



1 A bill to be entitled
2 An act relating to health insurance; amending s. 408.909,
3 F.S.; revising a definition; authorizing health flex plans
4 to limit coverage under certain circumstances; authorizing
5 a small business purchasing arrangement to limit
6 enrollment to certain residents; extending an expiration
7 date; creating s. 627.6042, F.S.; requiring policies of
8 insurers offering coverage of dependent children to
9 maintain such coverage until a child reaches age 25, under
10 certain circumstances; providing application; creating s.
11 627.60425, F.S.; providing limitations on certain binding
12 arbitration requirements; amending s. 627.6044, F.S.;
13 providing for payment of claims to nonnetwork providers
14 under specified conditions; providing a definition;
15 requiring the method used for determining payment of
16 claims to be included in filings; providing for
17 disclosure; amending s. 627.6415, F.S.; deleting an 18th
18 birthday age limitation on application of certain
19 dependent coverage requirements; amending s. 627.6475,
20 F.S.; revising risk-assuming carrier election requirements
21 and procedures; revising certain criteria and limitations
22 under the individual health reinsurance program; amending
23 s. 627.651, F.S.; correcting a cross reference; amending
24 s. 627.662, F.S.; revising a list of provisions applicable
25 to group, blanket, or franchise health insurance to
26 include use of specific methodology for payment of claims
27 provisions; amending s. 627.667, F.S.; deleting a
28 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; creating s. 641.31025, F.S.; requiring
53 specific reasons for denial of coverage under a health
54 maintenance organization contract; creating s. 641.31075,
55 F.S.; imposing compliance requirements upon health
56 maintenance organization replacements of other group



57 health coverage with organization coverage; amending s.
58 641.3111, F.S.; deleting a limitation on certain extension
59 of benefits provisions upon group health maintenance
60 contract termination; imposing additional extension of
61 benefits requirements upon such termination; amending ss.
62 627.651, 641.2018, 641.3107, and 641.513, F.S.; correcting
63 cross references; providing an effective date.
64

65 Be It Enacted by the Legislature of the State of Florida:
66

67 Section 1. Paragraph (e) of subsection (2), subsection
68 (3), paragraph (c) of subsection (5), and subsection (10) of
69 section 408.909, Florida Statutes, are amended to read:

70 408.909 Health flex plans.--

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

72 (e) "Health flex plan" means a health plan approved under
73 subsection (3) which guarantees payment for specified health
74 care coverage provided to the enrollee who purchases coverage
75 directly from the plan or through a small business purchasing
76 arrangement sponsored by a local government.

77 (3) PILOT PROGRAM.--The agency and the department shall
78 each approve or disapprove health flex plans that provide health
79 care coverage for eligible participants who reside in the three
80 areas of the state that have the highest number of uninsured
81 persons, as identified in the Florida Health Insurance Study
82 conducted by the agency and in Indian River County. A health
83 flex plan may limit or exclude benefits otherwise required by
84 law for insurers offering coverage in this state, may cap the



85 total amount of claims paid per year per enrollee, may limit the
 86 number of enrollees or the term of coverage, or may take any
 87 combination of those actions.

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

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

95 1. Contain any ambiguous, inconsistent, or misleading
 96 provisions or any exceptions or conditions that deceptively
 97 affect or limit the benefits purported to be assumed in the
 98 general coverage provided by the health flex plan;

99 2. Provide benefits that are unreasonable in relation to
 100 the premium charged or contain provisions that are unfair or
 101 inequitable or contrary to the public policy of this state, that
 102 encourage misrepresentation, or that result in unfair
 103 discrimination in sales practices; or

104 3. Cannot demonstrate that the health flex plan is
 105 financially sound and that the applicant is able to underwrite
 106 or finance the health care coverage provided.

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

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

111 (c) Are not covered by a private insurance policy and are
 112 not eligible for coverage through a public health insurance



113 program, such as Medicare or Medicaid, or another public health
 114 care program, such as KidCare, and have not been covered at any
 115 time during the past 6 months, except that a small business
 116 purchasing arrangement sponsored by a local government may limit
 117 enrollment to residents of this state who have not been covered
 118 at any time during the past 12 months; and

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

120 Section 2. Section 627.6042, Florida Statutes, is created
 121 to read:

122 627.6042 Dependent coverage.--

123 (1) If an insurer offers coverage that insures dependent
 124 children of the policyholder or certificateholder, the policy
 125 must insure a dependent child of the policyholder or
 126 certificateholder at least until the end of the calendar year in
 127 which the child reaches the age of 25, if the child meets all of
 128 the following:

129 (a) The child is dependent upon the policyholder or
 130 certificateholder for support.

131 (b) The child is living in the household of the
 132 policyholder or certificateholder or the child is a full-time or
 133 part-time student.

134 (2) Nothing in this section affects or preempts an
 135 insurer's right to medically underwrite or charge the
 136 appropriate premium.

137 Section 3. Section 627.60425, Florida Statutes, is created
 138 to read:

139 627.60425 Binding arbitration requirement
 140 limitations.--Notwithstanding any other provision of law, except



141 s. 624.155, an individual, blanket, group life, or group health
142 insurance policy; individual or group health maintenance
143 organization subscriber contract; prepaid limited health
144 organization subscriber contract; or any life or health
145 insurance policy or certificate delivered or issued for
146 delivery, including out-of-state group plans pursuant to s.
147 627.5515 or s. 627.6515 covering residents of this state, to any
148 resident of this state shall not require the submission of
149 disputes between the parties to the policy, contract, or plan to
150 binding arbitration unless the applicant has indicated that the
151 same policy, contract, or plan was offered and rejected without
152 arbitration and that the binding arbitration provision was fully
153 explained to the applicant and willingly accepted.

154 Section 4. Section 627.6044, Florida Statutes, is amended
155 to read:

156 627.6044 Use of a specific methodology for payment of
157 claims.--

158 (1) Each insurance policy that provides for payment of
159 claims to nonnetwork providers that is less than the payment of
160 the provider's billed charges to the insured, excluding
161 deductible, coinsurance, and copay amounts, shall:

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

167 (b) Where there are multiple network providers in the
168 geographical area in which the services were provided or, if



169 none, the closest geographic area, the carrier may use an
170 averaging method of the contracted amounts but not less than the
171 80th percentile of all network contracted amounts in the
172 geographic area.

173

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

183 (2) Each insurer issuing a policy that provides for
184 payment of claims based on a specific methodology shall provide
185 to an insured, upon her or his written request, an estimate of
186 the amount the insurer will pay for a particular medical
187 procedure or service. The estimate may be in the form of a range
188 of payments or an average payment and may specify that the
189 estimate is based on the assumption of a particular service
190 code. ~~The insurer may require the insured to provide detailed~~
191 ~~information regarding the procedure or service to be performed,~~
192 ~~including the procedure or service code number provided by the~~
193 ~~health care provider and the health care provider's estimated~~
194 ~~charge.~~ An insurer that provides an insured with a good faith
195 estimate is not bound by the estimate. However, a pattern of



196 providing estimates that vary significantly from the ultimate
197 insurance payment constitutes a violation of this code.

