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; extending an expiration date; 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 requirements and procedures; revising certain criteria and limitations under the individual health reinsurance program; amending s. 627.651, F.S.; correcting a cross reference; amending s. 627.662, F.S.; revising a list of provisions applicable to group, blanket, or franchise health insurance to include use of specific methodology for payment of claims provisions; amending s. 627.667, F.S.; deleting a limitation on application of certain extension of benefits

29 provisions; amending s. 627.6692, F.S.; increasing a time
30 period for payment of premium to continue coverage under a
31 group health plan; amending s. 627.6699, F.S.; revising
32 definitions; revising coverage enrollment eligibility
33 criteria for small employers; revising small employer
34 carrier election requirements and procedures; revising
35 certain criteria and limitations under the small employer
36 health reinsurance program; amending ss. 627.911 and
37 627.9175, F.S.; applying certain information reporting
38 requirements to health maintenance organizations; revising
39 health insurance information requirements and criteria;
40 authorizing the department to adopt rules; deleting an
41 annual report requirement; amending s. 627.9403, F.S.;
42 deleting an exemption for limited benefit policies from a
43 long-term care insurance restriction relating to nursing
44 home care; amending s. 641.185, F.S.; correcting a cross
45 reference; amending s. 641.31, F.S.; specifying
46 nonapplication to certain contracts; requiring health
47 maintenance organizations offering coverage of dependent
48 children to maintain such coverage until a child reaches
49 age 25, under certain circumstances; providing
50 application; providing requirements for contract
51 termination and denial of a claim related to limiting age
52 attainment; amending s. 641.3101, F.S.; providing a
53 compliance requirement for health maintenance contracts
54 using a specific payment of claims methodology; creating
55 s. 641.31025, F.S.; requiring specific reasons for denial
56 of coverage under a health maintenance organization

57 contract; creating s. 641.31075, F.S.; imposing compliance
58 requirements upon health maintenance organization
59 replacements of other group health coverage with
60 organization coverage; amending s. 641.3111, F.S.;
61 deleting a limitation on certain extension of benefits
62 provisions upon group health maintenance contract
63 termination; imposing additional extension of benefits
64 requirements upon such termination; amending ss. 627.651,
65 641.2018, 641.3107, and 641.513, F.S.; correcting cross
66 references; providing an effective date.
67
68 Be It Enacted by the Legislature of the State of Florida:
69
70 Section 1. Paragraph (e) of subsection (2), subsection
71 (3), paragraph (c) of subsection (5), and subsection (10) of
72 section 408.909, Florida Statutes, are amended to read:
73 408.909 Health flex plans.--
74 (2) DEFINITIONS.--As used in this section, the term:
75 (e) "Health flex plan" means a health plan approved under
76 subsection (3) which guarantees payment for specified health
77 care coverage provided to the enrollee who purchases coverage
78 directly from the plan or through a small business purchasing
79 arrangement sponsored by a local government.
80 (3) PILOT PROGRAM.--The agency and the department shall
81 each approve or disapprove health flex plans that provide health
82 care coverage for eligible participants who reside in the three
83 areas of the state that have the highest number of uninsured
84 persons, as identified in the Florida Health Insurance Study

85 conducted by the agency and in Indian River County. A health
86 flex plan may limit or exclude benefits otherwise required by
87 law for insurers offering coverage in this state, may cap the
88 total amount of claims paid per year per enrollee, may limit the
89 number of enrollees or the term of coverage, or may take any
90 combination of those actions.
91 (a) The agency shall develop guidelines for the review of
92 applications for health flex plans and shall disapprove or
93 withdraw approval of plans that do not meet or no longer meet
94 minimum standards for quality of care and access to care.
95 (b) The department shall develop guidelines for the review
96 of health flex plan applications and shall disapprove or shall
97 withdraw approval of plans that:
98 1. Contain any ambiguous, inconsistent, or misleading
99 provisions or any exceptions or conditions that deceptively
100 affect or limit the benefits purported to be assumed in the
101 general coverage provided by the health flex plan;
102 2. Provide benefits that are unreasonable in relation to
103 the premium charged or contain provisions that are unfair or
104 inequitable or contrary to the public policy of this state, that
105 encourage misrepresentation, or that result in unfair
106 discrimination in sales practices; or
107 3. Cannot demonstrate that the health flex plan is
108 financially sound and that the applicant is able to underwrite
109 or finance the health care coverage provided.
110 (c) The agency and the department may adopt rules as
111 needed to administer this section.

CODING: Words stricken are deletions; words underlined are additions.

112 (5) ELIGIBILITY.--Eligibility to enroll in an approved
113 health flex plan is limited to residents of this state who:
114 (c) Are not covered by a private insurance policy and are
115 not eligible for coverage through a public health insurance
116 program, such as Medicare or Medicaid, or another public health
117 care program, such as KidCare, and have not been covered at any
118 time during the past 6 months, except that a small business
119 purchasing arrangement sponsored by a local government may limit
120 enrollment to residents of this state who have not been covered
121 at any time during the past 12 months; and
122 (10) EXPIRATION.--This section expires July 1, 2008 ~~2004~~.
123 Section 2. Section 627.6042, Florida Statutes, is created
124 to read:
125 627.6042 Dependent coverage.--
126 (1) If an insurer offers coverage that insures dependent
127 children of the policyholder or certificateholder, the policy
128 must insure a dependent child of the policyholder or
129 certificateholder at least until the end of the calendar year in
130 which the child reaches the age of 25, if the child meets all of
131 the following:
132 (a) The child is dependent upon the policyholder or
133 certificateholder for support.
134 (b) The child is living in the household of the
135 policyholder or certificateholder or the child is a full-time or
136 part-time student.
137 (2) Nothing in this section affects or preempts an
138 insurer's right to medically underwrite or charge the
139 appropriate premium.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

140 Section 3. Section 627.60425, Florida Statutes, is created
141 to read:
142 627.60425 Binding arbitration requirement
143 limitations.--Notwithstanding any other provision of law, except
144 s. 624.155, an individual, blanket, group life, or group health
145 insurance policy; individual or group health maintenance
146 organization subscriber contract; prepaid limited health
147 organization subscriber contract; or any life or health
148 insurance policy or certificate delivered or issued for
149 delivery, including out-of-state group plans pursuant to s.
150 627.5515 or s. 627.6515 covering residents of this state, to any
151 resident of this state shall not require the submission of
152 disputes between the parties to the policy, contract, or plan to
153 binding arbitration unless the applicant has indicated that the
154 same policy, contract, or plan was offered and rejected without
155 arbitration and that the binding arbitration provision was fully
156 explained to the applicant and willingly accepted.
157 Section 4. Section 627.6044, Florida Statutes, is amended
158 to read:
159 627.6044 Use of a specific methodology for payment of
160 claims.--
161 (1) Each insurance policy that provides for payment of
162 claims to nonnetwork providers that is less than the payment of
163 the provider's billed charges to the insured, excluding
164 deductible, coinsurance, and copay amounts, shall:
165 (a) Provide benefits prior to deductible, coinsurance, and
166 copay amounts for using a nonnetwork provider that are at least
167 equal to the amount that would have been allowed had the insured

CODING: Words stricken are deletions; words underlined are additions.

