Amendment No.

CHAMBER ACTION

Senate House

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Representative Nelson offered the following:

Amendment (with title amendment)

Remove line 82 and insert:

Section 2. Section 627.6562, Florida Statutes, is amended to read:

627.6562 Dependent coverage.--

(1) If an insurer offers coverage under a group, blanket, or franchise health insurance policy that insures dependent children of the policyholder or certificateholder, unless the group policyholder chooses otherwise, the policy must insure a dependent child of the policyholder or certificateholder at least until the end of the calendar year in which the child reaches the age of 25, if the child ~~meets all of the following~~:

(a) Is unmarried, a dependent as defined in the Internal Revenue Code of 1986, as amended, and the child is dependent upon the policyholder or certificateholder for support.

(b) Is a resident of the state ~~The child is living in the household of the policyholder or certificateholder, or the child is a full-time or part-time student~~.

~~(2) A policy that is subject to the requirements of subsection (1) must also offer the policyholder or certificateholder the option to insure a child of the policyholder or certificateholder at least until the end of the calendar year in which the child reaches the age of 30, if the child:~~

~~(a) Is unmarried and does not have a dependent of his or her own;~~

~~(b) Is a resident of this state or a full-time or part-time student; and~~

(c) Is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is eligible for coverage as an employee under an employer sponsored health plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

(2) ~~(3)~~ If, pursuant to subsection (1) ~~(2)~~, a child is provided coverage under the parent's policy after the end of the calendar year in which the child reaches age 30 ~~25~~ and coverage for the child is subsequently terminated, the child is not eligible to be covered under the parent's policy unless the child was continuously covered by other creditable coverage

without a gap in coverage of more than 63 days. For the purposes of this subsection, the term "creditable coverage" has the same meaning as provided in s. 627.6561(5).

(3) ~~(4)~~ This section does not:

(a) Affect or preempt an insurer's right to medically underwrite or charge the appropriate premium;

(b) Require coverage for services provided to a dependent before October 1, 2090 ~~2008~~;

(c) Require an employer to pay all or part of the cost of coverage provided for a dependent under this section; or

(d) Prohibit an insurer or health maintenance organization from increasing the limiting age for dependent coverage to age 30 in policies or contracts issued or renewed prior to the effective date of this act.

(4) ~~(5)~~(a) Until April 1, 2009, the parent of a child who qualifies for coverage under subsection (1) ~~(2)~~ but whose coverage as a dependent child under the parent's plan terminated under the terms of the plan before October 1, 2008, may make a written election to reinstate coverage, without proof of insurability, under that plan as a dependent child pursuant to this section. All other dependent children who qualify for coverage under subsection (1) shall be automatically covered at least until the end of the calendar year in which the child reaches age 30, unless the insured provides the group policyholder with written evidence that the dependent child is married, is not a resident of this state, is covered under a separate comprehensive health insurance policy, is covered under

a health benefit plan, or is entitled to benefits under Title XVIII of the Social Security Act.

(b) The covered person's plan may require the payment of a premium by the covered person or dependent child, as appropriate, subject to the approval of the Office of Insurance Regulation, for any period of coverage relating to a dependent's written election for coverage pursuant to paragraph (a).

(c) Notice regarding the reinstatement of coverage for a dependent child as provided under this subsection must be provided to a covered person in the certificate of coverage prepared for covered persons by the insurer or by the covered person's employer. Such notice may be given through the group policyholder.

(5) ~~(6)~~ This section and any cross-references to this section are only intended to apply to group major medical policies and are not intended to apply to conversion policies, policies offered pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 or s. 627.6692, individual policies, out-of-state group policies written pursuant to s. 627.6515, or limited benefit or supplemental policies, including but not limited to, dental, vision, ~~does not apply to~~ accident only, specified disease, disability income, Medicare supplement, or long-term care insurance policies.

Section 3. Paragraph (b) of subsection (12) of section 627.6699, Florida Statutes, is amended, and paragraph (l) is added to subsection (13) of that section, to read:

627.6699 Employee Health Care Access Act.--

(12) STANDARD, BASIC, HIGH DEDUCTIBLE, AND LIMITED HEALTH BENEFIT PLANS.--

(b)1. Each small employer carrier issuing new health benefit plans shall offer to any small employer, upon request, a standard health benefit plan, a basic health benefit plan, and a high deductible plan that meets the requirements of a health savings account plan as defined by federal law or a health reimbursement arrangement as authorized by the Internal Revenue Service, that meet the criteria set forth in this section.

2. For purposes of this subsection, the terms "standard health benefit plan," "basic health benefit plan," and "high deductible plan" mean policies or contracts that a small employer carrier offers to eligible small employers that contain:

a. An exclusion for services that are not medically necessary or that are not covered preventive health services; and

b. A procedure for preauthorization by the small employer carrier, or its designees.