198 (3) The method used for determining the payment of claims
199 shall be included in filings made pursuant to s. 627.410(6) and
200 may not be changed unless such change is filed under s.
201 627.410(6).

202 (4) Any policy that provides that the insured is
203 responsible for the balance of a claim amount, excluding
204 deductible, coinsurance, and copay amounts, must disclose such
205 feature on the face of the policy or certificate and such
206 feature must be included in any outline of coverage provided to
207 the insured.

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

210 627.6415 Coverage for natural-born, adopted, and foster
211 children; children in insured's custodial care.--

212 (1) A health insurance policy that provides coverage for a
213 member of the family of the insured shall, as to the family
214 member's coverage, provide that the health insurance benefits
215 applicable to children of the insured also apply to an adopted
216 child or a foster child of the insured placed in compliance with
217 chapter 63, ~~prior to the child's 18th birthday,~~ from the moment
218 of placement in the residence of the insured. Except in the case
219 of a foster child, the policy may not exclude coverage for any
220 preexisting condition of the child. In the case of a newborn
221 child, coverage begins at the moment of birth if a written
222 agreement to adopt the child has been entered into by the
223 insured prior to the birth of the child, whether or not the



224 agreement is enforceable. This section does not require coverage
225 for an adopted child who is not ultimately placed in the
226 residence of the insured in compliance with chapter 63.

227 (4) In order to increase access to postnatal, infant, and
228 pediatric health care for all children placed in court-ordered
229 custody, including foster children, all health insurance
230 policies that provide coverage for a member of the family of the
231 insured shall, as to such family member's coverage, also provide
232 that the health insurance benefits applicable for children shall
233 be payable with respect to a foster child or other child in
234 court-ordered temporary or other custody of the insured, ~~prior~~
235 ~~to the child's 18th birthday.~~

236 Section 6. Paragraph (a) of subsection (5), paragraph (c)
237 of subsection (6), and paragraphs (b), (c), and (e) of
238 subsection (7) of section 627.6475, Florida Statutes, are
239 amended to read:

240 627.6475 Individual reinsurance pool.--

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

242 (a) Each health insurance issuer that offers individual
243 health insurance must elect to become a risk-assuming carrier or
244 a reinsuring carrier for purposes of this section. Each such
245 issuer must make ~~an initial election, binding through December~~
246 ~~31, 1999. The issuer's initial election must be made no later~~
247 ~~than October 31, 1997. By October 31, 1997, all issuers must~~
248 ~~file a final election, which is binding for 2 years, from~~
249 ~~January 1, 1998, through December 31, 1999, after which an~~
250 election that shall be binding indefinitely or until modified or
251 withdrawn for a period of 5 years. The department may permit an



252 issuer to modify its election at any time for good cause shown,
 253 ~~after a hearing.~~

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

255 (c) The department shall provide public notice of an
 256 issuer's filing a designation of election under this subsection
 257 to become a risk-assuming carrier and shall provide at least a
 258 21-day period for public comment upon receipt of such filing
 259 ~~prior to making a decision on the election. The department shall~~
 260 ~~hold a hearing on the election at the request of the issuer.~~

261 (7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.--

262 (b) A reinsuring carrier may reinsure with the program
 263 coverage of an eligible individual, subject to each of the
 264 following provisions:

265 1. A reinsuring carrier may reinsure an eligible
 266 individual within 90 ~~60~~ days after commencement of the coverage
 267 of the eligible individual.

268 2. The program may not reimburse a participating carrier
 269 with respect to the claims of a reinsured eligible individual
 270 until the carrier has paid incurred claims of an amount equal to
 271 the participating carrier's selected deductible level ~~at least~~
 272 ~~\$5,000~~ in a calendar year for benefits covered by the program.
 273 ~~In addition, the reinsuring carrier is responsible for 10~~
 274 ~~percent of the next \$50,000 and 5 percent of the next \$100,000~~
 275 ~~of incurred claims during a calendar year, and the program shall~~
 276 ~~reinsure the remainder.~~

277 3. The board shall annually adjust the initial level of
 278 claims and the maximum limit to be retained by the carrier to
 279 reflect increases in costs and utilization within the standard



280 market for health benefit plans within the state. The adjustment
281 may not be less than the annual change in the medical component
282 of the "Commerce Price Index for All Urban Consumers" of the
283 Bureau of Labor Statistics of the United States Department of
284 Labor, unless the board proposes and the department approves a
285 lower adjustment factor.

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

288 5. The premium rate charged for reinsurance by the program
289 to a health maintenance organization that is approved by the
290 Secretary of Health and Human Services as a federally qualified
291 health maintenance organization pursuant to 42 U.S.C. s.

292 300e(c)(2)(A) and that, as such, is subject to requirements that
293 limit the amount of risk that may be ceded to the program, which
294 requirements are more restrictive than subparagraph 2., shall be
295 reduced by an amount equal to that portion of the risk, if any,
296 which exceeds the amount set forth in subparagraph 2., which may
297 not be ceded to the program.

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

302 7. A reinsuring carrier shall apply its case-management
303 and claims-handling techniques, including, but not limited to,
304 utilization review, individual case management, preferred
305 provider provisions, other managed-care provisions, or methods
306 of operation consistently with both reinsured business and
307 nonreinsured business.



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

326 2. The board shall periodically review the methodology
327 established, including the system of classification and any
328 rating factors, to ensure that it reasonably reflects the claims
329 experience of the program. The board may propose changes to the
330 rates that are subject to the approval of the department.

331 (e)1. Before September ~~March~~ 1 of each calendar year, the
332 board shall determine and report to the department the program
333 net loss in the individual account for the previous year,
334 including administrative expenses for that year and the incurred



335 losses for that year, taking into account investment income and
336 other appropriate gains and losses.

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

339 a. The operating losses of the program shall be assessed
340 in the following order subject to the specified limitations. The
341 first tier of assessments shall be made against reinsuring
342 carriers in an amount that may not exceed 5 percent of each
343 reinsuring carrier's premiums for individual health insurance.
344 If such assessments have been collected and additional moneys
345 are needed, the board shall make a second tier of assessments in
346 an amount that may not exceed 0.5 percent of each carrier's
347 health benefit plan premiums.

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

353 c. The board shall equitably assess reinsuring carriers
354 for operating losses of the individual account based on market
355 share. The board shall annually assess each carrier a portion of
356 the operating losses of the individual account. The first tier
357 of assessments shall be determined by multiplying the operating
358 losses by a fraction, the numerator of which equals the
359 reinsuring carrier's earned premium pertaining to direct
360 writings of individual health insurance in the state during the
361 calendar year for which the assessment is levied, and the
362 denominator of which equals the total of all such premiums



363 earned by reinsuring carriers in the state during that calendar
364 year. The second tier of assessments shall be based on the
365 premiums that all carriers, except risk-assuming carriers,
366 earned on all health benefit plans written in this state. The
367 board may levy interim assessments against reinsuring carriers
368 to ensure the financial ability of the plan to cover claims
369 expenses and administrative expenses paid or estimated to be
370 paid in the operation of the plan for the calendar year prior to
371 the association's anticipated receipt of annual assessments for
372 that calendar year. Any interim assessment is due and payable
373 within 30 days after receipt by a carrier of the interim
374 assessment notice. Interim assessment payments shall be credited
375 against the carrier's annual assessment. Health benefit plan
376 premiums and benefits paid by a carrier that are less than an
377 amount determined by the board to justify the cost of collection
378 may not be considered for purposes of determining assessments.

