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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  
4 plans to limit coverage under certain circumstances;  
5 authorizing a small business purchasing arrangement to  
6 limit enrollment to certain residents; extending an  
7 expiration date; creating s. 627.6042, F.S.; requiring  
8 policies of insurers offering coverage of dependent  
9 children to maintain such coverage until a child reaches  
10 age 25, under certain circumstances; providing  
11 application; creating s. 627.60425, F.S.; providing  
12 limitations on certain binding arbitration requirements;  
13 amending s. 627.6044, F.S.; providing for payment of  
14 claims to nonnetwork providers under specified  
15 conditions; providing a definition; requiring the method  
16 used for determining payment of claims to be included in  
17 filings; providing for disclosure; amending s. 627.6415,  
18 F.S.; deleting an 18th birthday age limitation on  
19 application of certain dependent coverage requirements;  
20 amending s. 627.6475, F.S.; revising risk-assuming  
21 carrier election requirements and procedures; revising  
22 certain criteria and limitations under the individual  
23 health reinsurance program; amending s. 627.651, F.S.;  
24 correcting a cross reference; amending s. 627.662, F.S.;  
25 revising a list of provisions applicable to group,  
26 blanket, or franchise health insurance to include use of  
27 specific methodology for payment of claims provisions;  
28 amending s. 627.667, F.S.; deleting a limitation on  
29 application of certain extension of benefits provisions;  
30 amending s. 627.6692, F.S.; increasing a time period for



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31 payment of premium to continue coverage under a group  
 32 health plan; amending s. 627.6699, F.S.; revising  
 33 definitions; revising coverage enrollment eligibility  
 34 criteria for small employers; revising small employer  
 35 carrier election requirements and procedures; revising  
 36 certain criteria and limitations under the small employer  
 37 health reinsurance program; amending ss. 627.911 and  
 38 627.9175, F.S.; applying certain information reporting  
 39 requirements to health maintenance organizations;  
 40 revising health insurance information requirements and  
 41 criteria; authorizing the department to adopt rules;  
 42 deleting an annual report requirement; amending s.  
 43 627.9403, F.S.; deleting an exemption for limited benefit  
 44 policies from a long-term care insurance restriction  
 45 relating to nursing home care; amending s. 641.185, F.S.;  
 46 correcting a cross reference; amending s. 641.31, F.S.;  
 47 specifying nonapplication to certain contracts; requiring  
 48 health maintenance organizations offering coverage of  
 49 dependent children to maintain such coverage until a  
 50 child reaches age 25, under certain circumstances;  
 51 providing application; providing requirements for  
 52 contract termination and denial of a claim related to  
 53 limiting age attainment; creating s. 641.31025, F.S.;  
 54 requiring specific reasons for denial of coverage under a  
 55 health maintenance organization contract; creating s.  
 56 641.31075, F.S.; imposing compliance requirements upon  
 57 health maintenance organization replacements of other  
 58 group health coverage with organization coverage;  
 59 amending s. 641.3111, F.S.; deleting a limitation on  
 60 certain extension of benefits provisions upon group



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61 health maintenance contract termination; imposing  
62 additional extension of benefits requirements upon such  
63 termination; amending ss. 641.2018, 641.3107, and  
64 641.513, F.S.; correcting cross references; providing for  
65 construction of the act in pari materia with laws enacted  
66 during the 2003 Regular Session of the Legislature;  
67 providing an effective date.

68

69 Be It Enacted by the Legislature of the State of Florida:

70

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

74 408.909 Health flex plans.--

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

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

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



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91 combination of those actions.

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

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

99 1. Contain any ambiguous, inconsistent, or misleading  
100 provisions or any exceptions or conditions that deceptively  
101 affect or limit the benefits purported to be assumed in the  
102 general coverage provided by the health flex plan;

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

108 3. Cannot demonstrate that the health flex plan is  
109 financially sound and that the applicant is able to underwrite  
110 or finance the health care coverage provided.

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

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

115 (c) Are not covered by a private insurance policy and are  
116 not eligible for coverage through a public health insurance  
117 program, such as Medicare or Medicaid, or another public health  
118 care program, such as KidCare, and have not been covered at any  
119 time during the past 6 months, except that a small business  
120 purchasing arrangement sponsored by a local government may limit



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121 enrollment to residents of this state who have not been covered  
 122 at any time during the past 12 months; and

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

124 Section 2. Section 627.6042, Florida Statutes, is created  
 125 to read:

126 627.6042 Dependent coverage.--

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

133 (a) The child is dependent upon the policyholder or  
 134 certificateholder for support.

135 (b) The child is living in the household of the  
 136 policyholder or certificateholder or the child is a full-time or  
 137 part-time student.

138 (2) Nothing in this section affects or preempts an  
 139 insurer's right to medically underwrite or charge the  
 140 appropriate premium.

141 Section 3. Section 627.60425, Florida Statutes, is created  
 142 to read:

143 627.60425 Binding arbitration requirement  
 144 limitations.--Notwithstanding any other provision of law, except  
 145 s. 624.155, an individual, blanket, group life, or group health  
 146 insurance policy; individual or group health maintenance  
 147 organization subscriber contract; prepaid limited health  
 148 organization subscriber contract; or any life or health  
 149 insurance policy or certificate delivered or issued for  
 150 delivery, including out-of-state group plans pursuant to s.



