HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 723 w/CS 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	16 Y, 0 N w/CS	Chavis	Collins
3) Insurance			
4)			
5)			

SUMMARY ANALYSIS

The bill makes substantial changes to statutory provisions relating to health insurance.

HB 723 provides the following:

- Revises the definition of the term “health flex plans,” authorizes plans to limit the term of coverage, extends the required period without coverage to determine participation eligibility, provides exception for a business purchasing arrangement sponsored by a local government, provides an exception extending the expiration date of the program;
- Requires policies of insurers offering coverage of dependent children to maintain such coverage until the child reaches age 25, under certain circumstances;
- Provides for limitations to the requirements for binding arbitrations;
- Provides for the payment of claims to non-network providers under specified conditions and requires that the method used for determining payment of claims be included in filings;
- Deletes an age limitation on application of certain dependent coverage requirements;
- Revises risk-assuming carrier election requirements and procedures, revises certain criteria and limitations under the individual health reinsurance program;
- Revises a list of provisions applicable to group, blanket, or franchise health insurance to include use of specific methodology for payment of claims provisions;
- Deletes a limitation on application of certain extension of benefits provisions;
- Increases a time period for payment of premium to continue coverage under a group health plan;
- Revises certain definitions, revises small employer carrier election requirements, and revises certain criteria and limitations under the small employer health reinsurance program;
- Applies certain information reporting requirements and criteria to health maintenance organizations, revises health insurance information requirements and criteria; authorizes the Financial Services Commission to adopt rules, and deletes annual report requirements;
- Deletes exemption for limited benefit policies from a long-term care insurance restriction relating to nursing home care;
- Requires prepaid limited health service organizations and health maintenance organizations offering coverage of dependent children to maintain such coverage until the child reaches age 25, under certain circumstances, and provides requirements for contract termination and denial of claim related to limiting age attainment;
- Provides a Compliance requirement for health maintenance contracts using a specific payment of claims methodology;
- Requires that specific reasons for denial of coverage be provided;
- Imposes compliance requirements upon health maintenance organization replacements of other group health coverage with organization coverage; and
- Deletes a limitation on certain extension of benefits provisions upon group health maintenance contract termination, imposes additional extension of benefits requirements upon such termination;
- Corrects cross-references.

The bill takes effect upon becoming law.

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:

HB 723 provides the following:

- Amends s. 408.909, F.S., relating to heath flex plans. Revises the definition of the term "health flex plans." Authorizes plans to limit the term of coverage. Extends the required period without coverage to determine participation eligibility. Provides exception for a business purchasing arrangement sponsored by a local government. Provides an exception extending the expiration date of the program.
- Creates s. 627.6042, F.S., relating to dependent coverage. Requires policies of insurers offering coverage of dependent children to maintain such coverage until the child reaches age 25, under certain circumstances.
- Creates s. 627.60425, F.S., relating to binding arbitration requirement. Provides that individual, blanket, or group life or group health insurance policy, health maintenance organization subscriber contract, prepaid limited health organization subscriber contract, or any life or health insurance policy or certificate delivered or issued for deliver, including specified out-of-state group plans shall not be required to submit disputes between the parties to binding arbitration unless the applicant has indicated that the same policy, contract, or plan was offered without the binding arbitration requirement and that the binding arbitration provision was fully explained to the applicant and willingly accepted.
- Amends s. 627.6044, F.S., relating to use of specific methodology for payment of claims. Provides for the payment of claims to non-network providers under specified conditions and requires that the method used for determining payment of claims to be included in filings.
- Amends s. 627.6415, F.S., relating to coverage for natural-born, adopted, and foster children; children in insured's custodial care. Deletes an age limitation on application of certain dependent coverage requirements.
- Amends s. 627.6475, F.S., relating to individual reinsurance pool. Revises risk-assuming carrier election requirements and procedures including certain criteria and limitations under the individual health reinsurance program.
- Amends s. 627.662, F.S., relating to other provisions applicable. Revises a list of provisions applicable to group, blanket, or franchise health insurance to include use of specific methodology for payment of claims provisions.
- Amends s. 627.651, F.S., relating to group contracts and plans of self-insurance must meet group requirements;
- Amends s. 627.662, F.S., relating to application of provisions to group health insurance, blanket health insurance, and franchise health insurance.