3. A small employer carrier may include the following managed care provisions in the policy or contract to control costs:

a. A preferred provider arrangement or exclusive provider organization or any combination thereof, in which a small employer carrier enters into a written agreement with the provider to provide services at specified levels of reimbursement or to provide reimbursement to specified providers. Any such written agreement between a provider and a

small employer carrier must contain a provision under which the parties agree that the insured individual or covered member has no obligation to make payment for any medical service rendered by the provider which is determined not to be medically necessary. A carrier may use preferred provider arrangements or exclusive provider arrangements to the same extent as allowed in group products that are not issued to small employers.

b. A procedure for utilization review by the small employer carrier or its designees.

This subparagraph does not prohibit a small employer carrier from including in its policy or contract additional managed care and cost containment provisions, subject to the approval of the office, which have potential for controlling costs in a manner that does not result in inequitable treatment of insureds or subscribers. The carrier may use such provisions to the same extent as authorized for group products that are not issued to small employers.

4. The standard health benefit plan shall include:

a. Coverage for inpatient hospitalization;

b. Coverage for outpatient services;

c. Coverage for newborn children pursuant to s. 627.6575;

d. Coverage for child care supervision services pursuant to s. 627.6579;

e. Coverage for adopted children upon placement in the residence pursuant to s. 627.6578;

f. Coverage for mammograms pursuant to s. 627.6613;

g. Coverage for handicapped children pursuant to s. 627.6615;

h. Emergency or urgent care out of the geographic service area; and

i. Coverage for services provided by a hospice licensed under s. 400.602 in cases where such coverage would be the most appropriate and the most cost-effective method for treating a covered illness.

5. The standard health benefit plan and the basic health benefit plan may include a schedule of benefit limitations for specified services and procedures. If the committee develops such a schedule of benefits limitation for the standard health benefit plan or the basic health benefit plan, a small employer carrier offering the plan must offer the employer an option for increasing the benefit schedule amounts by 4 percent annually.

6. The basic health benefit plan shall include all of the benefits specified in subparagraph 4.; however, the basic health benefit plan shall place additional restrictions on the benefits and utilization and may also impose additional cost containment measures.

7. Sections 627.419(2), (3), and (4), 627.6562, 627.6574, 627.6612, 627.66121, 627.66122, 627.6616, 627.6618, 627.668, and 627.66911 apply to the standard health benefit plan and to the basic health benefit plan. However, notwithstanding said provisions, the plans may specify limits on the number of authorized treatments, if such limits are reasonable and do not discriminate against any type of provider.

8. The high deductible plan associated with a health savings account or a health reimbursement arrangement shall include all the benefits specified in subparagraph 4.

9. Each small employer carrier that provides for inpatient and outpatient services by allopathic hospitals may provide as an option of the insured similar inpatient and outpatient services by hospitals accredited by the American Osteopathic Association when such services are available and the osteopathic hospital agrees to provide the service.

(13) STANDARDS TO ASSURE FAIR MARKETING.--

(l)1. In order to improve the ability of small employers to obtain information including premium rates for small employer health benefit plans and to facilitate the application process, all small employer carriers shall use a uniform employee health status form. The office, in consultation with small employer carriers, shall develop such a form and the commission shall adopt such a form by rule. The form shall be designed to permit its use both as a written document and through electronic or other alternative delivery formats. The form shall include the following health data elements for all persons to be covered under the policy that occurred in the 2 years prior to the date of completion of the form:

a. Any treatment by any licensed medical practitioner.

b. Any procedure or treatment in a hospital, rehabilitation program, or surgical center.

c. All current medications prescribed by a licensed practitioner.

d. Current diagnosis of pregnancy.

e. Current use of any tobacco products.

f. Pending test results.

g. Workers compensation injury or illness.

h. Tests or treatments recommended but not completed.

2. The form shall require the signature of the employee completing the form. Use of a standardized form shall not prevent a small employer carrier from obtaining information from other sources in order to determine the appropriate premium rate for a small employer.

Section 4. This act shall take effect October 1. 2009, and shall apply to all policies issued or renewed on or after that date.

T I T L E A M E N D M E N T

Remove line 12 and insert:

credibility criteria for the rate adjustment; amending s. 627.6562, F.S.; revising criteria, requirements, and limitations for dependent coverage for group, blanket, or franchise health insurance policies; amending s. 627.6699, F.S.; expanding application of certain requirements to standard health and basic health benefit plans; requiring small employer carriers to use a uniform employee health status form; specifying form requirements; providing application; providing an