



CHAMBER ACTION

The Committee on Health Care recommends the following:

**Committee Substitute**

Remove the entire bill and insert:

A bill to be entitled

An act relating to health insurance; amending s. 408.909, F.S.; revising a definition; authorizing health flex plans to limit coverage under certain circumstances; authorizing a small business purchasing arrangement to limit enrollment to certain residents; creating s. 627.6042, F.S.; requiring policies of insurers offering coverage of dependent children to maintain such coverage until a child reaches age 25, under certain circumstances; providing application; creating s. 627.60425, F.S.; providing limitations on certain binding arbitration requirements; amending s. 627.6044, F.S.; providing for payment of claims to nonnetwork providers under specified conditions; providing a definition; requiring the method used for determining payment of claims to be included in filings; providing for disclosure; amending s. 627.6415, F.S.; deleting an 18th birthday age limitation on application of certain dependent coverage requirements; amending s. 627.6475, F.S.; revising risk-assuming carrier election



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29 requirements and procedures; revising certain criteria and  
30 limitations under the individual health reinsurance  
31 program; amending s. 627.651, F.S.; correcting a cross  
32 reference; amending s. 627.662, F.S.; revising a list of  
33 provisions applicable to group, blanket, or franchise  
34 health insurance to include use of specific methodology  
35 for payment of claims provisions; amending s. 627.667,  
36 F.S.; deleting a limitation on application of certain  
37 extension of benefits provisions; amending s. 627.6692,  
38 F.S.; increasing a time period for payment of premium to  
39 continue coverage under a group health plan; amending s.  
40 627.6699, F.S.; revising definitions; revising coverage  
41 enrollment eligibility criteria for small employers;  
42 revising small employer carrier election requirements and  
43 procedures; revising certain criteria and limitations  
44 under the small employer health reinsurance program;  
45 amending ss. 627.911 and 627.9175, F.S.; applying certain  
46 information reporting requirements to health maintenance  
47 organizations; revising health insurance information  
48 requirements and criteria; authorizing the department to  
49 adopt rules; deleting an annual report requirement;  
50 amending s. 627.9403, F.S.; deleting an exemption for  
51 limited benefit policies from a long-term care insurance  
52 restriction relating to nursing home care; amending s.  
53 641.185, F.S.; correcting a cross reference; amending s.  
54 641.31, F.S.; requiring health maintenance organizations  
55 offering coverage of dependent children to maintain such  
56 coverage until a child reaches age 25, under certain



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57 | circumstances; providing application; providing  
58 | requirements for contract termination and denial of a  
59 | claim related to limiting age attainment; amending s.  
60 | 641.3101, F.S.; providing a compliance requirement for  
61 | health maintenance contracts using a specific payment of  
62 | claims methodology; creating s. 641.31025, F.S.; requiring  
63 | specific reasons for denial of coverage under a health  
64 | maintenance organization contract; creating s. 641.31075,  
65 | F.S.; imposing compliance requirements upon health  
66 | maintenance organization replacements of other group  
67 | health coverage with organization coverage; amending s.  
68 | 641.3111, F.S.; deleting a limitation on certain extension  
69 | of benefits provisions upon group health maintenance  
70 | contract termination; imposing additional extension of  
71 | benefits requirements upon such termination; amending ss.  
72 | 627.651, 641.2018, 641.3107, and 641.513, F.S.; correcting  
73 | cross references; providing an effective date.

74

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

76

77 | Section 1. Paragraph (e) of subsection (2), subsection  
78 | (3), and paragraph (c) of subsection (5) of section 408.909,  
79 | Florida Statutes, are amended to read:

80 | 408.909 Health flex plans.--

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

82 | (e) "Health flex plan" means a health plan approved under  
83 | subsection (3) which guarantees payment for specified health  
84 | care coverage provided to the enrollee who purchases coverage



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85 directly from the plan or through a small business purchasing  
86 arrangement sponsored by a local government.

87 (3) PILOT PROGRAM.--The agency and the department shall  
88 each approve or disapprove health flex plans that provide health  
89 care coverage for eligible participants who reside in the three  
90 areas of the state that have the highest number of uninsured  
91 persons, as identified in the Florida Health Insurance Study  
92 conducted by the agency and in Indian River County. A health  
93 flex plan may limit or exclude benefits otherwise required by  
94 law for insurers offering coverage in this state, may cap the  
95 total amount of claims paid per year per enrollee, may limit the  
96 number of enrollees or the term of coverage, or may take any  
97 combination of those actions.

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

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

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

109 2. Provide benefits that are unreasonable in relation to  
110 the premium charged or contain provisions that are unfair or  
111 inequitable or contrary to the public policy of this state, that



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112 encourage misrepresentation, or that result in unfair  
113 discrimination in sales practices; or

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

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

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

121 (c) Are not covered by a private insurance policy and are  
122 not eligible for coverage through a public health insurance  
123 program, such as Medicare or Medicaid, or another public health  
124 care program, such as KidCare, and have not been covered at any  
125 time during the past 6 months, except that a small business  
126 purchasing arrangement sponsored by a local government may limit  
127 enrollment to residents of this state who have not been covered  
128 at any time during the past 12 months; and

129 Section 2. Section 627.6042, Florida Statutes, is created  
130 to read:

131 627.6042 Dependent coverage.--

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

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



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

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

146           Section 3. Section 627.60425, Florida Statutes, is created  
147 to read:

148           627.60425 Binding arbitration requirement  
149 limitations.--Notwithstanding any other provision of law, except  
150 s. 624.155, an individual, blanket, group life, or group health  
151 insurance policy; health maintenance organization subscriber  
152 contract; prepaid limited health organization subscriber  
153 contract; or any life or health insurance policy or certificate  
154 delivered or issued for delivery, including out-of-state group  
155 plans pursuant to s. 627.5515 or s. 627.6515 covering residents  
156 of this state, to any resident of this state shall not require  
157 the submission of disputes between the parties to the policy,  
158 contract, or plan to binding arbitration unless the applicant  
159 has indicated that the same policy, contract, or plan was  
160 offered and rejected and that the binding arbitration provision  
161 was fully explained to the applicant and willingly accepted.

162           Section 4. Section 627.6044, Florida Statutes, is amended  
163 to read:

164           627.6044 Use of a specific methodology for payment of  
165 claims.--

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



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

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

175 (b) Where there are multiple network providers in the  
176 geographical area in which the services were provided or, if  
177 none, the closest geographic area, the carrier may use an  
178 averaging method of the contracted amounts but not less than the  
179 80th percentile of all network contracted amounts in the  
180 geographic area.

181  
182 For purposes of this subsection, the term "network providers"  
183 means those providers for which an insured will not be  
184 responsible for any balance payment for services provided by  
185 such provider, excluding deductible, coinsurance, and copay  
186 amounts based on a specific methodology, including, but not  
187 limited to, usual and customary charges, reasonable and  
188 customary charges, or charges based upon the prevailing rate in  
189 the community, shall specify the formula or criteria used by the  
190 insurer in determining the amount to be paid.