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151 627.5515 or s. 627.6515 covering residents of this state, to any  
 152 resident of this state shall not require the submission of  
 153 disputes between the parties to the policy, contract, or plan to  
 154 binding arbitration unless the applicant has indicated that the  
 155 same policy, contract, or plan was offered and rejected without  
 156 arbitration and that the binding arbitration provision was fully  
 157 explained to the applicant and willingly accepted.

158 Section 4. Section 627.6044, Florida Statutes, is amended  
 159 to read:

160 627.6044 Use of a specific methodology for payment of  
 161 claims.--

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

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

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

177  
 178 For purposes of this subsection, the term "network providers"  
 179 means those providers for which an insured will not be  
 180 responsible for any balance payment for services provided by



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181 such provider, excluding deductible, coinsurance, and copay  
182 amounts based on a specific methodology, including, but not  
183 limited to, usual and customary charges, reasonable and  
184 customary charges, or charges based upon the prevailing rate in  
185 the community, shall specify the formula or criteria used by the  
186 insurer in determining the amount to be paid.

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

202 (3) The method used for determining the payment of claims  
203 shall be included in filings made pursuant to s. 627.410(6) and  
204 may not be changed unless such change is filed under s.  
205 627.410(6).

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



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211 the insured.

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

214 627.6415 Coverage for natural-born, adopted, and foster  
215 children; children in insured's custodial care.--

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

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

240 Section 6. Paragraph (a) of subsection (5), paragraph (c)





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241 of subsection (6), and paragraphs (b), (c), and (e) of  
 242 subsection (7) of section 627.6475, Florida Statutes, are  
 243 amended to read:

244 627.6475 Individual reinsurance pool.--

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

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

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

259 (c) The department shall provide public notice of an  
 260 issuer's filing a designation of election under this subsection  
 261 to become a risk-assuming carrier and shall provide at least a  
 262 21-day period for public comment upon receipt of such filing  
 263 ~~prior to making a decision on the election. The department shall~~  
 264 ~~hold a hearing on the election at the request of the issuer.~~

265 (7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.--

266 (b) A reinsuring carrier may reinsure with the program  
 267 coverage of an eligible individual, subject to each of the  
 268 following provisions:

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



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271 of the eligible individual.

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

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

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

292 5. The premium rate charged for reinsurance by the program  
293 to a health maintenance organization that is approved by the  
294 Secretary of Health and Human Services as a federally qualified  
295 health maintenance organization pursuant to 42 U.S.C. s.  
296 300e(c)(2)(A) and that, as such, is subject to requirements that  
297 limit the amount of risk that may be ceded to the program, which  
298 requirements are more restrictive than subparagraph 2., shall be  
299 reduced by an amount equal to that portion of the risk, if any,  
300 which exceeds the amount set forth in subparagraph 2., which may



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301 not be ceded to the program.

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

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

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

330 2. The board shall periodically review the methodology



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331 established, including the system of classification and any  
332 rating factors, to ensure that it reasonably reflects the claims  
333 experience of the program. The board may propose changes to the  
334 rates that are subject to the approval of the department.

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

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

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

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

357 c. The board shall equitably assess reinsuring carriers  
358 for operating losses of the individual account based on market  
359 share. The board shall annually assess each carrier a portion of  
360 the operating losses of the individual account. The first tier



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

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

390 3. Before September ~~March~~ 1 of each year, the board shall



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391 determine and file with the department an estimate of the  
 392 assessments needed to fund the losses incurred by the program in  
 393 the individual account for the previous calendar year.

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

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

404 627.651 Group contracts and plans of self-insurance must  
 405 meet group requirements.--

406 (4) This section does not apply to any plan which is  
 407 established or maintained by an individual employer in  
 408 accordance with the Employee Retirement Income Security Act of  
 409 1974, Pub. L. No. 93-406, or to a multiple-employer welfare  
 410 arrangement as defined in s. 624.437(1), except that a multiple-  
 411 employer welfare arrangement shall comply with ss. 627.419,  
 412 627.657, 627.6575, 627.6578, 627.6579, 627.6612, 627.66121,  
 413 627.66122, 627.6615, 627.6616, and 627.662(8)~~(7)~~. This  
 414 subsection does not allow an authorized insurer to issue a group  
 415 health insurance policy or certificate which does not comply  
 416 with this part.

417 Section 8. Section 627.662, Florida Statutes, is amended  
 418 to read:

419 627.662 Other provisions applicable.--The following  
 420 provisions apply to group health insurance, blanket health



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421 insurance, and franchise health insurance:

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

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

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

428 (4)~~(3)~~ Section 627.635, relating to excess insurance.

429 (5)~~(4)~~ Section 627.638, relating to direct payment for  
430 hospital or medical services.

431 (6)~~(5)~~ Section 627.640, relating to filing and  
432 classification of rates.

433 (7)~~(6)~~ Section 627.613, relating to timely payment of  
434 claims, or s. 627.6131, relating to payment of claims, whichever  
435 is applicable.

436 (8)~~(7)~~ Section 627.645(1), relating to denial of claims.

437 (9)~~(8)~~ Section 627.6471, relating to preferred provider  
438 organizations.