- Amends s. 627.667, F.S., relating to extension of benefits.
- Amends s. 627.6692, F.S., relating to continuation of coverage under group health insurance. Expands the time a covered employee or other qualified beneficiary has to elect continuation of health insurance coverage to the employer's group health plan from 30 to 63 days.
- Amends s. 627.6699, F.S., relating to the employee health care access act. Revises definitions of "dependent" and "eligible employer." ["Dependent" is revised to be consistent with s. 627.6562, F.S., and "eligible employer" is revised as recommended by the "Small Employer Benefit Committee, Final Report, November 2002.] Revises small employer carrier election requirements and procedures. Revises certain criteria and limitations under the small employer health reinsurance program. Moves certain reporting dates from March 1 of each year to September 1 of each year. Expands time frame that the board of the small employer health reinsurance program has to report under specified circumstances.
- Amends s. 627.911, F.S., relating to insurance reporting and scope. Expands certain information reporting requirements and criteria to also be applied to health maintenance organizations.
- Amends s. 627.9175, F.S., relating to reports of information on health insurance. Revises health insurance information requirements and criteria. Authorizes the Financial Services Commission to adopt rules governing compliance and provisions implementing electronic methodologies for use in furnishing records and documents. Deletes annual report requirements.
- Amends s. 627.9403, F.S., relating to long-term care insurance policies. Deletes exemption for limited benefit policies from a long-term care insurance restriction relating to nursing home care.
- Amends s. 641.185, F.S., relating to health maintenance organization subscriber protections. Updates cross-reference.
- Amends s. 641.31, F.S., relating to health maintenance organization contracts. Requires prepaid limited health service organizations and health maintenance organizations offering coverage of dependent children to maintain such coverage until the child reaches age 25, under circumstances. Provides requirements for contract termination and denial of a claim related to limiting age attainment.
- Amends s. 641.3101, F.S., relating to additional health maintenance organization contract contents. Provides a compliance requirement for health maintenance contracts using a specific payment of claims methodology.
- Creates s. 641.31025, F.S., relating to specific reasons for denial of coverage. Requires that specific reasons for denial of coverage be provided, including but not limited to, specific underwriting reasons, if applicable.
- Creates s. 641.31075, F.S., relating to health maintenance organization coverage replacement. Imposes compliance requirements upon health maintenance organization replacements of other group health coverage with organization coverage.
- Amends s. 641.3111, F.S., relating to health maintenance contract extension of benefits. Deletes a limitation on certain extension of benefits provisions upon group health maintenance contract termination. Imposes additional extension of benefits requirements upon such termination.
- Amends s. 627.651, F.S., relating to group contracts and plans of self-insurance requirements to meet group requirements; s. 627.2018, F.S., limited coverage for home health care authorized; s. 641.3107, F.S., relating to delivery of contract; and s. 641.513, F.S. relating to requirements for providing emergency services and care. Updates cross-references.
- Amends s. 641.2018, FS., relating to limited coverage for home health care correcting. Updates cross-references.
- Amends s. 641.3107, F.S., relating to delivery of contract. Updates cross-reference.
- Amends s. 641.513, F.S., relating to requirements for providing emergency services and care. Updates cross-reference.

The bill takes effect upon becoming law.

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 23, if:

- 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.

Binding Arbitration Clauses

Binding arbitration, in which a dispute is decided by a neutral party paid by one or more of the parties to the dispute, has several characteristics which make it more attractive to employers than going to court. Foremost among these is cost. Binding arbitration is generally perceived as less costly than court proceedings. These savings arise primarily from the fact that courts are extremely hesitant to review arbitrator's decisions unless a law has been violated or fraud has occurred.

HB 723 creates s. 627.60425, F.S., relating to binding arbitration requirement. The bill provides that, notwithstanding any other provision of law except s. 624.155, F.S., relating to civil remedy, that an certain specified policies, contracts, or plans shall not require the submission of disputes between the parties to binding arbitration unless the applicant has indicated that the same policy, contract, or plan was offered and rejected and that the binding arbitration provision was fully explained to the applicant and willingly accepted.

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.

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.

Extension of Benefits

Section 627.667(6), F.S., and s. 641.3111, F.S. requires that each group, blanket, and franchise health insurance policy or health maintenance contract provide for a specified timeframe for the extension of 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 or group contract.

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.