191 (2) Each insurer issuing a policy that provides for  
192 payment of claims based on a specific methodology shall provide  
193 to an insured, upon her or his written request, an estimate of  
194 the amount the insurer will pay for a particular medical  
195 procedure or service. The estimate may be in the form of a range



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196 of payments or an average payment and may specify that the  
197 estimate is based on the assumption of a particular service  
198 code. ~~The insurer may require the insured to provide detailed~~  
199 ~~information regarding the procedure or service to be performed,~~  
200 ~~including the procedure or service code number provided by the~~  
201 ~~health care provider and the health care provider's estimated~~  
202 ~~charge~~. An insurer that provides an insured with a good faith  
203 estimate is not bound by the estimate. However, a pattern of  
204 providing estimates that vary significantly from the ultimate  
205 insurance payment constitutes a violation of this code.

206 (3) The method used for determining the payment of claims  
207 shall be included in filings made pursuant to s. 627.410(6) and  
208 may not be changed unless such change is filed under s.  
209 627.410(6).

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

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

218 627.6415 Coverage for natural-born, adopted, and foster  
219 children; children in insured's custodial care.--

220 (1) A health insurance policy that provides coverage for a  
221 member of the family of the insured shall, as to the family  
222 member's coverage, provide that the health insurance benefits  
223 applicable to children of the insured also apply to an adopted





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224 child or a foster child of the insured placed in compliance with  
225 chapter 63, ~~prior to the child's 18th birthday~~, from the moment  
226 of placement in the residence of the insured. Except in the case  
227 of a foster child, the policy may not exclude coverage for any  
228 preexisting condition of the child. In the case of a newborn  
229 child, coverage begins at the moment of birth if a written  
230 agreement to adopt the child has been entered into by the  
231 insured prior to the birth of the child, whether or not the  
232 agreement is enforceable. This section does not require coverage  
233 for an adopted child who is not ultimately placed in the  
234 residence of the insured in compliance with chapter 63.

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

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

248 627.6475 Individual reinsurance pool.--

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

250 (a) Each health insurance issuer that offers individual  
251 health insurance must elect to become a risk-assuming carrier or



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252 a reinsuring carrier for purposes of this section. Each such  
253 issuer must make ~~an initial election, binding through December~~  
254 ~~31, 1999. The issuer's initial election must be made no later~~  
255 ~~than October 31, 1997. By October 31, 1997, all issuers must~~  
256 ~~file a final election, which is binding for 2 years, from~~  
257 ~~January 1, 1998, through December 31, 1999, after which an~~  
258 election that shall be binding indefinitely or until modified or  
259 withdrawn for a period of 5 years. The department may permit an  
260 issuer to modify its election at any time for good cause shown,  
261 ~~after a hearing.~~

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

263 (c) The department shall provide public notice of an  
264 issuer's filing a designation of election under this subsection  
265 to become a risk-assuming carrier and shall provide at least a  
266 21-day period for public comment upon receipt of such filing  
267 ~~prior to making a decision on the election. The department shall~~  
268 ~~hold a hearing on the election at the request of the issuer.~~

269 (7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.--

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

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

276 2. The program may not reimburse a participating carrier  
277 with respect to the claims of a reinsured eligible individual  
278 until the carrier has paid incurred claims of an amount equal to  
279 the participating carrier's selected deductible level ~~at least~~



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280 | ~~\$5,000~~ in a calendar year for benefits covered by the program.  
281 | ~~In addition, the reinsuring carrier is responsible for 10~~  
282 | ~~percent of the next \$50,000 and 5 percent of the next \$100,000~~  
283 | ~~of incurred claims during a calendar year, and the program shall~~  
284 | ~~reinsure the remainder.~~

285 |         3. The board shall annually adjust the initial level of  
286 | claims and the maximum limit to be retained by the carrier to  
287 | reflect increases in costs and utilization within the standard  
288 | market for health benefit plans within the state. The adjustment  
289 | may not be less than the annual change in the medical component  
290 | of the "Commerce Price Index for All Urban Consumers" of the  
291 | Bureau of Labor Statistics of the United States Department of  
292 | Labor, unless the board proposes and the department approves a  
293 | lower adjustment factor.

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

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

306 |         6. The board may consider adjustments to the premium rates  
307 | charged for reinsurance by the program or carriers that use



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308 effective cost-containment measures, including high-cost case  
309 management, as defined by the board.

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

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

334 2. The board shall periodically review the methodology  
335 established, including the system of classification and any



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336 rating factors, to ensure that it reasonably reflects the claims  
337 experience of the program. The board may propose changes to the  
338 rates that are subject to the approval of the department.

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

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

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

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

361 c. The board shall equitably assess reinsuring carriers  
362 for operating losses of the individual account based on market  
363 share. The board shall annually assess each carrier a portion of



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364 the operating losses of the individual account. The first tier  
365 of assessments shall be determined by multiplying the operating  
366 losses by a fraction, the numerator of which equals the  
367 reinsuring carrier's earned premium pertaining to direct  
368 writings of individual health insurance in the state during the  
369 calendar year for which the assessment is levied, and the  
370 denominator of which equals the total of all such premiums  
371 earned by reinsuring carriers in the state during that calendar  
372 year. The second tier of assessments shall be based on the  
373 premiums that all carriers, except risk-assuming carriers,  
374 earned on all health benefit plans written in this state. The  
375 board may levy interim assessments against reinsuring carriers  
376 to ensure the financial ability of the plan to cover claims  
377 expenses and administrative expenses paid or estimated to be  
378 paid in the operation of the plan for the calendar year prior to  
379 the association's anticipated receipt of annual assessments for  
380 that calendar year. Any interim assessment is due and payable  
381 within 30 days after receipt by a carrier of the interim  
382 assessment notice. Interim assessment payments shall be credited  
383 against the carrier's annual assessment. Health benefit plan  
384 premiums and benefits paid by a carrier that are less than an  
385 amount determined by the board to justify the cost of collection  
386 may not be considered for purposes of determining assessments.

387 d. Subject to the approval of the department, the board  
388 shall adjust the assessment formula for reinsuring carriers that  
389 are approved as federally qualified health maintenance  
390 organizations by the Secretary of Health and Human Services  
391 pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent, if any,



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392 that restrictions are placed on them which are not imposed on  
393 other carriers.

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

398 4. If the board determines that the assessments needed to  
399 fund the losses incurred by the program in the individual  
400 account for the previous calendar year will exceed the amount  
401 specified in subparagraph 2., the board shall evaluate the  
402 operation of the program and report its findings and  
403 recommendations to the department in the format established in  
404 s. 627.6699(11) for the comparable report for the small employer  
405 reinsurance program.