168 used a network provider but are not in excess of the actual
169 billed charges.
170 (b) Where there are multiple network providers in the
171 geographical area in which the services were provided or, if
172 none, the closest geographic area, the carrier may use an
173 averaging method of the contracted amounts but not less than the
174 80th percentile of all network contracted amounts in the
175 geographic area.
176
177 For purposes of this subsection, the term "network providers"
178 means those providers for which an insured will not be
179 responsible for any balance payment for services provided by
180 such provider, excluding deductible, coinsurance, and copay
181 amounts ~~based on a specific methodology, including, but not~~
182 ~~limited to, usual and customary charges, reasonable and~~
183 ~~customary charges, or charges based upon the prevailing rate in~~
184 ~~the community, shall specify the formula or criteria used by the~~
185 ~~insurer in determining the amount to be paid~~.
186 (2) Each insurer issuing a policy that provides for
187 payment of claims based on a specific methodology shall provide
188 to an insured, upon her or his written request, an estimate of
189 the amount the insurer will pay for a particular medical
190 procedure or service. The estimate may be in the form of a range
191 of payments or an average payment and may specify that the
192 estimate is based on the assumption of a particular service
193 code. ~~The insurer may require the insured to provide detailed~~
194 ~~information regarding the procedure or service to be performed,~~
195 ~~including the procedure or service code number provided by the~~

196 ~~health care provider and the health care provider's estimated~~
197 ~~charge.~~ An insurer that provides an insured with a good faith
198 estimate is not bound by the estimate. However, a pattern of
199 providing estimates that vary significantly from the ultimate
200 insurance payment constitutes a violation of this code.
201 (3) The method used for determining the payment of claims
202 shall be included in filings made pursuant to s. 627.410(6) and
203 may not be changed unless such change is filed under s.
204 627.410(6).
205 (4) Any policy that provides that the insured is
206 responsible for the balance of a claim amount, excluding
207 deductible, coinsurance, and copay amounts, must disclose such
208 feature on the face of the policy or certificate and such
209 feature must be included in any outline of coverage provided to
210 the insured.
211 Section 5. Subsections (1) and (4) of section 627.6415,
212 Florida Statutes, are amended to read:
213 627.6415 Coverage for natural-born, adopted, and foster
214 children; children in insured's custodial care.--
215 (1) A health insurance policy that provides coverage for a
216 member of the family of the insured shall, as to the family
217 member's coverage, provide that the health insurance benefits
218 applicable to children of the insured also apply to an adopted
219 child or a foster child of the insured placed in compliance with
220 chapter 63~~, prior to the child's 18th birthday,~~ from the moment
221 of placement in the residence of the insured. Except in the case
222 of a foster child, the policy may not exclude coverage for any
223 preexisting condition of the child. In the case of a newborn

224 child, coverage begins at the moment of birth if a written
225 agreement to adopt the child has been entered into by the
226 insured prior to the birth of the child, whether or not the
227 agreement is enforceable. This section does not require coverage
228 for an adopted child who is not ultimately placed in the
229 residence of the insured in compliance with chapter 63.
230 (4) In order to increase access to postnatal, infant, and
231 pediatric health care for all children placed in court-ordered
232 custody, including foster children, all health insurance
233 policies that provide coverage for a member of the family of the
234 insured shall, as to such family member's coverage, also provide
235 that the health insurance benefits applicable for children shall
236 be payable with respect to a foster child or other child in
237 court-ordered temporary or other custody of the insured~~, prior~~
238 ~~to the child's 18th birthday~~.
239 Section 6. Paragraph (a) of subsection (5), paragraph (c)
240 of subsection (6), and paragraphs (b), (c), and (e) of
241 subsection (7) of section 627.6475, Florida Statutes, are
242 amended to read:
243 627.6475 Individual reinsurance pool.--
244 (5) ISSUER'S ELECTION TO BECOME A RISK-ASSUMING CARRIER.--
245 (a) Each health insurance issuer that offers individual
246 health insurance must elect to become a risk-assuming carrier or
247 a reinsuring carrier for purposes of this section. Each such
248 issuer must make ~~an initial election, binding through December~~
249 ~~31, 1999. The issuer's initial election must be made no later~~
250 ~~than October 31, 1997. By October 31, 1997, all issuers must~~
251 ~~file a final election, which is binding for 2 years, from~~

252 ~~January 1, 1998, through December 31, 1999, after which~~ an
253 election that shall be binding indefinitely or until modified or
254 withdrawn ~~for a period of 5 years~~. The department may permit an
255 issuer to modify its election at any time for good cause shown~~,~~
256 ~~after a hearing~~.
257 (6) ELECTION PROCESS TO BECOME A RISK-ASSUMING CARRIER.--
258 (c) The department shall provide public notice of an
259 issuer's filing a designation of election under this subsection
260 to become a risk-assuming carrier and shall provide at least a
261 21-day period for public comment upon receipt of such filing
262 ~~prior to making a decision on the election~~. ~~The department shall~~
263 ~~hold a hearing on the election at the request of the issuer.~~
264 (7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.--
265 (b) A reinsuring carrier may reinsure with the program
266 coverage of an eligible individual, subject to each of the
267 following provisions:
268 1. A reinsuring carrier may reinsure an eligible
269 individual within 90 ~~60~~ days after commencement of the coverage
270 of the eligible individual.
271 2. The program may not reimburse a participating carrier
272 with respect to the claims of a reinsured eligible individual
273 until the carrier has paid incurred claims of an amount equal to
274 the participating carrier's selected deductible level ~~at least~~
275 ~~$5,000~~ in a calendar year for benefits covered by the program.
276 ~~In addition, the reinsuring carrier is responsible for 10~~
277 ~~percent of the next $50,000 and 5 percent of the next $100,000~~
278 ~~of incurred claims during a calendar year, and the program shall~~
279 ~~reinsure the remainder.~~

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

280 3. The board shall annually adjust the initial level of
281 claims and the maximum limit to be retained by the carrier to
282 reflect increases in costs and utilization within the standard
283 market for health benefit plans within the state. The adjustment
284 may not be less than the annual change in the medical component
285 of the "Commerce Price Index for All Urban Consumers" of the
286 Bureau of Labor Statistics of the United States Department of
287 Labor, unless the board proposes and the department approves a
288 lower adjustment factor.
289 4. A reinsuring carrier may terminate reinsurance for all
290 reinsured eligible individuals on any plan anniversary.
291 5. The premium rate charged for reinsurance by the program
292 to a health maintenance organization that is approved by the
293 Secretary of Health and Human Services as a federally qualified
294 health maintenance organization pursuant to 42 U.S.C. s.
295 300e(c)(2)(A) and that, as such, is subject to requirements that
296 limit the amount of risk that may be ceded to the program, which
297 requirements are more restrictive than subparagraph 2., shall be
298 reduced by an amount equal to that portion of the risk, if any,
299 which exceeds the amount set forth in subparagraph 2., which may
300 not be ceded to the program.
301 6. The board may consider adjustments to the premium rates
302 charged for reinsurance by the program or carriers that use
303 effective cost-containment measures, including high-cost case
304 management, as defined by the board.
305 7. A reinsuring carrier shall apply its case-management
306 and claims-handling techniques, including, but not limited to,
307 utilization review, individual case management, preferred

308 provider provisions, other managed-care provisions, or methods
309 of operation consistently with both reinsured business and
310 nonreinsured business.
311 (c)1. The board, as part of the plan of operation, shall
312 establish a methodology for determining premium rates to be
313 charged by the program for reinsuring eligible individuals
314 pursuant to this section. The methodology must include a system
315 for classifying individuals which reflects the types of case
316 characteristics commonly used by carriers in this state. The
317 methodology must provide for the development of basic
318 reinsurance premium rates, which shall be multiplied by the
319 factors set for them in this paragraph to determine the premium
320 rates for the program. The basic reinsurance premium rates shall
321 be established by the board, subject to the approval of the
322 department, and shall be set at levels that reasonably
323 approximate gross premiums charged to eligible individuals for
324 individual health insurance by health insurance issuers. The
325 premium rates set by the board may vary by geographical area, as
326 determined under this section, to reflect differences in cost.
327 ~~An eligible individual may be reinsured for a rate that is five~~
328 ~~times the rate established by the board.~~
329 2. The board shall periodically review the methodology
330 established, including the system of classification and any
331 rating factors, to ensure that it reasonably reflects the claims
332 experience of the program. The board may propose changes to the
333 rates that are subject to the approval of the department.
334 (e)1. Before September ~~March~~ 1 of each calendar year, the
335 board shall determine and report to the department the program

