

1 A bill to be entitled

2 An act relating to health insurance; amending s. 408.05,  
3 F.S.; changing the due date for a report from the Agency  
4 for Health Care Administration regarding the State Center  
5 for Health Statistics; amending s. 408.909, F.S.;  
6 providing an additional criterion for the Office of  
7 Insurance Regulation to disapprove or withdraw approval of  
8 health flex plans; amending s. 627.413, F.S.; authorizing  
9 insurers and health maintenance organizations to offer  
10 policies or contracts providing for a high-deductible plan  
11 meeting federal requirements and in conjunction with a  
12 health savings account; amending s. 627.638, F.S.;  
13 revising direct payment provisions for insurers; amending  
14 s. 627.6402, F.S.; revising the requirements for the  
15 healthy lifestyle premium rebate; amending s. 627.65626,  
16 F.S.; providing insurance rebates for healthy lifestyles;  
17 amending s. 627.6692, F.S.; extending a time period within  
18 which eligible employees may apply for continuation of  
19 coverage; amending s. 627.6699, F.S.; revising standards  
20 for determining applicability of the Employee Health Care  
21 Access Act; prescribing acts that may be performed by an  
22 employer without being considered contributing to premiums  
23 or facilitating administration of a policy; authorizing  
24 certain carriers to offer coverage to certain employees  
25 without being subject to the act under certain  
26 circumstances; requiring a carrier who offers such  
27 coverage to provide notice to the primary insured prior to  
28 cancellation for nonpayment of premium; revising an

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29 | availability of coverage provision of the Employee Health  
 30 | Care Access Act; including high-deductible plans meeting  
 31 | federal health savings account plan requirements; revising  
 32 | membership of the board of the small employer health  
 33 | reinsurance program; revising certain reporting dates  
 34 | relating to program losses and assessments; requiring the  
 35 | board to advise executive and legislative entities on  
 36 | health insurance issues; providing requirements; amending  
 37 | s. 641.27, F.S.; increasing the interval at which the  
 38 | office examines health maintenance organizations; deleting  
 39 | authorization for the office to accept an audit report  
 40 | from a certified public accountant in lieu of conducting  
 41 | its own examination; increasing an expense limitation;  
 42 | amending s. 641.31, F.S.; providing for an insurance  
 43 | rebate for members in a health wellness program; providing  
 44 | for the rebate to cease under certain conditions;  
 45 | providing effective dates.

46 |

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

48 |

49 | Section 1. Paragraph (1) of subsection (3) of section  
 50 | 408.05, Florida Statutes, is amended to read:

51 | 408.05 State Center for Health Statistics.--

52 | (3) COMPREHENSIVE HEALTH INFORMATION SYSTEM.--In order to  
 53 | produce comparable and uniform health information and  
 54 | statistics, the agency shall perform the following functions:

55 | (1) Develop, in conjunction with the State Comprehensive  
 56 | Health Information System Advisory Council, and implement a

57 | long-range plan for making available performance outcome and  
58 | financial data that will allow consumers to compare health care  
59 | services. The performance outcomes and financial data the agency  
60 | must make available shall include, but is not limited to,  
61 | pharmaceuticals, physicians, health care facilities, and health  
62 | plans and managed care entities. The agency shall submit the  
63 | initial plan to the Governor, the President of the Senate, and  
64 | the Speaker of the House of Representatives by January ~~March~~ 1,  
65 | 2006 ~~2005~~, and shall update the plan and report on the status of  
66 | its implementation annually thereafter. The agency shall also  
67 | make the plan and status report available to the public on its  
68 | Internet website. As part of the plan, the agency shall identify  
69 | the process and timeframes for implementation, any barriers to  
70 | implementation, and recommendations of changes in the law that  
71 | may be enacted by the Legislature to eliminate the barriers. As  
72 | preliminary elements of the plan, the agency shall:

73 |       1. Make available performance outcome and patient charge  
74 | data collected from health care facilities pursuant to s.  
75 | 408.061(1)(a) and (2). The agency shall determine which  
76 | conditions and procedures, performance outcomes, and patient  
77 | charge data to disclose based upon input from the council. When  
78 | determining which conditions and procedures are to be disclosed,  
79 | the council and the agency shall consider variation in costs,  
80 | variation in outcomes, and magnitude of variations and other  
81 | relevant information. When determining which performance  
82 | outcomes to disclose, the agency:

83 |       a. Shall consider such factors as volume of cases; average  
84 | patient charges; average length of stay; complication rates;

85 mortality rates; and infection rates, among others, which shall  
 86 be adjusted for case mix and severity, if applicable.

87 b. May consider such additional measures that are adopted  
 88 by the Centers for Medicare and Medicaid Studies, National  
 89 Quality Forum, the Joint Commission on Accreditation of  
 90 Healthcare Organizations, the Agency for Healthcare Research and  
 91 Quality, or a similar national entity that establishes standards  
 92 to measure the performance of health care providers, or by other  
 93 states.

94  
 95 When determining which patient charge data to disclose, the  
 96 agency shall consider such measures as average charge, average  
 97 net revenue per adjusted patient day, average cost per adjusted  
 98 patient day, and average cost per admission, among others.

99 2. Make available performance measures, benefit design,  
 100 and premium cost data from health plans licensed pursuant to  
 101 chapter 627 or chapter 641. The agency shall determine which  
 102 performance outcome and member and subscriber cost data to  
 103 disclose, based upon input from the council. When determining  
 104 which data to disclose, the agency shall consider information  
 105 that may be required by either individual or group purchasers to  
 106 assess the value of the product, which may include membership  
 107 satisfaction, quality of care, current enrollment or membership,  
 108 coverage areas, accreditation status, premium costs, plan costs,  
 109 premium increases, range of benefits, copayments and  
 110 deductibles, accuracy and speed of claims payment, credentials  
 111 of physicians, number of providers, names of network providers,  
 112 and hospitals in the network. Health plans shall make available

113 | to the agency any such data or information that is not currently  
 114 | reported to the agency or the office.

115 |         3. Determine the method and format for public disclosure  
 116 | of data reported pursuant to this paragraph. The agency shall  
 117 | make its determination based upon input from the Comprehensive  
 118 | Health Information System Advisory Council. At a minimum, the  
 119 | data shall be made available on the agency's Internet website in  
 120 | a manner that allows consumers to conduct an interactive search  
 121 | that allows them to view and compare the information for  
 122 | specific providers. The website must include such additional  
 123 | information as is determined necessary to ensure that the  
 124 | website enhances informed decisionmaking among consumers and  
 125 | health care purchasers, which shall include, at a minimum,  
 126 | appropriate guidance on how to use the data and an explanation  
 127 | of why the data may vary from provider to provider. The data  
 128 | specified in subparagraph 1. shall be released no later than  
 129 | January 1, 2006, for the reporting of infection rates, and no  
 130 | later than October 1, 2005, for mortality rates and complication  
 131 | rates ~~March 1, 2005~~. The data specified in subparagraph 2. shall  
 132 | be released no later than October ~~March~~ 1, 2006.

133 |         Section 2. Paragraph (b) of subsection (3) of section  
 134 | 408.909, Florida Statutes, is amended to read:

135 |         408.909 Health flex plans.--

136 |         (3) PROGRAM.--The agency and the office shall each approve  
 137 | or disapprove health flex plans that provide health care  
 138 | coverage for eligible participants. A health flex plan may limit  
 139 | or exclude benefits otherwise required by law for insurers  
 140 | offering coverage in this state, may cap the total amount of

141 | claims paid per year per enrollee, may limit the number of  
 142 | enrollees, or may take any combination of those actions. A  
 143 | health flex plan offering may include the option of a  
 144 | catastrophic plan supplementing the health flex plan.

