HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 723 Health Insurance
SPONSOR(S): Llorente and others
TIED BILLS: None. **IDEN./SIM. BILLS:** SB 1796 (s); HB 1573 (c)

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Services (Sub)	9 Y, 0 N	Chavis	Collins
2) Health Care			
3) Insurance			
4)			
5)			

SUMMARY ANALYSIS

HB 723 provides the following:

- Prohibits mandatory arbitration clauses in life and health insurance polices;
- Requires HMO's to explain denial of coverage under individual contracts;
- Requires plans with prescription drug benefits to provide specified coverage and limits tiers of coverage;
- Requires all lines of health coverage to utilize the same definition of eligible dependents, including adopted and foster children;
- Modifies individual carrier reinsurance pool practices and procedures;
- Increases minimum mandated benefit for home health services from $1,000 to $15,000;
- Requires all policies employing certain specified payment mechanisms to provide reasonable explanations and estimates, upon request;
- Establishes that a prior carrier is always responsible for medical cases still in the process of receiving services;
- Extends from 30 to 63 days the time for certain employees terminated from a group health plan to apply for continuation of coverage;
- Amends small group coverage: tightens definition of employee and employer; deletes 15% rating factor; allows for special enrollment for certain one-life groups; and modifies small group carrier reinsurance pool practices and procedures;
- Modifies annual carrier reporting to include HMO's and provides for collection of information regarding various health market segments;
- Removes a limitation affecting nursing home benefit policies to allow carrier to offer "nursing home only" coverage for less than the current two-year minimum; and
- Subjects HMOs to the same requirements as insurers when replacing coverage.

The bill takes effect upon becoming law.

The bill makes substantial changes to health care coverage.

On March 19, 2003, the Health Services Subcommittee adopted a "strike-everything" amendment. See Section IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES section for an explanation of the amendment.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. DOES THE BILL:

1. Reduce government?	Yes[]	No[x]	N/A[]
2. Lower taxes?	Yes[]	No[]	N/A[x]
3. Expand individual freedom?	Yes[x]	No[]	N/A[]
4. Increase personal responsibility?	Yes[]	No[]	N/A[x]
5. Empower families?	Yes[x]	No[]	N/A[]

For any principle that received a "no" above, please explain:

1. Numerous sections of the bill provide for increased regulation of health insurance polices and health maintenance contracts, including sections 2, 3, 6, 8, 9, 11,12, 13, 14, and 17.

B. EFFECT OF PROPOSED CHANGES:

Mandatory Arbitration Clauses

HB 723 expands definitions of unfair methods of competition and unfair deceptive acts or practice of s. 626.9541, F.S., to include mandatory arbitration by a life insurer, health insurer, or disability insurer. Arbitration is an alternative dispute resolution (ADR) technique that provides an alternative to litigation. Arbitration is intended to be a more efficient and cost-effective method of resolving rate disputes than litigation. Mandatory arbitration clauses require one party to agree to another's pre-dispute arbitration provision. Arbitration is different from mediation. Mediation achieves an end to conflict through agreement of the parties. Arbitration is the equivalent of a judge for hire, with the difference being that the parties create the rules by which the "trial" or in this case, arbitration will be run.

Some organizations are beginning to address consumer concerns relating to mandatory arbitration clauses. For example, recently the American Arbitration Association (AAA) implemented a cap to consumers' arbitration costs at $375, requiring businesses to pay the rest. In addition, the AAA will no longer enforce pre-dispute arbitration clauses in health insurance contracts. However, even with the AAA's prohibition, businesses can easily switch from using the AAA to other non-AAA arbitration providers.

Along with 34 other states, Florida has adopted the Uniform Arbitration Act, which is codified at Chapter 682, F.S., and cited as the Florida Arbitration Code (code). Parties can stipulate in their agreement or contract to exclude the code's application in any arbitration between them. Agreements to arbitrate are generally favored by the courts, however, the jurisdiction of the courts cannot be invoked to compel arbitration unless an agreement to arbitrate complies with the Florida Arbitration Code. *Knight v. H. S. Equities*, Inc., 280 So. 2d 456, 459 (Fla. 4th DCA 1973).

<u>Concerns about Mandatory Arbitration Clauses</u>

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

- Consumers are precluded from seeking a remedy against the business because the upfront cost of the arbitration process is too expensive, or consumers abandon the action due to unforeseen costs.
- Insurers are immunized from liability because consumers are deterred from bringing claims to arbitration due to the high costs.