336 net loss in the individual account for the previous year,
337 including administrative expenses for that year and the incurred
338 losses for that year, taking into account investment income and
339 other appropriate gains and losses.
340 2. Any net loss in the individual account for the year
341 shall be recouped by assessing the carriers as follows:
342 a. The operating losses of the program shall be assessed
343 in the following order subject to the specified limitations. The
344 first tier of assessments shall be made against reinsuring
345 carriers in an amount that may not exceed 5 percent of each
346 reinsuring carrier's premiums for individual health insurance.
347 If such assessments have been collected and additional moneys
348 are needed, the board shall make a second tier of assessments in
349 an amount that may not exceed 0.5 percent of each carrier's
350 health benefit plan premiums.
351 b. Except as provided in paragraph (f), risk-assuming
352 carriers are exempt from all assessments authorized pursuant to
353 this section. The amount paid by a reinsuring carrier for the
354 first tier of assessments shall be credited against any
355 additional assessments made.
356 c. The board shall equitably assess reinsuring carriers
357 for operating losses of the individual account based on market
358 share. The board shall annually assess each carrier a portion of
359 the operating losses of the individual account. The first tier
360 of assessments shall be determined by multiplying the operating
361 losses by a fraction, the numerator of which equals the
362 reinsuring carrier's earned premium pertaining to direct
363 writings of individual health insurance in the state during the

CODING: Words stricken are deletions; words underlined are additions.

364 calendar year for which the assessment is levied, and the
365 denominator of which equals the total of all such premiums
366 earned by reinsuring carriers in the state during that calendar
367 year. The second tier of assessments shall be based on the
368 premiums that all carriers, except risk-assuming carriers,
369 earned on all health benefit plans written in this state. The
370 board may levy interim assessments against reinsuring carriers
371 to ensure the financial ability of the plan to cover claims
372 expenses and administrative expenses paid or estimated to be
373 paid in the operation of the plan for the calendar year prior to
374 the association's anticipated receipt of annual assessments for
375 that calendar year. Any interim assessment is due and payable
376 within 30 days after receipt by a carrier of the interim
377 assessment notice. Interim assessment payments shall be credited
378 against the carrier's annual assessment. Health benefit plan
379 premiums and benefits paid by a carrier that are less than an
380 amount determined by the board to justify the cost of collection
381 may not be considered for purposes of determining assessments.
382 d. Subject to the approval of the department, the board
383 shall adjust the assessment formula for reinsuring carriers that
384 are approved as federally qualified health maintenance
385 organizations by the Secretary of Health and Human Services
386 pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent, if any,
387 that restrictions are placed on them which are not imposed on
388 other carriers.
389 3. Before September ~~March~~ 1 of each year, the board shall
390 determine and file with the department an estimate of the

391 assessments needed to fund the losses incurred by the program in
392 the individual account for the previous calendar year.
393 4. If the board determines that the assessments needed to
394 fund the losses incurred by the program in the individual
395 account for the previous calendar year will exceed the amount
396 specified in subparagraph 2., the board shall evaluate the
397 operation of the program and report its findings and
398 recommendations to the department in the format established in
399 s. 627.6699(11) for the comparable report for the small employer
400 reinsurance program.
401 Section 7. Subsection (4) of section 627.651, Florida
402 Statutes, is amended to read:
403 627.651 Group contracts and plans of self-insurance must
404 meet group requirements.--
405 (4) This section does not apply to any plan which is
406 established or maintained by an individual employer in
407 accordance with the Employee Retirement Income Security Act of
408 1974, Pub. L. No. 93-406, or to a multiple-employer welfare
409 arrangement as defined in s. 624.437(1), except that a multiple-
410 employer welfare arrangement shall comply with ss. 627.419,
411 627.657, 627.6575, 627.6578, 627.6579, 627.6612, 627.66121,
412 627.66122, 627.6615, 627.6616, and 627.662(8)~~(7)~~. This
413 subsection does not allow an authorized insurer to issue a group
414 health insurance policy or certificate which does not comply
415 with this part.
416 Section 8. Section 627.662, Florida Statutes, is amended
417 to read:

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

418 627.662 Other provisions applicable.--The following
419 provisions apply to group health insurance, blanket health
420 insurance, and franchise health insurance:
421 (1) Section 627.569, relating to use of dividends,
422 refunds, rate reductions, commissions, and service fees.
423 (2) Section 627.602(1)(f) and (2), relating to
424 identification numbers and statement of deductible provisions.
425 (3) Section 627.6044, relating to the use of specific
426 methodology for payment of claims.
427 (4)~~(3)~~ Section 627.635, relating to excess insurance.
428 (5)~~(4)~~ Section 627.638, relating to direct payment for
429 hospital or medical services.
430 (6)~~(5)~~ Section 627.640, relating to filing and
431 classification of rates.
432 (7)~~(6)~~ Section 627.613, relating to timely payment of
433 claims, or s. 627.6131, relating to payment of claims, whichever
434 is applicable.
435 (8)~~(7)~~ Section 627.645(1), relating to denial of claims.
436 (9)~~(8)~~ Section 627.6471, relating to preferred provider
437 organizations.
438 (10)~~(9)~~ Section 627.6472, relating to exclusive provider
439 organizations.
440 (11)~~(10)~~ Section 627.6473, relating to combined preferred
441 provider and exclusive provider policies.
442 (12)~~(11)~~ Section 627.6474, relating to provider contracts.
443 Section 9. Subsection (6) of section 627.667, Florida
444 Statutes, is amended to read:
445 627.667 Extension of benefits.--

446 (6) This section also applies to holders of group
447 certificates which are renewed, delivered, or issued for
448 delivery to residents of this state under group policies
449 effectuated or delivered outside this state~~, unless a succeeding~~
450 ~~carrier under a group policy has agreed to assume liability for~~
451 ~~the benefits~~.
452 Section 10. Paragraph (e) of subsection (5) of section
453 627.6692, Florida Statutes, is amended to read:
454 627.6692 Florida Health Insurance Coverage Continuation
455 Act.--
456 (5) CONTINUATION OF COVERAGE UNDER GROUP HEALTH PLANS.--
457 (e)1. A covered employee or other qualified beneficiary
458 who wishes continuation of coverage must pay the initial premium
459 and elect such continuation in writing to the insurance carrier
460 issuing the employer's group health plan within 63 ~~30~~ days after
461 receiving notice from the insurance carrier under paragraph (d).
462 Subsequent premiums are due by the grace period expiration date.
463 The insurance carrier or the insurance carrier's designee shall
464 process all elections promptly and provide coverage
465 retroactively to the date coverage would otherwise have
466 terminated. The premium due shall be for the period beginning on
467 the date coverage would have otherwise terminated due to the
468 qualifying event. The first premium payment must include the
469 coverage paid to the end of the month in which the first payment
470 is made. After the election, the insurance carrier must bill the
471 qualified beneficiary for premiums once each month, with a due
472 date on the first of the month of coverage and allowing a 30-day
473 grace period for payment.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

474 2. Except as otherwise specified in an election, any
475 election by a qualified beneficiary shall be deemed to include
476 an election of continuation of coverage on behalf of any other
477 qualified beneficiary residing in the same household who would
478 lose coverage under the group health plan by reason of a
479 qualifying event. This subparagraph does not preclude a
480 qualified beneficiary from electing continuation of coverage on
481 behalf of any other qualified beneficiary.
482 Section 11. Paragraphs (g), (h), (i), and (u) of
483 subsection (3), paragraph (c) of subsection (5), paragraph (a)
484 of subsection (9), paragraph (d) of subsection (10), and
485 paragraphs (f), (g), (h), and (j) of subsection (11) of section
486 627.6699, Florida Statutes, are amended to read:
487 627.6699 Employee Health Care Access Act.--
488 (3) DEFINITIONS.--As used in this section, the term:
489 (g) "Dependent" means the spouse or child as described in
490 s. 627.6562 of an eligible employee, subject to the applicable
491 terms of the health benefit plan covering that employee.
492 (h) "Eligible employee" means an employee who works full
493 time, having a normal workweek of 25 or more hours, who is paid
494 wages or a salary at least equal to the federal minimum hourly
495 wage applicable to such employee, and who has met any applicable
496 waiting-period requirements or other requirements of this act.
497 The term includes a self-employed individual, a sole proprietor,
498 a partner of a partnership, or an independent contractor, if the
499 sole proprietor, partner, or independent contractor is included
500 as an employee under a health benefit plan of a small employer,

CODING: Words stricken are deletions; words underlined are additions.

