532 risk-assuming carrier or a reinsuring carrier. ~~Each small~~
533 ~~employer carrier must make an initial election, binding through~~
534 ~~January 1, 1994. The carrier's initial election must be made no~~
535 ~~later than October 31, 1992. By October 31, 1993, all small~~
536 ~~employer carriers must file a final election, which is binding~~
537 ~~for 2 years, from January 1, 1994, through December 31, 1995,~~
538 ~~after which an election shall be binding for a period of 5~~
539 ~~years.~~ Any carrier that is not a small employer carrier on
540 October 31, 1992, and intends to become a small employer carrier

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541 after October 31, 1992, must file its designation when it files
542 the forms and rates it intends to use for small employer group
543 health insurance; such designation shall be binding indefinitely
544 or until modified or withdrawn ~~for 2 years after the date of~~
545 ~~approval of the forms and rates, and any subsequent designation~~
546 ~~is binding for 5 years~~. The department may permit a carrier to
547 modify its election at any time for good cause shown, ~~after a~~
548 ~~hearing~~.

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

550 (d) The department shall provide public notice of a small
551 employer carrier's filing a designation of election under
552 subsection (9) to become a risk-assuming carrier and shall
553 provide at least a 21-day period for public comment upon receipt
554 of such filing ~~prior to making a decision on the election~~. The
555 ~~department shall hold a hearing on the election at the request~~
556 ~~of the carrier~~.

557 (11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.--

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

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

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

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

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

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

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

581 7. Assess participating carriers in accordance with
582 paragraph (j), and make advance interim assessments as may be
583 reasonable and necessary for organizational and interim
584 operating expenses. Interim assessments shall be credited as
585 offsets against any regular assessments due following the close
586 of the calendar year.

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

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

595 10. To the extent necessary, increase the \$5,000
596 deductible reinsurance requirement to adjust for the effects of
597 inflation. The program may evaluate the desirability of
598 establishing different levels of deductibles. If different

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599 levels of deductibles are established, such levels and the
600 resulting premiums shall be approved by the department.

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

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

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

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

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627 4. The program may evaluate the option of allowing a small
628 employer carrier to reinsure an entire employer group or an
629 eligible employee at the first or subsequent renewal date. Any
630 such option and the resulting premium must be approved by the
631 department.

632 ~~5.4.~~ The program may not reimburse a participating carrier
633 with respect to the claims of a reinsured employee or dependent
634 until the carrier has paid incurred claims of an amount equal to
635 the participating carrier's selected deductible level ~~at least~~
636 ~~\$5,000~~ in a calendar year for benefits covered by the program.
637 ~~In addition, the reinsuring carrier shall be responsible for 10~~
638 ~~percent of the next \$50,000 and 5 percent of the next \$100,000~~
639 ~~of incurred claims during a calendar year and the program shall~~
640 ~~reinsure the remainder.~~

641 ~~6.5.~~ The board annually shall adjust the initial level of
642 claims and the maximum limit to be retained by the carrier to
643 reflect increases in costs and utilization within the standard
644 market for health benefit plans within the state. The adjustment
645 shall not be less than the annual change in the medical
646 component of the "Consumer Price Index for All Urban Consumers"
647 of the Bureau of Labor Statistics of the Department of Labor,
648 unless the board proposes and the department approves a lower
649 adjustment factor.

650 ~~7.6.~~ A small employer carrier may terminate reinsurance
651 for all reinsured employees or dependents on any plan
652 anniversary.

653 ~~8.7.~~ The premium rate charged for reinsurance by the
654 program to a health maintenance organization that is approved by
655 the Secretary of Health and Human Services as a federally

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656 qualified health maintenance organization pursuant to 42 U.S.C.
657 s. 300e(c)(2)(A) and that, as such, is subject to requirements
658 that limit the amount of risk that may be ceded to the program,
659 which requirements are more restrictive than subparagraph 5. 4-,
660 shall be reduced by an amount equal to that portion of the risk,
661 if any, which exceeds the amount set forth in subparagraph 5. 4-
662 which may not be ceded to the program.