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

408 627.651 Group contracts and plans of self-insurance must  
409 meet group requirements.--

410 (4) This section does not apply to any plan which is  
411 established or maintained by an individual employer in  
412 accordance with the Employee Retirement Income Security Act of  
413 1974, Pub. L. No. 93-406, or to a multiple-employer welfare  
414 arrangement as defined in s. 624.437(1), except that a multiple-  
415 employer welfare arrangement shall comply with ss. 627.419,  
416 627.657, 627.6575, 627.6578, 627.6579, 627.6612, 627.66121,  
417 627.66122, 627.6615, 627.6616, and 627.662(8)~~(7)~~. This  
418 subsection does not allow an authorized insurer to issue a group



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419 health insurance policy or certificate which does not comply  
420 with this part.

421 Section 8. Section 627.662, Florida Statutes, is amended  
422 to read:

423 627.662 Other provisions applicable.--The following  
424 provisions apply to group health insurance, blanket health  
425 insurance, and franchise health insurance:

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

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

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

432 (4)~~(3)~~ Section 627.635, relating to excess insurance.

433 (5)~~(4)~~ Section 627.638, relating to direct payment for  
434 hospital or medical services.

435 (6)~~(5)~~ Section 627.640, relating to filing and  
436 classification of rates.

437 (7)~~(6)~~ Section 627.613, relating to timely payment of  
438 claims, or s. 627.6131, relating to payment of claims, whichever  
439 is applicable.

440 (8)~~(7)~~ Section 627.645(1), relating to denial of claims.

441 (9)~~(8)~~ Section 627.6471, relating to preferred provider  
442 organizations.

443 (10)~~(9)~~ Section 627.6472, relating to exclusive provider  
444 organizations.

445 (11)~~(10)~~ Section 627.6473, relating to combined preferred  
446 provider and exclusive provider policies.





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447            (12)~~(11)~~ Section 627.6474, relating to provider contracts.

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

450            627.667 Extension of benefits.--

451            (6) This section also applies to holders of group  
452 certificates which are renewed, delivered, or issued for  
453 delivery to residents of this state under group policies  
454 effectuated or delivered outside this state, ~~unless a succeeding~~  
455 ~~carrier under a group policy has agreed to assume liability for~~  
456 ~~the benefits.~~

457            Section 10. Paragraph (e) of subsection (5) of section  
458 627.6692, Florida Statutes, is amended to read:

459            627.6692 Florida Health Insurance Coverage Continuation  
460 Act.--

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

462            (e)1. A covered employee or other qualified beneficiary  
463 who wishes continuation of coverage must pay the initial premium  
464 and elect such continuation in writing to the insurance carrier  
465 issuing the employer's group health plan within 63 ~~30~~ days after  
466 receiving notice from the insurance carrier under paragraph (d).  
467 Subsequent premiums are due by the grace period expiration date.  
468 The insurance carrier or the insurance carrier's designee shall  
469 process all elections promptly and provide coverage  
470 retroactively to the date coverage would otherwise have  
471 terminated. The premium due shall be for the period beginning on  
472 the date coverage would have otherwise terminated due to the  
473 qualifying event. The first premium payment must include the  
474 coverage paid to the end of the month in which the first payment



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475 is made. After the election, the insurance carrier must bill the  
476 qualified beneficiary for premiums once each month, with a due  
477 date on the first of the month of coverage and allowing a 30-day  
478 grace period for payment.

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

487 Section 11. Paragraphs (g), (h), (i), and (u) of  
488 subsection (3), paragraph (c) of subsection (5), paragraph (a)  
489 of subsection (9), paragraph (d) of subsection (10), and  
490 paragraphs (f), (g), (h), and (j) of subsection (11) of section  
491 627.6699, Florida Statutes, are amended to read:

492 627.6699 Employee Health Care Access Act.--

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

494 (g) "Dependent" has the same meaning as that provided in  
495 s. 627.6562 ~~means the spouse or child of an eligible employee,~~  
496 ~~subject to the applicable terms of the health benefit plan~~  
497 ~~covering that employee.~~

498 (h) "Eligible employee" means an employee who works full  
499 time, having a normal workweek of 25 or more hours, who is paid  
500 wages or a salary at least equal to the federal minimum hourly  
501 wage applicable to such employee, and who has met any applicable  
502 waiting-period requirements or other requirements of this act.



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503 The term includes a self-employed individual, a sole proprietor,  
504 a partner of a partnership, or an independent contractor, if the  
505 sole proprietor, partner, or independent contractor is included  
506 as an employee under a health benefit plan of a small employer,  
507 but does not include a part-time, temporary, or substitute  
508 employee.

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

513 (u) "Self-employed individual" means an individual or sole  
514 proprietor who derives his or her income from a trade or  
515 business carried on by the individual or sole proprietor which  
516 necessitates that the individual file federal income tax forms  
517 with supporting schedules and accompanying income reporting  
518 forms or federal income tax extensions of time to file forms  
519 with the Internal Revenue Service for the most recent tax year  
520 ~~results in taxable income as indicated on IRS Form 1040,~~  
521 ~~schedule C or F, and which generated taxable income in one of~~  
522 ~~the 2 previous years.~~

523 (5) AVAILABILITY OF COVERAGE.--

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

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



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531 | the plan. A rider for additional or increased benefits may be  
532 | medically underwritten and may only be added to the standard  
533 | health benefit plan. The increased rate charged for the  
534 | additional or increased benefit must be rated in accordance with  
535 | this section.

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

552 |       3.a. Beginning August 1, 2001, offer and issue basic and  
553 | standard small employer health benefit plans on a guaranteed-  
554 | issue basis, during a 31-day open enrollment period of August 1  
555 | through August 31 of each year, to every eligible small  
556 | employer, with fewer than two eligible employees, which small  
557 | employer is not formed primarily for the purpose of buying  
558 | health insurance and which elects to be covered under such plan,



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559 agrees to make the required premium payments, and satisfies the  
560 other provisions of the plan. Coverage provided under this sub-  
561 subparagraph ~~subparagraph~~ shall begin on October 1 of the same  
562 year as the date of enrollment, unless the small employer  
563 carrier and the small employer agree to a different date. A  
564 rider for additional or increased benefits may be medically  
565 underwritten and may only be added to the standard health  
566 benefit plan. The increased rate charged for the additional or  
567 increased benefit must be rated in accordance with this section.  
568 For purposes of this sub-subparagraph ~~subparagraph~~, a person,  
569 his or her spouse, and his or her dependent children constitute  
570 a single eligible employee if that person and spouse are  
571 employed by the same small employer and either that person or  
572 his or her spouse has a normal work week of less than 25 hours.