501 but does not include a part-time, temporary, or substitute
502 employee.
503 (i) "Established geographic area" means the county or
504 counties~~, or any portion of a county or counties,~~ within which
505 the carrier provides or arranges for health care services to be
506 available to its insureds, members, or subscribers.
507 (u) "Self-employed individual" means an individual or sole
508 proprietor who derives his or her income from a trade or
509 business carried on by the individual or sole proprietor which
510 necessitates that the individual file federal income tax forms
511 with supporting schedules and accompanying income reporting
512 forms or federal income tax extensions of time to file forms
513 with the Internal Revenue Service for the most recent tax year
514 ~~results in taxable income as indicated on IRS Form 1040,~~
515 ~~schedule C or F, and which generated taxable income in one of~~
516 ~~the 2 previous years~~.
517 (5) AVAILABILITY OF COVERAGE.--
518 (c) Every small employer carrier must, as a condition of
519 transacting business in this state:
520 1. Beginning July 1, 2000, offer and issue all small
521 employer health benefit plans on a guaranteed-issue basis to
522 every eligible small employer, with 2 to 50 eligible employees,
523 that elects to be covered under such plan, agrees to make the
524 required premium payments, and satisfies the other provisions of
525 the plan. A rider for additional or increased benefits may be
526 medically underwritten and may only be added to the standard
527 health benefit plan. The increased rate charged for the

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

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

556 year as the date of enrollment, unless the small employer
557 carrier and the small employer agree to a different date. A
558 rider for additional or increased benefits may be medically
559 underwritten and may only be added to the standard health
560 benefit plan. The increased rate charged for the additional or
561 increased benefit must be rated in accordance with this section.
562 For purposes of this sub-subparagraph ~~subparagraph~~, a person,
563 his or her spouse, and his or her dependent children constitute
564 a single eligible employee if that person and spouse are
565 employed by the same small employer and either that person or
566 his or her spouse has a normal work week of less than 25 hours.
567 b. Notwithstanding the restrictions set forth in sub-
568 subparagraph a., when a small employer group is losing coverage
569 because a carrier is exercising the provisions of s.
570 627.6571(3)(b) or s. 641.31074(3)(b), the eligible small
571 employer, as defined in sub-subparagraph a., shall be entitled
572 to enroll with another carrier offering small employer coverage
573 within 63 days after the notice of termination or the
574 termination date of the prior coverage, whichever is later.
575 Coverage provided under this sub-subparagraph shall begin
576 immediately upon enrollment unless the small employer carrier
577 and the small employer agree to a different date.
578 4. This paragraph does not limit a carrier's ability to
579 offer other health benefit plans to small employers if the
580 standard and basic health benefit plans are offered and
581 rejected.
582 (9) SMALL EMPLOYER CARRIER'S ELECTION TO BECOME A RISK-
583 ASSUMING CARRIER OR A REINSURING CARRIER.--

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

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

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

(11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.--

611 (f) The program has the general powers and authority
612 granted under the laws of this state to insurance companies and
613 health maintenance organizations licensed to transact business,
614 except the power to issue health benefit plans directly to
615 groups or individuals. In addition thereto, the program has
616 specific authority to:
617 1. Enter into contracts as necessary or proper to carry
618 out the provisions and purposes of this act, including the
619 authority to enter into contracts with similar programs of other
620 states for the joint performance of common functions or with
621 persons or other organizations for the performance of
622 administrative functions.
623 2. Sue or be sued, including taking any legal action
624 necessary or proper for recovering any assessments and penalties
625 for, on behalf of, or against the program or any carrier.
626 3. Take any legal action necessary to avoid the payment of
627 improper claims against the program.
628 4. Issue reinsurance policies, in accordance with the
629 requirements of this act.
630 5. Establish rules, conditions, and procedures for
631 reinsurance risks under the program participation.
632 6. Establish actuarial functions as appropriate for the
633 operation of the program.
634 7. Assess participating carriers in accordance with
635 paragraph (j), and make advance interim assessments as may be
636 reasonable and necessary for organizational and interim
637 operating expenses. Interim assessments shall be credited as

638 offsets against any regular assessments due following the close
639 of the calendar year.
640 8. Appoint appropriate legal, actuarial, and other
641 committees as necessary to provide technical assistance in the
642 operation of the program, and in any other function within the
643 authority of the program.
644 9. Borrow money to effect the purposes of the program. Any
645 notes or other evidences of indebtedness of the program which
646 are not in default constitute legal investments for carriers and
647 may be carried as admitted assets.
648 10. To the extent necessary, increase the $5,000
649 deductible reinsurance requirement to adjust for the effects of
650 inflation. The program may evaluate the desirability of
651 establishing different levels of deductibles. If different
652 levels of deductibles are established, such levels and the
653 resulting premiums shall be approved by the department.
654 (g) A reinsuring carrier may reinsure with the program
655 coverage of an eligible employee of a small employer, or any
656 dependent of such an employee, subject to each of the following
657 provisions:
658 1. With respect to a standard and basic health care plan,
659 the program may ~~must~~ reinsure the level of coverage provided;
660 and, with respect to any other plan, the program may ~~must~~
661 reinsure the coverage up to, but not exceeding, the level of
662 coverage provided under the standard and basic health care plan.
663 As an alternative to reinsuring the level of coverage provided
664 under the standard and basic health care plan, the program may
665 develop alternate levels of reinsurance designed to coordinate

666 with a reinsuring carrier's existing reinsurance. The levels of
667 reinsurance and resulting premiums must be approved by the
668 department.
669 2. Except in the case of a late enrollee, a reinsuring
670 carrier may reinsure an eligible employee or dependent within 60
671 days after the commencement of the coverage of the small
672 employer. A newly employed eligible employee or dependent of a
673 small employer may be reinsured within 60 days after the
674 commencement of his or her coverage.
675 3. A small employer carrier may reinsure an entire
676 employer group within 60 days after the commencement of the
677 group's coverage under the plan. The carrier may choose to
678 reinsure newly eligible employees and dependents of the
679 reinsured group pursuant to subparagraph 1.
680 4. The program may evaluate the option of allowing a small
681 employer carrier to reinsure an entire employer group or an
682 eligible employee at the first or subsequent renewal date. Any
683 such option and the resulting premium must be approved by the
684 department.
685 5. ~~4.~~ The program may not reimburse a participating carrier
686 with respect to the claims of a reinsured employee or dependent
687 until the carrier has paid incurred claims of an amount equal to
688 the participating carrier's selected deductible level ~~at least~~
689 ~~$5,000~~ in a calendar year for benefits covered by the program.
690 ~~In addition, the reinsuring carrier shall be responsible for 10~~
691 ~~percent of the next $50,000 and 5 percent of the next $100,000~~
692 ~~of incurred claims during a calendar year and the program shall~~
693 ~~reinsure the remainder.~~