- Written opinions of arbitration proceedings are rare so arbitrators and businesses are insulated from public scrutiny, as most clauses require that the arbitration proceedings be kept confidential. Subsequently, as no precedent is established, insurers have an advantage over consumers as repeat players to anticipate how certain issues will be decided as they strategize in future claims.
- Decisions may only be overturned if there is an applicable contract defense, or "manifest disregard" of the law. This is a difficult standard to meet where there is no written opinion of the arbitration proceedings. To vacate a decision, typically, a party must show:
    - A serious conflict of interest on part of neutral arbitrator;
    - The award wasn't "final";
    - The decision covered a subject outside the scope of the agreement; or
    - The decision provided an amount or kind of relief that arbitrator was expressly precluded from awarding.

Advantages of Mandatory Arbitration Clauses

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

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

Denial of Coverage by a Health Maintenance Organization

HB 723 amends s. 627.4091, F.S., relating to specific reasons for denial, cancellation, or nonrenewal to include expanding the current law to include health maintenance organization contracts, and prepaid limited health service organization plans in the requirement that the denial of an application for an insurance policy must be accompanied by the specific reasons for the denial, including the specific underwriting reasons, if applicable.

Prescription Drug Formularies

HB 723 creates section s. 627.4303, F.S., to require that any of the specifically listed health insurance policies, health maintenance contracts, prepaid limited health organization plan, or any policy or certificate delivered or issued for deliver to any person is this state, including out-of-state group plans, that provides prescription drug coverage benefits must cover all prescription drugs approved by the U.S. Food and Drug Administration, without any waiting period. The bill appears to create an open-ended prescription drug mandate which will require health plans/employers to provide coverage for lifestyle drugs and off-label uses (drugs approved by the FDA for one purpose but prescribed for another).

In addition, the bill requires that prescription drug formularies are to be limited to no more than three tiers of covers, including generic and nongeneric. The current trend in health care coverage appears to be to allow promote consumer choice and responsibility. Additional tiers allow consumer more flexibility and personal choice in co-pays and co-insurance.

A formulary is a list of the prescription drugs that are covered by your health care plan. Health plan companies choose drugs that are known to be safe, effective and affordable. Plans then negotiate discounted prices from manufacturers when there are several similar drugs on the market. Each health plan has its own formulary. Typically, a committee of health plan doctors and pharmacists decide

which medicines are included in the health plan formulary based on their determination on which medicines are safe, effective and economical. A "tiered" prescription drug formulary benefits means that the health plan offers tiers, or levels, of coverage for the cost of medicines. For example, with "three-tier pharmacy benefits" the patient would have three choices:

- A minimum co-payment for a lower-cost generic drug;
- A somewhat higher payment for brand-name drug in the formulary; and
- An even higher payment for a brand-name drug not included in the formulary.

Dependent Coverage

HB 723 creates in Part VI, Health Insurance Policies, s. 627.6042, F.S., to require all health insurance policies to utilize the same definition of eligible dependents, including adopted and foster children and provides the criteria for determining when a child is no longer a dependent and eligible for coverage under the policyholder's or certificateholder's plan. Specifically, the section requires that if the insurer insures the dependent child of a policyholder or certificateholder, the policy must insure the dependent child at least until the end of the of the calendar year in which the child reaches the age of 25, if:
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- The child is dependent upon the policy holder or certificateholder for support; or
- The child is living in the household of the policyholder or certificateholder or the child is a full-time or part-time student.

The section also provides that nothing in the section affects or preempts the insurer's right to medically underwrite or charge an appropriate premium.

HB 723 also amends s. 627.6415, F.S., relating to coverage for natural-born, adopted, and foster children; and certain children in the insured's custodial care, and deletes the limitation of the coverage relating to the child's 18th birthday. The result of this change is that newly created s. 627.6042, F.S., as provided above, would apply.

Reinsurance Pools

Involuntary pools and associations represent a mechanism employed by states to provide insurance coverage to those with expected higher than average probability of loss that otherwise would be excluded from obtaining coverage. Reporting entities are generally required to participate in the underwriting results, including premiums, losses, expenses, and other operations of involuntary pools, based on their proportionate share of similar business written in the state. Involuntary plans are also referred to as residual market plans, involuntary risk pools, and mandatory pools.

