

1 A bill to be entitled
 2 An act relating to health and human services; repealing s.
 3 408.50, F.S., relating to prospective payment
 4 arrangements; repealing s. 408.70, F.S., relating to
 5 managed competition in health care markets; repealing s.
 6 408.9091, F.S., relating to the Cover Florida Health Care
 7 Access Program; amending s. 627.6699, F.S., the Employee
 8 Health Care Access Act; deleting from the act provisions
 9 relating to the Florida Small Employer Health Reinsurance
 10 Program; amending ss. 112.363, 395.002, 395.003, 408.07,
 11 458.345, 459.021, 627.642, 627.6475, 627.6487, 627.657,
 12 627.6675, 641.3922, 945.603, and 1011.52, F.S.; conforming
 13 provisions to changes made by the act; providing effective
 14 dates.

15
 16 Be It Enacted by the Legislature of the State of Florida:

- 17
 18 Section 1. Section 408.50, Florida Statutes, is repealed.
 19 Section 2. Section 408.70, Florida Statutes, is repealed.
 20 Section 3. Effective January 1, 2014, section 408.9091,
 21 Florida Statutes, is repealed.

22 Section 4. Paragraph (d) of subsection (2) of section
 23 112.363, Florida Statutes, is amended to read:
 24 112.363 Retiree health insurance subsidy.—
 25 (2) ELIGIBILITY FOR RETIREE HEALTH INSURANCE SUBSIDY.—
 26 (d) Payment of the retiree health insurance subsidy shall
 27 be made only after coverage for health insurance for the retiree
 28 or beneficiary has been certified in writing to the Department

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29 of Management Services. Participation in a former employer's
 30 group health insurance program is not a requirement for
 31 eligibility under this section. ~~Coverage issued pursuant to s.~~
 32 ~~408.9091 is considered health insurance for the purposes of this~~
 33 ~~section.~~

34 Section 5. Subsection (23) of section 395.002, Florida
 35 Statutes, is amended to read

36 395.002 Definitions.—As used in this chapter:

37 (23) "Premises" means those buildings, beds, and equipment
 38 located at the address of the licensed facility and all other
 39 buildings, beds, and equipment for the provision of hospital,
 40 ambulatory surgical, or mobile surgical care located in such
 41 reasonable proximity to the address of the licensed facility as
 42 to appear to the public to be under the dominion and control of
 43 the licensee. For any licensee that is a teaching hospital as
 44 defined in s. 408.07 (44) ~~(45)~~, reasonable proximity includes any
 45 buildings, beds, services, programs, and equipment under the
 46 dominion and control of the licensee that are located at a site
 47 with a main address that is within 1 mile of the main address of
 48 the licensed facility; and all such buildings, beds, and
 49 equipment may, at the request of a licensee or applicant, be
 50 included on the facility license as a single premises.

51 Section 6. Paragraph (b) of subsection (2) of section
 52 395.003, Florida Statutes, is amended to read:

53 395.003 Licensure; denial, suspension, and revocation.—

54 (2)

55 (b) The agency shall, at the request of a licensee that is
 56 a teaching hospital as defined in s. 408.07 (44) ~~(45)~~, issue a

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57 | single license to a licensee for facilities that have been
 58 | previously licensed as separate premises, provided such
 59 | separately licensed facilities, taken together, constitute the
 60 | same premises as defined in s. 395.002(23). Such license for the
 61 | single premises shall include all of the beds, services, and
 62 | programs that were previously included on the licenses for the
 63 | separate premises. The granting of a single license under this
 64 | paragraph shall not in any manner reduce the number of beds,
 65 | services, or programs operated by the licensee.