145 | (b) The office shall develop guidelines for the review of  
 146 | health flex plan applications and provide regulatory oversight  
 147 | of health flex plan advertisement and marketing procedures. The  
 148 | office shall disapprove or shall withdraw approval of plans  
 149 | that:

150 | 1. Contain any ambiguous, inconsistent, or misleading  
 151 | provisions or any exceptions or conditions that deceptively  
 152 | affect or limit the benefits purported to be assumed in the  
 153 | general coverage provided by the health flex plan;

154 | 2. Provide benefits that are unreasonable in relation to  
 155 | the premium charged or contain provisions that are unfair or  
 156 | inequitable or contrary to the public policy of this state, that  
 157 | encourage misrepresentation, or that result in unfair  
 158 | discrimination in sales practices; ~~or~~

159 | 3. Cannot demonstrate that the health flex plan is  
 160 | financially sound and that the applicant is able to underwrite  
 161 | or finance the health care coverage provided; or

162 | 4. Cannot demonstrate that the applicant and its  
 163 | management are in compliance with the standards required under  
 164 | s. 624.404(3).

165 | Section 3. Subsection (6) is added to section 627.413,  
 166 | Florida Statutes, to read:

167 | 627.413 Contents of policies, in general; identification.-

168 | -

169       (6) Notwithstanding any other provision of the Florida  
 170 Insurance Code that is in conflict with federal requirements for  
 171 a health savings account qualified high-deductible health plan,  
 172 an insurer, or a health maintenance organization subject to part  
 173 I of chapter 641, which is authorized to issue health insurance  
 174 in this state may offer for sale an individual or group policy  
 175 or contract that provides for a high-deductible plan that meets  
 176 the federal requirements of a health savings account plan and  
 177 which is offered in conjunction with a health savings account.

178       Section 4. Subsection (2) of section 627.638, Florida  
 179 Statutes, is amended to read:

180       627.638 Direct payment for hospital, medical services.--

181       (2) Whenever, in any health insurance claim form, an  
 182 insured specifically authorizes payment of benefits directly to  
 183 any recognized hospital, ~~or~~ physician, or dentist, the insurer  
 184 shall make such payment to the designated provider of such  
 185 services, unless otherwise provided in the insurance contract.  
 186 The insurance contract may not prohibit, and claims forms must  
 187 provide an option for, the payment of benefits directly to a  
 188 licensed hospital, physician, or dentist for care provided  
 189 pursuant to s. 395.1041. The insurer may require written  
 190 attestation of assignment of benefits. Payment to the provider  
 191 from the insurer may not be more than the amount that the  
 192 insurer would otherwise have paid without the assignment.

193       Section 5. Section 627.6402, Florida Statutes, is amended  
 194 to read:

195       627.6402 Insurance rebates for healthy lifestyles.--

196 (1) Any rate, rating schedule, or rating manual for an  
 197 individual health insurance policy filed with the office may  
 198 ~~shall~~ provide for an appropriate rebate of premiums paid in the  
 199 last ~~calendar~~-year when the individual covered by such plan is  
 200 enrolled in and maintains participation in any health wellness,  
 201 maintenance, or improvement program approved by the health plan.  
 202 The rebate may be based on premiums paid in the last calendar  
 203 year or the last policy year. The individual must provide  
 204 evidence of demonstrative maintenance or improvement of the  
 205 individual's health status as determined by assessments of  
 206 agreed-upon health status indicators between the individual and  
 207 the health insurer, including, but not limited to, reduction in  
 208 weight, body mass index, and smoking cessation. Any rebate  
 209 provided by the health insurer is presumed to be appropriate  
 210 unless credible data demonstrates otherwise, or unless such  
 211 rebate program requires the insured to incur costs to qualify  
 212 for the rebate which equal or exceed the value of the rebate,  
 213 but in no event shall the rebate ~~not~~ exceed 10 percent of paid  
 214 premiums.