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

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



390 4. If the board determines that the assessments needed to
391 fund the losses incurred by the program in the individual
392 account for the previous calendar year will exceed the amount
393 specified in subparagraph 2., the board shall evaluate the
394 operation of the program and report its findings and
395 recommendations to the department in the format established in
396 s. 627.6699(11) for the comparable report for the small employer
397 reinsurance program.

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

400 627.651 Group contracts and plans of self-insurance must
401 meet group requirements.--

402 (4) This section does not apply to any plan which is
403 established or maintained by an individual employer in
404 accordance with the Employee Retirement Income Security Act of
405 1974, Pub. L. No. 93-406, or to a multiple-employer welfare
406 arrangement as defined in s. 624.437(1), except that a multiple-
407 employer welfare arrangement shall comply with ss. 627.419,
408 627.657, 627.6575, 627.6578, 627.6579, 627.6612, 627.66121,
409 627.66122, 627.6615, 627.6616, and 627.662(8)~~(7)~~. This
410 subsection does not allow an authorized insurer to issue a group
411 health insurance policy or certificate which does not comply
412 with this part.

413 Section 8. Section 627.662, Florida Statutes, is amended
414 to read:

415 627.662 Other provisions applicable.--The following
416 provisions apply to group health insurance, blanket health
417 insurance, and franchise health insurance:



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

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

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

424 (4)(3) Section 627.635, relating to excess insurance.

425 (5)(4) Section 627.638, relating to direct payment for
426 hospital or medical services.

427 (6)(5) Section 627.640, relating to filing and
428 classification of rates.

429 (7)(6) Section 627.613, relating to timely payment of
430 claims, or s. 627.6131, relating to payment of claims, whichever
431 is applicable.

432 (8)(7) Section 627.645(1), relating to denial of claims.

433 (9)(8) Section 627.6471, relating to preferred provider
434 organizations.

435 (10)(9) Section 627.6472, relating to exclusive provider
436 organizations.

437 (11)(10) Section 627.6473, relating to combined preferred
438 provider and exclusive provider policies.

439 (12)(11) Section 627.6474, relating to provider contracts.

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

442 627.667 Extension of benefits.--

443 (6) This section also applies to holders of group
444 certificates which are renewed, delivered, or issued for
445 delivery to residents of this state under group policies



446 effectuated or delivered outside this state, ~~unless a succeeding~~
447 ~~carrier under a group policy has agreed to assume liability for~~
448 ~~the benefits.~~

449 Section 10. Paragraph (e) of subsection (5) of section
450 627.6692, Florida Statutes, is amended to read:

451 627.6692 Florida Health Insurance Coverage Continuation
452 Act.--

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

454 (e)1. A covered employee or other qualified beneficiary
455 who wishes continuation of coverage must pay the initial premium
456 and elect such continuation in writing to the insurance carrier
457 issuing the employer's group health plan within 63 ~~30~~ days after
458 receiving notice from the insurance carrier under paragraph (d).
459 Subsequent premiums are due by the grace period expiration date.
460 The insurance carrier or the insurance carrier's designee shall
461 process all elections promptly and provide coverage
462 retroactively to the date coverage would otherwise have
463 terminated. The premium due shall be for the period beginning on
464 the date coverage would have otherwise terminated due to the
465 qualifying event. The first premium payment must include the
466 coverage paid to the end of the month in which the first payment
467 is made. After the election, the insurance carrier must bill the
468 qualified beneficiary for premiums once each month, with a due
469 date on the first of the month of coverage and allowing a 30-day
470 grace period for payment.

471 2. Except as otherwise specified in an election, any
472 election by a qualified beneficiary shall be deemed to include
473 an election of continuation of coverage on behalf of any other



474 qualified beneficiary residing in the same household who would
 475 lose coverage under the group health plan by reason of a
 476 qualifying event. This subparagraph does not preclude a
 477 qualified beneficiary from electing continuation of coverage on
 478 behalf of any other qualified beneficiary.

479 Section 11. Paragraphs (g), (h), (i), and (u) of
 480 subsection (3), paragraph (c) of subsection (5), paragraph (a)
 481 of subsection (9), paragraph (d) of subsection (10), and
 482 paragraphs (f), (g), (h), and (j) of subsection (11) of section
 483 627.6699, Florida Statutes, are amended to read:

484 627.6699 Employee Health Care Access Act.--

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

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

489 (h) "Eligible employee" means an employee who works full
 490 time, having a normal workweek of 25 or more hours, who is paid
 491 wages or a salary at least equal to the federal minimum hourly
 492 wage applicable to such employee, and who has met any applicable
 493 waiting-period requirements or other requirements of this act.
 494 The term includes a self-employed individual, a sole proprietor,
 495 a partner of a partnership, or an independent contractor, if the
 496 sole proprietor, partner, or independent contractor is included
 497 as an employee under a health benefit plan of a small employer,
 498 but does not include a part-time, temporary, or substitute
 499 employee.

500 (i) "Established geographic area" means the county or
 501 ~~counties, or any portion of a county or counties,~~ within which



502 the carrier provides or arranges for health care services to be
503 available to its insureds, members, or subscribers.

504 (u) "Self-employed individual" means an individual or sole
505 proprietor who derives his or her income from a trade or
506 business carried on by the individual or sole proprietor which
507 necessitates that the individual file federal income tax forms
508 with supporting schedules and accompanying income reporting
509 forms or federal income tax extensions of time to file forms
510 with the Internal Revenue Service for the most recent tax year
511 ~~results in taxable income as indicated on IRS Form 1040,~~
512 ~~schedule C or F, and which generated taxable income in one of~~
513 ~~the 2 previous years.~~

514 (5) AVAILABILITY OF COVERAGE.--

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

517 1. Beginning July 1, 2000, offer and issue all small
518 employer health benefit plans on a guaranteed-issue basis to
519 every eligible small employer, with 2 to 50 eligible employees,
520 that elects to be covered under such plan, agrees to make the
521 required premium payments, and satisfies the other provisions of
522 the plan. A rider for additional or increased benefits may be
523 medically underwritten and may only be added to the standard
524 health benefit plan. The increased rate charged for the
525 additional or increased benefit must be rated in accordance with
526 this section.

527 2. Beginning July 1, 2000, and until July 31, 2001, offer
528 and issue basic and standard small employer health benefit plans
529 on a guaranteed-issue basis to every eligible small employer



530 which is eligible for guaranteed renewal, has less than two
531 eligible employees, is not formed primarily for the purpose of
532 buying health insurance, elects to be covered under such plan,
533 agrees to make the required premium payments, and satisfies the
534 other provisions of the plan. A rider for additional or
535 increased benefits may be medically underwritten and may be
536 added only to the standard benefit plan. The increased rate
537 charged for the additional or increased benefit must be rated in
538 accordance with this section. For purposes of this subparagraph,
539 a person, his or her spouse, and his or her dependent children
540 shall constitute a single eligible employee if that person and
541 spouse are employed by the same small employer and either one
542 has a normal work week of less than 25 hours.