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

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

673 (h)1. The board, as part of the plan of operation, shall
674 establish a methodology for determining premium rates to be
675 charged by the program for reinsuring small employers and
676 individuals pursuant to this section. The methodology shall
677 include a system for classification of small employers that
678 reflects the types of case characteristics commonly used by
679 small employer carriers in the state. The methodology shall
680 provide for the development of basic reinsurance premium rates,
681 which shall be multiplied by the factors set for them in this
682 paragraph to determine the premium rates for the program. The
683 basic reinsurance premium rates shall be established by the
684 board, subject to the approval of the department, and shall be

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685 set at levels which reasonably approximate gross premiums
686 charged to small employers by small employer carriers for health
687 benefit plans with benefits similar to the standard and basic
688 health benefit plan. The premium rates set by the board may vary
689 by geographical area, as determined under this section, to
690 reflect differences in cost. ~~The multiplying factors must be~~
691 ~~established as follows:~~

692 ~~a. The entire group may be reinsured for a rate that is~~
693 ~~1.5 times the rate established by the board.~~

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

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

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

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

709 a. The operating losses of the program shall be assessed
710 in the following order subject to the specified limitations. The
711 first tier of assessments shall be made against reinsuring
712 carriers in an amount which shall not exceed 5 percent of each
713 reinsuring carrier's premiums from health benefit plans covering

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714 small employers. If such assessments have been collected and
715 additional moneys are needed, the board shall make a second tier
716 of assessments in an amount which shall not exceed 0.5 percent
717 of each carrier's health benefit plan premiums. Except as
718 provided in paragraph (n), risk-assuming carriers are exempt
719 from all assessments authorized pursuant to this section. The
720 amount paid by a reinsuring carrier for the first tier of
721 assessments shall be credited against any additional assessments
722 made.

723 b. The board shall equitably assess carriers for operating
724 losses of the plan based on market share. The board shall
725 annually assess each carrier a portion of the operating losses
726 of the plan. The first tier of assessments shall be determined
727 by multiplying the operating losses by a fraction, the numerator
728 of which equals the reinsuring carrier's earned premium
729 pertaining to direct writings of small employer health benefit
730 plans in the state during the calendar year for which the
731 assessment is levied, and the denominator of which equals the
732 total of all such premiums earned by reinsuring carriers in the
733 state during that calendar year. The second tier of assessments
734 shall be based on the premiums that all carriers, except risk-
735 assuming carriers, earned on all health benefit plans written in
736 this state. The board may levy interim assessments against
737 carriers to ensure the financial ability of the plan to cover
738 claims expenses and administrative expenses paid or estimated to
739 be paid in the operation of the plan for the calendar year prior
740 to the association's anticipated receipt of annual assessments
741 for that calendar year. Any interim assessment is due and
742 payable within 30 days after receipt by a carrier of the interim

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743 assessment notice. Interim assessment payments shall be credited
744 against the carrier's annual assessment. Health benefit plan
745 premiums and benefits paid by a carrier that are less than an
746 amount determined by the board to justify the cost of collection
747 may not be considered for purposes of determining assessments.

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

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

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

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772 department may evaluate the operations of the program and
773 implement such amendments to the plan of operation the
774 department deems necessary to reduce future losses and
775 assessments.

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

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

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

789 8. A carrier may seek, from the commissioner, a deferment,
790 in whole or in part, from any assessment made by the board. The
791 department may defer, in whole or in part, the assessment of a
792 carrier if, in the opinion of the department, the payment of the
793 assessment would place the carrier in a financially impaired
794 condition. If an assessment against a carrier is deferred, in
795 whole or in part, the amount by which the assessment is deferred
796 may be assessed against the other carriers in a manner
797 consistent with the basis for assessment set forth in this
798 section. The carrier receiving such deferment remains liable to
799 the program for the amount deferred and is prohibited from

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800 reinsuring any individuals or groups in the program if it fails
801 to pay assessments.

