By the Committees on Ways and Means; Banking and Insurance; and Senators Fasano, Lawson and Baker

576-2360-05

1 A bill to be entitled
2 An act relating to health insurance; amending
3 s. 408.05, F.S.; changing the due date for a
4 report from the Agency for Health Care
5 Administration regarding the State Center for
6 Health Statistics; amending s. 408.909, F.S.;
7 providing an additional criterion for the
8 Office of Insurance Regulation to disapprove or
9 withdraw approval of health flex plans;
10 amending s. 627.413, F.S.; authorizing insurers
11 and health maintenance organizations to offer
12 policies or contracts providing for a
13 high-deductible plan meeting federal
14 requirements and in conjunction with a health
15 savings account; amending s. 627.6487, F.S.;
16 revising the definition of the term "eligible
17 individual" for purposes of obtaining coverage
18 in the Florida Health Insurance Plan; amending
19 s. 627.64872, F.S.; revising definitions;
20 changing references to the Director of the
21 Office of Insurance Regulation to the
22 Commissioner of Insurance Regulation; deleting
23 obsolete language; providing additional
24 eligibility criteria; reducing premium rate
25 limitations; revising requirements for sources
26 of additional revenue; authorizing the board to
27 cancel policies under inadequate funding
28 conditions; providing a limitation; specifying
29 a maximum provider reimbursement rate;
30 requiring licensed providers to accept
31 assignment of plan benefits and consider

1 certain payments as payments in full; amending
2 s. 627.65626, F.S.; providing insurance rebates
3 for healthy lifestyles; amending s. 627.6692,
4 F.S.; extending a time period within which
5 eligible employees may apply for continuation
6 of coverage; amending s. 627.6699, F.S.;
7 revising standards for determining
8 applicability of the Employee Health Care
9 Access Act; prescribing acts that may be
10 performed by an employer without being
11 considered contributing to premiums or
12 facilitating administration of a policy;
13 authorizing certain carriers to offer coverage
14 to certain employees without being subject to
15 the act under certain circumstances; requiring
16 a carrier who offers such coverage to provide
17 notice to the primary insured prior to
18 cancellation for nonpayment of premium;
19 revising an availability of coverage provision
20 of the Employee Health Care Access Act;
21 including high-deductible plans meeting federal
22 health savings account plan requirements;
23 revising membership of the board of the small
24 employer health reinsurance program; revising
25 certain reporting dates relating to program
26 losses and assessments; requiring the board to
27 advise executive and legislative entities on
28 health insurance issues; providing
29 requirements; amending s. 641.27, F.S.;
30 increasing the interval at which the office
31 examines health maintenance organizations;

1 deleting authorization for the office to accept
2 an audit report from a certified public
3 accountant in lieu of conducting its own
4 examination; increasing an expense limitation;
5 amending s. 641.31, F.S.; providing for an
6 insurance rebate for members in a health
7 wellness program; providing for the rebate to
8 cease under certain conditions; creating a
9 high-deductible health insurance plan study
10 group; specifying membership; requiring the
11 study group to investigate certain issues
12 relating to high-deductible health insurance
13 plans; requiring the group to meet and submit
14 recommendations to the Governor and
15 Legislature; repealing s. 627.6402, F.S.,
16 relating to authorized insurance rebates for
17 healthy lifestyles; providing application;
18 providing appropriations; providing an
19 effective date.
20
21 Be It Enacted by the Legislature of the State of Florida:
22
23 Section 1. Paragraph (l) of subsection (3) of section
24 408.05, Florida Statutes, is amended to read:
25 408.05 State Center for Health Statistics.--
26 (3) COMPREHENSIVE HEALTH INFORMATION SYSTEM.--In order
27 to produce comparable and uniform health information and
28 statistics, the agency shall perform the following functions:
29 (l) Develop, in conjunction with the State
30 Comprehensive Health Information System Advisory Council, and
31 implement a long-range plan for making available performance

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

1 outcome and financial data that will allow consumers to
2 compare health care services. The performance outcomes and
3 financial data the agency must make available shall include,
4 but is not limited to, pharmaceuticals, physicians, health
5 care facilities, and health plans and managed care entities.
6 The agency shall submit the initial plan to the Governor, the
7 President of the Senate, and the Speaker of the House of
8 Representatives by <u>January</u> ~~March~~ 1, <u>2006</u> ~~2005~~, and shall
9 update the plan and report on the status of its implementation
10 annually thereafter. The agency shall also make the plan and
11 status report available to the public on its Internet website.
12 As part of the plan, the agency shall identify the process and
13 timeframes for implementation, any barriers to implementation,
14 and recommendations of changes in the law that may be enacted
15 by the Legislature to eliminate the barriers. As preliminary
16 elements of the plan, the agency shall:
17 1. Make available performance outcome and patient
18 charge data collected from health care facilities pursuant to
19 s. 408.061(1)(a) and (2). The agency shall determine which
20 conditions and procedures, performance outcomes, and patient
21 charge data to disclose based upon input from the council.
22 When determining which conditions and procedures are to be
23 disclosed, the council and the agency shall consider variation
24 in costs, variation in outcomes, and magnitude of variations
25 and other relevant information. When determining which
26 performance outcomes to disclose, the agency:
27 a. Shall consider such factors as volume of cases;
28 average patient charges; average length of stay; complication
29 rates; mortality rates; and infection rates, among others,
30 which shall be adjusted for case mix and severity, if
31 applicable.

CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

1 b. May consider such additional measures that are
2 adopted by the Centers for Medicare and Medicaid Studies,
3 National Quality Forum, the Joint Commission on Accreditation
4 of Healthcare Organizations, the Agency for Healthcare
5 Research and Quality, or a similar national entity that
6 establishes standards to measure the performance of health
7 care providers, or by other states.
8
9 When determining which patient charge data to disclose, the
10 agency shall consider such measures as average charge, average
11 net revenue per adjusted patient day, average cost per
12 adjusted patient day, and average cost per admission, among
13 others.
14 2. Make available performance measures, benefit
15 design, and premium cost data from health plans licensed
16 pursuant to chapter 627 or chapter 641. The agency shall
17 determine which performance outcome and member and subscriber
18 cost data to disclose, based upon input from the council. When
19 determining which data to disclose, the agency shall consider
20 information that may be required by either individual or group
21 purchasers to assess the value of the product, which may
22 include membership satisfaction, quality of care, current
23 enrollment or membership, coverage areas, accreditation
24 status, premium costs, plan costs, premium increases, range of
25 benefits, copayments and deductibles, accuracy and speed of
26 claims payment, credentials of physicians, number of
27 providers, names of network providers, and hospitals in the
28 network. Health plans shall make available to the agency any
29 such data or information that is not currently reported to the
30 agency or the office.
31

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

1 3. Determine the method and format for public
2 disclosure of data reported pursuant to this paragraph. The
3 agency shall make its determination based upon input from the
4 Comprehensive Health Information System Advisory Council. At a
5 minimum, the data shall be made available on the agency's
6 Internet website in a manner that allows consumers to conduct
7 an interactive search that allows them to view and compare the
8 information for specific providers. The website must include
9 such additional information as is determined necessary to
10 ensure that the website enhances informed decisionmaking among
11 consumers and health care purchasers, which shall include, at
12 a minimum, appropriate guidance on how to use the data and an
13 explanation of why the data may vary from provider to
14 provider. The data specified in subparagraph 1. shall be
15 released no later than March 1, 2005. The data specified in
16 subparagraph 2. shall be released no later than March 1, 2006.
17 Section 2. Paragraph (b) of subsection (3) of section
18 408.909, Florida Statutes, is amended to read:
19 408.909 Health flex plans.--
20 (3) PROGRAM.--The agency and the office shall each
21 approve or disapprove health flex plans that provide health
22 care coverage for eligible participants. A health flex plan
23 may limit or exclude benefits otherwise required by law for
24 insurers offering coverage in this state, may cap the total
25 amount of claims paid per year per enrollee, may limit the
26 number of enrollees, or may take any combination of those
27 actions. A health flex plan offering may include the option of
28 a catastrophic plan supplementing the health flex plan.
29 (b) The office shall develop guidelines for the review
30 of health flex plan applications and provide regulatory
31 oversight of health flex plan advertisement and marketing

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

1 procedures. The office shall disapprove or shall withdraw
2 approval of plans that:
3 1. Contain any ambiguous, inconsistent, or misleading
4 provisions or any exceptions or conditions that deceptively
5 affect or limit the benefits purported to be assumed in the
6 general coverage provided by the health flex plan;
7 2. Provide benefits that are unreasonable in relation
8 to the premium charged or contain provisions that are unfair
9 or inequitable or contrary to the public policy of this state,
10 that encourage misrepresentation, or that result in unfair
11 discrimination in sales practices; ~~or~~
12 3. Cannot demonstrate that the health flex plan is
13 financially sound and that the applicant is able to underwrite
14 or finance the health care coverage provided; or
15 4. Cannot demonstrate that the applicant and its
16 management are in compliance with the standards required under
17 s. 624.404(3).
18 Section 3. Subsection (6) is added to section 627.413,
19 Florida Statutes, to read:
20 627.413 Contents of policies, in general;
21 identification.--
22 (6) Notwithstanding any other provision of the Florida
23 Insurance Code that is in conflict with federal requirements
24 for a health savings account qualified high-deductible health
25 plan, an insurer, or a health maintenance organization subject
26 to part I of chapter 641, which is authorized to issue health
27 insurance in this state may offer for sale an individual or
28 group policy or contract that provides for a high-deductible
29 plan that meets the federal requirements of a health savings
30 account plan and which is offered in conjunction with a health
31 savings account.

1 Section 4. Paragraph (b) of subsection (3) of section
2 627.6487, Florida Statutes, is amended to read:
3 627.6487 Guaranteed availability of individual health
4 insurance coverage to eligible individuals.--
5 (3) For the purposes of this section, the term
6 "eligible individual" means an individual:
7 (b) Who is not eligible for coverage under:
8 1. A group health plan, as defined in s. 2791 of the
9 Public Health Service Act;
10 2. A conversion policy or contract issued by an
11 authorized insurer or health maintenance organization under s.
12 627.6675 or s. 641.3921, respectively, offered to an
13 individual who is no longer eligible for coverage under either
14 an insured or self-insured employer plan;
15 3. Part A or part B of Title XVIII of the Social
16 Security Act; ~~or~~
17 4. A state plan under Title XIX of such act, or any
18 successor program, and does not have other health insurance
19 coverage; <u>or</u>
20 <u>5. The Florida Health Insurance Plan as specified in</u>
21 <u>s. 627.64872 and such plan is accepting new enrollments.</u>
22 <u>However, a person whose previous coverage was under the</u>
23 <u>Florida Health Insurance Plan as specified in s. 627.64872 is</u>
24 <u>not an eligible individual as defined in s. 627.6487(3)(a).</u>
25 Section 5. Paragraphs (b), (c), and (n) of subsection
26 (2) and subsections (3), (6), (9), and (15) of section
27 627.64872, Florida Statutes, are amended, subsection (20) of
28 that section is renumbered as subsection (21), and a new
29 subsection (20) is added to that section, to read:
30 627.64872 Florida Health Insurance Plan.--
31 (2) DEFINITIONS.--As used in this section:

(b) "Commissioner" means the Commissioner of Insurance Regulation.