66 | Section 7. Subsections (42) through (45) of section
 67 | 408.07, Florida Statutes, are renumbered as subsections (41)
 68 | through (44), respectively, and present subsection (41) of that
 69 | section is amended to read:

70 | 408.07 Definitions.—As used in this chapter, with the
 71 | exception of ss. 408.031-408.045, the term:

72 | ~~(41) "Prospective payment arrangement" means a financial~~
 73 | ~~agreement negotiated between a hospital and an insurer, health~~
 74 | ~~maintenance organization, preferred provider organization, or~~
 75 | ~~other third party payor which contains, at a minimum, the~~
 76 | ~~elements provided for in s. 408.50.~~

77 | Section 8. Subsection (1) of section 458.345, Florida
 78 | Statutes, is amended to read:

79 | 458.345 Registration of resident physicians, interns, and
 80 | fellows; list of hospital employees; prescribing of medicinal
 81 | drugs; penalty.—

82 | (1) Any person desiring to practice as a resident
 83 | physician, assistant resident physician, house physician,
 84 | intern, or fellow in fellowship training which leads to

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85 subspecialty board certification in this state, or any person
86 desiring to practice as a resident physician, assistant resident
87 physician, house physician, intern, or fellow in fellowship
88 training in a teaching hospital in this state as defined in s.
89 408.07 (44) ~~(45)~~ or s. 395.805(2), who does not hold a valid,
90 active license issued under this chapter shall apply to the
91 department to be registered and shall remit a fee not to exceed
92 \$300 as set by the board. The department shall register any
93 applicant the board certifies has met the following
94 requirements:

95 (a) Is at least 21 years of age.

96 (b) Has not committed any act or offense within or without
97 the state which would constitute the basis for refusal to
98 certify an application for licensure pursuant to s. 458.331.

99 (c) Is a graduate of a medical school or college as
100 specified in s. 458.311(1)(f).

101 Section 9. Subsection (1) of section 459.021, Florida
102 Statutes, is amended to read:

103 459.021 Registration of resident physicians, interns, and
104 fellows; list of hospital employees; penalty.—

105 (1) Any person who holds a degree of Doctor of Osteopathic
106 Medicine from a college of osteopathic medicine recognized and
107 approved by the American Osteopathic Association who desires to
108 practice as a resident physician, assistant resident physician,
109 house physician, intern, or fellow in fellowship training which
110 leads to subspecialty board certification in this state, or any
111 person desiring to practice as a resident physician, assistant
112 resident physician, house physician, intern, or fellow in

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113 fellowship training in a teaching hospital in this state as
114 defined in s. 408.07 (44) ~~(45)~~ or s. 395.805(2), who does not hold
115 an active license issued under this chapter shall apply to the
116 department to be registered, on an application provided by the
117 department, before commencing such a training program and shall
118 remit a fee not to exceed \$300 as set by the board.

119 Section 10. Subsection (3) of section 627.642, Florida
120 Statutes, is amended to read:

121 627.642 Outline of coverage.—

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

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

128 (b) The name of the contract holder.

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

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

134 (e) A contact phone number or electronic address for
135 authorizations and admission certifications.

136 (f) A phone number or electronic address whereby the
137 covered person or hospital, physician, or other person rendering
138 services covered by the policy may obtain benefits verification
139 and information in order to estimate patient financial
140 responsibility, in compliance with privacy rules under the

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141 Health Insurance Portability and Accountability Act.

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

145
 146 The identification card must present the information in a
 147 readily identifiable manner or, alternatively, the information
 148 may be embedded on the card and available through magnetic
 149 stripe or smart card. The information may also be provided
 150 through other electronic technology.

151 Section 11. Section 627.6475, Florida Statutes, is amended
 152 to read:

153 627.6475 Individual reinsurance pool.—

154 (1) PURPOSE.—The purpose of this section is to provide for
 155 the establishment of a reinsurance program for coverage of
 156 individuals who are eligible for issuance of individual health
 157 insurance from a health insurance issuer pursuant to s.
 158 627.6487.

159 (2) DEFINITIONS.—As used in this section:

160 (a) ~~"Board," "carrier,"~~ and "Health benefit plan" has have
 161 the same meaning ascribed in s. 627.6699(3) (j).

162 (b) "Health insurance issuer," "issuer," and "individual
 163 health insurance" have the same meaning ascribed in s.
 164 627.6487(2).

165 ~~(c) "Reinsuring carrier" means a health insurance issuer
 166 that elects to comply with the requirements set forth in
 167 subsection (7).~~

168 (c) ~~(d)~~ "Risk-assuming carrier" means a health insurance

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169 issuer that elects to comply with the requirements set forth in
 170 subsection (6).