802 Section 12. Section 627.911, Florida Statutes, is amended
803 to read:

804 627.911 Scope of this part.--Any insurer or health
805 maintenance organization transacting insurance in this state
806 shall report information as required by this part.

807 Section 13. Section 627.9175, Florida Statutes, is amended
808 to read:

809 627.9175 Reports of information on health insurance.--

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

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

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

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

824 1. Direct premiums earned.

825 2. Direct losses incurred.

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

828 4. Number of policies.

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- 829 5. Number of certificates.
830 6. Number of total covered lives.

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

- 835 ~~1. The deductible amount;~~
836 ~~2. The coinsurance percentage;~~
837 ~~3. The out-of-pocket maximum;~~
838 ~~4. Outpatient benefits;~~
839 ~~5. Inpatient benefits; and~~
840 ~~6. Any exclusions for preexisting conditions.~~

841
842 ~~The department shall determine other appropriate benefits,~~
843 ~~exclusions, and limitations to be reported for inclusion in the~~
844 ~~consumer's guide published pursuant to this section.~~

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

849
850 ~~The department shall provide by rule a uniform format for the~~
851 ~~submission of this information in order to allow for meaningful~~
852 ~~comparisons of premiums charged for comparable benefits.~~

853 (3) The department may adopt rules to administer this
854 section, including, but not limited to, rules governing
855 compliance and provisions implementing electronic methodologies
856 for use in furnishing such records or documents. The commission
857 may by rule specify a uniform format for the submission of this

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858 ~~information in order to allow for meaningful comparisons shall~~
859 ~~publish annually a consumer's guide which summarizes and~~
860 ~~compares the information required to be reported under this~~
861 ~~subsection.~~

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

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

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

880 Section 14. Section 627.9403, Florida Statutes, is amended
881 to read:

882 627.9403 Scope.--The provisions of this part shall apply
883 to long-term care insurance policies delivered or issued for
884 delivery in this state, and to policies delivered or issued for
885 delivery outside this state to the extent provided in s.

886 627.9406, by an insurer, a fraternal benefit society as defined

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887 in s. 632.601, a health maintenance organization as defined in
888 s. 641.19, a prepaid health clinic as defined in s. 641.402, or
889 a multiple-employer welfare arrangement as defined in s.
890 624.437. A policy which is advertised, marketed, or offered as a
891 long-term care policy and as a Medicare supplement policy shall
892 meet the requirements of this part and the requirements of ss.
893 627.671-627.675 and, to the extent of a conflict, be subject to
894 the requirement that is more favorable to the policyholder or
895 certificateholder. The provisions of this part shall not apply
896 to a continuing care contract issued pursuant to chapter 651 and
897 shall not apply to guaranteed renewable policies issued prior to
898 October 1, 1988. Any limited benefit policy that limits coverage
899 to care in a nursing home or to one or more lower levels of care
900 required or authorized to be provided by this part or by
901 department rule must meet all requirements of this part that
902 apply to long-term care insurance policies, except ss.
903 627.9407(3)(c) and (d), (9), (10)(f), and (12) and 627.94073(2).
904 ~~If the limited benefit policy does not provide coverage for care~~
905 ~~in a nursing home, but does provide coverage for one or more~~
906 ~~lower levels of care, the policy shall also be exempt from the~~
907 ~~requirements of s. 627.9407(3)(d).~~

908 Section 15. Paragraph (b) of subsection (1) of section
909 641.185, Florida Statutes, is amended to read:

910 641.185 Health maintenance organization subscriber
911 protections.--

912 (1) With respect to the provisions of this part and part
913 III, the principles expressed in the following statements shall
914 serve as standards to be followed by the Department of Insurance
915 and the Agency for Health Care Administration in exercising

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916 their powers and duties, in exercising administrative
917 discretion, in administrative interpretations of the law, in
918 enforcing its provisions, and in adopting rules:

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

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

927 641.31 Health maintenance contracts.--

928 (3)

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

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944 and delivered in this state insuring groups of 51 or more
945 persons.