543 3.a. Beginning August 1, 2001, offer and issue basic and
544 standard small employer health benefit plans on a guaranteed-
545 issue basis, during a 31-day open enrollment period of August 1
546 through August 31 of each year, to every eligible small
547 employer, with fewer than two eligible employees, which small
548 employer is not formed primarily for the purpose of buying
549 health insurance and which elects to be covered under such plan,
550 agrees to make the required premium payments, and satisfies the
551 other provisions of the plan. Coverage provided under this sub-
552 subparagraph ~~subparagraph~~ shall begin on October 1 of the same
553 year as the date of enrollment, unless the small employer
554 carrier and the small employer agree to a different date. A
555 rider for additional or increased benefits may be medically
556 underwritten and may only be added to the standard health
557 benefit plan. The increased rate charged for the additional or



558 increased benefit must be rated in accordance with this section.
559 For purposes of this sub-subparagraph ~~subparagraph~~, a person,
560 his or her spouse, and his or her dependent children constitute
561 a single eligible employee if that person and spouse are
562 employed by the same small employer and either that person or
563 his or her spouse has a normal work week of less than 25 hours.

564 b. Notwithstanding the restrictions set forth in sub-
565 subparagraph a., when a small employer group is losing coverage
566 because a carrier is exercising the provisions of s.
567 627.6571(3)(b) or s. 641.31074(3)(b), the eligible small
568 employer, as defined in sub-subparagraph a., shall be entitled
569 to enroll with another carrier offering small employer coverage
570 within 63 days after the notice of termination or the
571 termination date of the prior coverage, whichever is later.
572 Coverage provided under this sub-subparagraph shall begin
573 immediately upon enrollment unless the small employer carrier
574 and the small employer agree to a different date.

575 4. This paragraph does not limit a carrier's ability to
576 offer other health benefit plans to small employers if the
577 standard and basic health benefit plans are offered and
578 rejected.

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

581 (a) A small employer carrier must elect to become either a
582 risk-assuming carrier or a reinsuring carrier. ~~Each small~~
583 ~~employer carrier must make an initial election, binding through~~
584 ~~January 1, 1994. The carrier's initial election must be made no~~
585 ~~later than October 31, 1992. By October 31, 1993, all small~~



586 ~~employer carriers must file a final election, which is binding~~
587 ~~for 2 years, from January 1, 1994, through December 31, 1995,~~
588 ~~after which an election shall be binding for a period of 5~~
589 ~~years.~~ Any carrier that is not a small employer carrier on
590 October 31, 1992, and intends to become a small employer carrier
591 after October 31, 1992, must file its designation when it files
592 the forms and rates it intends to use for small employer group
593 health insurance; such designation shall be binding indefinitely
594 or until modified or withdrawn ~~for 2 years after the date of~~
595 ~~approval of the forms and rates, and any subsequent designation~~
596 ~~is binding for 5 years.~~ The department may permit a carrier to
597 modify its election at any time for good cause shown, ~~after a~~
598 ~~hearing.~~

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

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

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

608 (f) The program has the general powers and authority
609 granted under the laws of this state to insurance companies and
610 health maintenance organizations licensed to transact business,
611 except the power to issue health benefit plans directly to
612 groups or individuals. In addition thereto, the program has
613 specific authority to:



614 1. Enter into contracts as necessary or proper to carry
615 out the provisions and purposes of this act, including the
616 authority to enter into contracts with similar programs of other
617 states for the joint performance of common functions or with
618 persons or other organizations for the performance of
619 administrative functions.

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

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

625 4. Issue reinsurance policies, in accordance with the
626 requirements of this act.

627 5. Establish rules, conditions, and procedures for
628 reinsurance risks under the program participation.

629 6. Establish actuarial functions as appropriate for the
630 operation of the program.

631 7. Assess participating carriers in accordance with
632 paragraph (j), and make advance interim assessments as may be
633 reasonable and necessary for organizational and interim
634 operating expenses. Interim assessments shall be credited as
635 offsets against any regular assessments due following the close
636 of the calendar year.

637 8. Appoint appropriate legal, actuarial, and other
638 committees as necessary to provide technical assistance in the
639 operation of the program, and in any other function within the
640 authority of the program.



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

645 10. To the extent necessary, increase the \$5,000
646 deductible reinsurance requirement to adjust for the effects of
647 inflation. The program may evaluate the desirability of
648 establishing different levels of deductibles. If different
649 levels of deductibles are established, such levels and the
650 resulting premiums shall be approved by the department.

651 (g) A reinsuring carrier may reinsure with the program
652 coverage of an eligible employee of a small employer, or any
653 dependent of such an employee, subject to each of the following
654 provisions:

655 1. With respect to a standard and basic health care plan,
656 the program may ~~must~~ reinsure the level of coverage provided;
657 and, with respect to any other plan, the program may ~~must~~
658 reinsure the coverage up to, but not exceeding, the level of
659 coverage provided under the standard and basic health care plan.
660 As an alternative to reinsuring the level of coverage provided
661 under the standard and basic health care plan, the program may
662 develop alternate levels of reinsurance designed to coordinate
663 with a reinsuring carrier's existing reinsurance. The levels of
664 reinsurance and resulting premiums must be approved by the
665 department.

666 2. Except in the case of a late enrollee, a reinsuring
667 carrier may reinsure an eligible employee or dependent within 60
668 days after the commencement of the coverage of the small



669 employer. A newly employed eligible employee or dependent of a
670 small employer may be reinsured within 60 days after the
671 commencement of his or her coverage.

672 3. A small employer carrier may reinsure an entire
673 employer group within 60 days after the commencement of the
674 group's coverage under the plan. The carrier may choose to
675 reinsure newly eligible employees and dependents of the
676 reinsured group pursuant to subparagraph 1.

677 4. The program may evaluate the option of allowing a small
678 employer carrier to reinsure an entire employer group or an
679 eligible employee at the first or subsequent renewal date. Any
680 such option and the resulting premium must be approved by the
681 department.

682 ~~5.4.~~ The program may not reimburse a participating carrier
683 with respect to the claims of a reinsured employee or dependent
684 until the carrier has paid incurred claims of an amount equal to
685 the participating carrier's selected deductible level ~~at least~~
686 \$5,000 in a calendar year for benefits covered by the program.
687 ~~In addition, the reinsuring carrier shall be responsible for 10~~
688 ~~percent of the next \$50,000 and 5 percent of the next \$100,000~~
689 ~~of incurred claims during a calendar year and the program shall~~
690 ~~reinsure the remainder.~~

691 ~~6.5.~~ The board annually shall adjust the initial level of
692 claims and the maximum limit to be retained by the carrier to
693 reflect increases in costs and utilization within the standard
694 market for health benefit plans within the state. The adjustment
695 shall not be less than the annual change in the medical
696 component of the "Consumer Price Index for All Urban Consumers"



697 of the Bureau of Labor Statistics of the Department of Labor,
698 unless the board proposes and the department approves a lower
699 adjustment factor.