573 b. Notwithstanding the restrictions set forth in sub-  
574 subparagraph a., when a small employer group is losing coverage  
575 because a carrier is exercising the provisions of s.  
576 627.6571(3)(b) or s. 641.31074(3)(b), the eligible small  
577 employer, as defined in sub-subparagraph a., shall be entitled  
578 to enroll with another carrier offering small employer coverage  
579 within 63 days after the notice of termination or the  
580 termination date of the prior coverage, whichever is later.  
581 Coverage provided under this sub-subparagraph shall begin  
582 immediately upon enrollment unless the small employer carrier  
583 and the small employer agree to a different date.

584 4. This paragraph does not limit a carrier's ability to  
585 offer other health benefit plans to small employers if the



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586 standard and basic health benefit plans are offered and  
587 rejected.

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

590 (a) A small employer carrier must elect to become either a  
591 risk-assuming carrier or a reinsuring carrier. ~~Each small~~  
592 ~~employer carrier must make an initial election, binding through~~  
593 ~~January 1, 1994. The carrier's initial election must be made no~~  
594 ~~later than October 31, 1992. By October 31, 1993, all small~~  
595 ~~employer carriers must file a final election, which is binding~~  
596 ~~for 2 years, from January 1, 1994, through December 31, 1995,~~  
597 ~~after which an election shall be binding for a period of 5~~  
598 ~~years.~~ Any carrier that is not a small employer carrier on  
599 October 31, 1992, and intends to become a small employer carrier  
600 after October 31, 1992, must file its designation when it files  
601 the forms and rates it intends to use for small employer group  
602 health insurance; such designation shall be binding indefinitely  
603 or until modified or withdrawn ~~for 2 years after the date of~~  
604 ~~approval of the forms and rates, and any subsequent designation~~  
605 ~~is binding for 5 years.~~ The department may permit a carrier to  
606 modify its election at any time for good cause shown, ~~after a~~  
607 ~~hearing.~~

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

609 (d) The department shall provide public notice of a small  
610 employer carrier's filing a designation of election under  
611 subsection (9) to become a risk-assuming carrier and shall  
612 provide at least a 21-day period for public comment upon receipt  
613 of such filing ~~prior to making a decision on the election.~~ The



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614 ~~department shall hold a hearing on the election at the request~~  
615 ~~of the carrier.~~

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

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

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

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

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

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

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

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

640 7. Assess participating carriers in accordance with  
641 paragraph (j), and make advance interim assessments as may be



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642 reasonable and necessary for organizational and interim  
643 operating expenses. Interim assessments shall be credited as  
644 offsets against any regular assessments due following the close  
645 of the calendar year.

646 8. Appoint appropriate legal, actuarial, and other  
647 committees as necessary to provide technical assistance in the  
648 operation of the program, and in any other function within the  
649 authority of the program.

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

654 10. To the extent necessary, increase the \$5,000  
655 deductible reinsurance requirement to adjust for the effects of  
656 inflation. The program may evaluate the desirability of  
657 establishing different levels of deductibles. If different  
658 levels of deductibles are established, such levels and the  
659 resulting premiums shall be approved by the department.

660 (g) A reinsuring carrier may reinsure with the program  
661 coverage of an eligible employee of a small employer, or any  
662 dependent of such an employee, subject to each of the following  
663 provisions:

664 1. With respect to a standard and basic health care plan,  
665 the program may ~~must~~ reinsure the level of coverage provided;  
666 and, with respect to any other plan, the program may ~~must~~  
667 reinsure the coverage up to, but not exceeding, the level of  
668 coverage provided under the standard and basic health care plan.  
669 As an alternative to reinsuring the level of coverage provided





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670 under the standard and basic health care plan, the program may  
671 develop alternate levels of reinsurance designed to coordinate  
672 with a reinsuring carrier's existing reinsurance. The levels of  
673 reinsurance and resulting premiums must be approved by the  
674 department.

675 2. Except in the case of a late enrollee, a reinsuring  
676 carrier may reinsure an eligible employee or dependent within 60  
677 days after the commencement of the coverage of the small  
678 employer. A newly employed eligible employee or dependent of a  
679 small employer may be reinsured within 60 days after the  
680 commencement of his or her coverage.

681 3. A small employer carrier may reinsure an entire  
682 employer group within 60 days after the commencement of the  
683 group's coverage under the plan. The carrier may choose to  
684 reinsure newly eligible employees and dependents of the  
685 reinsured group pursuant to subparagraph 1.

686 4. The program may evaluate the option of allowing a small  
687 employer carrier to reinsure an entire employer group or an  
688 eligible employee at the first or subsequent renewal date. Any  
689 such option and the resulting premium must be approved by the  
690 department.

691 ~~5.4.~~ The program may not reimburse a participating carrier  
692 with respect to the claims of a reinsured employee or dependent  
693 until the carrier has paid incurred claims of an amount equal to  
694 the participating carrier's selected deductible level ~~at least~~  
695 ~~\$5,000~~ in a calendar year for benefits covered by the program.  
696 ~~In addition, the reinsuring carrier shall be responsible for 10~~  
697 ~~percent of the next \$50,000 and 5 percent of the next \$100,000~~



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698 | ~~of incurred claims during a calendar year and the program shall~~  
699 | ~~reinsure the remainder.~~

700 |     ~~6.5-~~ The board annually shall adjust the initial level of  
701 | claims and the maximum limit to be retained by the carrier to  
702 | reflect increases in costs and utilization within the standard  
703 | market for health benefit plans within the state. The adjustment  
704 | shall not be less than the annual change in the medical  
705 | component of the "Consumer Price Index for All Urban Consumers"  
706 | of the Bureau of Labor Statistics of the Department of Labor,  
707 | unless the board proposes and the department approves a lower  
708 | adjustment factor.

709 |     ~~7.6-~~ A small employer carrier may terminate reinsurance  
710 | for all reinsured employees or dependents on any plan  
711 | anniversary.

712 |     ~~8.7-~~ The premium rate charged for reinsurance by the  
713 | program to a health maintenance organization that is approved by  
714 | the Secretary of Health and Human Services as a federally  
715 | qualified health maintenance organization pursuant to 42 U.S.C.  
716 | s. 300e(c)(2)(A) and that, as such, is subject to requirements  
717 | that limit the amount of risk that may be ceded to the program,  
718 | which requirements are more restrictive than subparagraph 5. 4-,  
719 | shall be reduced by an amount equal to that portion of the risk,  
720 | if any, which exceeds the amount set forth in subparagraph 5. 4-  
721 | which may not be ceded to the program.

722 |     ~~9.8-~~ The board may consider adjustments to the premium  
723 | rates charged for reinsurance by the program for carriers that  
724 | use effective cost containment measures, including high-cost  
725 | case management, as defined by the board.



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726        10.9. A reinsuring carrier shall apply its case-management  
727 and claims-handling techniques, including, but not limited to,  
728 utilization review, individual case management, preferred  
729 provider provisions, other managed care provisions or methods of  
730 operation, consistently with both reinsured business and  
731 nonreinsured business.