171 (d)~~(e)~~ "Eligible individual" has the same meaning ascribed
 172 in s. 627.6487(3).

173 (3) APPLICABILITY AND SCOPE.—This section applies to
 174 individual health insurance offered by a health insurance issuer
 175 to an eligible individual.

176 (4) MAINTENANCE OF RECORDS.—Each health insurance issuer
 177 that offers individual health insurance must maintain at its
 178 principal place of business a complete and detailed description
 179 of its rating practices and renewal practices, as required for
 180 small employer carriers pursuant to s. 627.6699(8).

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

182 (a) Each health insurance issuer that offers individual
 183 health insurance must elect to become a risk-assuming carrier ~~or~~
 184 ~~a reinsuring carrier~~ for purposes of this section. Each such
 185 issuer must make an initial election, binding through December
 186 31, 1999. The issuer's initial election must be made no later
 187 than October 31, 1997. By October 31, 1997, all issuers must
 188 file a final election, which is binding for 2 years, from
 189 January 1, 1998, through December 31, 1999, after which an
 190 election shall be binding for a period of 5 years. The office
 191 may permit an issuer to modify its election at any time for good
 192 cause shown, after a hearing.

193 ~~(b) The office shall establish an application process for~~
 194 ~~issuers seeking to change their status under this subsection.~~

195 (b)~~(e)~~ An election to become a risk-assuming carrier is
 196 subject to approval under this subsection.

197 ~~(d) An issuer that elects to cease participating as a~~
 198 ~~reinsuring carrier and to become a risk-assuming carrier may not~~
 199 ~~reinsure or continue to reinsure any individual health benefits~~
 200 ~~plan under subsection (7) once the issuer becomes a risk-~~
 201 ~~assuming carrier, and the issuer must pay a prorated assessment~~
 202 ~~based upon business issued as a reinsuring carrier for any~~
 203 ~~portion of the year that the business was reinsured. An issuer~~
 204 ~~that elects to cease participating as a risk-assuming carrier~~
 205 ~~and to become a reinsuring carrier may reinsure individual~~
 206 ~~health insurance under the terms set forth in subsection (7) and~~
 207 ~~must pay a prorated assessment based upon business issued as a~~
 208 ~~reinsuring carrier for any portion of the year that the business~~
 209 ~~was reinsured.~~

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

211 (a)1. A health insurance issuer that offers individual
 212 health insurance may become a risk-assuming carrier by filing
 213 with the office a designation of election under this subsection
 214 in a format and manner prescribed by the commission. The office
 215 shall approve the election of a health insurance issuer to
 216 become a risk-assuming carrier if the office finds that the
 217 issuer is capable of assuming that status pursuant to the
 218 criteria set forth in paragraph (b).

219 2. The office must approve or disapprove any designation
 220 as a risk-assuming carrier within 60 days after a filing.

221 (b) In determining whether to approve an application by an
 222 issuer to become a risk-assuming carrier, the office shall
 223 consider:

224 1. The issuer's financial ability to support the

225 assumption of the risk of individuals.

226 2. The issuer's history of rating and underwriting
227 individuals.

228 3. The issuer's commitment to market fairly to all
229 individuals in the state or its service area, as applicable.

230 ~~4. The issuer's ability to assume and manage the risk of~~
231 ~~enrolling individuals without the protection of the reinsurance~~
232 ~~program provided in subsection (7).~~

233 (c) The office shall provide public notice of an issuer's
234 designation of election under this subsection to become a risk-
235 assuming carrier and shall provide at least a 21-day period for
236 public comment prior to making a decision on the election. The
237 office shall hold a hearing on the election at the request of
238 the issuer.

239 (d) The office may rescind the approval granted to a risk-
240 assuming carrier under this subsection if the office finds that
241 the carrier no longer meets the criteria of paragraph (b).