Section 627.6475(5)(a), F.S., requires issuers that offer individual health insurance must elect to become a risk–assuming carrier or reinsuring carrier for the purposes of this section. Such election must be made is binding through December 31, 1999, and the initial election, must be made no later than October 31, 1997. By October 31, 1997, all issuers must file a final election which is binding for five years and the department may permit an issuer to modify its election at any time for good cause shown, after a hearing. HB 723 deletes the out-of-date timeframes and simply requires all such issuers to make an election which is binding indefinitely or until modified or withdrawn instead of the current five years. The bill deletes the requirement of the department to hold a hearing before allowing an insurer to modify its election.

Section 627.6475(6)(c), F.S., requires the department to provide public notice of an issuer's designation of election under this subsection and requires the department to provide at least a 21-day period for public comment before making a decision on the election. In addition, the department is required to hold a hearing before permitting an issuer to modify its election. HB 723 provides that upon the issuer's filing a designation of election the department must provide a 21-day period for comment upon receipt

of the filing. The bill deletes the requirement for the department to hold a hearing on the election at the request of the issuer.

Section 627.6475(7)(b)1., F.S., provides that a reinsuring carrier may reinsure an eligible individual within 60 days after the commencement of the coverage of the eligible individual. HB 723 expands this time to 90 days.

Section 627.6475(7)(b)2., F.S., provides that the Individual Health Reinsurance Program (program), may not reimburse a participating carrier with respect to the claims of a reinsured eligible individual until the carrier has paid incurred claims of at least $5,000 in a calendar year and, in addition, the reinsuring carrier is responsible for 10 percent of the next $50,000 and 5 percent of the next $100,000 of incurred claims during a calendar year, with the program reinsuring the remainder. HB 723 changes the reimbursement level to "an amount equal to the participating carrier's selected deductible level. In addition, the bill deletes the requirement for the reinsuring carrier 10% of the next $50,000 and 5% of the next $100,000 requirement.

Section 627.6475(7)(c)1., F.S., provides that the board, as authorized by the program, must establish a methodology for determining premium rates to be charged and authorizes that an individual may be reinsured for a rate that is five times the rate established by the board. HB 723 deletes the five times rate limitation.

Section 627.6475(7)(e)1., F.S., provides that before March 1 of each calendar year, the board must determine and report to the department the program net loss in the individual account for the previous year, including certain specified information. HB 723 changes the date to September 1.

Section 627.6475(7)(e)3., F.S., specifies that before March 1 of each year the board must determine and file with the department an estimate of the assessments needed to fund the losses incurred by the program in the individual account for the previous year. HB 723 changes the date to September 1.

Coverage for Home Health Care Services

The range of home health care services a patient can receive at home is limitless. Depending on the individual patient's situation, care can range from nursing care to specialized medical services such as laboratory work-ups. Typically, the patient and the physician will determine a care plan and identify the services needed at home. At-home care services may include:

- Physician care;
- Nursing care;
- Physical, occupational, and/or speech therapy;
- Medical social services;
- Care from home health aides;
- Homemaker or attendant care;
- Companionship;
- Volunteer care;
- Nutritional support;
- Laboratory and x-ray imaging;
- Pharmaceutical services;
- Transportation; and
- Home-delivered meals

Section 627.6617(2), F.S., provides coverage pursuant to this section may establish a maximum length of care for any policy year, but in no even shall the reimbursement be limited to an amount less than 1,000 per year. HB 723 increases the minimum reimbursement level to $15,000.

Group, Blanket, and Franchise Health Insurance Policies

Section 627.6044, F.S., requires individual health insurance policies that provide for payment of claims based on a specific methodology, including but not limited to, usual and customary charges, reasonable and customary charges, or charges based upon the prevailing rate in the community, to specify the formula or criteria used by the insurer in determining the amount to be paid. In addition, individual health insurers issuing a policy that provides for the payment of claims based on a specific methodology must provide to in insured, upon written request, an estimate of the amount the insurer will pay for a particular medical procedure or service and specifies the criteria for such estimate. HB 723 creates s. 627.662(3), F.S., and applies these requirements to group, blanket, and franchise health insurance policies.

Extension of Benefits

Section 627.667(6), F.S., requires that each group, blanket, and franchise health insurance policy provide for a specified timeframe for the extension health insurance benefits for a person who is totally disabled at the date of discontinuance of the policy, regardless of whether replacement coverage is obtained. The law also provides that these requirements apply to holders of group certificates which are renewed, delivered, or issued for delivery to residents of this state under group policies effectuated or delivered outside this state, unless a succeeding carrier under a group policy has agreed to assume liability for the benefits. HB 723 deletes the exception for succeeding carriers under a group policy.