439 (10)~~(9)~~ Section 627.6472, relating to exclusive provider  
440 organizations.

441 (11)~~(10)~~ Section 627.6473, relating to combined preferred  
442 provider and exclusive provider policies.

443 (12)~~(11)~~ Section 627.6474, relating to provider contracts.

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

446 627.667 Extension of benefits.--

447 (6) This section also applies to holders of group  
448 certificates which are renewed, delivered, or issued for  
449 delivery to residents of this state under group policies  
450 effectuated or delivered outside this state, ~~unless a succeeding~~



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451 ~~carrier under a group policy has agreed to assume liability for~~  
452 ~~the benefits.~~

453 Section 10. Paragraph (e) of subsection (5) of section  
454 627.6692, Florida Statutes, is amended to read:

455 627.6692 Florida Health Insurance Coverage Continuation  
456 Act.--

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

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

475 2. Except as otherwise specified in an election, any  
476 election by a qualified beneficiary shall be deemed to include  
477 an election of continuation of coverage on behalf of any other  
478 qualified beneficiary residing in the same household who would  
479 lose coverage under the group health plan by reason of a  
480 qualifying event. This subparagraph does not preclude a





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481 qualified beneficiary from electing continuation of coverage on  
482 behalf of any other qualified beneficiary.

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

488 627.6699 Employee Health Care Access Act.--

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

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

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

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

508 (u) "Self-employed individual" means an individual or sole  
509 proprietor who derives his or her income from a trade or  
510 business carried on by the individual or sole proprietor which



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511 necessitates that the individual file federal income tax forms  
512 with supporting schedules and accompanying income reporting  
513 forms or federal income tax extensions of time to file forms  
514 with the Internal Revenue Service for the most recent tax year  
515 ~~results in taxable income as indicated on IRS Form 1040,~~  
516 ~~schedule C or F, and which generated taxable income in one of~~  
517 ~~the 2 previous years.~~

518 (5) AVAILABILITY OF COVERAGE.--

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

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

531 2. Beginning July 1, 2000, and until July 31, 2001, offer  
532 and issue basic and standard small employer health benefit plans  
533 on a guaranteed-issue basis to every eligible small employer  
534 which is eligible for guaranteed renewal, has less than two  
535 eligible employees, is not formed primarily for the purpose of  
536 buying health insurance, elects to be covered under such plan,  
537 agrees to make the required premium payments, and satisfies the  
538 other provisions of the plan. A rider for additional or  
539 increased benefits may be medically underwritten and may be  
540 added only to the standard benefit plan. The increased rate



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541 charged for the additional or increased benefit must be rated in  
 542 accordance with this section. For purposes of this subparagraph,  
 543 a person, his or her spouse, and his or her dependent children  
 544 shall constitute a single eligible employee if that person and  
 545 spouse are employed by the same small employer and either one  
 546 has a normal work week of less than 25 hours.

547 3.a. Beginning August 1, 2001, offer and issue basic and  
 548 standard small employer health benefit plans on a guaranteed-  
 549 issue basis, during a 31-day open enrollment period of August 1  
 550 through August 31 of each year, to every eligible small  
 551 employer, with fewer than two eligible employees, which small  
 552 employer is not formed primarily for the purpose of buying  
 553 health insurance and which elects to be covered under such plan,  
 554 agrees to make the required premium payments, and satisfies the  
 555 other provisions of the plan. Coverage provided under this sub-  
 556 subparagraph ~~subparagraph~~ shall begin on October 1 of the same  
 557 year as the date of enrollment, unless the small employer  
 558 carrier and the small employer agree to a different date. A  
 559 rider for additional or increased benefits may be medically  
 560 underwritten and may only be added to the standard health  
 561 benefit plan. The increased rate charged for the additional or  
 562 increased benefit must be rated in accordance with this section.  
 563 For purposes of this sub-subparagraph ~~subparagraph~~, a person,  
 564 his or her spouse, and his or her dependent children constitute  
 565 a single eligible employee if that person and spouse are  
 566 employed by the same small employer and either that person or  
 567 his or her spouse has a normal work week of less than 25 hours.

568 b. Notwithstanding the restrictions set forth in sub-  
 569 subparagraph a., when a small employer group is losing coverage  
 570 because a carrier is exercising the provisions of s.



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571 627.6571(3)(b) or s. 641.31074(3)(b), the eligible small  
 572 employer, as defined in sub-subparagraph a., shall be entitled  
 573 to enroll with another carrier offering small employer coverage  
 574 within 63 days after the notice of termination or the  
 575 termination date of the prior coverage, whichever is later.  
 576 Coverage provided under this sub-subparagraph shall begin  
 577 immediately upon enrollment unless the small employer carrier  
 578 and the small employer agree to a different date.

579 4. This paragraph does not limit a carrier's ability to  
 580 offer other health benefit plans to small employers if the  
 581 standard and basic health benefit plans are offered and  
 582 rejected.

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

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



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601 modify its election at any time for good cause shown,~~after a~~  
602 ~~hearing.~~

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

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

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

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

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

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

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

629 4. Issue reinsurance policies, in accordance with the  
630 requirements of this act.



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631 5. Establish rules, conditions, and procedures for  
632 reinsurance risks under the program participation.