(c) "Dependent" means a resident spouse or resident unmarried child under the age of 19 years, a child who is a student under the age of 25 years and who is financially dependent upon the parent, or a child of any age who is disabled and dependent upon the parent.

~~(c) "Director" means the Director of the Office of Insurance Regulation.~~

(n) "Resident" means an individual who has been legally domiciled in this state for a period of at least 6 months and who physically resides in this state not less than 185 days per year.

(3) BOARD OF DIRECTORS.--

(a) The plan shall operate subject to the supervision and control of the board. The board shall consist of the commissioner ~~director~~ or his or her designated representative, who shall serve as a member of the board and shall be its chair, and an additional eight members, five of whom shall be appointed by the Governor, at least two of whom shall be individuals not representative of insurers or health care providers, one of whom shall be appointed by the President of the Senate, one of whom shall be appointed by the Speaker of the House of Representatives, and one of whom shall be appointed by the Chief Financial Officer.

(b) The term to be served on the board by the commissioner ~~Director of the Office of Insurance Regulation~~ shall be determined by continued employment in such position. The remaining initial board members shall serve for a period of time as follows: two members appointed by the Governor and the members appointed by the President of the Senate and the

1 Speaker of the House of Representatives shall serve a term of
2 2 years; and three members appointed by the Governor and the
3 Chief Financial Officer shall serve a term of 4 years.
4 Subsequent board members shall serve for a term of 3 years. A
5 board member's term shall continue until his or her successor
6 is appointed.
7 (c) Vacancies on the board shall be filled by the
8 appointing authority, such authority being the Governor, the
9 President of the Senate, the Speaker of the House of
10 Representatives, or the Chief Financial Officer. The
11 appointing authority may remove board members for cause.
12 (d) The <u>commissioner</u> ~~director~~, or his or her
13 recognized representative, shall be responsible for any
14 organizational requirements necessary for the initial meeting
15 of the board which shall take place no later than September 1,
16 2004.
17 (e) Members shall not be compensated in their capacity
18 as board members but shall be reimbursed for reasonable
19 expenses incurred in the necessary performance of their duties
20 in accordance with s. 112.061.
21 (f) The board shall submit to the Financial Services
22 Commission a plan of operation for the plan and any amendments
23 thereto necessary or suitable to ensure the fair, reasonable,
24 and equitable administration of the plan. The plan of
25 operation shall ensure that the plan qualifies to apply for
26 any available funding from the Federal Government that adds to
27 the financial viability of the plan. The plan of operation
28 shall become effective upon approval in writing by the
29 Financial Services Commission consistent with the date on
30 which the coverage under this section must be made available.
31 If the board fails to submit a suitable plan of operation

1 within 1 year after implementation ~~the appointment of the~~
2 ~~board of directors~~, or at any time thereafter fails to submit
3 suitable amendments to the plan of operation, the Financial
4 Services Commission shall adopt such rules as are necessary or
5 advisable to effectuate the provisions of this section. Such
6 rules shall continue in force until modified by the office or
7 superseded by a plan of operation submitted by the board and
8 approved by the Financial Services Commission.
9 (6) ~~INTERIM REPORT;~~ ANNUAL REPORT.--
10 ~~(a) By no later than December 1, 2004, the board shall~~
11 ~~report to the Governor, the President of the Senate, and the~~
12 ~~Speaker of the House of Representatives the results of an~~
13 ~~actuarial study conducted by the board to determine,~~
14 ~~including, but not limited to:~~
15 ~~1. The impact the creation of the plan will have on~~
16 ~~the small group insurance market and the individual market on~~
17 ~~premiums paid by insureds. This shall include an estimate of~~
18 ~~the total anticipated aggregate savings for all small~~
19 ~~employers in the state.~~
20 ~~2. The number of individuals the pool could reasonably~~
21 ~~cover at various funding levels, specifically, the number of~~
22 ~~people the pool may cover at each of those funding levels.~~
23 ~~3. A recommendation as to the best source of funding~~
24 ~~for the anticipated deficits of the pool.~~
25 ~~4. The effect on the individual and small group market~~
26 ~~by including in the Florida Health Insurance Plan persons~~
27 ~~eligible for coverage under s. 627.6487, as well as the cost~~
28 ~~of including these individuals.~~
29
30 ~~The board shall take no action to implement the Florida Health~~
31 ~~Insurance Plan, other than the completion of the actuarial~~

1 ~~study authorized in this paragraph, until funds are~~
2 ~~appropriated for startup cost and any projected deficits.~~
3 ~~(b)~~ No later than December 1, 2005, and annually
4 thereafter, the board shall submit to the Governor, the
5 President of the Senate, the Speaker of the House of
6 Representatives, and the substantive legislative committees of
7 the Legislature a report which includes an independent
8 actuarial study to determine, including, but not be limited
9 to:
10 <u>(a)</u>~~1.~~ The impact the creation of the plan has on the
11 small group and individual insurance market, specifically on
12 the premiums paid by insureds. This shall include an estimate
13 of the total anticipated aggregate savings for all small
14 employers in the state.
15 <u>(b)</u>~~2.~~ The actual number of individuals covered at the
16 current funding and benefit level, the projected number of
17 individuals that may seek coverage in the forthcoming fiscal
18 year, and the projected funding needed to cover anticipated
19 increase or decrease in plan participation.
20 ~~3. A recommendation as to the best source of funding~~
21 ~~for the anticipated deficits of the pool.~~
22 <u>(c)</u>~~4.~~ A summarization of the activities of the plan in
23 the preceding calendar year, including the net written and
24 earned premiums, plan enrollment, the expense of
25 administration, and the paid and incurred losses.
26 <u>(d)</u>~~5.~~ A review of the operation of the plan as to
27 whether the plan has met the intent of this section.
28 (9) ELIGIBILITY.--
29 (a) Any individual person who is and continues to be a
30 resident of this state shall be eligible for coverage under
31 the plan if:

CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

1. Evidence is provided that the person received notices of rejection or refusal to issue substantially similar coverage for health reasons from at least two health insurers or health maintenance organizations. A rejection or refusal by an insurer offering only stop-loss, excess of loss, or reinsurance coverage with respect to the applicant shall not be sufficient evidence under this paragraph;~~.~~

2. The person is enrolled in the Florida Comprehensive Health Association as of the date the plan is implemented; or~~.~~

3. Is an eligible individual as defined in s. 627.6487(3), excluding s. 627.6487(3)(b)5.

(b) Each resident dependent of a person who is eligible for coverage under the plan shall also be eligible for such coverage.