732        (h)1. The board, as part of the plan of operation, shall  
733 establish a methodology for determining premium rates to be  
734 charged by the program for reinsuring small employers and  
735 individuals pursuant to this section. The methodology shall  
736 include a system for classification of small employers that  
737 reflects the types of case characteristics commonly used by  
738 small employer carriers in the state. The methodology shall  
739 provide for the development of basic reinsurance premium rates,  
740 which shall be multiplied by the factors set for them in this  
741 paragraph to determine the premium rates for the program. The  
742 basic reinsurance premium rates shall be established by the  
743 board, subject to the approval of the department, and shall be  
744 set at levels which reasonably approximate gross premiums  
745 charged to small employers by small employer carriers for health  
746 benefit plans with benefits similar to the standard and basic  
747 health benefit plan. The premium rates set by the board may vary  
748 by geographical area, as determined under this section, to  
749 reflect differences in cost. ~~The multiplying factors must be~~  
750 ~~established as follows:~~

751        ~~a. The entire group may be reinsured for a rate that is~~  
752 ~~1.5 times the rate established by the board.~~



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

755 2. The board periodically shall review the methodology  
 756 established, including the system of classification and any  
 757 rating factors, to assure that it reasonably reflects the claims  
 758 experience of the program. The board may propose changes to the  
 759 rates which shall be subject to the approval of the department.

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

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

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



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780 assessments shall be credited against any additional assessments  
781 made.

782       b. The board shall equitably assess carriers for operating  
783 losses of the plan based on market share. The board shall  
784 annually assess each carrier a portion of the operating losses  
785 of the plan. The first tier of assessments shall be determined  
786 by multiplying the operating losses by a fraction, the numerator  
787 of which equals the reinsuring carrier's earned premium  
788 pertaining to direct writings of small employer health benefit  
789 plans in the state during the calendar year for which the  
790 assessment is levied, and the denominator of which equals the  
791 total of all such premiums earned by reinsuring carriers in the  
792 state during that calendar year. The second tier of assessments  
793 shall be based on the premiums that all carriers, except risk-  
794 assuming carriers, earned on all health benefit plans written in  
795 this state. The board may levy interim assessments against  
796 carriers to ensure the financial ability of the plan to cover  
797 claims expenses and administrative expenses paid or estimated to  
798 be paid in the operation of the plan for the calendar year prior  
799 to the association's anticipated receipt of annual assessments  
800 for that calendar year. Any interim assessment is due and  
801 payable within 30 days after receipt by a carrier of the interim  
802 assessment notice. Interim assessment payments shall be credited  
803 against the carrier's annual assessment. Health benefit plan  
804 premiums and benefits paid by a carrier that are less than an  
805 amount determined by the board to justify the cost of collection  
806 may not be considered for purposes of determining assessments.



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

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

818 4. If the board determines that the assessments needed to  
819 fund the losses incurred by the program in the previous calendar  
820 year will exceed the amount specified in subparagraph 2., the  
821 board shall evaluate the operation of the program and report its  
822 findings, including any recommendations for changes to the plan  
823 of operation, to the department within 240 ~~90~~ days following the  
824 end of the calendar year in which the losses were incurred. The  
825 evaluation shall include an estimate of future assessments, the  
826 administrative costs of the program, the appropriateness of the  
827 premiums charged and the level of carrier retention under the  
828 program, and the costs of coverage for small employers. If the  
829 board fails to file a report with the department within 240 ~~90~~  
830 days following the end of the applicable calendar year, the  
831 department may evaluate the operations of the program and  
832 implement such amendments to the plan of operation the  
833 department deems necessary to reduce future losses and  
834 assessments.



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

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

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

848           8. A carrier may seek, from the commissioner, a deferment,  
849 in whole or in part, from any assessment made by the board. The  
850 department may defer, in whole or in part, the assessment of a  
851 carrier if, in the opinion of the department, the payment of the  
852 assessment would place the carrier in a financially impaired  
853 condition. If an assessment against a carrier is deferred, in  
854 whole or in part, the amount by which the assessment is deferred  
855 may be assessed against the other carriers in a manner  
856 consistent with the basis for assessment set forth in this  
857 section. The carrier receiving such deferment remains liable to  
858 the program for the amount deferred and is prohibited from  
859 reinsuring any individuals or groups in the program if it fails  
860 to pay assessments.

861           Section 12. Section 627.911, Florida Statutes, is amended  
862 to read:



863           627.911 Scope of this part.--Any insurer or health  
864 maintenance organization transacting insurance in this state  
865 shall report information as required by this part.

866           Section 13. Section 627.9175, Florida Statutes, is amended  
867 to read:

868           627.9175 Reports of information on health insurance.--

869           (1) Each authorized health insurer or health maintenance  
870 organization shall submit annually to the department information  
871 concerning as to policies of individual health insurance  
872 coverage being issued or currently in force in this state. The  
873 information shall include information related to premium, number  
874 of policies, and covered lives for such policies and other  
875 information necessary to analyze trends in enrollment, premiums,  
876 and claim costs.

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

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

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

- 883           1. Direct premiums earned.
- 884           2. Direct losses incurred.
- 885           3. Direct premiums earned for new business issued during  
886 the year.
- 887           4. Number of policies.
- 888           5. Number of certificates.
- 889           6. Number of total covered lives.





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

- 894 ~~1. The deductible amount;~~
- 895 ~~2. The coinsurance percentage;~~
- 896 ~~3. The out-of-pocket maximum;~~
- 897 ~~4. Outpatient benefits;~~
- 898 ~~5. Inpatient benefits; and~~
- 899 ~~6. Any exclusions for preexisting conditions.~~

900

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

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

908

909 ~~The department shall provide by rule a uniform format for the~~  
910 ~~submission of this information in order to allow for meaningful~~  
911 ~~comparisons of premiums charged for comparable benefits.~~

912 (3) The department may adopt rules to administer this  
913 section, including, but not limited to, rules governing  
914 compliance and provisions implementing electronic methodologies  
915 for use in furnishing such records or documents. The commission  
916 may by rule specify a uniform format for the submission of this  
917 information in order to allow for meaningful comparisons shall



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918 ~~publish annually a consumer's guide which summarizes and~~  
 919 ~~compares the information required to be reported under this~~  
 920 ~~subsection.~~

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

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

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

939 Section 14. Section 627.9403, Florida Statutes, is amended  
 940 to read:

941 627.9403 Scope.--The provisions of this part shall apply  
 942 to long-term care insurance policies delivered or issued for  
 943 delivery in this state, and to policies delivered or issued for  
 944 delivery outside this state to the extent provided in s.