946 (9)(a)1. If a health maintenance organization offers
947 coverage for dependent children of the subscriber, the contract
948 must cover a dependent child of the subscriber at least until
949 the end of the calendar year in which the child reaches the age
950 of 23, if the child meets all of the following:

951 a. The child is dependent upon the subscriber for support.
952 b. The child is living in the household of the subscriber,
953 or the child is a full-time or part-time student.

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

957 (b)1. A contract that provides coverage for a family
958 member of the subscriber shall, as to such family member's
959 coverage, provide that benefits applicable to children of the
960 subscriber also apply to an adopted child or a foster child of
961 the subscriber placed in compliance with chapter 63 from the
962 moment of placement in the residence of the subscriber. Except
963 in the case of a foster child, the contract may not exclude
964 coverage for any preexisting condition of the child. In the case
965 of a newborn child, coverage begins at the moment of birth if a
966 written agreement to adopt such child has been entered into by
967 the subscriber prior to the birth of the child, whether or not
968 the agreement is enforceable. This section does not require
969 coverage for an adopted child who is not ultimately placed in
970 the residence of the subscriber in compliance with chapter 63.

971 2. A contract may require the subscriber to notify the
972 health maintenance organization of the birth or placement of an

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973 adopted child within a specified time period of not less than 30
974 days after the birth or placement in the residence of a child
975 adopted by the subscriber. If timely notice is given, the health
976 maintenance organization may not charge an additional premium
977 for coverage of the child for the duration of the notice period.
978 If timely notice is not given, the health maintenance
979 organization may charge an additional premium from the date of
980 birth or placement. If notice is given within 60 days after the
981 birth or placement of the child, the health maintenance
982 organization may not deny coverage for the child due to the
983 failure of the subscriber to timely notify the health
984 maintenance organization of the birth or placement of the child.

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

995 4. In order to increase access to postnatal, infant, and
996 pediatric health care for all children placed in court-ordered
997 custody, including foster children, all health maintenance
998 organization contracts that provide coverage for a family member
999 of the subscriber shall, as to such family member's coverage,
1000 provide that benefits applicable for children shall be payable

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1001 with respect to a foster child or other child in court-ordered,
1002 temporary, or other custody of the subscriber.

1003 (10) A contract that provides that coverage of a dependent
1004 child shall terminate upon attainment of the limiting age for
1005 dependent children specified in the contract shall also provide
1006 in substance that attainment of the limiting age does not
1007 terminate the coverage of the child while the child continues to
1008 be:

1009 (a) Incapable of self-sustaining employment by reason of
1010 mental retardation or physical handicap.

1011 (b) Chiefly dependent upon the subscriber for support and
1012 maintenance.

1013
1014 If a claim is denied under a contract for the stated reason that
1015 the child has attained the limiting age for dependent children
1016 specified in the contract, the notice of denial must state that
1017 the subscriber has the burden of establishing that the child
1018 continues to meet the criteria specified in paragraphs (a) and
1019 (b). All health maintenance contracts that provide coverage,
1020 benefits, or services for a member of the family of the
1021 subscriber must, as to such family member's coverage, benefits,
1022 or services, provide also that the coverage, benefits, or
1023 services applicable for children must be provided with respect
1024 to a newborn child of the subscriber, or covered family member
1025 of the subscriber, from the moment of birth. However, with
1026 respect to a newborn child of a covered family member other than
1027 the spouse of the insured or subscriber, the coverage for the
1028 newborn child terminates 18 months after the birth of the
1029 newborn child. The coverage, benefits, or services for newborn

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1030 ~~children must consist of coverage for injury or sickness,~~
1031 ~~including the necessary care or treatment of medically diagnosed~~
1032 ~~congenital defects, birth abnormalities, or prematurity, and~~
1033 ~~transportation costs of the newborn to and from the nearest~~
1034 ~~appropriate facility appropriately staffed and equipped to treat~~
1035 ~~the newborn's condition, when such transportation is certified~~
1036 ~~by the attending physician as medically necessary to protect the~~
1037 ~~health and safety of the newborn child.~~

