By the Committees on Health Care; Banking and Insurance; and Senator Atwater

587-2312-06

A bill to be entitled

An act relating to plans, policies, contracts, and programs for the provision of health care services; amending s. 408.909, F.S.; revising eligibility requirements for participation in health flex plans; amending s. 627.642, F.S.; requiring an identification card containing specified information to be given to insureds who have health and accident insurance; amending s. 627.657, F.S.; requiring an identification card containing specified information to be given to insureds under group health insurance policies; amending s. 636.204, F.S.; deleting a requirement that an application for licensure as a discount medical plan organization must be accompanied by a copy of the applicant's most recent financial statements; amending s. 636.206, F.S.; authorizing the Office of Insurance Regulation to examine or investigate the business of a discount medical plan organization under certain circumstances; amending s. 636.210, F.S.; providing an exception to the prohibited restrictions on free access to plan providers for hospital services; amending s. 636.216, F.S.; revising the charges and filing requirements for access to certain health care services; amending s. 636.218, F.S.; deleting a requirement that audited financial statements be included in the annual report filed by a discount medical plan organization; amending s.

636.220, F.S.; requiring a discount medical plan organization to certify in writing and under oath that certain requirements are satisfied; amending s. 641.31, F.S.; requiring an identification card to be given to persons having health care services through a health maintenance contract; amending ss. 383.145, 641.185, 641.2018, 641.3107, 641.3922, and 641.513, F.S.; conforming cross-references to changes made by the act; providing application; providing effective dates.

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

Section 1. Effective July 1, 2006, subsection (5) of section 408.909, Florida Statutes, is amended to read:

408.909 Health flex plans.--

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

(a)1. Are 64 years of age or younger;

2.~~(b)~~ Have a family income equal to or less than 250 ~~200~~ percent of the federal poverty level;

3.~~(c)~~ Are eligible under a federally approved Medicaid demonstration waiver and reside in Palm Beach County or Miami-Dade County;

4.~~(d)~~ Are not covered by a private insurance policy and are not eligible for coverage through a public health insurance program, such as Medicare or Medicaid, unless specifically authorized under paragraph (c), or another public health care program, such as KidCare, and have not been covered at any time during the past 6 months; and

5.~~(e)~~ Have applied for health care coverage through an approved health flex plan and have agreed to make any payments required for participation, including periodic payments or payments due at the time health care services are provided; or~~.~~

(b) Are part of an employer group in which at least 75 percent of the employees have a family income equal to or less than 250 percent of the federal poverty level and the employer has not offered health insurance during the past 6 months.

Section 2. Subsection (3) is added to section 627.642, Florida Statutes, to read:

627.642 Outline of coverage.--

(3) In addition to the outline of coverage, a policy as specified in s. 627.6699(3)(k) must be accompanied by an identification card that contains, at a minimum:

(a) The name of the organization issuing the policy or the name of the organization administering the policy, whichever applies.

(b) The name of the contract holder.

(c) The type of plan only if the plan is filed in the state, an indication that the plan is self-funded, or the name of the network.

(d) The member identification number, contract number, and policy or group number, if applicable.

(e) A contact phone number or electronic address for authorizations.

(f) A phone number or electronic address whereby the covered person or hospital, physician, or other person rendering services covered by the policy may determine if the plan is insured and may obtain a benefits verification in order to estimate patient financial responsibility, in

compliance with privacy rules under the Health Insurance Portability and Accountability Act.

(g) The national plan identifier, in accordance with the compliance date set forth by the federal Department of Health and Human Services.

The identification card must present the information in a readily identifiable manner or, alternatively, the information may be embedded on the card and available through magnetic stripe or smart card. The information may also be provided through other electronic technology.

Section 3. Present subsection (2) of section 627.657, Florida Statutes, is renumbered as subsection (3), and a new subsection (2) is added to that section, to read:

627.657 Provisions of group health insurance policies.--

(2) The medical policy as specified in s. 627.6699(3)(k) must be accompanied by an identification card that contains, at a minimum:

(a) The name of the organization issuing the policy or name of the organization administering the policy, whichever applies.

(b) The name of the certificateholder.

(c) The type of plan only if the plan is filed in the state, an indication that the plan is self-funded, or the name of the network.

(d) The member identification number, contract number, and policy or group number, if applicable.

(e) A contact phone number or electronic address for authorizations.