215 (2) The premium rebate authorized by this section shall be  
 216 effective for an insured on an annual basis, unless the  
 217 individual fails to maintain or improve his or her health status  
 218 while participating in an approved wellness program, or credible  
 219 evidence demonstrates that the individual is not participating  
 220 in the approved wellness program.

221 Section 6. Section 627.65626, Florida Statutes, is amended  
 222 to read:

223 627.65626 Insurance rebates for healthy lifestyles.--



224 (1) Any rate, rating schedule, or rating manual for a  
225 health insurance policy that provides creditable coverage as  
226 defined in s. 627.6561(5) filed with the office shall provide  
227 for an appropriate rebate of premiums paid in the last policy  
228 year, contract year, or calendar year when the majority of  
229 members of a health plan have enrolled and maintained  
230 participation in any health wellness, maintenance, or  
231 improvement program offered by the group policyholder and health  
232 plan employer. The rebate may be based upon premiums paid in the  
233 last calendar year or policy year. The group employer must  
234 provide evidence of demonstrative maintenance or improvement of  
235 the enrollees' health status as determined by assessments of  
236 agreed-upon health status indicators between the policyholder  
237 employer and the health insurer, including, but not limited to,  
238 reduction in weight, body mass index, and smoking cessation. The  
239 group or health insurer may contract with a third-party  
240 administrator to assemble and report the health status required  
241 in this subsection between the policyholder and the health  
242 insurer. Any rebate provided by the health insurer is presumed  
243 to be appropriate unless credible data demonstrates otherwise,  
244 or unless the rebate program requires the insured to incur costs  
245 to qualify for the rebate which equal or exceeds the value of  
246 the rebate, but the rebate may ~~shall~~ not exceed 10 percent of  
247 paid premiums.

248 (2) The premium rebate authorized by this section shall be  
249 effective for an insured on an annual basis unless the number of  
250 participating members on the policy renewal anniversary

251 | ~~employees~~ becomes less than the majority of the members  
 252 | ~~employees~~ eligible for participation in the wellness program.

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

255 | 627.6692 Florida Health Insurance Coverage Continuation  
 256 | Act.--

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

258 | (d)1. A qualified beneficiary must give written notice to  
 259 | the insurance carrier within 63 ~~30~~ days after the occurrence of  
 260 | a qualifying event. Unless otherwise specified in the notice, a  
 261 | notice by any qualified beneficiary constitutes notice on behalf  
 262 | of all qualified beneficiaries. The written notice must inform  
 263 | the insurance carrier of the occurrence and type of the  
 264 | qualifying event giving rise to the potential election by a  
 265 | qualified beneficiary of continuation of coverage under the  
 266 | group health plan issued by that insurance carrier, except that  
 267 | in cases where the covered employee has been involuntarily  
 268 | discharged, the nature of such discharge need not be disclosed.  
 269 | The written notice must, at a minimum, identify the employer,  
 270 | the group health plan number, the name and address of all  
 271 | qualified beneficiaries, and such other information required by  
 272 | the insurance carrier under the terms of the group health plan  
 273 | or the commission by rule, to the extent that such information  
 274 | is known by the qualified beneficiary.

275 | 2. Within 14 days after the receipt of written notice  
 276 | under subparagraph 1., the insurance carrier shall send each  
 277 | qualified beneficiary by certified mail an election and premium  
 278 | notice form, approved by the office, which form must provide for

279 | the qualified beneficiary's election or nonelection of  
280 | continuation of coverage under the group health plan and the  
281 | applicable premium amount due after the election to continue  
282 | coverage. This subparagraph does not require separate mailing of  
283 | notices to qualified beneficiaries residing in the same  
284 | household, but requires a separate mailing for each separate  
285 | household.