(c) Except for persons made eligible by subparagraph (a)3., a person shall not be eligible for coverage under the plan if:

1. The person has or obtains health insurance coverage substantially similar to or more comprehensive than a plan policy, or would be eligible to obtain such coverage, unless a person may maintain other coverage for the period of time the person is satisfying any preexisting condition waiting period under a plan policy or may maintain plan coverage for the period of time the person is satisfying a preexisting condition waiting period under another health insurance policy intended to replace the plan policy;~~.~~

2. The person is determined to be eligible for health care benefits under Medicaid, Medicare, the state's children's health insurance program, or any other federal, state, or local government program that provides health benefits;

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

1 3. The person voluntarily terminated plan coverage
2 unless 12 months have elapsed since such termination;
3 4. The person is an inmate or resident of a public
4 institution; or
5 5. The person's premiums are paid for or reimbursed
6 under any government-sponsored program, ~~or~~ by any government
7 agency or health care provider, or by any organization
8 sponsored by or affiliated with a health care provider.
9 (d) Coverage shall cease:
10 1. On the date a person is no longer a resident of
11 this state;
12 2. On the date a person requests coverage to end;
13 3. Upon the death of the covered person;
14 4. On the date state law requires cancellation or
15 nonrenewal of the policy; ~~or~~
16 5. At the option of the plan, 30 days after the plan
17 makes any inquiry concerning the person's eligibility or place
18 of residence to which the person does not reply; or~~.~~
19 6. Upon failure of the insured to pay for continued
20 coverage.
21 (e) Except under the circumstances described in this
22 subsection, coverage of a person who ceases to meet the
23 eligibility requirements of this subsection shall be
24 terminated at the end of the policy period for which the
25 necessary premiums have been paid.
26 (15) FUNDING OF THE PLAN.--
27 (a) Premiums.--
28 1. The plan shall establish premium rates for plan
29 coverage as provided in this section. Separate schedules of
30 premium rates based on age, sex, and geographical location may
31

apply for individual risks. Premium rates and schedules shall
be submitted to the office for approval prior to use.

2. Initial rates for plan coverage shall be limited to
no more than 200 percent ~~300 percent~~ of rates established for
individual standard risks as specified in s. 627.6675(3)(c).
Subject to the limits provided in this paragraph, subsequent
rates shall be established to provide fully for the expected
costs of claims, including recovery of prior losses, expenses
of operation, investment income of claim reserves, and any
other cost factors subject to the limitations described
herein, but in no event shall premiums exceed the 200-percent
~~300 percent~~ rate limitation provided in this section.
Notwithstanding the 200-percent ~~300 percent~~ rate limitation,
sliding scale premium surcharges based upon the insured's
income may apply to all enrollees, except those made eligible
for coverage by subparagraph (9)(a)3.

(b)1. Sources of additional revenue.--One-half of any
deficit incurred by the plan shall be ~~primarily~~ funded through
amounts appropriated by the Legislature from general revenue
sources, including, but not limited to, a portion of the
~~annual growth in~~ existing net insurance premium taxes, and
one-half of the deficit shall be funded by assessments on
insurers. The board shall operate the plan in such a manner
that the estimated cost of providing health insurance during
any fiscal year will not exceed total income the plan expects
to receive from policy premiums, funds available, and funds
appropriated by the Legislature, including any interest on
investments. After determining the amount of funds available
~~appropriated~~ to the board for a fiscal year, the board shall
estimate the number of new policies it believes the plan has
the financial capacity to insure during that year so that

1 costs do not exceed income. The board shall take steps
2 necessary to ensure that plan enrollment does not exceed the
3 number of residents it has estimated it has the financial
4 capacity to insure.
5 2. As a condition of doing business in this state, an
6 insurer shall pay an assessment to the board in the amount
7 prescribed by this paragraph. Each insurer shall annually be
8 assessed by the board a percentage of the insurer's earned
9 premium pertaining to direct writings of health insurance in
10 the state during the calendar year preceding that for which
11 the assessment is levied. Such percentage shall equal the
12 percentage that the amount appropriated by the Legislature for
13 funding the deficit incurred by the plan for the upcoming
14 fiscal year represents of all earned premium pertaining to
15 direct writings of health insurance in the state during the
16 calendar year preceding that for which the assessment is
17 levied.
18 3. The total of all assessments under this paragraph
19 upon an insurer may not exceed 0.3 percent of such insurer's
20 health insurance premium earned in this state during the
21 calendar year preceding the year for which the assessments
22 were levied.
23 4. All rights, title, and interest in the assessment
24 funds collected under this paragraph shall vest in this state.
25 However, all such funds and interest earned shall be used by
26 the plan to pay claims and administrative expenses.
27 (c) If assessments, appropriations, and other receipts
28 by the plan, board, or plan administrator exceed the actual
29 losses and administrative expenses of the plan, the excess
30 shall be held in interest and used by the board to offset
31 future losses. As used in this subsection, the term "future