633 6. Establish actuarial functions as appropriate for the  
634 operation of the program.

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

641 8. Appoint appropriate legal, actuarial, and other  
642 committees as necessary to provide technical assistance in the  
643 operation of the program, and in any other function within the  
644 authority of the program.

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

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

655 (g) A reinsuring carrier may reinsure with the program  
656 coverage of an eligible employee of a small employer, or any  
657 dependent of such an employee, subject to each of the following  
658 provisions:

659 1. With respect to a standard and basic health care plan,  
660 the program may ~~must~~ reinsure the level of coverage provided;



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

670 2. Except in the case of a late enrollee, a reinsuring  
671 carrier may reinsure an eligible employee or dependent within 60  
672 days after the commencement of the coverage of the small  
673 employer. A newly employed eligible employee or dependent of a  
674 small employer may be reinsured within 60 days after the  
675 commencement of his or her coverage.

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

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

686 5.4. The program may not reimburse a participating carrier  
687 with respect to the claims of a reinsured employee or dependent  
688 until the carrier has paid incurred claims of an amount equal to  
689 the participating carrier's selected deductible level ~~at least~~  
690 ~~\$5,000~~ in a calendar year for benefits covered by the program.



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691 ~~In addition, the reinsuring carrier shall be responsible for 10~~  
692 ~~percent of the next \$50,000 and 5 percent of the next \$100,000~~  
693 ~~of incurred claims during a calendar year and the program shall~~  
694 ~~reinsure the remainder.~~

695 6.5. The board annually shall adjust the initial level of  
696 claims and the maximum limit to be retained by the carrier to  
697 reflect increases in costs and utilization within the standard  
698 market for health benefit plans within the state. The adjustment  
699 shall not be less than the annual change in the medical  
700 component of the "Consumer Price Index for All Urban Consumers"  
701 of the Bureau of Labor Statistics of the Department of Labor,  
702 unless the board proposes and the department approves a lower  
703 adjustment factor.

704 7.6. A small employer carrier may terminate reinsurance  
705 for all reinsured employees or dependents on any plan  
706 anniversary.

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

717 9.8. The board may consider adjustments to the premium  
718 rates charged for reinsurance by the program for carriers that  
719 use effective cost containment measures, including high-cost  
720 case management, as defined by the board.





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

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

746 ~~a. The entire group may be reinsured for a rate that is~~  
747 ~~1.5 times the rate established by the board.~~

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

750 2. The board periodically shall review the methodology



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751 established, including the system of classification and any  
752 rating factors, to assure that it reasonably reflects the claims  
753 experience of the program. The board may propose changes to the  
754 rates which shall be subject to the approval of the department.

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

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

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

777 b. The board shall equitably assess carriers for operating  
778 losses of the plan based on market share. The board shall  
779 annually assess each carrier a portion of the operating losses  
780 of the plan. The first tier of assessments shall be determined



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

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

809 3. Before September ~~March~~ 1 of each year, the board shall  
 810 determine and file with the department an estimate of the



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811 assessments needed to fund the losses incurred by the program in  
812 the previous calendar year.

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

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

836 6. Each carrier's proportion of the assessment shall be  
837 determined annually by the board, based on annual statements and  
838 other reports considered necessary by the board and filed by the  
839 carriers with the board.

840 7. Provision shall be made in the plan of operation for



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841 the imposition of an interest penalty for late payment of an  
842 assessment.

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

856 Section 12. Section 627.911, Florida Statutes, is amended  
857 to read:

858 627.911 Scope of this part.--Any insurer or health  
859 maintenance organization transacting insurance in this state  
860 shall report information as required by this part.

861 Section 13. Section 627.9175, Florida Statutes, is amended  
862 to read:

863 627.9175 Reports of information on health insurance.--

864 (1) Each authorized health insurer or health maintenance  
865 organization shall submit annually to the office, on or before  
866 March 1 of each year, information concerning ~~department as to~~  
867 ~~policies of individual~~ health insurance coverage being issued or  
868 currently in force in this state. The information shall include  
869 information related to premium, number of policies, and covered  
870 lives for such policies and other information necessary to



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871 analyze trends in enrollment, premiums, and claim costs.

872 (2) The required information shall be broken down by

873 market segment, to include:

874 (a) Health insurance issuer, company, contact person, or

875 agent.

876 (b) All health insurance products issued or in force,

877 including, but not limited to:

878 1. Direct premiums earned.

879 2. Direct losses incurred.

880 3. Direct premiums earned for new business issued during

881 the year.

882 4. Number of policies.

883 5. Number of certificates.

884 6. Number of total covered lives.