286 |       (j) Notwithstanding paragraph (b), if a qualified  
287 | beneficiary in the military reserve or National Guard has  
288 | elected to continue coverage and is thereafter called to active  
289 | duty and the coverage under the group plan is terminated by the  
290 | beneficiary or the carrier due to the qualified beneficiary  
291 | becoming eligible for TRICARE (the health care program provided  
292 | by the United States Defense Department), the 18-month period or  
293 | such other applicable maximum time period for which the  
294 | qualified beneficiary would otherwise be entitled to continue  
295 | coverage is tolled during the time that he or she is covered  
296 | under the TRICARE program. Within 63 ~~30~~ days after the federal  
297 | TRICARE coverage terminates, the qualified beneficiary may elect  
298 | to continue coverage under the group health plan, retroactively  
299 | to the date coverage terminated under TRICARE, for the remainder  
300 | of the 18-month period or such other applicable time period,  
301 | subject to termination of coverage at the earliest of the  
302 | conditions specified in paragraph (b).

303 |       Section 8. Paragraph (a) of subsection (4), paragraph (c)  
304 | of subsection (5), and paragraphs (b) and (j) of subsection (11)  
305 | of section 627.6699, Florida Statutes, are amended, and

306 paragraph (o) is added to subsection (11) of that section, to  
307 read:

308 627.6699 Employee Health Care Access Act.--

309 (4) APPLICABILITY AND SCOPE.--

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

323 2. A carrier authorized to issue group or individual  
324 health benefit plans under this chapter or chapter 641 may offer  
325 coverage as described in this paragraph to individual employees  
326 without being subject to this section if the employer has not  
327 had a group health benefit plan in place in the prior 6 months.  
328 A carrier authorized to issue group or individual health benefit  
329 plans under this chapter or chapter 641 may offer coverage as  
330 described in this subparagraph to employees that are not  
331 eligible employees as defined in this section, whether or not  
332 the small employer has a group health benefit plan in place. A  
333 carrier that offers coverage as described in this subparagraph

334 must provide a cancellation notice to the primary insured at  
335 least 10 days prior to canceling the coverage for nonpayment of  
336 premium.

337 (5) AVAILABILITY OF COVERAGE.--

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

340 1. Offer and issue all small employer health benefit plans  
341 on a guaranteed-issue basis to every eligible small employer,  
342 with 2 to 50 eligible employees, that elects to be covered under  
343 such plan, agrees to make the required premium payments, and  
344 satisfies the other provisions of the plan. A rider for  
345 additional or increased benefits may be medically underwritten  
346 and may only be added to the standard health benefit plan. The  
347 increased rate charged for the additional or increased benefit  
348 must be rated in accordance with this section.

349 2. In the absence of enrollment availability in the  
350 Florida Health Insurance Plan, offer and issue basic and  
351 standard small employer health benefit plans and a high-  
352 deductible plan that meets the requirements of a health savings  
353 account plan or health reimbursement account as defined by  
354 federal law, on a guaranteed-issue basis, during a 31-day open  
355 enrollment period of August 1 through August 31 of each year, to  
356 every eligible small employer, with fewer than two eligible  
357 employees, which small employer is not formed primarily for the  
358 purpose of buying health insurance and which elects to be  
359 covered under such plan, agrees to make the required premium  
360 payments, and satisfies the other provisions of the plan.

361 Coverage provided under this subparagraph shall begin on October

362 | 1 of the same year as the date of enrollment, unless the small  
 363 | employer carrier and the small employer agree to a different  
 364 | date. A rider for additional or increased benefits may be  
 365 | medically underwritten and may only be added to the standard  
 366 | health benefit plan. The increased rate charged for the  
 367 | additional or increased benefit must be rated in accordance with  
 368 | this section. For purposes of this subparagraph, a person, his  
 369 | or her spouse, and his or her dependent children constitute a  
 370 | single eligible employee if that person and spouse are employed  
 371 | by the same small employer and either that person or his or her  
 372 | spouse has a normal work week of less than 25 hours. Any right  
 373 | to an open enrollment of health benefit coverage for groups of  
 374 | fewer than two employees, pursuant to this section, shall remain  
 375 | in full force and effect in the absence of the availability of  
 376 | new enrollment into the Florida Health Insurance Plan.