1038 ~~(a) A contract may require the subscriber to notify the~~
1039 ~~plan of the birth of a child within a time period, as specified~~
1040 ~~in the contract, of not less than 30 days after the birth, or a~~
1041 ~~contract may require the preenrollment of a newborn prior to~~
1042 ~~birth. However, if timely notice is given, a plan may not charge~~
1043 ~~an additional premium for additional coverage of the newborn~~
1044 ~~child for not less than 30 days after the birth of the child. If~~
1045 ~~timely notice is not given, the plan may charge an additional~~
1046 ~~premium from the date of birth. If notice is given within 60~~
1047 ~~days of the birth of the child, the contract may not deny~~
1048 ~~coverage of the child due to failure of the subscriber to timely~~
1049 ~~notify the plan of the birth of the child or to preenroll the~~
1050 ~~child.~~

1051 ~~(b) If the contract does not require the subscriber to~~
1052 ~~notify the plan of the birth of a child within a specified time~~
1053 ~~period, the plan may not deny coverage of the child nor may it~~
1054 ~~retroactively charge the subscriber an additional premium for~~
1055 ~~the child; however, the contract may prospectively charge the~~
1056 ~~member an additional premium for the child if the plan provides~~
1057 ~~at least 45 days' notice of the additional charge.~~

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1058 (11)~~(10)~~ No alteration of any written application for any
1059 health maintenance contract shall be made by any person other
1060 than the applicant without his or her written consent, except
1061 that insertions may be made by the health maintenance
1062 organization, for administrative purposes only, in such manner
1063 as to indicate clearly that such insertions are not to be
1064 ascribed to the applicant.

1065 (12)~~(11)~~ No contract shall contain any waiver of rights or
1066 benefits provided to or available to subscribers under the
1067 provisions of any law or rule applicable to health maintenance
1068 organizations.

1069 (13)~~(12)~~ Each health maintenance contract, certificate, or
1070 member handbook shall state that emergency services and care
1071 shall be provided to subscribers in emergency situations not
1072 permitting treatment through the health maintenance
1073 organization's providers, without prior notification to and
1074 approval of the organization. Not less than 75 percent of the
1075 reasonable charges for covered services and supplies shall be
1076 paid by the organization, up to the subscriber contract benefit
1077 limits. Payment also may be subject to additional applicable
1078 copayment provisions, not to exceed \$100 per claim. The health
1079 maintenance contract, certificate, or member handbook shall
1080 contain the definitions of "emergency services and care" and
1081 "emergency medical condition" as specified in s. 641.19(7) and
1082 (8), shall describe procedures for determination by the health
1083 maintenance organization of whether the services qualify for
1084 reimbursement as emergency services and care, and shall contain
1085 specific examples of what does constitute an emergency. In
1086 providing for emergency services and care as a covered service,

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1087 a health maintenance organization shall be governed by s.
1088 641.513.

1089 ~~(14)~~(13) In addition to the requirements of this section,
1090 with respect to a person who is entitled to have payments for
1091 health care costs made under Medicare, Title XVIII of the Social
1092 Security Act ("Medicare"), parts A and/or B:

1093 (a) The health maintenance organization shall mail or
1094 deliver notification to the Medicare beneficiary of the date of
1095 enrollment in the health maintenance organization within 10 days
1096 after receiving notification of enrollment approval from the
1097 United States Department of Health and Human Services, Health
1098 Care Financing Administration. When a Medicare beneficiary who
1099 is a subscriber of the health maintenance organization requests
1100 disenrollment from the organization, the organization shall mail
1101 or deliver to the beneficiary notice of the effective date of
1102 the disenrollment within 10 days after receipt of the written
1103 disenrollment request. The health maintenance organization shall
1104 forward the disenrollment request to the United States
1105 Department of Health and Human Services, Health Care Financing
1106 Administration, in a timely manner so as to effectuate the next
1107 available disenrollment date, as prescribed by such federal
1108 agency.