Florida Health Insurance Coverage Continuation Act

Federal and Florida law require that all groups with 20 or more employees must allow individuals who lose coverage as a result of a qualifying event to continue as an insured member of the group for 18 to 36 months. Employers are responsible for notifying their employees or their dependents of this right. This coverage is referred to as COBRA. Florida law extends similar protection to groups with less than 20 employees. Under COBRA, an eligible employee has 63 days after notification to make a written election to continue health care coverage.

Section 627.6692(e)5., F.S., provides that an eligible employee has 30 days after notification to make a written election to continue health care coverage. HB 723 expands the time an eligible employee has to make a written election to continue health insurance coverage under Florida's Mini-COBRA law from 30 days to 63 days. This makes the timeframe consistent with the federal COBRA timeframe.

Small Employee Health Care Access Act

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

"Eligible employee"

Section 627.6699(3)(h), F.S., provides a definition of "eligible employee" as an employee who works full time, having a normal workweek of 25 or more hours, and who has met any applicable waiting-period requirements or other requirements of the act. The definition specifically identifies certain types of business entities. In June 2002, Florida Treasurer and Insurance Commissioner Tom Gallagher assembled a Small Employer Benefit Plan Committee (committee). The committee was again comprised of representatives of carriers, agents, employers, and employees. They were instructed to re-design the Standard and Basic plans to better meet Market needs and explore options and offer recommendations for making health plans available to small businesses more accessible and affordable. Among the recommendations, the committee recommended that the statutory definition of a small group employee be modified to include the phrase "an employee, other than owner, who works

full time, having a normal workweek of 25 or more hours and is paid wages or a salary at least equal to federal minimum hourly wage applicable to such employee." HB 723 amends the definition of "eligible employee" to include the specification recommended by the committee.

"Established geographical area"

Section 627.6699(3)(i), F.S., includes in the definition of "established geographical area" "portions of county or counties." HB 723 deletes the phrase as insurers and health maintenance organizations are not licensed for nor provide policies or contracts on a "portion of county or counties" basis.

"Modified community rating

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

Section 627.6699(3)(n), F.S, defines "modified community rating" to allow insurers to separate the experience of small employer groups with fewer than two employees (i.e., one-life cases) from the experience of small employer groups with 2-50 eligible employees for the purpose of determining an alternative modified community rating. Adjustments are permitted for: claims experience, health status, or duration of coverage pursuant to subparagraph (6)(b)5., F.S., and administrative and acquisition expenses as permitted under subparagraph (6)(b)5., F.S. HB 723 deletes adjustments for claims experience, health status, or duration.

"Self-employed individual"

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

As a result of the above, the committee recommended the revision of the definition to read: "self-employed individual" means an individual or sole proprietor who derives his or her income from a trade or business carried on by the individual or sole proprietor which necessitates the filing of (1) Federal Income Tax Forms, with supporting schedules and accompanying income reporting forms or (2) Federal Income Tax Extensions of Time To File Forms with the Internal IRS for the most recent tax year. HB 723 deletes the language relating to IRS form 1040, schedule C or F and replaces it with the committee's recommendation requiring the individual file with the IRS for the most recent tax year federal income tax forms with supporting schedules and accompanying income reporting forms or federal income tax extensions of time to file the forms.

Availability of Coverage

Section 627.6699(5), F.S., currently does not provide for the continuation of coverage when a small employer group is losing coverage due to a carrier or health maintenance organization exercising the provision of s. 627.6571(3)(b), or s. 641.31074(3)(b), F.S., by discontinuing offering all health insurance or health coverage in the small-group market or the large group market, or both and follows the

requirements of those sections. HB 723 creates s. 627.6699(5)(c)3.b., F.S., providing that notwithstanding the provisions of sub-subparagraph a., providing for specified open enrollment periods, when a small employer group is losing coverage due to the carrier or health maintenance organization discontinuing offering all health insurance or health coverage pursuant to s. 627.6517(3)(b), or s. 641.31074(3)(b), F.S., the employer is entitled to enroll with another carrier within 63 days after the notice of termination or the termination of the prior coverage, whichever is later. In addition, the bill provides that the coverage will begin immediately upon enrollment unless the small employer carrier and the small employer agree to a different date.

Adjustment of Rating Factors

Section 627.6699(6)(b)5., F.S., authorizes small group carriers to adjust a small employer's rate by plus or minus 15 percent, based on health status, claims experience, or duration of coverage. The renewal premium can be adjusted up to 10 percent annually (up to the total 15 percent limit) of the carrier's approved rate, based on these additional factors. HB 723 deletes the authorization for the plus or minus 15 percent surcharge.