885 ~~(a) A summary of typical benefits, exclusions, and~~

886 ~~limitations for each type of individual policy form currently~~

887 ~~being issued in the state. The summary shall include, as~~

888 ~~appropriate:~~

889 ~~1. The deductible amount;~~

890 ~~2. The coinsurance percentage;~~

891 ~~3. The out-of-pocket maximum;~~

892 ~~4. Outpatient benefits;~~

893 ~~5. Inpatient benefits; and~~

894 ~~6. Any exclusions for preexisting conditions.~~

895

896 ~~The department shall determine other appropriate benefits,~~

897 ~~exclusions, and limitations to be reported for inclusion in the~~

898 ~~consumer's guide published pursuant to this section.~~

899 ~~(b) A schedule of rates for each type of individual policy~~

900 ~~form reflecting typical variations by age, sex, region of the~~



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901 ~~state, or any other applicable factor which is in use and is~~  
902 ~~determined to be appropriate for inclusion by the department.~~

903  
904 ~~The department shall provide by rule a uniform format for the~~  
905 ~~submission of this information in order to allow for meaningful~~  
906 ~~comparisons of premiums charged for comparable benefits.~~

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

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

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

930 ~~(c) The department shall analyze the data reported under~~



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931 ~~this subsection and shall annually make available to the public~~  
932 ~~a summary of its findings as to the types of cost containment~~  
933 ~~measures reported and the estimated effect of these measures.~~

934 Section 14. Section 627.9403, Florida Statutes, is amended  
935 to read:

936 627.9403 Scope.--The provisions of this part shall apply  
937 to long-term care insurance policies delivered or issued for  
938 delivery in this state, and to policies delivered or issued for  
939 delivery outside this state to the extent provided in s.

940 627.9406, by an insurer, a fraternal benefit society as defined  
941 in s. 632.601, a health maintenance organization as defined in  
942 s. 641.19, a prepaid health clinic as defined in s. 641.402, or  
943 a multiple-employer welfare arrangement as defined in s.

944 624.437. A policy which is advertised, marketed, or offered as a  
945 long-term care policy and as a Medicare supplement policy shall  
946 meet the requirements of this part and the requirements of ss.

947 627.671-627.675 and, to the extent of a conflict, be subject to  
948 the requirement that is more favorable to the policyholder or  
949 certificateholder. The provisions of this part shall not apply

950 to a continuing care contract issued pursuant to chapter 651 and  
951 shall not apply to guaranteed renewable policies issued prior to  
952 October 1, 1988. Any limited benefit policy that limits coverage

953 to care in a nursing home or to one or more lower levels of care  
954 required or authorized to be provided by this part or by

955 department rule must meet all requirements of this part that  
956 apply to long-term care insurance policies, except ss.

957 627.9407(3)(c) and (d), (9), (10)(f), and (12) and 627.94073(2).

958 ~~If the limited benefit policy does not provide coverage for care~~  
959 ~~in a nursing home, but does provide coverage for one or more~~  
960 ~~lower levels of care, the policy shall also be exempt from the~~





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961 ~~requirements of s. 627.9407(3)(d).~~

962 Section 15. Paragraph (b) of subsection (1) of section  
963 641.185, Florida Statutes, is amended to read:

964 641.185 Health maintenance organization subscriber  
965 protections.--

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

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

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

981 641.31 Health maintenance contracts.--

982 (3)

983 (d) Any change in rates charged for the contract must be  
984 filed with the department not less than 30 days in advance of  
985 the effective date. At the expiration of such 30 days, the rate  
986 filing shall be deemed approved unless prior to such time the  
987 filing has been affirmatively approved or disapproved by order  
988 of the department. The approval of the filing by the department  
989 constitutes a waiver of any unexpired portion of such waiting  
990 period. The department may extend by not more than an additional



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991 15 days the period within which it may so affirmatively approve  
992 or disapprove any such filing, by giving notice of such  
993 extension before expiration of the initial 30-day period. At the  
994 expiration of any such period as so extended, and in the absence  
995 of such prior affirmative approval or disapproval, any such  
996 filing shall be deemed approved. This paragraph does not apply  
997 to group health maintenance organization contracts effectuated  
998 and delivered in this state insuring groups of 51 or more  
999 persons.

1000 (9)(a)1. If a health maintenance organization offers  
1001 coverage for dependent children of the subscriber, the contract  
1002 must cover a dependent child of the subscriber at least until  
1003 the end of the calendar year in which the child reaches the age  
1004 of 23, if the child meets all of the following:

1005 a. The child is dependent upon the subscriber for support.  
1006 b. The child is living in the household of the subscriber,  
1007 or the child is a full-time or part-time student.

1008 2. Nothing in this paragraph affects or preempts a health  
1009 maintenance organization's right to medically underwrite or  
1010 charge the appropriate premium.

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



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1021 the subscriber prior to the birth of the child, whether or not  
1022 the agreement is enforceable. This section does not require  
1023 coverage for an adopted child who is not ultimately placed in  
1024 the residence of the subscriber in compliance with chapter 63.

1025 2. A contract may require the subscriber to notify the  
1026 health maintenance organization of the birth or placement of an  
1027 adopted child within a specified time period of not less than 30  
1028 days after the birth or placement in the residence of a child  
1029 adopted by the subscriber. If timely notice is given, the health  
1030 maintenance organization may not charge an additional premium  
1031 for coverage of the child for the duration of the notice period.  
1032 If timely notice is not given, the health maintenance  
1033 organization may charge an additional premium from the date of  
1034 birth or placement. If notice is given within 60 days after the  
1035 birth or placement of the child, the health maintenance  
1036 organization may not deny coverage for the child due to the  
1037 failure of the subscriber to timely notify the health  
1038 maintenance organization of the birth or placement of the child.