377 |         3. This paragraph does not limit a carrier's ability to  
 378 | offer other health benefit plans to small employers if the  
 379 | standard and basic health benefit plans are offered and  
 380 | rejected.

381 |         (11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.--

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

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

389       a. Five members shall be representatives of health  
390 insurers licensed under chapter 624 or chapter 641. Two members  
391 shall be agents who are actively engaged in the sale of health  
392 insurance. Four members shall be employers or representatives of  
393 employers. One member shall be a person covered under an  
394 individual health insurance policy issued by a licensed insurer  
395 in this state. One member shall represent the Agency for Health  
396 Care Administration and shall be recommended by the Secretary of  
397 Health Care Administration. ~~The director of the office shall~~  
398 ~~include representatives of small employer carriers subject to~~  
399 ~~assessment under this subsection. If two or more carriers elect~~  
400 ~~to be risk assuming carriers, the membership must include at~~  
401 ~~least two representatives of risk assuming carriers; if one~~  
402 ~~carrier is risk assuming, one member must be a representative of~~  
403 ~~such carrier. At least one member must be a carrier who is~~  
404 ~~subject to the assessments, but is not a small employer carrier.~~  
405 ~~Subject to such restrictions, at least five members shall be~~  
406 ~~selected from individuals recommended by small employer carriers~~  
407 ~~pursuant to procedures provided by rule of the commission. Three~~  
408 ~~members shall be selected from a list of health insurance~~  
409 ~~carriers that issue individual health insurance policies. At~~  
410 ~~least two of the three members selected must be reinsuring~~  
411 ~~carriers. Two members shall be selected from a list of insurance~~  
412 ~~agents who are actively engaged in the sale of health insurance.~~  
413       b. A member appointed under this subparagraph shall serve  
414 a term of 4 years and shall continue in office until the  
415 member's successor takes office, except that, in order to  
416 provide for staggered terms, the director of the office shall

417 designate two of the initial appointees under this subparagraph  
418 to serve terms of 2 years and shall designate three of the  
419 initial appointees under this subparagraph to serve terms of 3  
420 years.

421 3. The director of the office may remove a member for  
422 cause.

423 4. Vacancies on the board shall be filled in the same  
424 manner as the original appointment for the unexpired portion of  
425 the term.

426 ~~5. The director of the office may require an entity that~~  
427 ~~recommends persons for appointment to submit additional lists of~~  
428 ~~recommended appointees.~~

429 (j)1. Before July ~~March~~ 1 of each calendar year, the board  
430 shall determine and report to the office the program net loss  
431 for the previous year, including administrative expenses for  
432 that year, and the incurred losses for the year, taking into  
433 account investment income and other appropriate gains and  
434 losses.

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

437 a. The operating losses of the program shall be assessed  
438 in the following order subject to the specified limitations. The  
439 first tier of assessments shall be made against reinsuring  
440 carriers in an amount which shall not exceed 5 percent of each  
441 reinsuring carrier's premiums from health benefit plans covering  
442 small employers. If such assessments have been collected and  
443 additional moneys are needed, the board shall make a second tier  
444 of assessments in an amount which shall not exceed 0.5 percent



445 of each carrier's health benefit plan premiums. Except as  
446 provided in paragraph (n), risk-assuming carriers are exempt  
447 from all assessments authorized pursuant to this section. The  
448 amount paid by a reinsuring carrier for the first tier of  
449 assessments shall be credited against any additional assessments  
450 made.