945 627.9406, by an insurer, a fraternal benefit society as defined



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946 in s. 632.601, a health maintenance organization as defined in  
 947 s. 641.19, a prepaid health clinic as defined in s. 641.402, or  
 948 a multiple-employer welfare arrangement as defined in s.  
 949 624.437. A policy which is advertised, marketed, or offered as a  
 950 long-term care policy and as a Medicare supplement policy shall  
 951 meet the requirements of this part and the requirements of ss.  
 952 627.671-627.675 and, to the extent of a conflict, be subject to  
 953 the requirement that is more favorable to the policyholder or  
 954 certificateholder. The provisions of this part shall not apply  
 955 to a continuing care contract issued pursuant to chapter 651 and  
 956 shall not apply to guaranteed renewable policies issued prior to  
 957 October 1, 1988. Any limited benefit policy that limits coverage  
 958 to care in a nursing home or to one or more lower levels of care  
 959 required or authorized to be provided by this part or by  
 960 department rule must meet all requirements of this part that  
 961 apply to long-term care insurance policies, except ss.  
 962 627.9407(3)(c) and (d), (9), (10)(f), and (12) and 627.94073(2).  
 963 ~~If the limited benefit policy does not provide coverage for care~~  
 964 ~~in a nursing home, but does provide coverage for one or more~~  
 965 ~~lower levels of care, the policy shall also be exempt from the~~  
 966 ~~requirements of s. 627.9407(3)(d).~~

967 Section 15. Paragraph (b) of subsection (1) of section  
 968 641.185, Florida Statutes, is amended to read:

969 641.185 Health maintenance organization subscriber  
 970 protections.--

971 (1) With respect to the provisions of this part and part  
 972 III, the principles expressed in the following statements shall  
 973 serve as standards to be followed by the Department of Insurance



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974 and the Agency for Health Care Administration in exercising  
975 their powers and duties, in exercising administrative  
976 discretion, in administrative interpretations of the law, in  
977 enforcing its provisions, and in adopting rules:

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

983 Section 16. Subsections (9) through (17) of section  
984 641.31, Florida Statutes, are amended to read:

985 641.31 Health maintenance contracts.--

986 (9)(a)1. If a health maintenance organization offers  
987 coverage for dependent children of the subscriber, the contract  
988 must cover a dependent child of the subscriber at least until  
989 the end of the calendar year in which the child reaches the age  
990 of 25, if the child meets all of the following:

991 a. The child is dependent upon the subscriber for support.

992 b. The child is living in the household of the subscriber,  
993 or the child is a full-time or part-time student.

994 2. Nothing in this paragraph affects or preempts a health  
995 maintenance organization's right to medically underwrite or  
996 charge the appropriate premium.

997 (b)1. A contract that provides coverage for a family  
998 member of the subscriber shall, as to such family member's  
999 coverage, provide that benefits applicable to children of the  
1000 subscriber also apply to an adopted child or a foster child of  
1001 the subscriber placed in compliance with chapter 63 from the



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1002 moment of placement in the residence of the subscriber. Except  
 1003 in the case of a foster child, the contract may not exclude  
 1004 coverage for any preexisting condition of the child. In the case  
 1005 of a newborn child, coverage begins at the moment of birth if a  
 1006 written agreement to adopt such child has been entered into by  
 1007 the subscriber prior to the birth of the child, whether or not  
 1008 the agreement is enforceable. This section does not require  
 1009 coverage for an adopted child who is not ultimately placed in  
 1010 the residence of the subscriber in compliance with chapter 63.

1011 2. A contract may require the subscriber to notify the  
 1012 health maintenance organization of the birth or placement of an  
 1013 adopted child within a specified time period of not less than 30  
 1014 days after the birth or placement in the residence of a child  
 1015 adopted by the subscriber. If timely notice is given, the health  
 1016 maintenance organization may not charge an additional premium  
 1017 for coverage of the child for the duration of the notice period.  
 1018 If timely notice is not given, the health maintenance  
 1019 organization may charge an additional premium from the date of  
 1020 birth or placement. If notice is given within 60 days after the  
 1021 birth or placement of the child, the health maintenance  
 1022 organization may not deny coverage for the child due to the  
 1023 failure of the subscriber to timely notify the health  
 1024 maintenance organization of the birth or placement of the child.

1025 3. If the contract does not require the subscriber to  
 1026 notify the health maintenance organization of the birth or  
 1027 placement of an adopted child within a specified time period,  
 1028 the health maintenance organization may not deny coverage for  
 1029 such child or retroactively charge the subscriber an additional



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1030 premium for such child. However, the health maintenance  
 1031 organization may prospectively charge the subscriber an  
 1032 additional premium for the child if the health maintenance  
 1033 organization provides at least 45 days' notice of the additional  
 1034 premium required.

1035 4. In order to increase access to postnatal, infant, and  
 1036 pediatric health care for all children placed in court-ordered  
 1037 custody, including foster children, all health maintenance  
 1038 organization contracts that provide coverage for a family member  
 1039 of the subscriber shall, as to such family member's coverage,  
 1040 provide that benefits applicable for children shall be payable  
 1041 with respect to a foster child or other child in court-ordered,  
 1042 temporary, or other custody of the subscriber.

1043 (10) A contract that provides that coverage of a dependent  
 1044 child shall terminate upon attainment of the limiting age for  
 1045 dependent children specified in the contract shall also provide  
 1046 in substance that attainment of the limiting age does not  
 1047 terminate the coverage of the child while the child continues to  
 1048 be:

1049 (a) Incapable of self-sustaining employment by reason of  
 1050 mental retardation or physical handicap.

1051 (b) Chiefly dependent upon the subscriber for support and  
 1052 maintenance.

1053  
 1054 If a claim is denied under a contract for the stated reason that  
 1055 the child has attained the limiting age for dependent children  
 1056 specified in the contract, the notice of denial must state that  
 1057 the subscriber has the burden of establishing that the child



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1058 continues to meet the criteria specified in paragraphs (a) and  
1059 (b). ~~All health maintenance contracts that provide coverage,~~  
1060 ~~benefits, or services for a member of the family of the~~  
1061 ~~subscriber must, as to such family member's coverage, benefits,~~  
1062 ~~or services, provide also that the coverage, benefits, or~~  
1063 ~~services applicable for children must be provided with respect~~  
1064 ~~to a newborn child of the subscriber, or covered family member~~  
1065 ~~of the subscriber, from the moment of birth. However, with~~  
1066 ~~respect to a newborn child of a covered family member other than~~  
1067 ~~the spouse of the insured or subscriber, the coverage for the~~  
1068 ~~newborn child terminates 18 months after the birth of the~~  
1069 ~~newborn child. The coverage, benefits, or services for newborn~~  
1070 ~~children must consist of coverage for injury or sickness,~~  
1071 ~~including the necessary care or treatment of medically diagnosed~~  
1072 ~~congenital defects, birth abnormalities, or prematurity, and~~  
1073 ~~transportation costs of the newborn to and from the nearest~~  
1074 ~~appropriate facility appropriately staffed and equipped to treat~~  
1075 ~~the newborn's condition, when such transportation is certified~~  
1076 ~~by the attending physician as medically necessary to protect the~~  
1077 ~~health and safety of the newborn child.~~