242 ~~(7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.—~~

243 ~~(a) The individual health reinsurance program shall~~
244 ~~operate subject to the supervision and control of the board of~~
245 ~~the small employer health reinsurance program established~~
246 ~~pursuant to s. 627.6699(11). The board shall establish a~~
247 ~~separate, segregated account for eligible individuals reinsured~~
248 ~~pursuant to this section, which account may not be commingled~~
249 ~~with the small employer health reinsurance account.~~

250 ~~(b) A reinsuring carrier may reinsure with the program~~
251 ~~coverage of an eligible individual, subject to each of the~~
252 ~~following provisions:~~

253 ~~1. A reinsuring carrier may reinsure an eligible~~
 254 ~~individual within 60 days after commencement of the coverage of~~
 255 ~~the eligible individual.~~

256 ~~2. The program may not reimburse a participating carrier~~
 257 ~~with respect to the claims of a reinsured eligible individual~~
 258 ~~until the carrier has paid incurred claims of at least \$5,000 in~~
 259 ~~a calendar year for benefits covered by the program. In~~
 260 ~~addition, the reinsuring carrier is responsible for 10 percent~~
 261 ~~of the next \$50,000 and 5 percent of the next \$100,000 of~~
 262 ~~incurred claims during a calendar year, and the program shall~~
 263 ~~reinsure the remainder.~~

264 ~~3. The board shall annually adjust the initial level of~~
 265 ~~claims and the maximum limit to be retained by the carrier to~~
 266 ~~reflect increases in costs and utilization within the standard~~
 267 ~~market for health benefit plans within the state. The adjustment~~
 268 ~~may not be less than the annual change in the medical component~~
 269 ~~of the "Commerce Price Index for All Urban Consumers" of the~~
 270 ~~Bureau of Labor Statistics of the United States Department of~~
 271 ~~Labor, unless the board proposes and the office approves a lower~~
 272 ~~adjustment factor.~~

273 ~~4. A reinsuring carrier may terminate reinsurance for all~~
 274 ~~reinsured eligible individuals on any plan anniversary.~~

275 ~~5. The premium rate charged for reinsurance by the program~~
 276 ~~to a health maintenance organization that is approved by the~~
 277 ~~Secretary of Health and Human Services as a federally qualified~~
 278 ~~health maintenance organization pursuant to 42 U.S.C. s.~~
 279 ~~300e(c)(2)(A) and that, as such, is subject to requirements that~~
 280 ~~limit the amount of risk that may be ceded to the program, which~~

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281 ~~requirements are more restrictive than subparagraph 2., shall be~~
282 ~~reduced by an amount equal to that portion of the risk, if any,~~
283 ~~which exceeds the amount set forth in subparagraph 2., which may~~
284 ~~not be ceded to the program.~~

285 ~~6. The board may consider adjustments to the premium rates~~
286 ~~charged for reinsurance by the program or carriers that use~~
287 ~~effective cost containment measures, including high cost case~~
288 ~~management, as defined by the board.~~

289 ~~7. A reinsuring carrier shall apply its case management~~
290 ~~and claims handling techniques, including, but not limited to,~~
291 ~~utilization review, individual case management, preferred~~
292 ~~provider provisions, other managed care provisions, or methods~~
293 ~~of operation consistently with both reinsured business and~~
294 ~~nonreinsured business.~~

295 ~~(c)1. The board, as part of the plan of operation, shall~~
296 ~~establish a methodology for determining premium rates to be~~
297 ~~charged by the program for reinsuring eligible individuals~~
298 ~~pursuant to this section. The methodology must include a system~~
299 ~~for classifying individuals which reflects the types of case~~
300 ~~characteristics commonly used by carriers in this state. The~~
301 ~~methodology must provide for the development of basic~~
302 ~~reinsurance premium rates, which shall be multiplied by the~~
303 ~~factors set for them in this paragraph to determine the premium~~
304 ~~rates for the program. The basic reinsurance premium rates shall~~
305 ~~be established by the board, subject to the approval of the~~
306 ~~office, and shall be set at levels that reasonably approximate~~
307 ~~gross premiums charged to eligible individuals for individual~~
308 ~~health insurance by health insurance issuers. The premium rates~~