1039 3. If the contract does not require the subscriber to  
1040 notify the health maintenance organization of the birth or  
1041 placement of an adopted child within a specified time period,  
1042 the health maintenance organization may not deny coverage for  
1043 such child or retroactively charge the subscriber an additional  
1044 premium for such child. However, the health maintenance  
1045 organization may prospectively charge the subscriber an  
1046 additional premium for the child if the health maintenance  
1047 organization provides at least 45 days' notice of the additional  
1048 premium required.

1049 4. In order to increase access to postnatal, infant, and  
1050 pediatric health care for all children placed in court-ordered



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1051 custody, including foster children, all health maintenance  
 1052 organization contracts that provide coverage for a family member  
 1053 of the subscriber shall, as to such family member's coverage,  
 1054 provide that benefits applicable for children shall be payable  
 1055 with respect to a foster child or other child in court-ordered,  
 1056 temporary, or other custody of the subscriber.

1057 (10) A contract that provides that coverage of a dependent  
 1058 child shall terminate upon attainment of the limiting age for  
 1059 dependent children specified in the contract shall also provide  
 1060 in substance that attainment of the limiting age does not  
 1061 terminate the coverage of the child while the child continues to  
 1062 be:

1063 (a) Incapable of self-sustaining employment by reason of  
 1064 mental retardation or physical handicap.

1065 (b) Chiefly dependent upon the subscriber for support and  
 1066 maintenance.

1067  
 1068 If a claim is denied under a contract for the stated reason that  
 1069 the child has attained the limiting age for dependent children  
 1070 specified in the contract, the notice of denial must state that  
 1071 the subscriber has the burden of establishing that the child  
 1072 continues to meet the criteria specified in paragraphs (a) and  
 1073 (b). All health maintenance contracts that provide coverage,  
 1074 benefits, or services for a member of the family of the  
 1075 subscriber must, as to such family member's coverage, benefits,  
 1076 or services, provide also that the coverage, benefits, or  
 1077 services applicable for children must be provided with respect  
 1078 to a newborn child of the subscriber, or covered family member  
 1079 of the subscriber, from the moment of birth. However, with  
 1080 respect to a newborn child of a covered family member other than



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1081 ~~the spouse of the insured or subscriber, the coverage for the~~  
1082 ~~newborn child terminates 18 months after the birth of the~~  
1083 ~~newborn child. The coverage, benefits, or services for newborn~~  
1084 ~~children must consist of coverage for injury or sickness,~~  
1085 ~~including the necessary care or treatment of medically diagnosed~~  
1086 ~~congenital defects, birth abnormalities, or prematurity, and~~  
1087 ~~transportation costs of the newborn to and from the nearest~~  
1088 ~~appropriate facility appropriately staffed and equipped to treat~~  
1089 ~~the newborn's condition, when such transportation is certified~~  
1090 ~~by the attending physician as medically necessary to protect the~~  
1091 ~~health and safety of the newborn child.~~

1092 ~~(a) A contract may require the subscriber to notify the~~  
1093 ~~plan of the birth of a child within a time period, as specified~~  
1094 ~~in the contract, of not less than 30 days after the birth, or a~~  
1095 ~~contract may require the preenrollment of a newborn prior to~~  
1096 ~~birth. However, if timely notice is given, a plan may not charge~~  
1097 ~~an additional premium for additional coverage of the newborn~~  
1098 ~~child for not less than 30 days after the birth of the child. If~~  
1099 ~~timely notice is not given, the plan may charge an additional~~  
1100 ~~premium from the date of birth. If notice is given within 60~~  
1101 ~~days of the birth of the child, the contract may not deny~~  
1102 ~~coverage of the child due to failure of the subscriber to timely~~  
1103 ~~notify the plan of the birth of the child or to preenroll the~~  
1104 ~~child.~~

1105 ~~(b) If the contract does not require the subscriber to~~  
1106 ~~notify the plan of the birth of a child within a specified time~~  
1107 ~~period, the plan may not deny coverage of the child nor may it~~  
1108 ~~retroactively charge the subscriber an additional premium for~~  
1109 ~~the child; however, the contract may prospectively charge the~~  
1110 ~~member an additional premium for the child if the plan provides~~



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1111 ~~at least 45 days' notice of the additional charge.~~

1112 (11)~~(10)~~ No alteration of any written application for any  
1113 health maintenance contract shall be made by any person other  
1114 than the applicant without his or her written consent, except  
1115 that insertions may be made by the health maintenance  
1116 organization, for administrative purposes only, in such manner  
1117 as to indicate clearly that such insertions are not to be  
1118 ascribed to the applicant.

1119 (12)~~(11)~~ No contract shall contain any waiver of rights or  
1120 benefits provided to or available to subscribers under the  
1121 provisions of any law or rule applicable to health maintenance  
1122 organizations.

1123 (13)~~(12)~~ Each health maintenance contract, certificate, or  
1124 member handbook shall state that emergency services and care  
1125 shall be provided to subscribers in emergency situations not  
1126 permitting treatment through the health maintenance  
1127 organization's providers, without prior notification to and  
1128 approval of the organization. Not less than 75 percent of the  
1129 reasonable charges for covered services and supplies shall be  
1130 paid by the organization, up to the subscriber contract benefit  
1131 limits. Payment also may be subject to additional applicable  
1132 copayment provisions, not to exceed \$100 per claim. The health  
1133 maintenance contract, certificate, or member handbook shall  
1134 contain the definitions of "emergency services and care" and  
1135 "emergency medical condition" as specified in s. 641.19(7) and  
1136 (8), shall describe procedures for determination by the health  
1137 maintenance organization of whether the services qualify for  
1138 reimbursement as emergency services and care, and shall contain  
1139 specific examples of what does constitute an emergency. In  
1140 providing for emergency services and care as a covered service,



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1141 a health maintenance organization shall be governed by s.  
1142 641.513.