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

694 6.~~5.~~ The board annually shall adjust the initial level of
695 claims and the maximum limit to be retained by the carrier to
696 reflect increases in costs and utilization within the standard
697 market for health benefit plans within the state. The adjustment
698 shall not be less than the annual change in the medical
699 component of the "Consumer Price Index for All Urban Consumers"
700 of the Bureau of Labor Statistics of the Department of Labor,
701 unless the board proposes and the department approves a lower
702 adjustment factor.
703 7.~~6.~~ A small employer carrier may terminate reinsurance
704 for all reinsured employees or dependents on any plan
705 anniversary.
706 8.~~7.~~ The premium rate charged for reinsurance by the
707 program to a health maintenance organization that is approved by
708 the Secretary of Health and Human Services as a federally
709 qualified health maintenance organization pursuant to 42 U.S.C.
710 s. 300e(c)(2)(A) and that, as such, is subject to requirements
711 that limit the amount of risk that may be ceded to the program,
712 which requirements are more restrictive than subparagraph 5. ~~4.~~,
713 shall be reduced by an amount equal to that portion of the risk,
714 if any, which exceeds the amount set forth in subparagraph 5. ~~4.~~
715 which may not be ceded to the program.
716 9.~~8.~~ The board may consider adjustments to the premium
717 rates charged for reinsurance by the program for carriers that
718 use effective cost containment measures, including high-cost
719 case management, as defined by the board.
720 10.~~9.~~ A reinsuring carrier shall apply its case-management
721 and claims-handling techniques, including, but not limited to,

722 utilization review, individual case management, preferred
723 provider provisions, other managed care provisions or methods of
724 operation, consistently with both reinsured business and
725 nonreinsured business.
726 (h)1. The board, as part of the plan of operation, shall
727 establish a methodology for determining premium rates to be
728 charged by the program for reinsuring small employers and
729 individuals pursuant to this section. The methodology shall
730 include a system for classification of small employers that
731 reflects the types of case characteristics commonly used by
732 small employer carriers in the state. The methodology shall
733 provide for the development of basic reinsurance premium rates,
734 which shall be multiplied by the factors set for them in this
735 paragraph to determine the premium rates for the program. The
736 basic reinsurance premium rates shall be established by the
737 board, subject to the approval of the department, and shall be
738 set at levels which reasonably approximate gross premiums
739 charged to small employers by small employer carriers for health
740 benefit plans with benefits similar to the standard and basic
741 health benefit plan. The premium rates set by the board may vary
742 by geographical area, as determined under this section, to
743 reflect differences in cost. ~~The multiplying factors must be~~
744 ~~established as follows:~~
745 ~~a. The entire group may be reinsured for a rate that is~~
746 ~~1.5 times the rate established by the board.~~
747 ~~b. An eligible employee or dependent may be reinsured for~~
748 ~~a rate that is 5 times the rate established by the board.~~

749 2. The board periodically shall review the methodology
750 established, including the system of classification and any
751 rating factors, to assure that it reasonably reflects the claims
752 experience of the program. The board may propose changes to the
753 rates which shall be subject to the approval of the department.
754 (j)1. Before September ~~March~~ 1 of each calendar year, the
755 board shall determine and report to the department the program
756 net loss for the previous year, including administrative
757 expenses for that year, and the incurred losses for the year,
758 taking into account investment income and other appropriate
759 gains and losses.
760 2. Any net loss for the year shall be recouped by
761 assessment of the carriers, as follows:
762 a. The operating losses of the program shall be assessed
763 in the following order subject to the specified limitations. The
764 first tier of assessments shall be made against reinsuring
765 carriers in an amount which shall not exceed 5 percent of each
766 reinsuring carrier's premiums from health benefit plans covering
767 small employers. If such assessments have been collected and
768 additional moneys are needed, the board shall make a second tier
769 of assessments in an amount which shall not exceed 0.5 percent
770 of each carrier's health benefit plan premiums. Except as
771 provided in paragraph (n), risk-assuming carriers are exempt
772 from all assessments authorized pursuant to this section. The
773 amount paid by a reinsuring carrier for the first tier of
774 assessments shall be credited against any additional assessments
775 made.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

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

804 health maintenance organizations by the Secretary of Health and
805 Human Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the
806 extent, if any, that restrictions are placed on them that are
807 not imposed on other small employer carriers.
808 3. Before September ~~March~~ 1 of each year, the board shall
809 determine and file with the department an estimate of the
810 assessments needed to fund the losses incurred by the program in
811 the previous calendar year.
812 4. If the board determines that the assessments needed to
813 fund the losses incurred by the program in the previous calendar
814 year will exceed the amount specified in subparagraph 2., the
815 board shall evaluate the operation of the program and report its
816 findings, including any recommendations for changes to the plan
817 of operation, to the department within 240 ~~90~~ days following the
818 end of the calendar year in which the losses were incurred. The
819 evaluation shall include an estimate of future assessments, the
820 administrative costs of the program, the appropriateness of the
821 premiums charged and the level of carrier retention under the
822 program, and the costs of coverage for small employers. If the
823 board fails to file a report with the department within 240 ~~90~~
824 days following the end of the applicable calendar year, the
825 department may evaluate the operations of the program and
826 implement such amendments to the plan of operation the
827 department deems necessary to reduce future losses and
828 assessments.
829 5. If assessments exceed the amount of the actual losses
830 and administrative expenses of the program, the excess shall be
831 held as interest and used by the board to offset future losses

832 or to reduce program premiums. As used in this paragraph, the
833 term "future losses" includes reserves for incurred but not
834 reported claims.
835 6. Each carrier's proportion of the assessment shall be
836 determined annually by the board, based on annual statements and
837 other reports considered necessary by the board and filed by the
838 carriers with the board.
839 7. Provision shall be made in the plan of operation for
840 the imposition of an interest penalty for late payment of an
841 assessment.
842 8. A carrier may seek, from the commissioner, a deferment,
843 in whole or in part, from any assessment made by the board. The
844 department may defer, in whole or in part, the assessment of a
845 carrier if, in the opinion of the department, the payment of the
846 assessment would place the carrier in a financially impaired
847 condition. If an assessment against a carrier is deferred, in
848 whole or in part, the amount by which the assessment is deferred
849 may be assessed against the other carriers in a manner
850 consistent with the basis for assessment set forth in this
851 section. The carrier receiving such deferment remains liable to
852 the program for the amount deferred and is prohibited from
853 reinsuring any individuals or groups in the program if it fails
854 to pay assessments.
855 Section 12. Section 627.911, Florida Statutes, is amended
856 to read:
857 627.911 Scope of this part.--Any insurer or health
858 maintenance organization transacting insurance in this state
859 shall report information as required by this part.