700 ~~7.6.~~ A small employer carrier may terminate reinsurance
701 for all reinsured employees or dependents on any plan
702 anniversary.

703 ~~8.7.~~ The premium rate charged for reinsurance by the
704 program to a health maintenance organization that is approved by
705 the Secretary of Health and Human Services as a federally
706 qualified health maintenance organization pursuant to 42 U.S.C.
707 s. 300e(c)(2)(A) and that, as such, is subject to requirements
708 that limit the amount of risk that may be ceded to the program,
709 which requirements are more restrictive than subparagraph ~~5. 4.~~,
710 shall be reduced by an amount equal to that portion of the risk,
711 if any, which exceeds the amount set forth in subparagraph ~~5. 4.~~
712 which may not be ceded to the program.

713 ~~9.8.~~ The board may consider adjustments to the premium
714 rates charged for reinsurance by the program for carriers that
715 use effective cost containment measures, including high-cost
716 case management, as defined by the board.

717 ~~10.9.~~ A reinsuring carrier shall apply its case-management
718 and claims-handling techniques, including, but not limited to,
719 utilization review, individual case management, preferred
720 provider provisions, other managed care provisions or methods of
721 operation, consistently with both reinsured business and
722 nonreinsured business.

723 (h)1. The board, as part of the plan of operation, shall
724 establish a methodology for determining premium rates to be



725 charged by the program for reinsuring small employers and
726 individuals pursuant to this section. The methodology shall
727 include a system for classification of small employers that
728 reflects the types of case characteristics commonly used by
729 small employer carriers in the state. The methodology shall
730 provide for the development of basic reinsurance premium rates,
731 which shall be multiplied by the factors set for them in this
732 paragraph to determine the premium rates for the program. The
733 basic reinsurance premium rates shall be established by the
734 board, subject to the approval of the department, and shall be
735 set at levels which reasonably approximate gross premiums
736 charged to small employers by small employer carriers for health
737 benefit plans with benefits similar to the standard and basic
738 health benefit plan. The premium rates set by the board may vary
739 by geographical area, as determined under this section, to
740 reflect differences in cost. ~~The multiplying factors must be~~
741 ~~established as follows:~~

742 ~~a. The entire group may be reinsured for a rate that is~~
743 ~~1.5 times the rate established by the board.~~

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

746 2. The board periodically shall review the methodology
747 established, including the system of classification and any
748 rating factors, to assure that it reasonably reflects the claims
749 experience of the program. The board may propose changes to the
750 rates which shall be subject to the approval of the department.

751 (j)1. Before September ~~March~~ 1 of each calendar year, the
752 board shall determine and report to the department the program



753 net loss for the previous year, including administrative
754 expenses for that year, and the incurred losses for the year,
755 taking into account investment income and other appropriate
756 gains and losses.

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

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

773 b. The board shall equitably assess carriers for operating
774 losses of the plan based on market share. The board shall
775 annually assess each carrier a portion of the operating losses
776 of the plan. The first tier of assessments shall be determined
777 by multiplying the operating losses by a fraction, the numerator
778 of which equals the reinsuring carrier's earned premium
779 pertaining to direct writings of small employer health benefit
780 plans in the state during the calendar year for which the



781 assessment is levied, and the denominator of which equals the
782 total of all such premiums earned by reinsuring carriers in the
783 state during that calendar year. The second tier of assessments
784 shall be based on the premiums that all carriers, except risk-
785 assuming carriers, earned on all health benefit plans written in
786 this state. The board may levy interim assessments against
787 carriers to ensure the financial ability of the plan to cover
788 claims expenses and administrative expenses paid or estimated to
789 be paid in the operation of the plan for the calendar year prior
790 to the association's anticipated receipt of annual assessments
791 for that calendar year. Any interim assessment is due and
792 payable within 30 days after receipt by a carrier of the interim
793 assessment notice. Interim assessment payments shall be credited
794 against the carrier's annual assessment. Health benefit plan
795 premiums and benefits paid by a carrier that are less than an
796 amount determined by the board to justify the cost of collection
797 may not be considered for purposes of determining assessments.

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

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



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

826 5. If assessments exceed the amount of the actual losses
827 and administrative expenses of the program, the excess shall be
828 held as interest and used by the board to offset future losses
829 or to reduce program premiums. As used in this paragraph, the
830 term "future losses" includes reserves for incurred but not
831 reported claims.

832 6. Each carrier's proportion of the assessment shall be
833 determined annually by the board, based on annual statements and
834 other reports considered necessary by the board and filed by the
835 carriers with the board.



836 7. Provision shall be made in the plan of operation for
837 the imposition of an interest penalty for late payment of an
838 assessment.

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

852 Section 12. Section 627.911, Florida Statutes, is amended
853 to read:

854 627.911 Scope of this part.--Any insurer or health
855 maintenance organization transacting insurance in this state
856 shall report information as required by this part.

857 Section 13. Section 627.9175, Florida Statutes, is amended
858 to read:

859 627.9175 Reports of information on health insurance.--

860 (1) Each authorized health insurer or health maintenance
861 organization shall submit annually to the office, on or before
862 March 1 of each year, information concerning ~~department as to~~
863 ~~policies of individual~~ health insurance coverage being issued or



864 currently in force in this state. The information shall include
 865 information related to premium, number of policies, and covered
 866 lives for such policies and other information necessary to
 867 analyze trends in enrollment, premiums, and claim costs.

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

870 (a) Health insurance issuer, company, contact person, or
 871 agent.

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

- 874 1. Direct premiums earned.
- 875 2. Direct losses incurred.
- 876 3. Direct premiums earned for new business issued during
 877 the year.
- 878 4. Number of policies.
- 879 5. Number of certificates.
- 880 6. Number of total covered lives.

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

- 885 ~~1. The deductible amount;~~
- 886 ~~2. The coinsurance percentage;~~
- 887 ~~3. The out-of-pocket maximum;~~
- 888 ~~4. Outpatient benefits;~~
- 889 ~~5. Inpatient benefits; and~~
- 890 ~~6. Any exclusions for preexisting conditions.~~

891



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

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

899
900 ~~The department shall provide by rule a uniform format for the~~
901 ~~submission of this information in order to allow for meaningful~~
902 ~~comparisons of premiums charged for comparable benefits.~~

903 (3) The department may adopt rules to administer this
904 section, including, but not limited to, rules governing
905 compliance and provisions implementing electronic methodologies
906 for use in furnishing such records or documents. The commission
907 may by rule specify a uniform format for the submission of this
908 information in order to allow for meaningful comparisons shall
909 ~~publish annually a consumer's guide which summarizes and~~
910 ~~compares the information required to be reported under this~~
911 ~~subsection.~~

912 ~~(2)(a) Every insurer transacting health insurance in this~~
913 ~~state shall report annually to the department, not later than~~
914 ~~April 1, information relating to any measure the insurer has~~
915 ~~implemented or proposes to implement during the next calendar~~
916 ~~year for the purpose of containing health insurance costs or~~
917 ~~cost increases. The reports shall identify each measure and the~~
918 ~~forms to which the measure is applied, shall provide an~~