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

Section 627.6699(9)(a), F.S., requires each small employer carrier to elect to become either a risk-assuming carrier or a reinsuring carrier by no later than October 31, 1992; and that such election is binding through January 1, 1994. In addition, such carriers are required to file, by October 31, 1993, a final election, which is binding for two years, from January 1, 1994, through December 31, 1995, after which the election is binding for a period of five years. In addition, subsequent elections are binding for two years after the date of approval of the forms and rates, and any subsequent designation is binding for five years. However, the department may permit a carrier to modify its election at any time for good cause shown, after a hearing. HB 723 deletes obsolete language; requires that the election is binding indefinitely or until modified or withdrawn; and deletes the requirement for the department to hold a hearing when permitting a carrier to modify its election.

Election Process to Become a Risk Assuming Carrier

Section 627.6699(10)(d), F.S., requires that the department provide a public notice of a small employer carrier's designation of election to become a risk-assuming carrier and must provide a 21-day period for public comment prior to making a decision on the election. The department is also required to hold a hearing on the election at the request of the carrier. HB 723 provides that the department must provide the public notice upon the carrier's filing a designation of election and that the 21-day period for public comment must begin upon the receipt of the filing. The bill deletes the requirement of the department to hold a hearing, if requested by the carrier, prior to making a decision on the election.

Small Employer Health Reinsurance Program

The Florida Health Reinsurance Program (program) was established in 1992 as a part of small group insurance reform. Its purpose was to provide a mechanism for small group carriers, who are required to provide coverage on a guaranteed issue basis, to transfer selected risks to a pool comprised of other small group carriers. Participation in the program is voluntary. The submitting carrier pays a significant extra premium beyond that collected from the employer. Section 627.6699(11)(f)10., F.S., provides that the program has the general powers and authority as other insurance companies and health maintenance organizations licensed to transact business, except for the power to issue health benefit plans to groups or individuals. In addition to other authority granted the program, the program has the authority to increase the $5,000 deductible reinsurance requirement to adjust for the effects of inflations. HB 723 expands this authority to permit the program to evaluate the desirability of establishing different levels of deductibles, and in the event that such deductibles are established, such levels and resulting premiums must be approved by the department.

Current law also requires that, with respect to a standard and basic health care plan, the program must reinsure the level of coverage provided; and with respect to any other plan must reinsure the coverage up to, but not exceeding, the level of coverage provided under the standard and basic health plan. HB 723 makes permissive the language relating to the reinsurance coverage. In addition, the bill authorizes the program to develop alternative levels of reinsurance designed to coordinate with a reinsuring carrier's existing reinsurance; however, such reinsurance and resulting premiums must be approved by the department.

Additionally, the bill authorizes the program to evaluate the option of allowing a small employer carrier to reinsure an entire employer group or an eligible employee at the first or subsequent renewal date; however, any such option and the resulting premium must be approved by the department.

Current law prohibits the program from reimbursing a participating carrier with respect to the claims of a reinsured employee or dependent until the carrier has paid incurred claims of at least $5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier is responsible for 10 percent of the next $50,000 and 5 percent of the next $100,000 of incurred claims during a calendar year and the program must reinsure the remainder. HB 723 deletes the $5,000 threshold and replaces it with a threshold that is "an amount equal to the participating carrier's selected deductible level." The bill also deletes the requirements relating to the balance and remainder.

Current law directs the board, as part of the plan of operation, to establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology must provide for the development of basic reinsurance premium rates, which must be multiplied by the factors set for them to determine the premium rates for the program. The multiplying factors must be established as follows: the entire group may be reinsured for a rate that is 1.5 times the rate established by the board; and an eligible employee or dependent may be reinsured for a rate that is 5 times the rate established by the board. HB 723 deletes the criteria relating to the multiplying factors.

Current law requires that before March 1 of each calendar year, the board must determine and report to the department the program net loss for the previous year, including administrative expenses for that year, and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. HB 723 changes the date for the report from March 1 to September 1.

Current law requires that before March 1 of each year, the board must determine and file with the department an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year. HB 723 changes the date for the report from March 1 to September 1.

Current law requires that if the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified by statute, the board must evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the department within 90 days following the end of the calendar year in which the losses were incurred; and provides that if the board should fail to submit the report within the 90 days, the department may evaluate the operation and implement such amendments to the plan of operation as the department deems is necessary. HB 723 extends the time period to 240 days.