451       b. The board shall equitably assess carriers for operating  
452 losses of the plan based on market share. The board shall  
453 annually assess each carrier a portion of the operating losses  
454 of the plan. The first tier of assessments shall be determined  
455 by multiplying the operating losses by a fraction, the numerator  
456 of which equals the reinsuring carrier's earned premium  
457 pertaining to direct writings of small employer health benefit  
458 plans in the state during the calendar year for which the  
459 assessment is levied, and the denominator of which equals the  
460 total of all such premiums earned by reinsuring carriers in the  
461 state during that calendar year. The second tier of assessments  
462 shall be based on the premiums that all carriers, except risk-  
463 assuming carriers, earned on all health benefit plans written in  
464 this state. The board may levy interim assessments against  
465 carriers to ensure the financial ability of the plan to cover  
466 claims expenses and administrative expenses paid or estimated to  
467 be paid in the operation of the plan for the calendar year prior  
468 to the association's anticipated receipt of annual assessments  
469 for that calendar year. Any interim assessment is due and  
470 payable within 30 days after receipt by a carrier of the interim  
471 assessment notice. Interim assessment payments shall be credited  
472 against the carrier's annual assessment. Health benefit plan

473 premiums and benefits paid by a carrier that are less than an  
474 amount determined by the board to justify the cost of collection  
475 may not be considered for purposes of determining assessments.

476 c. Subject to the approval of the office, the board shall  
477 make an adjustment to the assessment formula for reinsuring  
478 carriers that are approved as federally qualified health  
479 maintenance organizations by the Secretary of Health and Human  
480 Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent,  
481 if any, that restrictions are placed on them that are not  
482 imposed on other small employer carriers.

483 3. Before July ~~March~~ 1 of each year, the board shall  
484 determine and file with the office an estimate of the  
485 assessments needed to fund the losses incurred by the program in  
486 the previous calendar year.

487 4. If the board determines that the assessments needed to  
488 fund the losses incurred by the program in the previous calendar  
489 year will exceed the amount specified in subparagraph 2., the  
490 board shall evaluate the operation of the program and report its  
491 findings, including any recommendations for changes to the plan  
492 of operation, to the office within 180 ~~90~~ days following the end  
493 of the calendar year in which the losses were incurred. The  
494 evaluation shall include an estimate of future assessments, the  
495 administrative costs of the program, the appropriateness of the  
496 premiums charged and the level of carrier retention under the  
497 program, and the costs of coverage for small employers. If the  
498 board fails to file a report with the office within 180 ~~90~~ days  
499 following the end of the applicable calendar year, the office  
500 may evaluate the operations of the program and implement such

501 amendments to the plan of operation the office deems necessary  
502 to reduce future losses and assessments.

503 5. If assessments exceed the amount of the actual losses  
504 and administrative expenses of the program, the excess shall be  
505 held as interest and used by the board to offset future losses  
506 or to reduce program premiums. As used in this paragraph, the  
507 term "future losses" includes reserves for incurred but not  
508 reported claims.

509 6. Each carrier's proportion of the assessment shall be  
510 determined annually by the board, based on annual statements and  
511 other reports considered necessary by the board and filed by the  
512 carriers with the board.

513 7. Provision shall be made in the plan of operation for  
514 the imposition of an interest penalty for late payment of an  
515 assessment.

516 8. A carrier may seek, from the office, a deferment, in  
517 whole or in part, from any assessment made by the board. The  
518 office may defer, in whole or in part, the assessment of a  
519 carrier if, in the opinion of the office, the payment of the  
520 assessment would place the carrier in a financially impaired  
521 condition. If an assessment against a carrier is deferred, in  
522 whole or in part, the amount by which the assessment is deferred  
523 may be assessed against the other carriers in a manner  
524 consistent with the basis for assessment set forth in this  
525 section. The carrier receiving such deferment remains liable to  
526 the program for the amount deferred and is prohibited from  
527 reinsuring any individuals or groups in the program if it fails  
528 to pay assessments.

529       (o) The board shall advise the office, the Agency for  
 530 Health Care Administration, the department, other executive  
 531 departments, and the Legislature on health insurance issues.  
 532 Specifically, the board shall:

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

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

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

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

547       5. Issue a report to the office on the state of the health  
 548 insurance market by September 1 each year. The report shall  
 549 include recommendations for changes in the health insurance  
 550 market, results from implementation of previous recommendations,  
 551 and information on health insurance markets.