309 ~~set by the board may vary by geographical area, as determined~~
 310 ~~under this section, to reflect differences in cost. An eligible~~
 311 ~~individual may be reinsured for a rate that is five times the~~
 312 ~~rate established by the board.~~

313 ~~2. The board shall periodically review the methodology~~
 314 ~~established, including the system of classification and any~~
 315 ~~rating factors, to ensure that it reasonably reflects the claims~~
 316 ~~experience of the program. The board may propose changes to the~~
 317 ~~rates that are subject to the approval of the office.~~

318 ~~(d) If individual health insurance for an eligible~~
 319 ~~individual is entirely or partially reinsured with the program~~
 320 ~~pursuant to this section, the premium charged to the eligible~~
 321 ~~individual for any rating period for the coverage issued must be~~
 322 ~~the same premium that would have been charged to that individual~~
 323 ~~if the health insurance issuer elected not to reinsure coverage~~
 324 ~~for that individual.~~

325 ~~(e)1. Before March 1 of each calendar year, the board~~
 326 ~~shall determine and report to the office the program net loss in~~
 327 ~~the individual account for the previous year, including~~
 328 ~~administrative expenses for that year and the incurred losses~~
 329 ~~for that year, taking into account investment income and other~~
 330 ~~appropriate gains and losses.~~

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

333 ~~a. The operating losses of the program shall be assessed~~
 334 ~~in the following order subject to the specified limitations. The~~
 335 ~~first tier of assessments shall be made against reinsuring~~
 336 ~~carriers in an amount that may not exceed 5 percent of each~~

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337 ~~reinsuring carrier's premiums for individual health insurance.~~
338 ~~If such assessments have been collected and additional moneys~~
339 ~~are needed, the board shall make a second tier of assessments in~~
340 ~~an amount that may not exceed 0.5 percent of each carrier's~~
341 ~~health benefit plan premiums.~~

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

347 ~~e. The board shall equitably assess reinsuring carriers~~
348 ~~for operating losses of the individual account based on market~~
349 ~~share. The board shall annually assess each carrier a portion of~~
350 ~~the operating losses of the individual account. The first tier~~
351 ~~of assessments shall be determined by multiplying the operating~~
352 ~~losses by a fraction, the numerator of which equals the~~
353 ~~reinsuring carrier's earned premium pertaining to direct~~
354 ~~writings of individual health insurance in the state during the~~
355 ~~calendar year for which the assessment is levied, and the~~
356 ~~denominator of which equals the total of all such premiums~~
357 ~~earned by reinsuring carriers in the state during that calendar~~
358 ~~year. The second tier of assessments shall be based on the~~
359 ~~premiums that all carriers, except risk-assuming carriers,~~
360 ~~earned on all health benefit plans written in this state. The~~
361 ~~board may levy interim assessments against reinsuring carriers~~
362 ~~to ensure the financial ability of the plan to cover claims~~
363 ~~expenses and administrative expenses paid or estimated to be~~
364 ~~paid in the operation of the plan for the calendar year prior to~~

365 ~~the association's anticipated receipt of annual assessments for~~
 366 ~~that calendar year. Any interim assessment is due and payable~~
 367 ~~within 30 days after receipt by a carrier of the interim~~
 368 ~~assessment notice. Interim assessment payments shall be credited~~
 369 ~~against the carrier's annual assessment. Health benefit plan~~
 370 ~~premiums and benefits paid by a carrier that are less than an~~
 371 ~~amount determined by the board to justify the cost of collection~~
 372 ~~may not be considered for purposes of determining assessments.~~

373 ~~d. Subject to the approval of the office, the board shall~~
 374 ~~adjust the assessment formula for reinsuring carriers that are~~
 375 ~~approved as federally qualified health maintenance organizations~~
 376 ~~by the Secretary of Health and Human Services pursuant to 42~~
 377 ~~U.S.C. s. 300e(c)(2)(A) to the extent, if any, that restrictions~~
 378 ~~are placed on them which are not imposed on other carriers.~~

379 ~~3. Before March 1 of each year, the board shall determine~~
 380 ~~and file with the office an estimate of the assessments needed~~
 381 ~~to fund the losses incurred by the program in the individual~~
 382 ~~account for the previous calendar year.~~