1 losses" including reserves for claims incurred but not
2 reported.
3 (d) Each insurer's assessment shall be determined
4 annually by the board or plan administrator based on annual
5 statements and other reports deemed necessary by the board or
6 plan administrator and filed with the board or plan
7 administrator by the insurer.
8 (e) Insurers may recover the assessment in the normal
9 course of their respective businesses by including the
10 percentage, as indicated in subparagraph (b)2., as a claim
11 cost in determining rates.
12 (f) In the event of inadequate funding, the board may
13 cancel existing policies on a nondiscriminatory basis as
14 necessary to remedy the situation. No policy may be canceled
15 if a covered individual is currently making a claim.
16 (20) PROVIDER REIMBURSEMENT.--Notwithstanding any
17 other provision of law, the maximum reimbursement rate to
18 health care providers for all covered, medically necessary
19 services shall be 100 percent of Medicare's allowed payment
20 amount for that particular provider and service. All licensed
21 providers in this state shall accept assignment of plan
22 benefits and consider the Medicare allowed payment amount as
23 payment in full.
24 Section 6. Section 627.65626, Florida Statutes, is
25 amended to read:
26 627.65626 Insurance rebates for healthy lifestyles.--
27 (1) Any rate, rating schedule, or rating manual for a
28 health insurance policy that provides creditable coverage as
29 defined in s. 627.6561(5) filed with the office shall provide
30 for an appropriate rebate of premiums paid in the last policy
31 ~~calendar~~ year when the majority of members of a health plan

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

have enrolled and maintained participation in any health wellness, maintenance, or improvement program offered by the group policyholder ~~employer~~. The group ~~employer~~ must provide evidence of demonstrative maintenance or improvement of the enrollees' health status as determined by assessments of agreed-upon health status indicators between the policyholder ~~employer~~ and the health insurer, including, but not limited to, reduction in weight, body mass index, and smoking cessation. Any rebate provided by the health insurer is presumed to be appropriate unless credible data demonstrates otherwise, or unless the rebate program requires the insured to incur costs to qualify for the rebate which equal or exceeds the value of the rebate, but the rebate may ~~shall~~ not exceed 10 percent of paid premiums.

(2) The premium rebate authorized by this section shall be effective for an insured on an annual basis unless the number of participating members on the policy renewal anniversary ~~employees~~ becomes less than the majority of the members ~~employees~~ eligible for participation in the wellness program.

Section 7. Paragraphs (d) and (j) of subsection (5) of section 627.6692, Florida Statutes, are amended to read:

627.6692 Florida Health Insurance Coverage Continuation Act.--

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

(d)1. A qualified beneficiary must give written notice to the insurance carrier within 63 ~~30~~ days after the occurrence of a qualifying event. Unless otherwise specified in the notice, a notice by any qualified beneficiary constitutes notice on behalf of all qualified beneficiaries.

1 The written notice must inform the insurance carrier of the
2 occurrence and type of the qualifying event giving rise to the
3 potential election by a qualified beneficiary of continuation
4 of coverage under the group health plan issued by that
5 insurance carrier, except that in cases where the covered
6 employee has been involuntarily discharged, the nature of such
7 discharge need not be disclosed. The written notice must, at a
8 minimum, identify the employer, the group health plan number,
9 the name and address of all qualified beneficiaries, and such
10 other information required by the insurance carrier under the
11 terms of the group health plan or the commission by rule, to
12 the extent that such information is known by the qualified
13 beneficiary.
14 2. Within 14 days after the receipt of written notice
15 under subparagraph 1., the insurance carrier shall send each
16 qualified beneficiary by certified mail an election and
17 premium notice form, approved by the office, which form must
18 provide for the qualified beneficiary's election or
19 nonelection of continuation of coverage under the group health
20 plan and the applicable premium amount due after the election
21 to continue coverage. This subparagraph does not require
22 separate mailing of notices to qualified beneficiaries
23 residing in the same household, but requires a separate
24 mailing for each separate household.
25 (j) Notwithstanding paragraph (b), if a qualified
26 beneficiary in the military reserve or National Guard has
27 elected to continue coverage and is thereafter called to
28 active duty and the coverage under the group plan is
29 terminated by the beneficiary or the carrier due to the
30 qualified beneficiary becoming eligible for TRICARE (the
31 health care program provided by the United States Defense

Department), the 18-month period or such other applicable maximum time period for which the qualified beneficiary would otherwise be entitled to continue coverage is tolled during the time that he or she is covered under the TRICARE program. Within 63 ~~30~~ days after the federal TRICARE coverage terminates, the qualified beneficiary may elect to continue coverage under the group health plan, retroactively to the date coverage terminated under TRICARE, for the remainder of the 18-month period or such other applicable time period, subject to termination of coverage at the earliest of the conditions specified in paragraph (b).

Section 8. Paragraph (a) of subsection (4), paragraph (c) of subsection (5), and paragraphs (b) and (j) of subsection (11) of section 627.6699, Florida Statutes, are amended, and paragraph (o) is added to subsection (11) of that section, to read:

627.6699 Employee Health Care Access Act.--

(4) APPLICABILITY AND SCOPE.--

(a)1. This section applies to a health benefit plan that provides coverage to employees of a small employer in this state, unless the coverage ~~policy~~ is marketed directly to the individual employee, and the employer does not contribute directly or indirectly to ~~participate in~~ the ~~collection or distribution of~~ premiums or facilitate the administration of the coverage ~~policy~~ in any manner. For the purposes of this paragraph, an employer is not deemed to be contributing to the premiums or facilitating the administration of coverage if the employer does not contribute to the premium and merely collects the premiums for coverage from an employee's wages or salary through payroll deduction and submits payment for the premiums of one or more employees in a lump sum to a carrier.