1109 (b) The health maintenance contract, certificate, or
1110 member handbook shall be delivered to the subscriber no later
1111 than the earlier of 10 working days after the health maintenance
1112 organization and the Health Care Financing Administration of the
1113 United States Department of Health and Human Services approve
1114 the subscriber's enrollment application or the effective date of
1115 coverage of the subscriber under the health maintenance

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1116 contract. However, if notice from the Health Care Financing
1117 Administration of its approval of the subscriber's enrollment
1118 application is received by the health maintenance organization
1119 after the effective coverage date prescribed by the Health Care
1120 Financing Administration, the health maintenance organization
1121 shall deliver the contract, certificate, or member handbook to
1122 the subscriber within 10 days after receiving such notice. When
1123 a Medicare recipient is enrolled in a health maintenance
1124 organization program, the contract, certificate, or member
1125 handbook shall be accompanied by a health maintenance
1126 organization identification sticker with instruction to the
1127 Medicare beneficiary to place the sticker on the Medicare
1128 identification card.

1129 ~~(15)~~(14) Whenever a subscriber of a health maintenance
1130 organization is also a Medicaid recipient, the health
1131 maintenance organization's coverage shall be primary to the
1132 recipient's Medicaid benefits and the organization shall be a
1133 third party subject to the provisions of s. 409.910(4).

1134 ~~(16)~~(15)(a) All health maintenance contracts,
1135 certificates, and member handbooks shall contain the following
1136 provision:

1137

1138 "Grace Period: This contract has a (insert a number not less
1139 than 10) day grace period. This provision means that if any
1140 required premium is not paid on or before the date it is due, it
1141 may be paid during the following grace period. During the grace
1142 period, the contract will stay in force."

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1144 (b) The required provision of paragraph (a) shall not
1145 apply to certificates or member handbooks delivered to
1146 individual subscribers under a group health maintenance contract
1147 when the employer or other person who will hold the contract on
1148 behalf of the subscriber group pays the entire premium for the
1149 individual subscribers. However, such required provision shall
1150 apply to the group health maintenance contract.

1151 ~~(17)~~(16) The contracts must clearly disclose the intent of
1152 the health maintenance organization as to the applicability or
1153 nonapplicability of coverage to preexisting conditions. If
1154 coverage of the contract is not to be applicable to preexisting
1155 conditions, the contract shall specify, in substance, that
1156 coverage pertains solely to accidental bodily injuries resulting
1157 from accidents occurring after the effective date of coverage
1158 and that sicknesses are limited to those which first manifest
1159 themselves subsequent to the effective date of coverage.

1160 ~~(17) All health maintenance contracts that provide~~
1161 ~~coverage for a member of the family of the subscriber, shall, as~~
1162 ~~to such family member's coverage, provide that coverage,~~
1163 ~~benefits, or services applicable for children shall be provided~~
1164 ~~with respect to an adopted child of the subscriber, which child~~
1165 ~~is placed in compliance with chapter 63, from the moment of~~
1166 ~~placement in the residence of the subscriber. Such contracts may~~
1167 ~~not exclude coverage for any preexisting condition of the child.~~
1168 ~~In the case of a newborn child, coverage shall begin from the~~
1169 ~~moment of birth if a written agreement to adopt such child has~~
1170 ~~been entered into by the subscriber prior to the birth of the~~
1171 ~~child, whether or not such agreement is enforceable. However,~~
1172 ~~coverage for such child shall not be required in the event that~~

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1173 ~~the child is not ultimately placed in the residence of the~~
1174 ~~subscriber in compliance with chapter 63.~~

1175 Section 17. Section 641.31025, Florida Statutes, is
1176 created to read:

1177 641.31025 Specific reasons for denial of coverage.--The
1178 denial of an application for a health maintenance organization
1179 contract must be accompanied by the specific reasons for the
1180 denial, including, but not limited to, the specific underwriting
1181 reasons, if applicable.