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

554       641.27 Examination by the department.--

555       (1) The office shall examine the affairs, transactions,  
 556 accounts, business records, and assets of any health maintenance

557 organization as often as it deems it expedient for the  
558 protection of the people of this state, but not less frequently  
559 than once every 5 3 years. ~~In lieu of making its own financial~~  
560 ~~examination, the office may accept an independent certified~~  
561 ~~public accountant's audit report prepared on a statutory~~  
562 ~~accounting basis consistent with this part.~~ However, except when  
563 the medical records are requested and copies furnished pursuant  
564 to s. 456.057, medical records of individuals and records of  
565 physicians providing service under contract to the health  
566 maintenance organization shall not be subject to audit, although  
567 they may be subject to subpoena by court order upon a showing of  
568 good cause. For the purpose of examinations, the office may  
569 administer oaths to and examine the officers and agents of a  
570 health maintenance organization concerning its business and  
571 affairs. The examination of each health maintenance organization  
572 by the office shall be subject to the same terms and conditions  
573 as apply to insurers under chapter 624. In no event shall  
574 expenses of all examinations exceed a maximum of \$50,000 ~~\$20,000~~  
575 for any 1-year period. Any rehabilitation, liquidation,  
576 conservation, or dissolution of a health maintenance  
577 organization shall be conducted under the supervision of the  
578 department, which shall have all power with respect thereto  
579 granted to it under the laws governing the rehabilitation,  
580 liquidation, reorganization, conservation, or dissolution of  
581 life insurance companies.

582 Section 10. Subsection (40) of section 641.31, Florida  
583 Statutes, is amended to read:

584 641.31 Health maintenance contracts.--

585           (40) (a) Any group rate, rating schedule, or rating manual  
 586 for a health maintenance organization policy, which provides  
 587 creditable coverage as defined in s. 627.6561(5), filed with the  
 588 office shall provide for an appropriate rebate of premiums paid  
 589 in the last policy year, contract year, or calendar year when  
 590 the majority of members of a health individual ~~covered by such~~  
 591 ~~plan are is~~ enrolled in and maintained ~~maintains~~ participation  
 592 in any health wellness, maintenance, or improvement program  
 593 offered by the group contract holder ~~approved by the health~~  
 594 ~~plan~~. The group individual must provide evidence of  
 595 demonstrative maintenance or improvement of his or her health  
 596 status as determined by assessments of agreed-upon health status  
 597 indicators between the group individual and the health insurer,  
 598 including, but not limited to, reduction in weight, body mass  
 599 index, and smoking cessation. Any rebate provided by the health  
 600 maintenance organization insurer ~~is~~ presumed to be appropriate  
 601 unless credible data demonstrates otherwise, or unless the  
 602 rebate program requires the insured to incur costs to qualify  
 603 for the rebate which equals or exceeds the value of the rebate  
 604 but the rebate may ~~shall~~ not exceed 10 percent of paid premiums.

605           (b) The premium rebate authorized by this section shall be  
 606 effective for a subscriber ~~an insured~~ on an annual basis, unless  
 607 the number of participating members on the contract renewal  
 608 anniversary becomes fewer than the majority of the members  
 609 eligible for participation in the wellness program individual  
 610 ~~fails to maintain or improve his or her health status while~~  
 611 ~~participating in an approved wellness program, or credible~~

612 ~~evidence demonstrates that the individual is not participating~~  
613 ~~in the approved wellness program.~~

614 (c) A health maintenance organization that issues  
615 individual contracts may offer a premium rebate, as provided  
616 under this section, for a healthy lifestyle program.

617 Section 11. Except as otherwise expressly provided in this  
618 act and except for this section, which shall take effect upon  
619 becoming a law, this act shall take effect July 1, 2005, and  
620 shall apply to all policies or contracts issued or renewed on or  
621 after July 1, 2005.

622