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

1 2. A carrier authorized to issue group or individual
2 health benefit plans under this chapter or chapter 641 may
3 offer coverage as described in this paragraph to individual
4 employees without being subject to this section if the
5 employer has not had a group health benefit plan in place in
6 the prior 12 months. A carrier authorized to issue group or
7 individual health benefit plans under this chapter or chapter
8 641 may offer coverage as described in this paragraph to
9 employees that are not eligible employees as defined in this
10 section, whether or not the small employer has a group health
11 benefit plan in place. A carrier that offers coverage as
12 described in this paragraph must provide a cancellation notice
13 to the primary insured at least 10 days prior to canceling the
14 coverage for nonpayment of premium.
15 (5) AVAILABILITY OF COVERAGE.--
16 (c) Every small employer carrier must, as a condition
17 of transacting business in this state:
18 1. Offer and issue all small employer health benefit
19 plans on a guaranteed-issue basis to every eligible small
20 employer, with 2 to 50 eligible employees, that elects to be
21 covered under such plan, agrees to make the required premium
22 payments, and satisfies the other provisions of the plan. A
23 rider for additional or increased benefits may be medically
24 underwritten and may only be added to the standard health
25 benefit plan. The increased rate charged for the additional or
26 increased benefit must be rated in accordance with this
27 section.
28 2. In the absence of enrollment availability in the
29 Florida Health Insurance Plan, offer and issue basic and
30 standard small employer health benefit plans and a
31 high-deductible plan that meets the requirements of a health

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

1 savings account plan or health reimbursement account as
2 defined by federal law, on a guaranteed-issue basis, during a
3 31-day open enrollment period of August 1 through August 31 of
4 each year, to every eligible small employer, with fewer than
5 two eligible employees, which small employer is not formed
6 primarily for the purpose of buying health insurance and which
7 elects to be covered under such plan, agrees to make the
8 required premium payments, and satisfies the other provisions
9 of the plan. Coverage provided under this subparagraph shall
10 begin on October 1 of the same year as the date of enrollment,
11 unless the small employer carrier and the small employer agree
12 to a different date. A rider for additional or increased
13 benefits may be medically underwritten and may only be added
14 to the standard health benefit plan. The increased rate
15 charged for the additional or increased benefit must be rated
16 in accordance with this section. For purposes of this
17 subparagraph, a person, his or her spouse, and his or her
18 dependent children constitute a single eligible employee if
19 that person and spouse are employed by the same small employer
20 and either that person or his or her spouse has a normal work
21 week of less than 25 hours. Any right to an open enrollment of
22 health benefit coverage for groups of fewer than two
23 employees, pursuant to this section, shall remain in full
24 force and effect in the absence of the availability of new
25 enrollment into the Florida Health Insurance Plan.
26 3. This paragraph does not limit a carrier's ability
27 to offer other health benefit plans to small employers if the
28 standard and basic health benefit plans are offered and
29 rejected.
30 (11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.--
31

(b)1. The program shall operate subject to the supervision and control of the board.

2. Effective upon this act becoming a law, the board shall consist of the director of the office or his or her designee, who shall serve as the chairperson, and 13 additional members who are representatives of carriers and insurance agents and are appointed by the director of the office and serve as follows:

a. Five members shall be representatives of health insurers licensed under chapter 624 or chapter 641. Two members shall be agents who are actively engaged in the sale of health insurance. Four members shall be employers or representatives of employers. One member shall be a person covered under an individual health insurance policy issued by a licensed insurer in this state. One member shall represent the Agency for Health Care Administration and shall be recommended by the Secretary of Health Care Administration. ~~The director of the office shall include representatives of small employer carriers subject to assessment under this subsection. If two or more carriers elect to be risk assuming carriers, the membership must include at least two representatives of risk assuming carriers; if one carrier is risk assuming, one member must be a representative of such carrier. At least one member must be a carrier who is subject to the assessments, but is not a small employer carrier. Subject to such restrictions, at least five members shall be selected from individuals recommended by small employer carriers pursuant to procedures provided by rule of the commission. Three members shall be selected from a list of health insurance carriers that issue individual health insurance policies. At least two of the three members selected~~

1 ~~must be reinsuring carriers. Two members shall be selected~~
2 ~~from a list of insurance agents who are actively engaged in~~
3 ~~the sale of health insurance.~~
4 b. A member appointed under this subparagraph shall
5 serve a term of 4 years and shall continue in office until the
6 member's successor takes office, except that, in order to
7 provide for staggered terms, the director of the office shall
8 designate two of the initial appointees under this
9 subparagraph to serve terms of 2 years and shall designate
10 three of the initial appointees under this subparagraph to
11 serve terms of 3 years.
12 3. The director of the office may remove a member for
13 cause.
14 4. Vacancies on the board shall be filled in the same
15 manner as the original appointment for the unexpired portion
16 of the term.
17 ~~5. The director of the office may require an entity~~
18 ~~that recommends persons for appointment to submit additional~~
19 ~~lists of recommended appointees.~~
20 (j)1. Before <u>July</u> ~~March~~ 1 of each calendar year, the
21 board shall determine and report to the office the program net
22 loss for the previous year, including administrative expenses
23 for that year, and the incurred losses for the year, taking
24 into account investment income and other appropriate gains and
25 losses.
26 2. Any net loss for the year shall be recouped by
27 assessment of the carriers, as follows:
28 a. The operating losses of the program shall be
29 assessed in the following order subject to the specified
30 limitations. The first tier of assessments shall be made
31 against reinsuring carriers in an amount which shall not