1143 (14)~~(13)~~ In addition to the requirements of this section,  
1144 with respect to a person who is entitled to have payments for  
1145 health care costs made under Medicare, Title XVIII of the Social  
1146 Security Act ("Medicare"), parts A and/or B:

1147 (a) The health maintenance organization shall mail or  
1148 deliver notification to the Medicare beneficiary of the date of  
1149 enrollment in the health maintenance organization within 10 days  
1150 after receiving notification of enrollment approval from the  
1151 United States Department of Health and Human Services, Health  
1152 Care Financing Administration. When a Medicare beneficiary who  
1153 is a subscriber of the health maintenance organization requests  
1154 disenrollment from the organization, the organization shall mail  
1155 or deliver to the beneficiary notice of the effective date of  
1156 the disenrollment within 10 days after receipt of the written  
1157 disenrollment request. The health maintenance organization shall  
1158 forward the disenrollment request to the United States  
1159 Department of Health and Human Services, Health Care Financing  
1160 Administration, in a timely manner so as to effectuate the next  
1161 available disenrollment date, as prescribed by such federal  
1162 agency.

1163 (b) The health maintenance contract, certificate, or  
1164 member handbook shall be delivered to the subscriber no later  
1165 than the earlier of 10 working days after the health maintenance  
1166 organization and the Health Care Financing Administration of the  
1167 United States Department of Health and Human Services approve  
1168 the subscriber's enrollment application or the effective date of  
1169 coverage of the subscriber under the health maintenance  
1170 contract. However, if notice from the Health Care Financing



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1171 Administration of its approval of the subscriber's enrollment  
1172 application is received by the health maintenance organization  
1173 after the effective coverage date prescribed by the Health Care  
1174 Financing Administration, the health maintenance organization  
1175 shall deliver the contract, certificate, or member handbook to  
1176 the subscriber within 10 days after receiving such notice. When  
1177 a Medicare recipient is enrolled in a health maintenance  
1178 organization program, the contract, certificate, or member  
1179 handbook shall be accompanied by a health maintenance  
1180 organization identification sticker with instruction to the  
1181 Medicare beneficiary to place the sticker on the Medicare  
1182 identification card.

1183 (15)~~(14)~~ Whenever a subscriber of a health maintenance  
1184 organization is also a Medicaid recipient, the health  
1185 maintenance organization's coverage shall be primary to the  
1186 recipient's Medicaid benefits and the organization shall be a  
1187 third party subject to the provisions of s. 409.910(4).

1188 (16)~~(15)~~(a) All health maintenance contracts,  
1189 certificates, and member handbooks shall contain the following  
1190 provision:

1191  
1192 "Grace Period: This contract has a (insert a number not less  
1193 than 10) day grace period. This provision means that if any  
1194 required premium is not paid on or before the date it is due, it  
1195 may be paid during the following grace period. During the grace  
1196 period, the contract will stay in force."

1197  
1198 (b) The required provision of paragraph (a) shall not  
1199 apply to certificates or member handbooks delivered to  
1200 individual subscribers under a group health maintenance contract





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1201 when the employer or other person who will hold the contract on  
1202 behalf of the subscriber group pays the entire premium for the  
1203 individual subscribers. However, such required provision shall  
1204 apply to the group health maintenance contract.

1205 (17)~~(16)~~ The contracts must clearly disclose the intent of  
1206 the health maintenance organization as to the applicability or  
1207 nonapplicability of coverage to preexisting conditions. If  
1208 coverage of the contract is not to be applicable to preexisting  
1209 conditions, the contract shall specify, in substance, that  
1210 coverage pertains solely to accidental bodily injuries resulting  
1211 from accidents occurring after the effective date of coverage  
1212 and that sicknesses are limited to those which first manifest  
1213 themselves subsequent to the effective date of coverage.

1214 ~~(17) All health maintenance contracts that provide~~  
1215 ~~coverage for a member of the family of the subscriber, shall, as~~  
1216 ~~to such family member's coverage, provide that coverage,~~  
1217 ~~benefits, or services applicable for children shall be provided~~  
1218 ~~with respect to an adopted child of the subscriber, which child~~  
1219 ~~is placed in compliance with chapter 63, from the moment of~~  
1220 ~~placement in the residence of the subscriber. Such contracts may~~  
1221 ~~not exclude coverage for any preexisting condition of the child.~~  
1222 ~~In the case of a newborn child, coverage shall begin from the~~  
1223 ~~moment of birth if a written agreement to adopt such child has~~  
1224 ~~been entered into by the subscriber prior to the birth of the~~  
1225 ~~child, whether or not such agreement is enforceable. However,~~  
1226 ~~coverage for such child shall not be required in the event that~~  
1227 ~~the child is not ultimately placed in the residence of the~~  
1228 ~~subscriber in compliance with chapter 63.~~

1229 Section 17. Section 641.31025, Florida Statutes, is  
1230 created to read:



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1231       641.31025 Specific reasons for denial of coverage.--The  
 1232 denial of an application for a health maintenance organization  
 1233 contract must be accompanied by the specific reasons for the  
 1234 denial, including, but not limited to, the specific underwriting  
 1235 reasons, if applicable.