(f) A phone number or electronic address whereby the covered person or hospital, physician, or other person rendering services covered by the policy may determine if the plan is insured and may obtain a benefits verification in order to estimate patient financial responsibility, in compliance with privacy rules under the Health Insurance Portability and Accountability Act.

(g) The national plan identifier, in accordance with the compliance date set forth by the federal Department of Health and Human Services.

The identification card must present the information in a readily identifiable manner or, alternatively, the information may be embedded on the card and available through magnetic stripe or smart card. The information may also be provided through other electronic technology.

Section 4. Subsection (2) of section 636.204, Florida Statutes, is amended to read:

636.204 License required.--

(2) An application for a license to operate as a discount medical plan organization must be filed with the office on a form prescribed by the commission. Such application must be sworn to by an officer or authorized representative of the applicant and be accompanied by the following, if applicable:

(a) A copy of the applicant's articles of incorporation or other organizing documents, including all amendments.

(b) A copy of the applicant's bylaws.

(c) A list of the names, addresses, official positions, and biographical information of the individuals who

are responsible for conducting the applicant's affairs, including, but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the officers, contracted management company personnel, and any person or entity owning or having the right to acquire 10 percent or more of the voting securities of the applicant. Such listing must fully disclose the extent and nature of any contracts or arrangements between any individual who is responsible for conducting the applicant's affairs and the discount medical plan organization, including any possible conflicts of interest.

(d) A complete biographical statement, on forms prescribed by the commission, an independent investigation report, and a set of fingerprints, as provided in chapter 624, with respect to each individual identified under paragraph (c).

(e) A statement generally describing the applicant, its facilities and personnel, and the medical services to be offered.

(f) A copy of the form of all contracts made or to be made between the applicant and any providers or provider networks regarding the provision of medical services to members.

(g) A copy of the form of any contract made or arrangement to be made between the applicant and any person listed in paragraph (c).

(h) A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any function, including, but not limited

to, marketing, administration, enrollment, investment management, and subcontracting for the provision of health services to members.

~~(i) A copy of the applicant's most recent financial statements audited by an independent certified public accountant. An applicant that is a subsidiary of a parent entity that is publicly traded and that prepares audited financial statements reflecting the consolidated operations of the parent entity and the subsidiary may petition the office to accept, in lieu of the audited financial statement of the applicant, the audited financial statement of the parent entity and a written guaranty by the parent entity that the minimum capital requirements of the applicant required by this part will be met by the parent entity.~~

(i)~~(j)~~ A description of the proposed method of marketing.

(j)~~(k)~~ A description of the subscriber complaint procedures to be established and maintained.

(k)~~(l)~~ The fee for issuance of a license.

(l)~~(m)~~ Such other information as the commission or office may reasonably require to make the determinations required by this part.

Section 5. Subsection (1) of section 636.206, Florida Statutes, is amended to read:

636.206 Examinations and investigations.--

(1) The office may examine or investigate the business and affairs of any discount medical plan organization if the commissioner has reason to believe that the discount medical plan organization is not complying with the requirements of this part. The office may order any discount medical plan organization or applicant to produce any records, books,

files, advertising and solicitation materials, or other information and may take statements under oath to determine whether the discount medical plan organization or applicant is in violation of the law or is acting contrary to the public interest. The expenses incurred in conducting any examination or investigation must be paid by the discount medical plan organization or applicant. Examinations and investigations must be conducted as provided in chapter 624.

Section 6. Subsection (1) of section 636.210, Florida Statutes, is amended to read:

636.210 Prohibited activities of a discount medical plan organization.--

(1) A discount medical plan organization may not:

(a) Use in its advertisements, marketing material, brochures, and discount cards the term "insurance" except as otherwise provided in this part or as a disclaimer of any relationship between discount medical plan organization benefits and insurance;

(b) Use in its advertisements, marketing material, brochures, and discount cards the terms "health plan," "coverage," "copay," "copayments," "preexisting conditions," "guaranteed issue," "premium," "PPO," "preferred provider organization," or other terms in a manner that could reasonably mislead a person into believing the discount medical plan was health insurance;

(c) Have restrictions on free access to plan providers, <u>except for hospital services,</u> including, but not limited to, waiting periods and notification periods; or

(d) Pay providers any fees for medical services.