1182 Section 18. Section 641.31075, Florida Statutes, is
1183 created to read:

1184 641.31075 Replacement.--Any health maintenance
1185 organization that is replacing any other group health coverage
1186 with its group health maintenance coverage shall comply with s.
1187 627.666.

1188 Section 19. Subsections (1) and (3) of section 641.3111,
1189 Florida Statutes, are amended to read:

1190 641.3111 Extension of benefits.--

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

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1202 The required provision must provide for continuation of contract
1203 benefits in connection with the treatment of a specific accident
1204 or illness incurred while the contract was in effect. Such
1205 extension of benefits may be limited to the occurrence of the
1206 earliest of the following events:

1207 (a) The expiration of 12 months.

1208 (b) Such time as the member is no longer totally disabled.

1209 ~~(c) A succeeding carrier elects to provide replacement~~
1210 ~~coverage without limitation as to the disability condition.~~

1211 (c)(d) The maximum benefits payable under the contract
1212 have been paid.

1213 (3) In the case of maternity coverage, ~~when not covered by~~
1214 ~~the succeeding carrier,~~ a reasonable extension of benefits or
1215 accrued liability provision is required, which provision
1216 provides for continuation of the contract benefits in connection
1217 with maternity expenses for a pregnancy that commenced while the
1218 policy was in effect. The extension shall be for the period of
1219 that pregnancy and shall not be based upon total disability.

1220 Section 20. Subsection (4) of section 627.651, Florida
1221 Statutes, is amended to read:

1222 627.651 Group contracts and plans of self-insurance must
1223 meet group requirements.--

1224 (4) This section does not apply to any plan which is
1225 established or maintained by an individual employer in
1226 accordance with the Employee Retirement Income Security Act of
1227 1974, Pub. L. No. 93-406, or to a multiple-employer welfare
1228 arrangement as defined in s. 624.437(1), except that a multiple-
1229 employer welfare arrangement shall comply with ss. 627.419,
1230 627.657, 627.6575, 627.6578, 627.6579, 627.6612, 627.66121,

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1231 627.66122, 627.6615, 627.6616, and 627.662~~(8)~~~~(7)~~. This
1232 subsection does not allow an authorized insurer to issue a group
1233 health insurance policy or certificate which does not comply
1234 with this part.

1235 Section 21. Subsection (1) of section 641.2018, Florida
1236 Statutes, is amended to read:

1237 641.2018 Limited coverage for home health care
1238 authorized.--

1239 (1) Notwithstanding other provisions of this chapter, a
1240 health maintenance organization may issue a contract that limits
1241 coverage to home health care services only. The organization and
1242 the contract shall be subject to all of the requirements of this
1243 part that do not require or otherwise apply to specific benefits
1244 other than home care services. To this extent, all of the
1245 requirements of this part apply to any organization or contract
1246 that limits coverage to home care services, except the
1247 requirements for providing comprehensive health care services as
1248 provided in ss. 641.19(4), (12), and (13), and 641.31(1), except
1249 ss. 641.31~~(9)~~, (13)~~(12)~~, ~~(17)~~, (18), (19), (20), (21), and (24)
1250 and 641.31095.

1251 Section 22. Section 641.3107, Florida Statutes, is amended
1252 to read:

1253 641.3107 Delivery of contract.--Unless delivered upon
1254 execution or issuance, a health maintenance contract,
1255 certificate of coverage, or member handbook shall be mailed or
1256 delivered to the subscriber or, in the case of a group health
1257 maintenance contract, to the employer or other person who will
1258 hold the contract on behalf of the subscriber group within 10
1259 working days from approval of the enrollment form by the health

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1260 maintenance organization or by the effective date of coverage,
 1261 whichever occurs first. However, if the employer or other person
 1262 who will hold the contract on behalf of the subscriber group
 1263 requires retroactive enrollment of a subscriber, the
 1264 organization shall deliver the contract, certificate, or member
 1265 handbook to the subscriber within 10 days after receiving notice
 1266 from the employer of the retroactive enrollment. This section
 1267 does not apply to the delivery of those contracts specified in
 1268 s. 641.31(14)~~(13)~~.