1236           Section 18. Section 641.31075, Florida Statutes, is  
 1237 created to read:

1238       641.31075 Replacement.--Any health maintenance  
 1239 organization that is replacing any other group health coverage  
 1240 with its group health maintenance coverage shall comply with s.  
 1241 627.666.

1242           Section 19. Subsections (1) and (3) of section 641.3111,  
 1243 Florida Statutes, are amended to read:

1244       641.3111 Extension of benefits.--

1245       (1) Every group health maintenance contract shall provide  
 1246 that termination of the contract shall be without prejudice to  
 1247 any continuous loss which commenced while the contract was in  
 1248 force, but any extension of benefits beyond the period the  
 1249 contract was in force may be predicated upon the continuous  
 1250 total disability of the subscriber ~~and may be limited to payment~~  
 1251 ~~for the treatment of a specific accident or illness incurred~~  
 1252 ~~while the subscriber was a member.~~ The extension is required  
 1253 regardless of whether the group contract holder or other entity  
 1254 secures replacement coverage from a new insurer or health  
 1255 maintenance organization or foregoes the provision of coverage.  
 1256 The required provision must provide for continuation of contract  
 1257 benefits in connection with the treatment of a specific accident  
 1258 or illness incurred while the contract was in effect. Such  
 1259 extension of benefits may be limited to the occurrence of the  
 1260 earliest of the following events:



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1261 (a) The expiration of 12 months.

1262 (b) Such time as the member is no longer totally disabled.

1263 ~~(c) A succeeding carrier elects to provide replacement~~  
 1264 ~~coverage without limitation as to the disability condition.~~

1265 (c)~~(d)~~ The maximum benefits payable under the contract  
 1266 have been paid.

1267 (3) In the case of maternity coverage, ~~when not covered by~~  
 1268 ~~the succeeding carrier,~~ a reasonable extension of benefits or  
 1269 accrued liability provision is required, which provision  
 1270 provides for continuation of the contract benefits in connection  
 1271 with maternity expenses for a pregnancy that commenced while the  
 1272 policy was in effect. The extension shall be for the period of  
 1273 that pregnancy and shall not be based upon total disability.

1274 Section 20. Subsection (1) of section 641.2018, Florida  
 1275 Statutes, is amended to read:

1276 641.2018 Limited coverage for home health care  
 1277 authorized.--

1278 (1) Notwithstanding other provisions of this chapter, a  
 1279 health maintenance organization may issue a contract that limits  
 1280 coverage to home health care services only. The organization and  
 1281 the contract shall be subject to all of the requirements of this  
 1282 part that do not require or otherwise apply to specific benefits  
 1283 other than home care services. To this extent, all of the  
 1284 requirements of this part apply to any organization or contract  
 1285 that limits coverage to home care services, except the  
 1286 requirements for providing comprehensive health care services as  
 1287 provided in ss. 641.19(4), (12), and (13), and 641.31(1), except  
 1288 ss. 641.31~~(9)~~, (13)~~(12)~~, ~~(17)~~, (18), (19), (20), (21), and (24)  
 1289 and 641.31095.

1290 Section 21. Section 641.3107, Florida Statutes, is amended



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1291 to read:

1292           641.3107 Delivery of contract.--Unless delivered upon  
 1293 execution or issuance, a health maintenance contract,  
 1294 certificate of coverage, or member handbook shall be mailed or  
 1295 delivered to the subscriber or, in the case of a group health  
 1296 maintenance contract, to the employer or other person who will  
 1297 hold the contract on behalf of the subscriber group within 10  
 1298 working days from approval of the enrollment form by the health  
 1299 maintenance organization or by the effective date of coverage,  
 1300 whichever occurs first. However, if the employer or other person  
 1301 who will hold the contract on behalf of the subscriber group  
 1302 requires retroactive enrollment of a subscriber, the  
 1303 organization shall deliver the contract, certificate, or member  
 1304 handbook to the subscriber within 10 days after receiving notice  
 1305 from the employer of the retroactive enrollment. This section  
 1306 does not apply to the delivery of those contracts specified in  
 1307 s. 641.31(14)~~(13)~~.

1308           Section 22. Subsection (4) of section 641.513, Florida  
 1309 Statutes, is amended to read:

1310           641.513 Requirements for providing emergency services and  
 1311 care.--

1312           (4) A subscriber may be charged a reasonable copayment, as  
 1313 provided in s. 641.31(13)~~(12)~~, for the use of an emergency room.

1314           Section 23. If any law amended by this act was also  
 1315 amended by a law enacted at the 2003 Regular Session of the  
 1316 Legislature, such laws shall be construed as if they had been  
 1317 enacted at the same session of the Legislature, and full effect  
 1318 shall be given to each if possible.

1319           Section 24. This act shall take effect upon becoming a  
 1320 law.