Section 7. Section 636.216, Florida Statutes, is amended to read:

636.216 Charge or form filings.--

(1) All charges to members must be filed with the office. ~~and~~ Any charge to members greater than $30 per month or $360 per year for access to health care services other than those provided by physicians licensed under chapter 458 or chapter 459, or by hospitals licensed under chapter 395, must be approved by the office before the charges can be used. Any charge to members greater than $60 per month or $720 per year for health care services that include services provided by physicians licensed under chapter 458 or chapter 459, or by hospitals licensed under chapter 395, must be approved by the office before the charges may be used. The discount medical plan organization has the burden of proof that the charges bear a reasonable relation to the benefits received by the member.

(2) There must be a written agreement between the discount medical plan organization and the member specifying the benefits under the discount medical plan and complying with the disclosure requirements of this part.

(3) All forms used, including the written agreement pursuant to subsection (2), must first be filed with ~~and approved by~~ the office. Every form filed shall be identified by a unique form number placed in the lower left corner of each form.

(4) A charge ~~or form~~ is considered approved on the 60th day after its date of filing unless it has been previously disapproved by the office. ~~The office shall disapprove any form that does not meet the requirements of this part or that is unreasonable, discriminatory, misleading, or unfair.~~ If such filing is ~~filings are~~ disapproved, the

office shall notify the discount medical plan organization and shall specify in the notice the reasons for disapproval.

Section 8. Section 636.218, Florida Statutes, is amended to read:

636.218 Annual reports.--

(1) Each discount medical plan organization must file with the office, within 3 months after the end of each fiscal year, an annual report.

(2) Such reports must be on forms prescribed by the commission and must include:

~~(a) Audited financial statements prepared in accordance with generally accepted accounting principles certified by an independent certified public accountant, including the organization's balance sheet, income statement, and statement of changes in cash flow for the preceding year. An organization that is a subsidiary of a parent entity that is publicly traded and that prepares audited financial statements reflecting the consolidated operations of the parent entity and the organization may petition the office to accept, in lieu of the audited financial statement of the organization, the audited financial statement of the parent entity and a written guaranty by the parent entity that the minimum capital requirements of the organization required by this part will be met by the parent entity.~~

(a)~~(b)~~ If different from the initial application or the last annual report, a list of the names and residence addresses of all persons responsible for the conduct of the organization's affairs, together with a disclosure of the extent and nature of any contracts or arrangements between such persons and the discount medical plan organization, including any possible conflicts of interest.

(b)~~(c)~~ The number of discount medical plan members in the state.

(c)~~(d)~~ Such other information relating to the performance of the discount medical plan organization as is reasonably required by the commission or office.

(3) Every discount medical plan organization which fails to file an annual report in the form and within the time required by this section shall forfeit up to $500 for each day for the first 10 days during which the neglect continues and shall forfeit up to $1,000 for each day after the first 10 days during which the neglect continues; and, upon notice by the office to that effect, the organization's authority to enroll new members or to do business in this state ceases while such default continues. The office shall deposit all sums collected by the office under this section to the credit of the Insurance Regulatory Trust Fund. The office may not collect more than $50,000 for each report.

Section 9. Section 636.220, Florida Statutes, is amended to read:

636.220 Minimum capital requirements.--

(1) Each discount medical plan organization must at all times maintain a net worth of at least $150,000 and shall certify in writing and under oath at the time of licensure and annually thereafter that the minimum capitalization requirements of this part are satisfied.

(2) The office may not issue a license unless the discount medical plan organization has a net worth of at least $150,000.

Section 10. Present subsections (5) through (40) of section 641.31, Florida Statutes, are renumbered as

subsections (6) through (41), respectively, and a new subsection (5) is added to that section, to read:

641.31 Health maintenance contracts.--

(5) The contract, certificate, or member handbook must be accompanied by an identification card that contains, at a minimum:

(a) The name of the organization offering the contract or name of the organization administering the contract, whichever applies.

(b) The name of the subscriber.

(c) A statement that the health plan is a health maintenance organization. Only a health plan with a certificate of authority issued under this chapter may be identified as a health maintenance organization.

(d) The member identification number, contract number, and group number, if applicable.

(e) A contact phone number or electronic address for authorizations.

(f) A phone number or electronic address whereby the covered person or hospital, physician, or other person rendering services covered by the contract may determine if the plan is insured and may obtain a benefits verification in order to estimate patient financial responsibility, in compliance with privacy rules under the Health Insurance Portability and Accountability Act.

(g) The national plan identifier, in accordance with the compliance date set forth by the federal Department of Health and Human Services.

The identification card must present the information in a readily identifiable manner or, alternatively, the information

may be embedded on the card and available through magnetic stripe or smart card. The information may also be provided through other electronic technology.