Health Insurance Carriers Reporting Requirements

Section 627.911, F.S., requires any insurer transacting insurance in this state must report information as required by statute. HB 723 expands this requirement to include health maintenance organizations.

Reports of Information on Health Insurance

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

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

HB 723 substantially rewrites s. 627.9175, F.S., and expands the requirements to include health maintenance organizations. The bill requires authorized health insurers and health maintenance organizations to submit to the department on an annual basis information concerning coverage being issued or currently in force in the state. The information must include information related to premium, number of policies, and covered lives for such policies and other information necessary to analyze trends in enrollment, premiums and claim costs. The bill provides a list of specific required information that must be provided by both insurers and health maintenance organizations. The department will continue to publish an annual consumer's guide and to analyze the data reported under subsection (2) and must make a summary of its findings as to the types of cost containment measure reported and the estimated effect of these measures available to the public on an annual basis.

Long-Term Care Insurance Policies

Section 627.9403, F.S., regulates long-term care insurance policies. In part, the current law provides an exemption for limited benefit policies which do not provide coverage for care in a nursing home, but does provide coverage for one or more levels of care. HB 723 deletes the exemption for such policies.

Prepaid Limited Health Service Contracts

Section 636.016, F.S., provides requirements for prepaid limited health service contracts and provides that such coverage, benefits, or services for a member of the family of the subscriber must, as to the family member's coverage, benefits, or services applicable to children apply to preenrolled newborn children of the subscriber, or covered family member of the scriber from the moment of birth or adoption pursuant to chapter 63, F.S. HB 723 substantially rewrites the language relating to dependent children of the contract holder and provides that such coverage must continue until the end of the calendar year in which the child reaches the age of 25, if:

- The child is dependent upon the contract holder for support.
- The child is living in the household of the contract holder or the child is a full-time or part-time student.

In addition, the bill provides that nothing in the section affects or preempts a prepaid limited health service organization's right to medically underwrite or charge the appropriate premium.

The bill also requires that a contract that provides coverage for a family member of the contract holder must, as to the family member's coverage, provide that benefits applicable to children of the contract holder also apply to:

- An adopted child; or
- A foster child of the contract holder placed in compliance with chapter 63 from the moment of placement in the residence of the contract holder.

The bill provides that except in the case of the foster child, the policy is prohibited from excluding coverage for any preexisting condition of the child. In addition, in the case of a newborn child, coverage begins at the moment of birth, if a written agreement to adopt such child has been entered into by the contract holder prior to the birth of the child, whether or not the agreement is enforceable. However, the section does not require coverage for an adopted child who is not ultimately placed win the residence of the contract holder.

The bill authorizes the contract to require the contract holder to notify the insurer of the birth or placement of an adopted child within a specified time period of not less than 30 days after the birth or placement in the residence of child adopted by the contract holder and provides criteria for charging additional premiums in the event of an untimely notice.

The bill provides that if the contract does not require the contract holder to notify the insurer within a specified time period, the insurer may not deny coverage or charge an additional premium. However, an insurer may prospectively charge the contract holder an additional premium for the child if the insurer provides at least 45 days' notice of the additional premium required.

The bill provides that family member coverage is applicable for all children placed in court-ordered custody, including foster children, and that benefits are applicable with respect to a foster child or other children in court-ordered temporary or other custody of the contract holder.

The bill provides that the coverage of a dependent child terminates upon attainment of the limiting age for dependent children specified in the contract and that the contract shall also specify in substance that attainment of the limiting age does not terminate the coverage of the child while the child continues to be:

- Incapable of self-sustaining employment by reason of mental retardation or physical handicap.
- Chiefly dependent upon the contract holder or subscriber for support or maintenance.

The bill requires that if a claim is denied under the contract for the stated reason that the child has attained the limiting age for dependent children specified, the notice of denial must state that the contract holder has the burden of establishing that the child continues to meet the criteria specified.

Health Maintenance Contracts

Provider Contracts

Section 641.31(9), F.S., provides requirements relating to health maintenance organizations and subsections (9) and (17) provide requirements related to dependent coverage. The bill substantially rewrites s. 641.31(9), F.S., relating to dependent children and creates subsection (10) and deletes subsection (17). [Note: The requirements related to dependent children are the same as listed above relating to prepaid limited health services contracts.]