919 ~~explanation as to how the measure is used, and shall provide an~~
920 ~~estimate of the cost effect of the measure.~~

921 ~~(b) The department shall promulgate forms to be used by~~
922 ~~insurers in reporting information pursuant to this subsection~~
923 ~~and shall utilize such forms to analyze the effects of health~~
924 ~~care cost containment programs used by health insurers in this~~
925 ~~state.~~

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

930 Section 14. Section 627.9403, Florida Statutes, is amended
931 to read:

932 627.9403 Scope.--The provisions of this part shall apply
933 to long-term care insurance policies delivered or issued for
934 delivery in this state, and to policies delivered or issued for
935 delivery outside this state to the extent provided in s.
936 627.9406, by an insurer, a fraternal benefit society as defined
937 in s. 632.601, a health maintenance organization as defined in
938 s. 641.19, a prepaid health clinic as defined in s. 641.402, or
939 a multiple-employer welfare arrangement as defined in s.
940 624.437. A policy which is advertised, marketed, or offered as a
941 long-term care policy and as a Medicare supplement policy shall
942 meet the requirements of this part and the requirements of ss.
943 627.671-627.675 and, to the extent of a conflict, be subject to
944 the requirement that is more favorable to the policyholder or
945 certificateholder. The provisions of this part shall not apply
946 to a continuing care contract issued pursuant to chapter 651 and



947 shall not apply to guaranteed renewable policies issued prior to
948 October 1, 1988. Any limited benefit policy that limits coverage
949 to care in a nursing home or to one or more lower levels of care
950 required or authorized to be provided by this part or by
951 department rule must meet all requirements of this part that
952 apply to long-term care insurance policies, except ss.
953 627.9407(3)(c) and (d), (9), (10)(f), and (12) and 627.94073(2).
954 ~~If the limited benefit policy does not provide coverage for care~~
955 ~~in a nursing home, but does provide coverage for one or more~~
956 ~~lower levels of care, the policy shall also be exempt from the~~
957 ~~requirements of s. 627.9407(3)(d).~~

958 Section 15. Paragraph (b) of subsection (1) of section
959 641.185, Florida Statutes, is amended to read:

960 641.185 Health maintenance organization subscriber
961 protections.--

962 (1) With respect to the provisions of this part and part
963 III, the principles expressed in the following statements shall
964 serve as standards to be followed by the Department of Insurance
965 and the Agency for Health Care Administration in exercising
966 their powers and duties, in exercising administrative
967 discretion, in administrative interpretations of the law, in
968 enforcing its provisions, and in adopting rules:

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



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

977 641.31 Health maintenance contracts.--

978 (3)

979 (d) Any change in rates charged for the contract must be
 980 filed with the department not less than 30 days in advance of
 981 the effective date. At the expiration of such 30 days, the rate
 982 filing shall be deemed approved unless prior to such time the
 983 filing has been affirmatively approved or disapproved by order
 984 of the department. The approval of the filing by the department
 985 constitutes a waiver of any unexpired portion of such waiting
 986 period. The department may extend by not more than an additional
 987 15 days the period within which it may so affirmatively approve
 988 or disapprove any such filing, by giving notice of such
 989 extension before expiration of the initial 30-day period. At the
 990 expiration of any such period as so extended, and in the absence
 991 of such prior affirmative approval or disapproval, any such
 992 filing shall be deemed approved. This paragraph does not apply
 993 to group health maintenance organization contracts effectuated
 994 and delivered in this state insuring groups of 51 or more
 995 persons.

996 (9)(a)1. If a health maintenance organization offers
 997 coverage for dependent children of the subscriber, the contract
 998 must cover a dependent child of the subscriber at least until
 999 the end of the calendar year in which the child reaches the age
 1000 of 23, if the child meets all of the following:

1001 a. The child is dependent upon the subscriber for support.



1002 b. The child is living in the household of the subscriber,
1003 or the child is a full-time or part-time student.

1004 2. Nothing in this paragraph affects or preempts a health
1005 maintenance organization's right to medically underwrite or
1006 charge the appropriate premium.

1007 (b)1. A contract that provides coverage for a family
1008 member of the subscriber shall, as to such family member's
1009 coverage, provide that benefits applicable to children of the
1010 subscriber also apply to an adopted child or a foster child of
1011 the subscriber placed in compliance with chapter 63 from the
1012 moment of placement in the residence of the subscriber. Except
1013 in the case of a foster child, the contract may not exclude
1014 coverage for any preexisting condition of the child. In the case
1015 of a newborn child, coverage begins at the moment of birth if a
1016 written agreement to adopt such child has been entered into by
1017 the subscriber prior to the birth of the child, whether or not
1018 the agreement is enforceable. This section does not require
1019 coverage for an adopted child who is not ultimately placed in
1020 the residence of the subscriber in compliance with chapter 63.

1021 2. A contract may require the subscriber to notify the
1022 health maintenance organization of the birth or placement of an
1023 adopted child within a specified time period of not less than 30
1024 days after the birth or placement in the residence of a child
1025 adopted by the subscriber. If timely notice is given, the health
1026 maintenance organization may not charge an additional premium
1027 for coverage of the child for the duration of the notice period.
1028 If timely notice is not given, the health maintenance
1029 organization may charge an additional premium from the date of



1030 birth or placement. If notice is given within 60 days after the
1031 birth or placement of the child, the health maintenance
1032 organization may not deny coverage for the child due to the
1033 failure of the subscriber to timely notify the health
1034 maintenance organization of the birth or placement of the child.

1035 3. If the contract does not require the subscriber to
1036 notify the health maintenance organization of the birth or
1037 placement of an adopted child within a specified time period,
1038 the health maintenance organization may not deny coverage for
1039 such child or retroactively charge the subscriber an additional
1040 premium for such child. However, the health maintenance
1041 organization may prospectively charge the subscriber an
1042 additional premium for the child if the health maintenance
1043 organization provides at least 45 days' notice of the additional
1044 premium required.

1045 4. In order to increase access to postnatal, infant, and
1046 pediatric health care for all children placed in court-ordered
1047 custody, including foster children, all health maintenance
1048 organization contracts that provide coverage for a family member
1049 of the subscriber shall, as to such family member's coverage,
1050 provide that benefits applicable for children shall be payable
1051 with respect to a foster child or other child in court-ordered,
1052 temporary, or other custody of the subscriber.

1053 (10) A contract that provides that coverage of a dependent
1054 child shall terminate upon attainment of the limiting age for
1055 dependent children specified in the contract shall also provide
1056 in substance that attainment of the limiting age does not



1057 terminate the coverage of the child while the child continues to
 1058 be:

1059 (a) Incapable of self-sustaining employment by reason of
 1060 mental retardation or physical handicap.

1061 (b) Chiefly dependent upon the subscriber for support and
 1062 maintenance.