860 Section 13. Section 627.9175, Florida Statutes, is amended
861 to read:
862 627.9175 Reports of information on health insurance.--
863 (1) Each authorized health insurer or health maintenance
864 organization shall submit annually to the office, on or before
865 March 1 of each year, information concerning department as to
866 policies of individual health insurance coverage being issued or
867 currently in force in this state. The information shall include
868 information related to premium, number of policies, and covered
869 lives for such policies and other information necessary to
870 analyze trends in enrollment, premiums, and claim costs.
871 (2) The required information shall be broken down by
872 market segment, to include:
873 (a) Health insurance issuer, company, contact person, or
874 agent.
875 (b) All health insurance products issued or in force,
876 including, but not limited to:
877 1. Direct premiums earned.
878 2. Direct losses incurred.
879 3. Direct premiums earned for new business issued during
880 the year.
881 4. Number of policies.
882 5. Number of certificates.
883 6. Number of total covered lives.
884 (a) A summary of typical benefits, exclusions, and
885 limitations for each type of individual policy form currently
886 being issued in the state. The summary shall include, as
887 appropriate:

888 ~~1. The deductible amount;~~
889 ~~2. The coinsurance percentage;~~
890 ~~3. The out-of-pocket maximum;~~
891 ~~4. Outpatient benefits;~~
892 ~~5. Inpatient benefits; and~~
893 ~~6. Any exclusions for preexisting conditions.~~
894
895 ~~The department shall determine other appropriate benefits,~~
896 ~~exclusions, and limitations to be reported for inclusion in the~~
897 ~~consumer's guide published pursuant to this section.~~
898 ~~(b) A schedule of rates for each type of individual policy~~
899 ~~form reflecting typical variations by age, sex, region of the~~
900 ~~state, or any other applicable factor which is in use and is~~
901 ~~determined to be appropriate for inclusion by the department.~~
902
903 ~~The department shall provide by rule a uniform format for the~~
904 ~~submission of this information in order to allow for meaningful~~
905 ~~comparisons of premiums charged for comparable benefits.~~
906 (3) The department may adopt rules to administer this
907 section, including, but not limited to, rules governing
908 compliance and provisions implementing electronic methodologies
909 for use in furnishing such records or documents. The commission
910 may by rule specify a uniform format for the submission of this
911 information in order to allow for meaningful comparisons ~~shall~~
912 ~~publish annually a consumer's guide which summarizes and~~
913 ~~compares the information required to be reported under this~~
914 ~~subsection~~.

915 ~~(2)(a) Every insurer transacting health insurance in this~~
916 ~~state shall report annually to the department, not later than~~
917 ~~April 1, information relating to any measure the insurer has~~
918 ~~implemented or proposes to implement during the next calendar~~
919 ~~year for the purpose of containing health insurance costs or~~
920 ~~cost increases. The reports shall identify each measure and the~~
921 ~~forms to which the measure is applied, shall provide an~~
922 ~~explanation as to how the measure is used, and shall provide an~~
923 ~~estimate of the cost effect of the measure.~~
924 ~~(b) The department shall promulgate forms to be used by~~
925 ~~insurers in reporting information pursuant to this subsection~~
926 ~~and shall utilize such forms to analyze the effects of health~~
927 ~~care cost containment programs used by health insurers in this~~
928 ~~state.~~
929 ~~(c) The department shall analyze the data reported under~~
930 ~~this subsection and shall annually make available to the public~~
931 ~~a summary of its findings as to the types of cost containment~~
932 ~~measures reported and the estimated effect of these measures.~~
933 Section 14. Section 627.9403, Florida Statutes, is amended
934 to read:
935 627.9403 Scope.--The provisions of this part shall apply
936 to long-term care insurance policies delivered or issued for
937 delivery in this state, and to policies delivered or issued for
938 delivery outside this state to the extent provided in s.
939 627.9406, by an insurer, a fraternal benefit society as defined
940 in s. 632.601, a health maintenance organization as defined in
941 s. 641.19, a prepaid health clinic as defined in s. 641.402, or
942 a multiple-employer welfare arrangement as defined in s.

943 624.437. A policy which is advertised, marketed, or offered as a
944 long-term care policy and as a Medicare supplement policy shall
945 meet the requirements of this part and the requirements of ss.
946 627.671-627.675 and, to the extent of a conflict, be subject to
947 the requirement that is more favorable to the policyholder or
948 certificateholder. The provisions of this part shall not apply
949 to a continuing care contract issued pursuant to chapter 651 and
950 shall not apply to guaranteed renewable policies issued prior to
951 October 1, 1988. Any limited benefit policy that limits coverage
952 to care in a nursing home or to one or more lower levels of care
953 required or authorized to be provided by this part or by
954 department rule must meet all requirements of this part that
955 apply to long-term care insurance policies, except ss.
956 627.9407(3)(c) and (d), (9), (10)(f), and (12) and 627.94073(2).
957 ~~If the limited benefit policy does not provide coverage for care~~
958 ~~in a nursing home, but does provide coverage for one or more~~
959 ~~lower levels of care, the policy shall also be exempt from the~~
960 ~~requirements of s. 627.9407(3)(d).~~
961 Section 15. Paragraph (b) of subsection (1) of section
962 641.185, Florida Statutes, is amended to read:
963 641.185 Health maintenance organization subscriber
964 protections.--
965 (1) With respect to the provisions of this part and part
966 III, the principles expressed in the following statements shall
967 serve as standards to be followed by the Department of Insurance
968 and the Agency for Health Care Administration in exercising
969 their powers and duties, in exercising administrative

970 discretion, in administrative interpretations of the law, in
971 enforcing its provisions, and in adopting rules:
972 (b) A health maintenance organization subscriber should
973 receive quality health care from a broad panel of providers,
974 including referrals, preventive care pursuant to s. 641.402(1),
975 emergency screening and services pursuant to ss. 641.31(13)~~(12)~~
976 and 641.513, and second opinions pursuant to s. 641.51.
977 Section 16. Paragraph (d) of subsection (3) and
978 subsections (9) through (17) of section 641.31, Florida
979 Statutes, are amended to read:
980 641.31 Health maintenance contracts.--
981 (3)
982 (d) Any change in rates charged for the contract must be
983 filed with the department not less than 30 days in advance of
984 the effective date. At the expiration of such 30 days, the rate
985 filing shall be deemed approved unless prior to such time the
986 filing has been affirmatively approved or disapproved by order
987 of the department. The approval of the filing by the department
988 constitutes a waiver of any unexpired portion of such waiting
989 period. The department may extend by not more than an additional
990 15 days the period within which it may so affirmatively approve
991 or disapprove any such filing, by giving notice of such
992 extension before expiration of the initial 30-day period. At the
993 expiration of any such period as so extended, and in the absence
994 of such prior affirmative approval or disapproval, any such
995 filing shall be deemed approved. This paragraph does not apply
996 to group health maintenance organization contracts effectuated

997 and delivered in this state insuring groups of 51 or more
998 persons.
999 (9)(a)1. If a health maintenance organization offers
1000 coverage for dependent children of the subscriber, the contract
1001 must cover a dependent child of the subscriber at least until
1002 the end of the calendar year in which the child reaches the age
1003 of 23, if the child meets all of the following:
1004 a. The child is dependent upon the subscriber for support.
1005 b. The child is living in the household of the subscriber,
1006 or the child is a full-time or part-time student.
1007 2. Nothing in this paragraph affects or preempts a health
1008 maintenance organization's right to medically underwrite or
1009 charge the appropriate premium.
1010 (b)1. A contract that provides coverage for a family
1011 member of the subscriber shall, as to such family member's
1012 coverage, provide that benefits applicable to children of the
1013 subscriber also apply to an adopted child or a foster child of
1014 the subscriber placed in compliance with chapter 63 from the
1015 moment of placement in the residence of the subscriber. Except
1016 in the case of a foster child, the contract may not exclude
1017 coverage for any preexisting condition of the child. In the case
1018 of a newborn child, coverage begins at the moment of birth if a
1019 written agreement to adopt such child has been entered into by
1020 the subscriber prior to the birth of the child, whether or not
1021 the agreement is enforceable. This section does not require
1022 coverage for an adopted child who is not ultimately placed in
1023 the residence of the subscriber in compliance with chapter 63.