Additional Contract Contents

Section 641.3101, F.S., provides requirements related to additional terms of a health maintenance contract. HB 723 renumbers the section and creates subsection (2) providing that a health maintenance organization contract that provides for payment of claims based on a specific methodology, including but not limited to, usual and customary charges, reasonable and customary charges, or charges based upon the prevailing rate in the community, to specify and disclose the formula or criteria used by the organization in determining the amount to be paid. In addition, a health maintenance organization issuing a contract that provides for the payment of claims based on a specific methodology must provide to the contract holder, upon written request, an estimate of the amount the

contract holder will pay for a particular medical procedure or service and specifies the criteria for such estimate.

Replacement

HB 723 creates s. 641.31075, F.S., providing that when a health maintenance organization replaces any other group health coverage with its group health maintenance coverage that it must comply with s. 627.666, F.S. Specifically, the section provides that each person who was covered by prior coverage must be covered by the succeeding coverage and that the prior coverage is subject to certain extension of benefits. In addition, requirements related to succeeding insurers in applying and deductibles, out-of-pocket limitations, or waiting periods is specified; as is criteria relating to determination of prior benefits. In addition, the requirements of this section are applicable to a group whose benefits had previously been self-insured or to a self-insurer providing coverage to a group that had been previously covered by an insurer or another self-insurer.

Extension of Benefits

Section 641.3111, F.S., provides that every group health maintenance contract must provide that termination of the contract without prejudice to any continuous loss which commenced while the contract was in force, but that any extension of benefits beyond the period the contract was in force may be predicated upon the continuous total disability of the subscriber and may be limited to payment for the treatment of a specific accident or illness incurred while the subscriber was a member. HB 723 deletes the limitation to the payment for treatment and requires that the extension is regardless whether the group contract holder or other entity secures replacement coverage from a new insurer or health maintenance organization or foregoes the provision of coverage. In addition, the bill requires that the required provision must provide for continuation of contract benefits in connection with the treatment of a specific accident or illness incurred while the contract was in effect.

The bill creates subsection (15) which prohibits a managed care provider or prepaid limited health service organization, from issuing a contract or service agreement which requires the submission of disputes between the parties to the contract or service agreement to arbitration.

Unfair Methods of Competition and Unfair or Deceptive Acts or Practices Defined

HB 723 creates s. 641.411(9), F.S., which prohibits a prepaid health clinic from issuing a policy or contract which requires the submission of disputes between the parties to the policy or contract to arbitration.

Group Contracts and Plans of Self-Insurance

HB 723 amends s. 627.651(4), F.S., relating to group contracts and plans of self-insurance and provides a cross reference that requires Multiple-employer welfare arrangements, as defined in s. 625.437(1), F.S., to provide certain disclosures when employing certain payment and claims methodologies and to provide an estimate of the amount payable for a specific procedure upon request.

Limited Coverage for Home Health Care

HB 723 amends s. 641.2018(1), F.S., relating to limited coverage for home health care and provides a cross reference that modifies the current limitation to allow health maintenance organizations that issue contracts that limit coverage to home health care services only to offer such coverage for less than the current two year minimum.

Delivery of Contract

HB 723 amends s. 641.3107, F.S, relating to deliver of contracts and provides a cross reference that amends the definition of eligible dependents.

Requirements for Providing Emergency Services and Care

HB 723 amends s. 641.513(4), F.S., relating to requirements for providing emergency services and care and provides a cross reference that amends the definition of eligible dependents.

The bill takes effect upon becoming law.

C. SECTION DIRECTORY:

Section 1. Adds paragraph (bb) to subsection (1) of section 626.9541, F.S, prohibiting mandatory arbitration clause in policies.

Section 2. Amends section 627.4091, F.S., relating to specific reasons for denial, cancellation, or nonrenewable.

Section 3. Creates section 627.4303, F.S., relating to prescription drug formularies. Provides additional requirements and limitations on plans with prescription drug benefits.

Section 4. Creates section 627.6042, F.S. relating to dependent coverage. Amends definition of eligible dependents.

Section 5. Amends subsection (1) and (4) of section 627.6415, F.S., relating to coverage for natural-born, adopted, and foster children and children in insured's custodial care.

Section 6. Amends paragraph (a) of subsection (5), paragraph (c) of subsection (6), and paragraphs (b), (c), and (e) of subsection (7) of section 627.6475, relating to issuer's election to become a risk-assuming carrier; election process to become a risk-assuming carrier; and individual health reinsurance program. Modifying individual carrier reinsurance pool practices and procedures.

Section 7. Amends subsection (2) of section 627.6617, F.S., relating to coverage for home health care services. Increasing minimum mandated benefit.