1078 ~~(a) A contract may require the subscriber to notify the~~  
1079 ~~plan of the birth of a child within a time period, as specified~~  
1080 ~~in the contract, of not less than 30 days after the birth, or a~~  
1081 ~~contract may require the preenrollment of a newborn prior to~~  
1082 ~~birth. However, if timely notice is given, a plan may not charge~~  
1083 ~~an additional premium for additional coverage of the newborn~~  
1084 ~~child for not less than 30 days after the birth of the child. If~~  
1085 ~~timely notice is not given, the plan may charge an additional~~



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1086 ~~premium from the date of birth. If notice is given within 60~~  
1087 ~~days of the birth of the child, the contract may not deny~~  
1088 ~~coverage of the child due to failure of the subscriber to timely~~  
1089 ~~notify the plan of the birth of the child or to preenroll the~~  
1090 ~~child.~~

1091 ~~(b) If the contract does not require the subscriber to~~  
1092 ~~notify the plan of the birth of a child within a specified time~~  
1093 ~~period, the plan may not deny coverage of the child nor may it~~  
1094 ~~retroactively charge the subscriber an additional premium for~~  
1095 ~~the child; however, the contract may prospectively charge the~~  
1096 ~~member an additional premium for the child if the plan provides~~  
1097 ~~at least 45 days' notice of the additional charge.~~

1098 ~~(11)(10)~~ No alteration of any written application for any  
1099 health maintenance contract shall be made by any person other  
1100 than the applicant without his or her written consent, except  
1101 that insertions may be made by the health maintenance  
1102 organization, for administrative purposes only, in such manner  
1103 as to indicate clearly that such insertions are not to be  
1104 ascribed to the applicant.

1105 ~~(12)(11)~~ No contract shall contain any waiver of rights or  
1106 benefits provided to or available to subscribers under the  
1107 provisions of any law or rule applicable to health maintenance  
1108 organizations.

1109 ~~(13)(12)~~ Each health maintenance contract, certificate, or  
1110 member handbook shall state that emergency services and care  
1111 shall be provided to subscribers in emergency situations not  
1112 permitting treatment through the health maintenance  
1113 organization's providers, without prior notification to and





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1114 approval of the organization. Not less than 75 percent of the  
 1115 reasonable charges for covered services and supplies shall be  
 1116 paid by the organization, up to the subscriber contract benefit  
 1117 limits. Payment also may be subject to additional applicable  
 1118 copayment provisions, not to exceed \$100 per claim. The health  
 1119 maintenance contract, certificate, or member handbook shall  
 1120 contain the definitions of "emergency services and care" and  
 1121 "emergency medical condition" as specified in s. 641.19(7) and  
 1122 (8), shall describe procedures for determination by the health  
 1123 maintenance organization of whether the services qualify for  
 1124 reimbursement as emergency services and care, and shall contain  
 1125 specific examples of what does constitute an emergency. In  
 1126 providing for emergency services and care as a covered service,  
 1127 a health maintenance organization shall be governed by s.  
 1128 641.513.

1129 (14)~~(13)~~ In addition to the requirements of this section,  
 1130 with respect to a person who is entitled to have payments for  
 1131 health care costs made under Medicare, Title XVIII of the Social  
 1132 Security Act ("Medicare"), parts A and/or B:

1133 (a) The health maintenance organization shall mail or  
 1134 deliver notification to the Medicare beneficiary of the date of  
 1135 enrollment in the health maintenance organization within 10 days  
 1136 after receiving notification of enrollment approval from the  
 1137 United States Department of Health and Human Services, Health  
 1138 Care Financing Administration. When a Medicare beneficiary who  
 1139 is a subscriber of the health maintenance organization requests  
 1140 disenrollment from the organization, the organization shall mail  
 1141 or deliver to the beneficiary notice of the effective date of



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1142 the disenrollment within 10 days after receipt of the written  
1143 disenrollment request. The health maintenance organization shall  
1144 forward the disenrollment request to the United States  
1145 Department of Health and Human Services, Health Care Financing  
1146 Administration, in a timely manner so as to effectuate the next  
1147 available disenrollment date, as prescribed by such federal  
1148 agency.

1149 (b) The health maintenance contract, certificate, or  
1150 member handbook shall be delivered to the subscriber no later  
1151 than the earlier of 10 working days after the health maintenance  
1152 organization and the Health Care Financing Administration of the  
1153 United States Department of Health and Human Services approve  
1154 the subscriber's enrollment application or the effective date of  
1155 coverage of the subscriber under the health maintenance  
1156 contract. However, if notice from the Health Care Financing  
1157 Administration of its approval of the subscriber's enrollment  
1158 application is received by the health maintenance organization  
1159 after the effective coverage date prescribed by the Health Care  
1160 Financing Administration, the health maintenance organization  
1161 shall deliver the contract, certificate, or member handbook to  
1162 the subscriber within 10 days after receiving such notice. When  
1163 a Medicare recipient is enrolled in a health maintenance  
1164 organization program, the contract, certificate, or member  
1165 handbook shall be accompanied by a health maintenance  
1166 organization identification sticker with instruction to the  
1167 Medicare beneficiary to place the sticker on the Medicare  
1168 identification card.



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1169        (15)~~(14)~~ Whenever a subscriber of a health maintenance  
 1170 organization is also a Medicaid recipient, the health  
 1171 maintenance organization's coverage shall be primary to the  
 1172 recipient's Medicaid benefits and the organization shall be a  
 1173 third party subject to the provisions of s. 409.910(4).

1174        (16)~~(15)~~(a) All health maintenance contracts,  
 1175 certificates, and member handbooks shall contain the following  
 1176 provision:

1177  
 1178 "Grace Period: This contract has a (insert a number not less  
 1179 than 10) day grace period. This provision means that if any  
 1180 required premium is not paid on or before the date it is due, it  
 1181 may be paid during the following grace period. During the grace  
 1182 period, the contract will stay in force."

1183  
 1184        (b) The required provision of paragraph (a) shall not  
 1185 apply to certificates or member handbooks delivered to  
 1186 individual subscribers under a group health maintenance contract  
 1187 when the employer or other person who will hold the contract on  
 1188 behalf of the subscriber group pays the entire premium for the  
 1189 individual subscribers. However, such required provision shall  
 1190 apply to the group health maintenance contract.

1191        (17)~~(16)~~ The contracts must clearly disclose the intent of  
 1192 the health maintenance organization as to the applicability or  
 1193 nonapplicability of coverage to preexisting conditions. If  
 1194 coverage of the contract is not to be applicable to preexisting  
 1195 conditions, the contract shall specify, in substance, that  
 1196 coverage pertains solely to accidental bodily injuries resulting



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1197 from accidents occurring after the effective date of coverage  
1198 and that sicknesses are limited to those which first manifest  
1199 themselves subsequent to the effective date of coverage.