1024 2. A contract may require the subscriber to notify the
1025 health maintenance organization of the birth or placement of an
1026 adopted child within a specified time period of not less than 30
1027 days after the birth or placement in the residence of a child
1028 adopted by the subscriber. If timely notice is given, the health
1029 maintenance organization may not charge an additional premium
1030 for coverage of the child for the duration of the notice period.
1031 If timely notice is not given, the health maintenance
1032 organization may charge an additional premium from the date of
1033 birth or placement. If notice is given within 60 days after the
1034 birth or placement of the child, the health maintenance
1035 organization may not deny coverage for the child due to the
1036 failure of the subscriber to timely notify the health
1037 maintenance organization of the birth or placement of the child.
1038 3. If the contract does not require the subscriber to
1039 notify the health maintenance organization of the birth or
1040 placement of an adopted child within a specified time period,
1041 the health maintenance organization may not deny coverage for
1042 such child or retroactively charge the subscriber an additional
1043 premium for such child. However, the health maintenance
1044 organization may prospectively charge the subscriber an
1045 additional premium for the child if the health maintenance
1046 organization provides at least 45 days' notice of the additional
1047 premium required.
1048 4. In order to increase access to postnatal, infant, and
1049 pediatric health care for all children placed in court-ordered
1050 custody, including foster children, all health maintenance
1051 organization contracts that provide coverage for a family member

1052 of the subscriber shall, as to such family member's coverage,
1053 provide that benefits applicable for children shall be payable
1054 with respect to a foster child or other child in court-ordered,
1055 temporary, or other custody of the subscriber.
1056 (10) A contract that provides that coverage of a dependent
1057 child shall terminate upon attainment of the limiting age for
1058 dependent children specified in the contract shall also provide
1059 in substance that attainment of the limiting age does not
1060 terminate the coverage of the child while the child continues to
1061 be:
1062 (a) Incapable of self-sustaining employment by reason of
1063 mental retardation or physical handicap.
1064 (b) Chiefly dependent upon the subscriber for support and
1065 maintenance.
1066
1067 If a claim is denied under a contract for the stated reason that
1068 the child has attained the limiting age for dependent children
1069 specified in the contract, the notice of denial must state that
1070 the subscriber has the burden of establishing that the child
1071 continues to meet the criteria specified in paragraphs (a) and
1072 (b). ~~All health maintenance contracts that provide coverage,~~
1073 ~~benefits, or services for a member of the family of the~~
1074 ~~subscriber must, as to such family member's coverage, benefits,~~
1075 ~~or services, provide also that the coverage, benefits, or~~
1076 ~~services applicable for children must be provided with respect~~
1077 ~~to a newborn child of the subscriber, or covered family member~~
1078 ~~of the subscriber, from the moment of birth. However, with~~
1079 ~~respect to a newborn child of a covered family member other than~~

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

1080 ~~the spouse of the insured or subscriber, the coverage for the~~
1081 ~~newborn child terminates 18 months after the birth of the~~
1082 ~~newborn child. The coverage, benefits, or services for newborn~~
1083 ~~children must consist of coverage for injury or sickness,~~
1084 ~~including the necessary care or treatment of medically diagnosed~~
1085 ~~congenital defects, birth abnormalities, or prematurity, and~~
1086 ~~transportation costs of the newborn to and from the nearest~~
1087 ~~appropriate facility appropriately staffed and equipped to treat~~
1088 ~~the newborn's condition, when such transportation is certified~~
1089 ~~by the attending physician as medically necessary to protect the~~
1090 ~~health and safety of the newborn child.~~
1091 ~~(a) A contract may require the subscriber to notify the~~
1092 ~~plan of the birth of a child within a time period, as specified~~
1093 ~~in the contract, of not less than 30 days after the birth, or a~~
1094 ~~contract may require the preenrollment of a newborn prior to~~
1095 ~~birth. However, if timely notice is given, a plan may not charge~~
1096 ~~an additional premium for additional coverage of the newborn~~
1097 ~~child for not less than 30 days after the birth of the child. If~~
1098 ~~timely notice is not given, the plan may charge an additional~~
1099 ~~premium from the date of birth. If notice is given within 60~~
1100 ~~days of the birth of the child, the contract may not deny~~
1101 ~~coverage of the child due to failure of the subscriber to timely~~
1102 ~~notify the plan of the birth of the child or to preenroll the~~
1103 ~~child.~~
1104 ~~(b) If the contract does not require the subscriber to~~
1105 ~~notify the plan of the birth of a child within a specified time~~
1106 ~~period, the plan may not deny coverage of the child nor may it~~
1107 ~~retroactively charge the subscriber an additional premium for~~

1108 ~~the child; however, the contract may prospectively charge the~~
1109 ~~member an additional premium for the child if the plan provides~~
1110 ~~at least 45 days' notice of the additional charge.~~
1111 (11)~~(10)~~ No alteration of any written application for any
1112 health maintenance contract shall be made by any person other
1113 than the applicant without his or her written consent, except
1114 that insertions may be made by the health maintenance
1115 organization, for administrative purposes only, in such manner
1116 as to indicate clearly that such insertions are not to be
1117 ascribed to the applicant.
1118 (12)~~(11)~~ No contract shall contain any waiver of rights or
1119 benefits provided to or available to subscribers under the
1120 provisions of any law or rule applicable to health maintenance
1121 organizations.
1122 (13)~~(12)~~ Each health maintenance contract, certificate, or
1123 member handbook shall state that emergency services and care
1124 shall be provided to subscribers in emergency situations not
1125 permitting treatment through the health maintenance
1126 organization's providers, without prior notification to and
1127 approval of the organization. Not less than 75 percent of the
1128 reasonable charges for covered services and supplies shall be
1129 paid by the organization, up to the subscriber contract benefit
1130 limits. Payment also may be subject to additional applicable
1131 copayment provisions, not to exceed $100 per claim. The health
1132 maintenance contract, certificate, or member handbook shall
1133 contain the definitions of "emergency services and care" and
1134 "emergency medical condition" as specified in s. 641.19(7) and
1135 (8), shall describe procedures for determination by the health

1136 maintenance organization of whether the services qualify for
1137 reimbursement as emergency services and care, and shall contain
1138 specific examples of what does constitute an emergency. In
1139 providing for emergency services and care as a covered service,
1140 a health maintenance organization shall be governed by s.
1141 641.513.
1142 (14)~~(13)~~ In addition to the requirements of this section,
1143 with respect to a person who is entitled to have payments for
1144 health care costs made under Medicare, Title XVIII of the Social
1145 Security Act ("Medicare"), parts A and/or B:
1146 (a) The health maintenance organization shall mail or
1147 deliver notification to the Medicare beneficiary of the date of
1148 enrollment in the health maintenance organization within 10 days
1149 after receiving notification of enrollment approval from the
1150 United States Department of Health and Human Services, Health
1151 Care Financing Administration. When a Medicare beneficiary who
1152 is a subscriber of the health maintenance organization requests
1153 disenrollment from the organization, the organization shall mail
1154 or deliver to the beneficiary notice of the effective date of
1155 the disenrollment within 10 days after receipt of the written
1156 disenrollment request. The health maintenance organization shall
1157 forward the disenrollment request to the United States
1158 Department of Health and Human Services, Health Care Financing
1159 Administration, in a timely manner so as to effectuate the next
1160 available disenrollment date, as prescribed by such federal
1161 agency.
1162 (b) The health maintenance contract, certificate, or
1163 member handbook shall be delivered to the subscriber no later

1164 than the earlier of 10 working days after the health maintenance
1165 organization and the Health Care Financing Administration of the
1166 United States Department of Health and Human Services approve
1167 the subscriber's enrollment application or the effective date of
1168 coverage of the subscriber under the health maintenance
1169 contract. However, if notice from the Health Care Financing
1170 Administration of its approval of the subscriber's enrollment
1171 application is received by the health maintenance organization
1172 after the effective coverage date prescribed by the Health Care
1173 Financing Administration, the health maintenance organization
1174 shall deliver the contract, certificate, or member handbook to
1175 the subscriber within 10 days after receiving such notice. When
1176 a Medicare recipient is enrolled in a health maintenance
1177 organization program, the contract, certificate, or member
1178 handbook shall be accompanied by a health maintenance
1179 organization identification sticker with instruction to the
1180 Medicare beneficiary to place the sticker on the Medicare
1181 identification card.
1182 (15)~~(14)~~ Whenever a subscriber of a health maintenance
1183 organization is also a Medicaid recipient, the health
1184 maintenance organization's coverage shall be primary to the
1185 recipient's Medicaid benefits and the organization shall be a
1186 third party subject to the provisions of s. 409.910(4).
1187 (16)~~(15)~~(a) All health maintenance contracts,
1188 certificates, and member handbooks shall contain the following
1189 provision:
1190

CODING: Words stricken are deletions; words underlined are additions.