1063
 1064 If a claim is denied under a contract for the stated reason that
 1065 the child has attained the limiting age for dependent children
 1066 specified in the contract, the notice of denial must state that
 1067 the subscriber has the burden of establishing that the child
 1068 continues to meet the criteria specified in paragraphs (a) and
 1069 (b). All health maintenance contracts that provide coverage,
 1070 benefits, or services for a member of the family of the
 1071 subscriber must, as to such family member's coverage, benefits,
 1072 or services, provide also that the coverage, benefits, or
 1073 services applicable for children must be provided with respect
 1074 to a newborn child of the subscriber, or covered family member
 1075 of the subscriber, from the moment of birth. However, with
 1076 respect to a newborn child of a covered family member other than
 1077 the spouse of the insured or subscriber, the coverage for the
 1078 newborn child terminates 18 months after the birth of the
 1079 newborn child. The coverage, benefits, or services for newborn
 1080 children must consist of coverage for injury or sickness,
 1081 including the necessary care or treatment of medically diagnosed
 1082 congenital defects, birth abnormalities, or prematurity, and
 1083 transportation costs of the newborn to and from the nearest
 1084 appropriate facility appropriately staffed and equipped to treat



1085 ~~the newborn's condition, when such transportation is certified~~
1086 ~~by the attending physician as medically necessary to protect the~~
1087 ~~health and safety of the newborn child.~~

1088 ~~(a) A contract may require the subscriber to notify the~~
1089 ~~plan of the birth of a child within a time period, as specified~~
1090 ~~in the contract, of not less than 30 days after the birth, or a~~
1091 ~~contract may require the preenrollment of a newborn prior to~~
1092 ~~birth. However, if timely notice is given, a plan may not charge~~
1093 ~~an additional premium for additional coverage of the newborn~~
1094 ~~child for not less than 30 days after the birth of the child. If~~
1095 ~~timely notice is not given, the plan may charge an additional~~
1096 ~~premium from the date of birth. If notice is given within 60~~
1097 ~~days of the birth of the child, the contract may not deny~~
1098 ~~coverage of the child due to failure of the subscriber to timely~~
1099 ~~notify the plan of the birth of the child or to preenroll the~~
1100 ~~child.~~

1101 ~~(b) If the contract does not require the subscriber to~~
1102 ~~notify the plan of the birth of a child within a specified time~~
1103 ~~period, the plan may not deny coverage of the child nor may it~~
1104 ~~retroactively charge the subscriber an additional premium for~~
1105 ~~the child; however, the contract may prospectively charge the~~
1106 ~~member an additional premium for the child if the plan provides~~
1107 ~~at least 45 days' notice of the additional charge.~~

1108 (11)~~(10)~~ No alteration of any written application for any
1109 health maintenance contract shall be made by any person other
1110 than the applicant without his or her written consent, except
1111 that insertions may be made by the health maintenance
1112 organization, for administrative purposes only, in such manner



1113 as to indicate clearly that such insertions are not to be
1114 ascribed to the applicant.

1115 (12)~~(11)~~ No contract shall contain any waiver of rights or
1116 benefits provided to or available to subscribers under the
1117 provisions of any law or rule applicable to health maintenance
1118 organizations.

1119 (13)~~(12)~~ Each health maintenance contract, certificate, or
1120 member handbook shall state that emergency services and care
1121 shall be provided to subscribers in emergency situations not
1122 permitting treatment through the health maintenance
1123 organization's providers, without prior notification to and
1124 approval of the organization. Not less than 75 percent of the
1125 reasonable charges for covered services and supplies shall be
1126 paid by the organization, up to the subscriber contract benefit
1127 limits. Payment also may be subject to additional applicable
1128 copayment provisions, not to exceed \$100 per claim. The health
1129 maintenance contract, certificate, or member handbook shall
1130 contain the definitions of "emergency services and care" and
1131 "emergency medical condition" as specified in s. 641.19(7) and
1132 (8), shall describe procedures for determination by the health
1133 maintenance organization of whether the services qualify for
1134 reimbursement as emergency services and care, and shall contain
1135 specific examples of what does constitute an emergency. In
1136 providing for emergency services and care as a covered service,
1137 a health maintenance organization shall be governed by s.
1138 641.513.

1139 (14)~~(13)~~ In addition to the requirements of this section,
1140 with respect to a person who is entitled to have payments for



1141 health care costs made under Medicare, Title XVIII of the Social
1142 Security Act ("Medicare"), parts A and/or B:

1143 (a) The health maintenance organization shall mail or
1144 deliver notification to the Medicare beneficiary of the date of
1145 enrollment in the health maintenance organization within 10 days
1146 after receiving notification of enrollment approval from the
1147 United States Department of Health and Human Services, Health
1148 Care Financing Administration. When a Medicare beneficiary who
1149 is a subscriber of the health maintenance organization requests
1150 disenrollment from the organization, the organization shall mail
1151 or deliver to the beneficiary notice of the effective date of
1152 the disenrollment within 10 days after receipt of the written
1153 disenrollment request. The health maintenance organization shall
1154 forward the disenrollment request to the United States
1155 Department of Health and Human Services, Health Care Financing
1156 Administration, in a timely manner so as to effectuate the next
1157 available disenrollment date, as prescribed by such federal
1158 agency.

1159 (b) The health maintenance contract, certificate, or
1160 member handbook shall be delivered to the subscriber no later
1161 than the earlier of 10 working days after the health maintenance
1162 organization and the Health Care Financing Administration of the
1163 United States Department of Health and Human Services approve
1164 the subscriber's enrollment application or the effective date of
1165 coverage of the subscriber under the health maintenance
1166 contract. However, if notice from the Health Care Financing
1167 Administration of its approval of the subscriber's enrollment
1168 application is received by the health maintenance organization



1169 after the effective coverage date prescribed by the Health Care
1170 Financing Administration, the health maintenance organization
1171 shall deliver the contract, certificate, or member handbook to
1172 the subscriber within 10 days after receiving such notice. When
1173 a Medicare recipient is enrolled in a health maintenance
1174 organization program, the contract, certificate, or member
1175 handbook shall be accompanied by a health maintenance
1176 organization identification sticker with instruction to the
1177 Medicare beneficiary to place the sticker on the Medicare
1178 identification card.

1179 (15)~~(14)~~ Whenever a subscriber of a health maintenance
1180 organization is also a Medicaid recipient, the health
1181 maintenance organization's coverage shall be primary to the
1182 recipient's Medicaid benefits and the organization shall be a
1183 third party subject to the provisions of s. 409.910(4).

1184 (16)~~(15)~~(a) All health maintenance contracts,
1185 certificates, and member handbooks shall contain the following
1186 provision:

1187
1188 "Grace Period: This contract has a (insert a number not less
1189 than 10) day grace period. This provision means that if any
1190 required premium is not paid on or before the date it is due, it
1191 may be paid during the following grace period. During the grace
1192 period, the contract will stay in force."

1193
1194 (b) The required provision of paragraph (a) shall not
1195 apply to certificates or member handbooks delivered to
1196 individual subscribers under a group health maintenance contract



1197 when the employer or other person who will hold the contract on
1198 behalf of the subscriber group pays the entire premium for the
1199 individual subscribers. However, such required provision shall
1200 apply to the group health maintenance contract.