1200 ~~(17) All health maintenance contracts that provide~~  
1201 ~~coverage for a member of the family of the subscriber, shall, as~~  
1202 ~~to such family member's coverage, provide that coverage,~~  
1203 ~~benefits, or services applicable for children shall be provided~~  
1204 ~~with respect to an adopted child of the subscriber, which child~~  
1205 ~~is placed in compliance with chapter 63, from the moment of~~  
1206 ~~placement in the residence of the subscriber. Such contracts may~~  
1207 ~~not exclude coverage for any preexisting condition of the child.~~  
1208 ~~In the case of a newborn child, coverage shall begin from the~~  
1209 ~~moment of birth if a written agreement to adopt such child has~~  
1210 ~~been entered into by the subscriber prior to the birth of the~~  
1211 ~~child, whether or not such agreement is enforceable. However,~~  
1212 ~~coverage for such child shall not be required in the event that~~  
1213 ~~the child is not ultimately placed in the residence of the~~  
1214 ~~subscriber in compliance with chapter 63.~~

1215 Section 17. Section 641.3101, Florida Statutes, is amended  
1216 to read:

1217 641.3101 Additional contract contents.--

1218 (1) A health maintenance contract may contain additional  
1219 provisions not inconsistent with this part which are:

1220 (a)~~(1)~~ Necessary, on account of the manner in which the  
1221 organization is constituted or operated, in order to state the  
1222 rights and obligations of the parties to the contract; or



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1223            ~~(b)(2)~~ Desired by the organization and neither prohibited  
1224 by law nor in conflict with any provisions required to be  
1225 included therein.

1226            (2) A health maintenance contract that uses a specific  
1227 methodology for payment of claims shall comply with s. 627.6044.

1228            Section 18. Section 641.31025, Florida Statutes, is  
1229 created to read:

1230            641.31025 Specific reasons for denial of coverage.--The  
1231 denial of an application for a health maintenance organization  
1232 contract must be accompanied by the specific reasons for the  
1233 denial, including, but not limited to, the specific underwriting  
1234 reasons, if applicable.

1235            Section 19. Section 641.31075, Florida Statutes, is  
1236 created to read:

1237            641.31075 Replacement.--Any health maintenance  
1238 organization that is replacing any other group health coverage  
1239 with its group health maintenance coverage shall comply with s.  
1240 627.666.

1241            Section 20. Subsection (1) of section 641.3111, Florida  
1242 Statutes, is amended to read:

1243            641.3111 Extension of benefits.--

1244            (1) Every group health maintenance contract shall provide  
1245 that termination of the contract shall be without prejudice to  
1246 any continuous loss which commenced while the contract was in  
1247 force, but any extension of benefits beyond the period the  
1248 contract was in force may be predicated upon the continuous  
1249 total disability of the subscriber ~~and may be limited to payment~~  
1250 ~~for the treatment of a specific accident or illness incurred~~



1251 ~~while the subscriber was a member.~~ The extension is required  
 1252 regardless of whether the group contract holder or other entity  
 1253 secures replacement coverage from a new insurer or health  
 1254 maintenance organization or foregoes the provision of coverage.  
 1255 The required provision must provide for continuation of contract  
 1256 benefits in connection with the treatment of a specific accident  
 1257 or illness incurred while the contract was in effect. Such  
 1258 extension of benefits may be limited to the occurrence of the  
 1259 earliest of the following events:

- 1260 (a) The expiration of 12 months.
- 1261 (b) Such time as the member is no longer totally disabled.
- 1262 (c) A succeeding carrier elects to provide replacement  
 1263 coverage without limitation as to the disability condition.
- 1264 (d) The maximum benefits payable under the contract have  
 1265 been paid.

1266 Section 21. Subsection (4) of section 627.651, Florida  
 1267 Statutes, is amended to read:

1268 627.651 Group contracts and plans of self-insurance must  
 1269 meet group requirements.--

1270 (4) This section does not apply to any plan which is  
 1271 established or maintained by an individual employer in  
 1272 accordance with the Employee Retirement Income Security Act of  
 1273 1974, Pub. L. No. 93-406, or to a multiple-employer welfare  
 1274 arrangement as defined in s. 624.437(1), except that a multiple-  
 1275 employer welfare arrangement shall comply with ss. 627.419,  
 1276 627.657, 627.6575, 627.6578, 627.6579, 627.6612, 627.66121,  
 1277 627.66122, 627.6615, 627.6616, and 627.662(8)~~(7)~~. This  
 1278 subsection does not allow an authorized insurer to issue a group



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1279 health insurance policy or certificate which does not comply  
1280 with this part.

1281 Section 22. Subsection (1) of section 641.2018, Florida  
1282 Statutes, is amended to read:

1283 641.2018 Limited coverage for home health care  
1284 authorized.--

1285 (1) Notwithstanding other provisions of this chapter, a  
1286 health maintenance organization may issue a contract that limits  
1287 coverage to home health care services only. The organization and  
1288 the contract shall be subject to all of the requirements of this  
1289 part that do not require or otherwise apply to specific benefits  
1290 other than home care services. To this extent, all of the  
1291 requirements of this part apply to any organization or contract  
1292 that limits coverage to home care services, except the  
1293 requirements for providing comprehensive health care services as  
1294 provided in ss. 641.19(4), (12), and (13), and 641.31(1), except  
1295 ss. 641.31~~(9)~~, (13)~~(12)~~, ~~(17)~~, (18), (19), (20), (21), and (24)  
1296 and 641.31095.

1297 Section 23. Section 641.3107, Florida Statutes, is amended  
1298 to read:

1299 641.3107 Delivery of contract.--Unless delivered upon  
1300 execution or issuance, a health maintenance contract,  
1301 certificate of coverage, or member handbook shall be mailed or  
1302 delivered to the subscriber or, in the case of a group health  
1303 maintenance contract, to the employer or other person who will  
1304 hold the contract on behalf of the subscriber group within 10  
1305 working days from approval of the enrollment form by the health  
1306 maintenance organization or by the effective date of coverage,



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1307 | whichever occurs first. However, if the employer or other person  
1308 | who will hold the contract on behalf of the subscriber group  
1309 | requires retroactive enrollment of a subscriber, the  
1310 | organization shall deliver the contract, certificate, or member  
1311 | handbook to the subscriber within 10 days after receiving notice  
1312 | from the employer of the retroactive enrollment. This section  
1313 | does not apply to the delivery of those contracts specified in  
1314 | s. 641.31(14)~~(13)~~.

1315 |       Section 24. Subsection (4) of section 641.513, Florida  
1316 | Statutes, is amended to read:

1317 |       641.513 Requirements for providing emergency services and  
1318 | care.--

1319 |       (4) A subscriber may be charged a reasonable copayment, as  
1320 | provided in s. 641.31(13)~~(12)~~, for the use of an emergency room.

1321 |       Section 25. This act shall take effect upon becoming a  
1322 | law.