1191 "Grace Period: This contract has a (insert a number not less
1192 than 10) day grace period. This provision means that if any
1193 required premium is not paid on or before the date it is due, it
1194 may be paid during the following grace period. During the grace
1195 period, the contract will stay in force."
1196
1197 (b) The required provision of paragraph (a) shall not
1198 apply to certificates or member handbooks delivered to
1199 individual subscribers under a group health maintenance contract
1200 when the employer or other person who will hold the contract on
1201 behalf of the subscriber group pays the entire premium for the
1202 individual subscribers. However, such required provision shall
1203 apply to the group health maintenance contract.
1204 (17)~~(16)~~ The contracts must clearly disclose the intent of
1205 the health maintenance organization as to the applicability or
1206 nonapplicability of coverage to preexisting conditions. If
1207 coverage of the contract is not to be applicable to preexisting
1208 conditions, the contract shall specify, in substance, that
1209 coverage pertains solely to accidental bodily injuries resulting
1210 from accidents occurring after the effective date of coverage
1211 and that sicknesses are limited to those which first manifest
1212 themselves subsequent to the effective date of coverage.
1213 ~~(17) All health maintenance contracts that provide~~
1214 ~~coverage for a member of the family of the subscriber, shall, as~~
1215 ~~to such family member's coverage, provide that coverage,~~
1216 ~~benefits, or services applicable for children shall be provided~~
1217 ~~with respect to an adopted child of the subscriber, which child~~
1218 ~~is placed in compliance with chapter 63, from the moment of~~

~~placement in the residence of the subscriber. Such contracts may not exclude coverage for any preexisting condition of the child. In the case of a newborn child, coverage shall begin from the moment of birth if a written agreement to adopt such child has been entered into by the subscriber prior to the birth of the child, whether or not such agreement is enforceable. However, coverage for such child shall not be required in the event that the child is not ultimately placed in the residence of the subscriber in compliance with chapter 63.~~

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

641.3101 Additional contract contents.--

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

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

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

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

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

641.31025 Specific reasons for denial of coverage.--The denial of an application for a health maintenance organization contract must be accompanied by the specific reasons for the

1246 denial, including, but not limited to, the specific underwriting
1247 reasons, if applicable.
1248 Section 19. Section 641.31075, Florida Statutes, is
1249 created to read:
1250 641.31075 Replacement.--Any health maintenance
1251 organization that is replacing any other group health coverage
1252 with its group health maintenance coverage shall comply with s.
1253 627.666.
1254 Section 20. Subsections (1) and (3) of section 641.3111,
1255 Florida Statutes, are amended to read:
1256 641.3111 Extension of benefits.--
1257 (1) Every group health maintenance contract shall provide
1258 that termination of the contract shall be without prejudice to
1259 any continuous loss which commenced while the contract was in
1260 force, but any extension of benefits beyond the period the
1261 contract was in force may be predicated upon the continuous
1262 total disability of the subscriber ~~and may be limited to payment~~
1263 ~~for the treatment of a specific accident or illness incurred~~
1264 ~~while the subscriber was a member~~. The extension is required
1265 regardless of whether the group contract holder or other entity
1266 secures replacement coverage from a new insurer or health
1267 maintenance organization or foregoes the provision of coverage.
1268 The required provision must provide for continuation of contract
1269 benefits in connection with the treatment of a specific accident
1270 or illness incurred while the contract was in effect. Such
1271 extension of benefits may be limited to the occurrence of the
1272 earliest of the following events:
1273 (a) The expiration of 12 months.

1274 (b) Such time as the member is no longer totally disabled.
1275 ~~(c) A succeeding carrier elects to provide replacement~~
1276 ~~coverage without limitation as to the disability condition.~~
1277 (c)~~(d)~~ The maximum benefits payable under the contract
1278 have been paid.
1279 (3) In the case of maternity coverage, ~~when not covered by~~
1280 ~~the succeeding carrier,~~ a reasonable extension of benefits or
1281 accrued liability provision is required, which provision
1282 provides for continuation of the contract benefits in connection
1283 with maternity expenses for a pregnancy that commenced while the
1284 policy was in effect. The extension shall be for the period of
1285 that pregnancy and shall not be based upon total disability.
1286 Section 21. Subsection (4) of section 627.651, Florida
1287 Statutes, is amended to read:
1288 627.651 Group contracts and plans of self-insurance must
1289 meet group requirements.--
1290 (4) This section does not apply to any plan which is
1291 established or maintained by an individual employer in
1292 accordance with the Employee Retirement Income Security Act of
1293 1974, Pub. L. No. 93-406, or to a multiple-employer welfare
1294 arrangement as defined in s. 624.437(1), except that a multiple-
1295 employer welfare arrangement shall comply with ss. 627.419,
1296 627.657, 627.6575, 627.6578, 627.6579, 627.6612, 627.66121,
1297 627.66122, 627.6615, 627.6616, and 627.662(8)~~(7)~~. This
1298 subsection does not allow an authorized insurer to issue a group
1299 health insurance policy or certificate which does not comply
1300 with this part.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

1301 Section 22. Subsection (1) of section 641.2018, Florida
1302 Statutes, is amended to read:
1303 641.2018 Limited coverage for home health care
1304 authorized.--
1305 (1) Notwithstanding other provisions of this chapter, a
1306 health maintenance organization may issue a contract that limits
1307 coverage to home health care services only. The organization and
1308 the contract shall be subject to all of the requirements of this
1309 part that do not require or otherwise apply to specific benefits
1310 other than home care services. To this extent, all of the
1311 requirements of this part apply to any organization or contract
1312 that limits coverage to home care services, except the
1313 requirements for providing comprehensive health care services as
1314 provided in ss. 641.19(4), (12), and (13), and 641.31(1), except
1315 ss. 641.31~~(9),~~ (13)~~(12)~~, ~~(17),~~ (18), (19), (20), (21), and (24)
1316 and 641.31095.
1317 Section 23. Section 641.3107, Florida Statutes, is amended
1318 to read:
1319 641.3107 Delivery of contract.--Unless delivered upon
1320 execution or issuance, a health maintenance contract,
1321 certificate of coverage, or member handbook shall be mailed or
1322 delivered to the subscriber or, in the case of a group health
1323 maintenance contract, to the employer or other person who will
1324 hold the contract on behalf of the subscriber group within 10
1325 working days from approval of the enrollment form by the health
1326 maintenance organization or by the effective date of coverage,
1327 whichever occurs first. However, if the employer or other person
1328 who will hold the contract on behalf of the subscriber group

1329 requires retroactive enrollment of a subscriber, the
1330 organization shall deliver the contract, certificate, or member
1331 handbook to the subscriber within 10 days after receiving notice
1332 from the employer of the retroactive enrollment. This section
1333 does not apply to the delivery of those contracts specified in
1334 s. 641.31(14)~~(13)~~.
1335 Section 24. Subsection (4) of section 641.513, Florida
1336 Statutes, is amended to read:
1337 641.513 Requirements for providing emergency services and
1338 care.--
1339 (4) A subscriber may be charged a reasonable copayment, as
1340 provided in s. 641.31(13)~~(12)~~, for the use of an emergency room.
1341 Section 25. This act shall take effect upon becoming a
1342 law.