1 exceed 5 percent of each reinsuring carrier's premiums from
2 health benefit plans covering small employers. If such
3 assessments have been collected and additional moneys are
4 needed, the board shall make a second tier of assessments in
5 an amount which shall not exceed 0.5 percent of each carrier's
6 health benefit plan premiums. Except as provided in paragraph
7 (n), risk-assuming carriers are exempt from all assessments
8 authorized pursuant to this section. The amount paid by a
9 reinsuring carrier for the first tier of assessments shall be
10 credited against any additional assessments made.
11 b. The board shall equitably assess carriers for
12 operating losses of the plan based on market share. The board
13 shall annually assess each carrier a portion of the operating
14 losses of the plan. The first tier of assessments shall be
15 determined by multiplying the operating losses by a fraction,
16 the numerator of which equals the reinsuring carrier's earned
17 premium pertaining to direct writings of small employer health
18 benefit plans in the state during the calendar year for which
19 the assessment is levied, and the denominator of which equals
20 the total of all such premiums earned by reinsuring carriers
21 in the state during that calendar year. The second tier of
22 assessments shall be based on the premiums that all carriers,
23 except risk-assuming carriers, earned on all health benefit
24 plans written in this state. The board may levy interim
25 assessments against carriers to ensure the financial ability
26 of the plan to cover claims expenses and administrative
27 expenses paid or estimated to be paid in the operation of the
28 plan for the calendar year prior to the association's
29 anticipated receipt of annual assessments for that calendar
30 year. Any interim assessment is due and payable within 30 days
31 after receipt by a carrier of the interim assessment notice.

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

1 Interim assessment payments shall be credited against the
2 carrier's annual assessment. Health benefit plan premiums and
3 benefits paid by a carrier that are less than an amount
4 determined by the board to justify the cost of collection may
5 not be considered for purposes of determining assessments.
6 c. Subject to the approval of the office, the board
7 shall make an adjustment to the assessment formula for
8 reinsuring carriers that are approved as federally qualified
9 health maintenance organizations by the Secretary of Health
10 and Human Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to
11 the extent, if any, that restrictions are placed on them that
12 are not imposed on other small employer carriers.
13 3. Before July ~~March~~ 1 of each year, the board shall
14 determine and file with the office an estimate of the
15 assessments needed to fund the losses incurred by the program
16 in the previous calendar year.
17 4. If the board determines that the assessments needed
18 to fund the losses incurred by the program in the previous
19 calendar year will exceed the amount specified in subparagraph
20 2., the board shall evaluate the operation of the program and
21 report its findings, including any recommendations for changes
22 to the plan of operation, to the office within 180 ~~90~~ days
23 following the end of the calendar year in which the losses
24 were incurred. The evaluation shall include an estimate of
25 future assessments, the administrative costs of the program,
26 the appropriateness of the premiums charged and the level of
27 carrier retention under the program, and the costs of coverage
28 for small employers. If the board fails to file a report with
29 the office within 180 ~~90~~ days following the end of the
30 applicable calendar year, the office may evaluate the
31 operations of the program and implement such amendments to the

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

1 plan of operation the office deems necessary to reduce future
2 losses and assessments.
3 5. If assessments exceed the amount of the actual
4 losses and administrative expenses of the program, the excess
5 shall be held as interest and used by the board to offset
6 future losses or to reduce program premiums. As used in this
7 paragraph, the term "future losses" includes reserves for
8 incurred but not reported claims.
9 6. Each carrier's proportion of the assessment shall
10 be determined annually by the board, based on annual
11 statements and other reports considered necessary by the board
12 and filed by the carriers with the board.
13 7. Provision shall be made in the plan of operation
14 for the imposition of an interest penalty for late payment of
15 an assessment.
16 8. A carrier may seek, from the office, a deferment,
17 in whole or in part, from any assessment made by the board.
18 The office may defer, in whole or in part, the assessment of a
19 carrier if, in the opinion of the office, the payment of the
20 assessment would place the carrier in a financially impaired
21 condition. If an assessment against a carrier is deferred, in
22 whole or in part, the amount by which the assessment is
23 deferred may be assessed against the other carriers in a
24 manner consistent with the basis for assessment set forth in
25 this section. The carrier receiving such deferment remains
26 liable to the program for the amount deferred and is
27 prohibited from reinsuring any individuals or groups in the
28 program if it fails to pay assessments.
29 (o) The board shall advise the office, the agency, the
30 department, and other executive and legislative entities on
31 health insurance issues. Specifically, the board shall:

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

1. Provide a forum for stakeholders, consisting of insurers, employers, agents, consumers, and regulators, in the private health insurance market in this state.

2. Review and recommend strategies to improve the functioning of the health insurance markets in this state with a specific focus on market stability, access, and pricing.

3. Make recommendations to the office for legislation addressing health insurance market issues and provide comments on health insurance legislation proposed by the office.

4. Meet at least three times each year. One meeting shall be held to hear reports and to secure public comment on the health insurance market, to develop any legislation needed to address health insurance market issues, and to provide comments on health insurance legislation proposed by the office.

5. By September 1 each year, issue a report to the office on the state of the health insurance market. The report shall include recommendations for changes in the health insurance market, results from implementation of previous recommendations, and information on health insurance markets.