1201 (17)~~(16)~~ The contracts must clearly disclose the intent of
1202 the health maintenance organization as to the applicability or
1203 nonapplicability of coverage to preexisting conditions. If
1204 coverage of the contract is not to be applicable to preexisting
1205 conditions, the contract shall specify, in substance, that
1206 coverage pertains solely to accidental bodily injuries resulting
1207 from accidents occurring after the effective date of coverage
1208 and that sicknesses are limited to those which first manifest
1209 themselves subsequent to the effective date of coverage.

1210 ~~(17) All health maintenance contracts that provide~~
1211 ~~coverage for a member of the family of the subscriber, shall, as~~
1212 ~~to such family member's coverage, provide that coverage,~~
1213 ~~benefits, or services applicable for children shall be provided~~
1214 ~~with respect to an adopted child of the subscriber, which child~~
1215 ~~is placed in compliance with chapter 63, from the moment of~~
1216 ~~placement in the residence of the subscriber. Such contracts may~~
1217 ~~not exclude coverage for any preexisting condition of the child.~~
1218 ~~In the case of a newborn child, coverage shall begin from the~~
1219 ~~moment of birth if a written agreement to adopt such child has~~
1220 ~~been entered into by the subscriber prior to the birth of the~~
1221 ~~child, whether or not such agreement is enforceable. However,~~
1222 ~~coverage for such child shall not be required in the event that~~
1223 ~~the child is not ultimately placed in the residence of the~~
1224 ~~subscriber in compliance with chapter 63.~~



1225 Section 17. Section 641.31025, Florida Statutes, is
 1226 created to read:

1227 641.31025 Specific reasons for denial of coverage.--The
 1228 denial of an application for a health maintenance organization
 1229 contract must be accompanied by the specific reasons for the
 1230 denial, including, but not limited to, the specific underwriting
 1231 reasons, if applicable.

1232 Section 18. Section 641.31075, Florida Statutes, is
 1233 created to read:

1234 641.31075 Replacement.--Any health maintenance
 1235 organization that is replacing any other group health coverage
 1236 with its group health maintenance coverage shall comply with s.
 1237 627.666.

1238 Section 19. Subsections (1) and (3) of section 641.3111,
 1239 Florida Statutes, are amended to read:

1240 641.3111 Extension of benefits.--

1241 (1) Every group health maintenance contract shall provide
 1242 that termination of the contract shall be without prejudice to
 1243 any continuous loss which commenced while the contract was in
 1244 force, but any extension of benefits beyond the period the
 1245 contract was in force may be predicated upon the continuous
 1246 total disability of the subscriber ~~and may be limited to payment~~
 1247 ~~for the treatment of a specific accident or illness incurred~~
 1248 ~~while the subscriber was a member.~~ The extension is required
 1249 regardless of whether the group contract holder or other entity
 1250 secures replacement coverage from a new insurer or health
 1251 maintenance organization or foregoes the provision of coverage.
 1252 The required provision must provide for continuation of contract



1253 benefits in connection with the treatment of a specific accident
 1254 or illness incurred while the contract was in effect. Such
 1255 extension of benefits may be limited to the occurrence of the
 1256 earliest of the following events:

- 1257 (a) The expiration of 12 months.
- 1258 (b) Such time as the member is no longer totally disabled.
- 1259 ~~(c) A succeeding carrier elects to provide replacement~~
 1260 ~~coverage without limitation as to the disability condition.~~
- 1261 (c)(d) The maximum benefits payable under the contract
 1262 have been paid.

1263 (3) In the case of maternity coverage, ~~when not covered by~~
 1264 ~~the succeeding carrier,~~ a reasonable extension of benefits or
 1265 accrued liability provision is required, which provision
 1266 provides for continuation of the contract benefits in connection
 1267 with maternity expenses for a pregnancy that commenced while the
 1268 policy was in effect. The extension shall be for the period of
 1269 that pregnancy and shall not be based upon total disability.

1270 Section 20. Subsection (4) of section 627.651, Florida
 1271 Statutes, is amended to read:

1272 627.651 Group contracts and plans of self-insurance must
 1273 meet group requirements.--

1274 (4) This section does not apply to any plan which is
 1275 established or maintained by an individual employer in
 1276 accordance with the Employee Retirement Income Security Act of
 1277 1974, Pub. L. No. 93-406, or to a multiple-employer welfare
 1278 arrangement as defined in s. 624.437(1), except that a multiple-
 1279 employer welfare arrangement shall comply with ss. 627.419,
 1280 627.657, 627.6575, 627.6578, 627.6579, 627.6612, 627.66121,



1281 627.66122, 627.6615, 627.6616, and 627.662(8)~~(7)~~. This
 1282 subsection does not allow an authorized insurer to issue a group
 1283 health insurance policy or certificate which does not comply
 1284 with this part.

1285 Section 21. Subsection (1) of section 641.2018, Florida
 1286 Statutes, is amended to read:

1287 641.2018 Limited coverage for home health care
 1288 authorized.--

1289 (1) Notwithstanding other provisions of this chapter, a
 1290 health maintenance organization may issue a contract that limits
 1291 coverage to home health care services only. The organization and
 1292 the contract shall be subject to all of the requirements of this
 1293 part that do not require or otherwise apply to specific benefits
 1294 other than home care services. To this extent, all of the
 1295 requirements of this part apply to any organization or contract
 1296 that limits coverage to home care services, except the
 1297 requirements for providing comprehensive health care services as
 1298 provided in ss. 641.19(4), (12), and (13), and 641.31(1), except
 1299 ss. 641.31~~(9)~~, (13)~~(12)~~, ~~(17)~~, (18), (19), (20), (21), and (24)
 1300 and 641.31095.

1301 Section 22. Section 641.3107, Florida Statutes, is amended
 1302 to read:

1303 641.3107 Delivery of contract.--Unless delivered upon
 1304 execution or issuance, a health maintenance contract,
 1305 certificate of coverage, or member handbook shall be mailed or
 1306 delivered to the subscriber or, in the case of a group health
 1307 maintenance contract, to the employer or other person who will
 1308 hold the contract on behalf of the subscriber group within 10



1309 working days from approval of the enrollment form by the health
 1310 maintenance organization or by the effective date of coverage,
 1311 whichever occurs first. However, if the employer or other person
 1312 who will hold the contract on behalf of the subscriber group
 1313 requires retroactive enrollment of a subscriber, the
 1314 organization shall deliver the contract, certificate, or member
 1315 handbook to the subscriber within 10 days after receiving notice
 1316 from the employer of the retroactive enrollment. This section
 1317 does not apply to the delivery of those contracts specified in
 1318 s. 641.31(14)~~(13)~~.

1319 Section 23. Subsection (4) of section 641.513, Florida
 1320 Statutes, is amended to read:

1321 641.513 Requirements for providing emergency services and
 1322 care.--

1323 (4) A subscriber may be charged a reasonable copayment, as
 1324 provided in s. 641.31(13)~~(12)~~, for the use of an emergency room.

1325 Section 24. This act shall take effect upon becoming a
 1326 law.