383 ~~4. If the board determines that the assessments needed to~~
 384 ~~fund the losses incurred by the program in the individual~~
 385 ~~account for the previous calendar year will exceed the amount~~
 386 ~~specified in subparagraph 2., the board shall evaluate the~~
 387 ~~operation of the program and report its findings and~~
 388 ~~recommendations to the office in the format established in s.~~
 389 ~~627.6699(11) for the comparable report for the small employer~~
 390 ~~reinsurance program.~~

391 ~~(f) Notwithstanding paragraph (e), the administrative~~
 392 ~~expenses of the program shall be recouped by assessing risk-~~

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393 ~~assuming carriers and reinsuring carriers, and such amounts may~~
394 ~~not be considered part of the operating losses of the plan for~~
395 ~~the purposes of this paragraph. Each carrier's portion of such~~
396 ~~administrative expenses shall be determined by multiplying the~~
397 ~~total of such administrative expenses by a fraction, the~~
398 ~~numerator of which equals the carrier's earned premium~~
399 ~~pertaining to direct writing of individual health benefit plans~~
400 ~~in the state during the calendar year for which the assessment~~
401 ~~is levied, and the denominator of which equals the total of such~~
402 ~~premiums earned by all carriers in the state during such~~
403 ~~calendar year.~~

404 ~~(g) Except as otherwise provided in this section, the~~
405 ~~board and the office shall have all powers, duties, and~~
406 ~~responsibilities with respect to carriers that issue and~~
407 ~~reinsure individual health insurance, as specified for the board~~
408 ~~and the office in s. 627.6699(11) with respect to small employer~~
409 ~~carriers, including, but not limited to, the provisions of s.~~
410 ~~627.6699(11) relating to:~~

411 ~~1. Use of assessments that exceed the amount of actual~~
412 ~~losses and expenses.~~

413 ~~2. The annual determination of each carrier's proportion~~
414 ~~of the assessment.~~

415 ~~3. Interest for late payment of assessments.~~

416 ~~4. Authority for the office to approve deferment of an~~
417 ~~assessment against a carrier.~~

418 ~~5. Limited immunity from legal actions or carriers.~~

419 ~~6. Development of standards for compensation to be paid to~~
420 ~~agents. Such standards shall be limited to those specifically~~

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421 ~~enumerated in s. 627.6699(13)(d).~~

422 ~~7. Monitoring compliance by carriers with this section.~~

423 ~~(7)-(8) STANDARDS TO ASSURE FAIR MARKETING.-~~

424 (a) Each health insurance issuer that offers individual
 425 health insurance shall actively market coverage to eligible
 426 individuals in the state. The provisions of s. 627.6699(11)~~(13)~~
 427 that apply to small employer carriers that market policies to
 428 small employers ~~shall~~ also apply to health insurance issuers
 429 that offer individual health insurance with respect to marketing
 430 policies to individuals.

431 (b) A violation of this section by a health insurance
 432 issuer or an agent is an unfair trade practice under s. 626.9541
 433 or ss. 641.3903 and 641.3907.

434 ~~(8)-(9) RULEMAKING AUTHORITY.-~~The commission may adopt
 435 rules to administer this section, including rules governing
 436 compliance by carriers.

437 Section 12. Subsection (9) of section 627.6487, Florida
 438 Statutes, is amended to read:

439 627.6487 Guaranteed availability of individual health
 440 insurance coverage to eligible individuals.-

441 (9) Each health insurance issuer that offers individual
 442 health insurance coverage to an eligible individual shall elect
 443 to become a risk-assuming carrier ~~or a reinsuring carrier~~, as
 444 provided by s. 627.6475.

445 Section 13. Subsection (2) of section 627.657, Florida
 446 Statutes, is amended to read:

447 627.657 Provisions of group health insurance policies.-

448 (2) The medical policy as specified in s.

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449 627.6699(3) (j) ~~(k)~~ must be accompanied by an identification card
450 that contains, at a minimum:

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

454 (b) The name of the certificateholder.

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

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

460 (e) A contact phone number or electronic address for
461 authorizations and admission certifications.