Section 8. Amends section 627.6622, F.S., relating to other provisions applicable to group health insurance, blanket health insurance, and franchise health insurance. Requires certain disclosures.

Section 9. Amends subsection (6) of section 627.667, F.S., relating to extension of benefits. Providing responsibility for medical cases still receiving services.

Section 10. Amends paragraph (e) of subsection (5) of section 627.6692, F.S., relating to Florida Health Insurance Coverage Continuation Act. Amending timeframes.

Section 11. Paragraphs (h), (i), (n), and (u) of subsection (3), paragraph (c) of subsection (5), paragraph (b) of subsection (6), paragraph (a) of subsection (9), paragraph (d) of subsection (10), and paragraphs (f), (g), (h), and (j) of subsection (11) of section 627.6699, F.S., relating to employee health care access act. Amends definitions, deletion of rating factors, provides for special enrollment for certain one-life groups, and modifies group carrier reinsurance pool practices and procedures.

Section 12. Amends section 627.911, F.S., relating to scope of this part. Modifies annual reporting requirements.

Section 13. Amends section 627.9175, F.S., relating to reports of information on health insurance. Modifies annual reporting requirements.

Section 14. Amends section 627.9403, F.S., relating to scope. Amends limitation affecting nursing home benefit policies.

Section 15. Amends subsection (5) of section 636.016, F.S., relating to prepaid limited health service contracts.

Section 16. Amends subsections (9) through (17) of section 641.31, F.S., relating to health maintenance contracts.

Section 17. Amends section 641.3101, F.S., relating to additional contract contents. Requires certain disclosures.

Section 18. Creates section 641.31075, F.S., relating to replacement. Provides certain credit for pre-existing conditions when changing plans.

Section 19. Amends subsection (1) of section 641.3111, F.S., relating to extension of benefits. Providing responsibility for medical cases still receiving services.

Section 20. Adds subsection (5) to section 641.3903, F.S., relating to unfair methods of competition and unfair or deceptive acts or practices defined. Prohibits mandatory arbitration clauses in managed care provider or prepaid limited health service organizations.

Section 21. Adds subsection (9) to section 641.441, F.S., relating to unfair methods of competition and unfair or deceptive acts or practices defined. Prohibits mandatory arbitration clauses in prepaid health clinic policies or contracts.

Section 22. Amends subsection (4) of section 627.651, F.S., relating to group contracts and plans of self-insurance must meet group requirements. Requires certain disclosures.

Section 23. Amends subsection (1) of section 641.2018, F.S., relating to limited coverage for home health care. Amends limitation affecting home health care services under a health maintenance organization.

Section 24. Amends section 641.3107, F.S., relating to delivery of contract. Provides a cross reference to amend the definition of eligible dependents.

Section 25. Amends subsection (4) of section 641.513, F.S., relating to requirements for providing emergency services and care. Provides a cross reference to amend the definition of eligible dependents.

Section 26. Provides an effective date of upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

There are several sections of the bill which may result in increased costs to consumers.

Prescription drug coverage: Expanded requirements for prescription drug benefits and limitations on the drug benefit plans' ability to provide expanded consumer choice through flexibility may also result in increased costs associated with policies and contracts with drug benefit plans. Typically, employer groups that purchase this type coverage for their employees select the type of drug coverage they want to provide. This provision may act as a mandate on small employers, as large self-insured plans would be exempt.

The prohibition of mandatory arbitration for disputes could result in increase litigation and contribute to increased costs of health coverage plans.

The expanded definitions for dependent coverage may also contribute to increased costs to health coverage plans by keeping young, healthy people out of the insurance pool.

Modified Community Rating and Rating Factors: These factors were added back in 2000 as a result of a coalition effort by small businesses, agents, and carriers. Some carriers have indicated they will leave the market if they are unable to utilize a rating factor. The rating factor is not revenue generating since the revenue generated must be offset by revenue forgone through discounts given.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenues.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The Department of Financial Services currently has rulemaking authority for the various provisions.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On March 19, 2003, the Health Services Subcommittee adopted a “strike-everything” amendment. The amendment:

- Deletes section relating to prescription drug fomularies;
- Deletes provisions removing allowance for small group rating factors;
- Deletes section raising minimum benefit for home health care services;
- Deletes section classifying “mandatory arbitration” as “unfair Methods of Completion and Unfair or Deceptive Acts or Practices Defined;”
- Adds requirement that “mandatory arbitration” clauses must be disclosed to the consumer and that alternative coverage without such a requirement must be made available; and
- Amends definition of “dependent coverage” in all applicable sections.