1269 Section 23. Subsection (4) of section 641.513, Florida
 1270 Statutes, is amended to read:

1271 641.513 Requirements for providing emergency services and
 1272 care.--

1273 (4) A subscriber may be charged a reasonable copayment, as
 1274 provided in s. 641.31(13)~~(12)~~, for the use of an emergency room.

1275 Section 24. This act shall take effect upon becoming a
 1276 law.

1277
 1278 ===== T I T L E A M E N D M E N T =====

1279 Remove line 607, and insert:
 1280 An act relating to health insurance; amending s. 408.909,
 1281 F.S.; revising a definition; authorizing health flex plans
 1282 to limit coverage under certain circumstances; authorizing
 1283 a small business purchasing arrangement to limit
 1284 enrollment to certain residents; extending an expiration
 1285 date; creating s. 627.6042, F.S.; requiring policies of
 1286 insurers offering coverage of dependent children to
 1287 maintain such coverage until a child reaches age 25, under
 1288 certain circumstances; providing application; creating s.

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1289 627.60425, F.S.; providing limitations on certain binding
1290 arbitration requirements; amending s. 627.6044, F.S.;
1291 providing for payment of claims to nonnetwork providers
1292 under specified conditions; providing a definition;
1293 requiring the method used for determining payment of
1294 claims to be included in filings; providing for
1295 disclosure; amending s. 627.6415, F.S.; deleting an 18th
1296 birthday age limitation on application of certain
1297 dependent coverage requirements; amending s. 627.6475,
1298 F.S.; revising risk-assuming carrier election requirements
1299 and procedures; revising certain criteria and limitations
1300 under the individual health reinsurance program; amending
1301 s. 627.651, F.S.; correcting a cross reference; amending
1302 s. 627.662, F.S.; revising a list of provisions applicable
1303 to group, blanket, or franchise health insurance to
1304 include use of specific methodology for payment of claims
1305 provisions; amending s. 627.667, F.S.; deleting a
1306 limitation on application of certain extension of benefits
1307 provisions; amending s. 627.6692, F.S.; increasing a time
1308 period for payment of premium to continue coverage under a
1309 group health plan; amending s. 627.6699, F.S.; revising
1310 definitions; revising coverage enrollment eligibility
1311 criteria for small employers; revising small employer
1312 carrier election requirements and procedures; revising
1313 certain criteria and limitations under the small employer
1314 health reinsurance program; amending ss. 627.911 and
1315 627.9175, F.S.; applying certain information reporting
1316 requirements to health maintenance organizations; revising
1317 health insurance information requirements and criteria;

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1318 authorizing the department to adopt rules; deleting an
1319 annual report requirement; amending s. 627.9403, F.S.;
1320 deleting an exemption for limited benefit policies from a
1321 long-term care insurance restriction relating to nursing
1322 home care; amending s. 641.185, F.S.; correcting a cross
1323 reference; amending s. 641.31, F.S.; specifying
1324 nonapplication to certain contracts; requiring health
1325 maintenance organizations offering coverage of dependent
1326 children to maintain such coverage until a child reaches
1327 age 25, under certain circumstances; providing
1328 application; providing requirements for contract
1329 termination and denial of a claim related to limiting age
1330 attainment; creating s. 641.31025, F.S.; requiring
1331 specific reasons for denial of coverage under a health
1332 maintenance organization contract; creating s. 641.31075,
1333 F.S.; imposing compliance requirements upon health
1334 maintenance organization replacements of other group
1335 health coverage with organization coverage; amending s.
1336 641.3111, F.S.; deleting a limitation on certain extension
1337 of benefits provisions upon group health maintenance
1338 contract termination; imposing additional extension of
1339 benefits requirements upon such termination; amending ss.
1340 627.651, 641.2018, 641.3107, and 641.513, F.S.; correcting
1341 cross references; amending s. 395.301,