462 (f) A phone number or electronic address whereby the
463 covered person or hospital, physician, or other person rendering
464 services covered by the policy may obtain benefits verification
465 and information in order to estimate patient financial
466 responsibility, in compliance with privacy rules under the
467 Health Insurance Portability and Accountability Act.

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

471

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

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477 Section 14. Subsection (11) of section 627.6675, Florida
478 Statutes, is amended to read:

479 627.6675 Conversion on termination of eligibility.—Subject
480 to all of the provisions of this section, a group policy
481 delivered or issued for delivery in this state by an insurer or
482 nonprofit health care services plan that provides, on an
483 expense-incurred basis, hospital, surgical, or major medical
484 expense insurance, or any combination of these coverages, shall
485 provide that an employee or member whose insurance under the
486 group policy has been terminated for any reason, including
487 discontinuance of the group policy in its entirety or with
488 respect to an insured class, and who has been continuously
489 insured under the group policy, and under any group policy
490 providing similar benefits that the terminated group policy
491 replaced, for at least 3 months immediately prior to
492 termination, shall be entitled to have issued to him or her by
493 the insurer a policy or certificate of health insurance,
494 referred to in this section as a "converted policy." A group
495 insurer may meet the requirements of this section by contracting
496 with another insurer, authorized in this state, to issue an
497 individual converted policy, which policy has been approved by
498 the office under s. 627.410. An employee or member shall not be
499 entitled to a converted policy if termination of his or her
500 insurance under the group policy occurred because he or she
501 failed to pay any required contribution, or because any
502 discontinued group coverage was replaced by similar group
503 coverage within 31 days after discontinuance.

504 (11) ALTERNATIVE PLANS.—The insurer shall, in addition to

505 the option required by subsection (10), offer the standard
 506 health benefit plan, as established pursuant to s.
 507 627.6699 (10) ~~(12)~~. The insurer may, at its option, also offer
 508 alternative plans for group health conversion in addition to the
 509 plans required by this section.

510 Section 15. Subsections (10) and (12) through (17) of
 511 section 627.6699, Florida Statutes, are renumbered as
 512 subsections (9) and (10) through (15), respectively, and present
 513 subsections (2), (3), (9), (10), and (11), paragraph (a) of
 514 present subsection (12), paragraph (e) of present subsection
 515 (13), paragraph (k) of present subsection (15), and paragraphs
 516 (a), (c), and (d) of present subsection (16) of that section are
 517 amended, to read:

518 627.6699 Employee Health Care Access Act.—

519 (2) PURPOSE AND INTENT.—The purpose and intent of this
 520 section is to promote the availability of health insurance
 521 coverage to small employers regardless of their claims
 522 experience or their employees' health status, to establish rules
 523 regarding renewability of that coverage, to establish
 524 limitations on the use of exclusions for preexisting conditions,
 525 to provide for development of a standard health benefit plan and
 526 a basic health benefit plan to be offered to all small
 527 employers, ~~to provide for establishment of a reinsurance program~~
 528 ~~for coverage of small employers~~, and to improve the overall
 529 fairness and efficiency of the small group health insurance
 530 market.

531 (3) DEFINITIONS.—As used in this section, the term:

532 (a) "Actuarial certification" means a written statement,

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533 by a member of the American Academy of Actuaries or another
534 person acceptable to the office, that a small employer carrier
535 is in compliance with subsection (6), based upon the person's
536 examination, including a review of the appropriate records and
537 of the actuarial assumptions and methods used by the carrier in
538 establishing premium rates for applicable health benefit plans.

539 (b) "Basic health benefit plan" and "standard health
540 benefit plan" mean low-cost health care plans developed pursuant
541 to subsection (10) ~~(12)~~.

542 ~~(c) "Board" means the board of directors of the program.~~

543 (c) ~~(d)~~ "Carrier" means a person who provides health
544 benefit plans in this state, including an authorized insurer, a
545 health maintenance organization, a multiple-employer welfare
546 arrangement, or any other person providing a health benefit plan
547 that is subject to insurance regulation in this state. However,
548 the term does not include a multiple-employer welfare
549 arrangement, which multiple-employer welfare arrangement
550 operates solely for the benefit of the members or the members
551 and the employees of such members, and was in existence on
552 January 1, 1992.