Section 9. Subsection (1) of section 641.27, Florida Statutes, is amended to read:

641.27 Examination by the department.--

(1) The office shall examine the affairs, transactions, accounts, business records, and assets of any health maintenance organization as often as it deems it expedient for the protection of the people of this state, but not less frequently than once every 5 ~~3~~ years. ~~In lieu of making its own financial examination, the office may accept an independent certified public accountant's audit report prepared on a statutory accounting basis consistent with this~~

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

1 ~~part.~~ However, except when the medical records are requested
2 and copies furnished pursuant to s. 456.057, medical records
3 of individuals and records of physicians providing service
4 under contract to the health maintenance organization shall
5 not be subject to audit, although they may be subject to
6 subpoena by court order upon a showing of good cause. For the
7 purpose of examinations, the office may administer oaths to
8 and examine the officers and agents of a health maintenance
9 organization concerning its business and affairs. The
10 examination of each health maintenance organization by the
11 office shall be subject to the same terms and conditions as
12 apply to insurers under chapter 624. In no event shall
13 expenses of all examinations exceed a maximum of $50,000
14 ~~$20,000~~ for any 1-year period. Any rehabilitation,
15 liquidation, conservation, or dissolution of a health
16 maintenance organization shall be conducted under the
17 supervision of the department, which shall have all power with
18 respect thereto granted to it under the laws governing the
19 rehabilitation, liquidation, reorganization, conservation, or
20 dissolution of life insurance companies.
21 Section 10. Subsection (40) of section 641.31, Florida
22 Statutes, is amended to read:
23 641.31 Health maintenance contracts.--
24 (40)(a) Any group rate, rating schedule, or rating
25 manual for a health maintenance organization policy filed with
26 the office shall provide for an appropriate rebate of premiums
27 paid in the last contract ~~calendar~~ year when the majority of
28 members of a health ~~individual covered by such~~ plan have ~~is~~
29 enrolled in and maintained ~~maintains~~ participation in any
30 health wellness, maintenance, or improvement program offered
31 by the group contract holder ~~approved by the health plan~~. The

group ~~individual~~ must provide evidence of demonstrative maintenance or improvement of the group's ~~his or her~~ health status as determined by assessments of agreed-upon health status indicators between the group ~~individual~~ and the health insurer, including, but not limited to, reduction in weight, body mass index, and smoking cessation. Any rebate provided by the health maintenance organization ~~insurer~~ is presumed to be appropriate unless credible data demonstrates otherwise, or unless the rebate program requires the insured to incur costs to qualify for the rebate which equals or exceeds the value of the rebate but the rebate may ~~shall~~ not exceed 10 percent of paid premiums.

(b) The premium rebate authorized by this section shall be effective for a subscriber ~~an insured~~ on an annual basis, unless the number of participating members on the contract renewal anniversary becomes fewer than the majority of the members eligible for participation in the wellness program ~~individual fails to maintain or improve his or her health status while participating in an approved wellness program, or credible evidence demonstrates that the individual is not participating in the approved wellness program~~.

Section 11. (1) An 11-member high-deductible health insurance plan study group is created, to be composed of:

(a) Three representatives of employers offering high-deductible health plans to their employees, one of whom shall be a small employer as defined in s. 627.6699, Florida Statutes, who shall be appointed by the Florida Chamber of Commerce.

(b) Three representatives of commercial health plans, to be appointed by the Florida Insurance Council.

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

1 (c) Three representatives of hospitals, to be
2 appointed by the Florida Hospital Association.
3 (d) The Secretary of the Agency for Health Care
4 Administration, or the secretary's designee, who shall serve
5 as co-chair.
6 (e) The Director of the Office of Insurance
7 Regulation, or the director's designee, who shall serve as
8 co-chair.
9 (2) The study group shall study the following issues
10 related to high-deductible health insurance plans, including,
11 but not limited to, health savings accounts and health
12 reimbursement arrangements:
13 (a) The impact of high deductibles on access to health
14 care services and pharmaceutical benefits.
15 (b) The impact of high deductibles on utilization of
16 health care services and overutilization of health care
17 services.
18 (c) The impact on hospitals' inability to collect
19 deductibles and copayments.
20 (d) The ability of hospitals and insureds to
21 determine, prior to service delivery, the level of deductible
22 and copayment required of the insured.
23 (e) Methods to assist hospitals and insureds in
24 determining prior to service delivery the status of the
25 insured in meeting annual deductible requirements and any
26 subsequent copayments.
27 (f) Methods to assist hospitals in the collection of
28 deductibles and copayments, including electronic payments.
29 (g) Alternative approaches to the collection of
30 deductibles and copayments when either the extent of patient
31 financial responsibility is unknown in advance or there are no

1 funds electronically available from the patient to pay for the
2 deductible and any associated copayment.
3 (3) The study group shall also study the following
4 issues in addition to those specified in subsection (2):
5 (a) The assignment of benefits attestations and
6 contract provisions that nullify the attestations of insureds.
7 (b) The standardization of insured or subscriber
8 identifications cards.
9 (c) The standardization of claim edits or insuring
10 that claim edits comply with nationally recognized editing
11 guidelines.
12 (4) The study group shall meet by August 1, 2005, and
13 shall submit recommendations to the Governor, the President of
14 the Senate, and the Speaker of the House of Representatives by
15 January 1, 2006.
16 Section 12. Section 627.6402, Florida Statutes, is
17 repealed.
18 Section 13. The sum of $2.5 million is appropriated
19 from the General Revenue Fund to the Florida Health Insurance
20 Plan for the purposes of implementing the plan.
21 Section 14. The sum of $202,000 in nonrecurring funds
22 is appropriated from the General Revenue Fund to the Agency
23 for Health Care Administration for the purpose of implementing
24 section 11 of this act during the 2005-2006 fiscal year.
25 Section 15. This act shall take effect July 1, 2005,
26 and shall apply to all policies or contracts issued or renewed
27 on or after July 1, 2005.
28
29
30
31

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

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR
CS Senate Bill 1660

The Committee Substitute reduces the appropriation from the General Revenue Fund to the Florida Health Insurance Plan from $5 million to $2.5 million.

The Committee Substitute allows the FHIP board to assess health insurers for one-half of the FHIP deficit anticipated for the upcoming year.

The Committee Substitute appropriates $202,000 from the General Revenue Fund to the Agency for Health Care Administration to implement the High Deductible Health Insurance study group.