Section 11. Paragraph (j) of subsection (3) of section 383.145, Florida Statutes, is amended to read:

383.145 Newborn and infant hearing screening.--

(3) REQUIREMENTS FOR SCREENING OF NEWBORNS; INSURANCE COVERAGE; REFERRAL FOR ONGOING SERVICES.--

(j) The initial procedure for screening the hearing of the newborn or infant and any medically necessary followup reevaluations leading to diagnosis shall be a covered benefit, reimbursable under Medicaid as an expense compensated supplemental to the per diem rate for Medicaid patients enrolled in MediPass or Medicaid patients covered by a fee for service program. For Medicaid patients enrolled in HMOs, providers shall be reimbursed directly by the Medicaid Program Office at the Medicaid rate. This service may not be considered a covered service for the purposes of establishing the payment rate for Medicaid HMOs. All health insurance policies and health maintenance organizations as provided under ss. 627.6416, 627.6579, and 641.31(31)~~(30)~~, except for supplemental policies that only provide coverage for specific diseases, hospital indemnity, or Medicare supplement, or to the supplemental polices, shall compensate providers for the covered benefit at the contracted rate. Nonhospital-based providers shall be eligible to bill Medicaid for the professional and technical component of each procedure code.

Section 12. Paragraphs (b) and (i) of subsection (1) of section 641.185, Florida Statutes, are amended to read:

641.185 Health maintenance organization subscriber protections.--

(1) With respect to the provisions of this part and part III, the principles expressed in the following statements shall serve as standards to be followed by the commission, the office, the department, and the Agency for Health Care Administration in exercising their powers and duties, in exercising administrative discretion, in administrative interpretations of the law, in enforcing its provisions, and in adopting rules:

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

(i) A health maintenance organization subscriber should receive timely and, if necessary, urgent grievances and appeals within the health maintenance organization pursuant to ss. 641.228, 641.31(6)~~(5)~~, 641.47, and 641.511.

Section 13. Subsection (1) of section 641.2018, Florida Statutes, is amended to read:

641.2018 Limited coverage for home health care authorized.--

(1) Notwithstanding other provisions of this chapter, a health maintenance organization may issue a contract that limits coverage to home health care services only. The organization and the contract shall be subject to all of the requirements of this part that do not require or otherwise apply to specific benefits other than home care services. To this extent, all of the requirements of this part apply to any organization or contract that limits coverage to home care services, except the requirements for providing comprehensive

health care services as provided in ss. 641.19(4), (11), and (12), and 641.31(1), except ss. 641.31(10)~~(9)~~, (13)~~(12), (17)~~, (18), (19), (20), (21),(22), and(25)~~(24)~~ and 641.31095.

Section 14. Section 641.3107, Florida Statutes, is amended to read:

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

Section 15. Paragraph (a) of subsection (7) of section 641.3922, Florida Statutes, is amended to read:

641.3922 Conversion contracts; conditions.--Issuance of a converted contract shall be subject to the following conditions:

(7) REASONS FOR CANCELLATION; TERMINATION.--The converted health maintenance contract must contain a cancellation or nonrenewability clause providing that the health maintenance organization may refuse to renew the contract of any person covered thereunder, but cancellation or

nonrenewal must be limited to one or more of the following reasons:

(a) Fraud or intentional misrepresentation, subject to the limitations of s. 641.31(24)~~(23)~~, in applying for any benefits under the converted health maintenance contract.~~;~~

Section 16. Subsection (4) of section 641.513, Florida Statutes, is amended to read:

641.513 Requirements for providing emergency services and care.--

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

Section 17. Except as otherwise expressly provided in this act, this act shall take effect January 1, 2007, and shall apply to identification cards issued for policies or certificates issued or renewed on or after that date.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN COMMITTEE SUBSTITUTE FOR CS for Senate Bill 1274

The committee substitute extends eligibility for a health flex plan to persons who are part of an employer group in which at least 75 percent of the employees have a family income equal to or less than 250 percent of the federal poverty level and the employer has not offered health insurance during the past six months.

The committee substitute also removes the requirement that discount medical plan organizations file audited financial statements; requires the organizations to certify that minimum capitalization requirements are satisfied; allows for a market investigation by OIR of an organization only "for cause"; allows organizations to require a waiting period for accessing hospital services; allows organizations to charge up to $60 per month without prior approval from OIR for plans that cover physicians or hospital services; and requires an organization to file forms for informational purposes with OIR before they can market the form.