"Dependent"

Section. 627.6699(3)(g), F.S., provides a definition of "dependent" as the spouse or child of an eligible employee, subject to the applicable terms of the health benefit plan covering that employee. HB 723 revises the definition by cross-references to s. 627.6562, F.S., relating to group, blanket, and franchise health insurance policies, dependent coverage.

"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.

"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.

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 bill deletes the requirement for the department to publish on an annual basis a consumer's guide winch summarizes and compares the information required to be reported. The bill authorizes the department to adopt rules to administer this section, including the adoption of rules governing compliance and provisions implementing a uniform format for the submission this information in order to all for meaningful comparisons.

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.

Health Maintenance Contracts

Provider Contracts – Dependent Coverage

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.

Specific reasons for denial of coverage

HB 723 creates s. 641.31025, F.S., relating to specific reasons for denial of coverage, requiring that a denial of an application for a health maintenance organization contract must be accompanied by the specific reasons for the denial, including, but not limited to, the specific underwriting reasons, if applicable.

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.

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.

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.

Health Flex Plan Pilot Program

In 2002, the Legislature created, in s. 408.909, F.S., the Health Flex Plan pilot program. The pilot program permits entities to develop alternative health care coverage plans, referred to as health flex plans, for uninsured persons who have a family income equal to or less than 200 percent of the federal poverty level. The goal of the program is to improve the affordability and availability of heath care coverage for low-income Floridians who are unable to obtain health coverage, by encouraging the development of alternative approaches to traditional health insurance that still provide basic and preventative health care services.

A health flex plan is permitted to take measures that are impermissible for regular care providers, including:

- Limiting or excluding benefits that are otherwise required by law for insurers offering coverage in Florida;
- Capping the total amount of claims paid per year per enrollee; and
- Limiting the number of enrollees

A health flex plan may be developed and implemented by health insurers, health maintenance organizations (HMOs), health care provider-sponsored organizations, local governments, heath care districts, or other community-based organizations. Current law specifies that the agency must develop guidelines for reviewing health flex plan applications and must disapprove or withdraw approval of plans that do not meet minimum standards for quality of care and access to care. The Office of Insurance Regulation (office) must also develop guidelines for reviewing health flex plan applications and must disapprove or withdraw approval of plans that:

- Contain any ambiguous, inconsistent, or misleading provisions, or exceptions or conditions that deceptively affect or limit the benefits purported to be assumed in the general coverage provided by the plan;
- Provide benefits that are unreasonable in relation to the premium charged, contain provisions that are unfair or inequitable or contrary to the public policy of this state or that encourage misrepresentation, or result in unfair discrimination in sales practices; or
- Cannot demonstrate the health flex plan is financially sound and that the applicant has the ability to underwrite or finance the benefits provided.

The statute attempts to target the pilot programs in areas of the state that have the greatest number of the uninsured poor. The statute authorizes the agency and the office to approve health flex plans in the three areas of the state having the highest number of uninsured persons. These areas are District 1 (Bay, Escambia, Gadsden, Leon, Okaloosa, and Santa Rosa Counties), District 16 (Broward County), and District 17 (Dade County). The statue also authorizes the issuance of health flex plans in Indian River County.

Eligibility to enroll in a health flex plan is limited to Florida residents who are under 65 years of age and have a family income equal to or less than 200 percent of the federal poverty level. The enrollee must not be covered by a private insurance policy, must not be eligible for coverage through a public health insurance program such as Medicare, Medicaid, or Kidcare, and must not have been covered at any time during the past 6 months. The enrollee must also have applied for health care coverage through

an approved plan and agree to make any payments required for participation, including periodic payments or payments due at the time health care services are provided.

The agency must evaluate the pilot program and its effects on the entities that seek approval as health flex plans, as well as the number of enrollees and the scope of the coverage afforded. The agency and the office are mandated to assess the health flex plans and their potential applicability in other settings. By January 1, 2004, the agency and the office are to submit their findings in a report to the Governor, President of the Senate, and the Speaker of the House of Representatives. Each approved health flex plan is required to maintain records of enrollment, finances, and claims experience to enable the agency and the department to monitor the plan. The statute authorizing the creation of the health flex pilot program expires on July 1, 2004.

According to the agency, two health flex plans have been approved, in Dade County. One plan is physician group based; the other is HMO based. No other applications have been received by the agency, and no health flex programs have been created other than the two in Dade County.

The agency has also reported they have conducted a survey to assess the interest of health plan providers in the health flex plan pilot program. Of the 145 surveys that were mailed electronically to potential providers, 76 (52%) responded. Forty-one respondents knew about the program. Two indicated an interest in applying. Forty-seven were not interested in expanding their product line; one indicated that the 200 percent poverty line was too restrictive; one was interested in other areas of the state; five believed the plan would not be profitable; and 15 indicated they did not have the resources to market the plan. The agency is implementing an informational and marketing plan to encourage more program participation.

The bill expands health flex plans to include approved plans purchased by enrollees directly from the plan or through a small business purchasing arrangement sponsored by a local government. It also authorizes a plan sponsored by a local government made available to residents who have not been covered by any health insurance plan or coverage through a public health insurance program for 12 months to limit the term of coverage. The bill extends the pilot project to July 1, 2008, from the current expiration of July 1, 2004.

The bill takes effect upon becoming law.

C. SECTION DIRECTORY:

Section 1. Amends s. 408.909, F.S., relating to health flex plans.

Section 2. Creates s. 627.6042, F.S., relating to dependent coverage.

Section 3. Creates s. 627.60425, F.S., relating to binding arbitration requirement limitations.

Section 4. Amends s. 627.6044, F.S., relating to the use of a specific methodology for payment of claims.

Section 5. Amends s. 627.6415, F.S., relating to coverage for natural-born, adopted, and foster children; children in insured's custodial care.

Section 6. Amends s. 627.6475, F.S., relating to individual reinsurance pool.

Section 7. Amends s. 627.651, F.S., relating to group contracts and plans of self-insurance must meet group requirements.

Section 8. Amends s. 627.662, F.S., relating to other provides that apply to group health insurance, blanket health insurance, and franchise health insurance.

Section 9. Amends s. 627.667, F.S., relating to extension of benefits.

Section 10. Amends s. 627.6692, F.S., relating to continuation of coverage under group health plans.

Section 11. Amends s. 627.6699, F.S., relating to employee health care access act.

Section 12. Amends s. 627.911, F.S., relating to scope of this part applying to certain insurers or health maintenance organizations.

Section 13. Amends s. 627.9175, F.S., relating to reports of information on health insurance.

Section 14. Amends s. 627.9403, F.S., relating to scope of this part applying to certain long-term care insurance policies.

Section 15, Amends s. 641.185, F.S., relating to health maintenance organization subscriber protections.

Section 16. Amends s. 641.31, F.S., relating to health maintenance contracts.

Section 17. Amends s. 641.3101, F.S., relating to additional health maintenance contract contents.

Section 18. Creates s. 641.31025, F.S., relating to specific reasons for denial of coverage.

Section 19. Creates s. 641.31075, F.S., relating to replacement group health insurance policy by a group health maintenance contract.

Section 20. Amends s. 641.3111, F.S., relating to extension of benefits by a group health maintenance contract.

Section 21. Amends s. 627.651, F.S., relating to group contracts and plans of self-insurance must meet group requirements.

Section 22. Amends s. 641.2018, F.S., relating to limited coverage for home health care.

Section 23. Amends s. 6451.3107, F.S., relating to delivery of contract.

Section 24. Amends s. 641.513, F.S., relating to requirements for providing emergency services and care.

Section 25. 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:

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.

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. HB 723 authorizes the department to adopt rules related to the electronic submission of certain records, documents, and information.

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.

On April 15, 2003, the Health Care Committee amended a substitute “strike-everything” amendment and reported the bill favorably with a CS. The CS differs from the subcommittee’s “strike-everything” as follows:

- Deletes section relating to “mandatory arbitration”;
- Creates section relating to “binding arbitration”;
- Deletes section amending plan and contract requirements;
- Deletes section amending minimum reimbursement limitations amount for home health care services;
- Deletes amendments to employee health care access act relating to modified community rating and amends definition for dependents;
- Amends language relating to annual report by the Department of Financial Services and authorizes the department to adopt rules related to this section for the electronic submission by carriers and plans of required information, records, and documents;
- Deletes amendments relating to prepaid limited health service organizations;
- Creates new section requiring specific reasons for denial of coverage by an health maintenance organization;
- Creates new section requiring compliance to group insurance replacement laws by health maintenance organizations; and
- Amends section relating to health flex plans providing for small business purchasing arrangements sponsored by local governments and provides limits.