553 (d) ~~(e)~~ "Case management program" means the specific
554 supervision and management of the medical care provided or
555 prescribed for a specific individual, which may include the use
556 of health care providers designated by the carrier.

557 (e) ~~(f)~~ "Creditable coverage" has the same meaning ascribed
558 in s. 627.6561.

559 (f) ~~(g)~~ "Dependent" means the spouse or child of an
560 eligible employee, subject to the applicable terms of the health

561 benefit plan covering that employee.

562 (g)~~(h)~~ "Eligible employee" means an employee who works
 563 full time, having a normal workweek of 25 or more hours, and who
 564 has met any applicable waiting-period requirements or other
 565 requirements of this act. The term includes a self-employed
 566 individual, a sole proprietor, a partner of a partnership, or an
 567 independent contractor, if the sole proprietor, partner, or
 568 independent contractor is included as an employee under a health
 569 benefit plan of a small employer, but does not include a part-
 570 time, temporary, or substitute employee.

571 (h)~~(i)~~ "Established geographic area" means the county or
 572 counties, or any portion of a county or counties, within which
 573 the carrier provides or arranges for health care services to be
 574 available to its insureds, members, or subscribers.

575 (i)~~(j)~~ "Guaranteed-issue basis" means an insurance policy
 576 that must be offered to an employer, employee, or dependent of
 577 the employee, regardless of health status, preexisting
 578 conditions, or claims history.

579 (j)~~(k)~~ "Health benefit plan" means any hospital or medical
 580 policy or certificate, hospital or medical service plan
 581 contract, or health maintenance organization subscriber
 582 contract. The term does not include accident-only, specified
 583 disease, individual hospital indemnity, credit, dental-only,
 584 vision-only, Medicare supplement, long-term care, or disability
 585 income insurance; similar supplemental plans provided under a
 586 separate policy, certificate, or contract of insurance, which
 587 cannot duplicate coverage under an underlying health plan and
 588 are specifically designed to fill gaps in the underlying health

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589 plan, coinsurance, or deductibles; coverage issued as a
590 supplement to liability insurance; workers' compensation or
591 similar insurance; or automobile medical-payment insurance.

592 (k)~~(l)~~ "Late enrollee" means an eligible employee or
593 dependent as defined under s. 627.6561(1)(b).

594 (l)~~(m)~~ "Limited benefit policy or contract" means a policy
595 or contract that provides coverage for each person insured under
596 the policy for a specifically named disease or diseases, a
597 specifically named accident, or a specifically named limited
598 market that fulfills an experimental or reasonable need, such as
599 the small group market.

600 (m)~~(n)~~ "Modified community rating" means a method used to
601 develop carrier premiums which spreads financial risk across a
602 large population; allows the use of separate rating factors for
603 age, gender, family composition, tobacco usage, and geographic
604 area as determined under paragraph (5)(j); and allows
605 adjustments for: claims experience, health status, or duration
606 of coverage as permitted under subparagraph (6)(b)5.; and
607 administrative and acquisition expenses as permitted under
608 subparagraph (6)(b)5.

609 (n)~~(o)~~ "Participating carrier" means any carrier that
610 issues health benefit plans in this state except a small
611 employer carrier that elects to be a risk-assuming carrier.

612 ~~(p) "Plan of operation" means the plan of operation of the
613 program, including articles, bylaws, and operating rules,
614 adopted by the board under subsection (11).~~

615 ~~(q) "Program" means the Florida Small Employer Carrier
616 Reinsurance Program created under subsection (11).~~

617 (o)~~(r)~~ "Rating period" means the calendar period for which
 618 premium rates established by a small employer carrier are
 619 assumed to be in effect.

620 ~~(s) "Reinsuring carrier" means a small employer carrier~~
 621 ~~that elects to comply with the requirements set forth in~~
 622 ~~subsection (11).~~

623 (p)~~(t)~~ "Risk-assuming carrier" means a small employer
 624 carrier that elects to comply with the requirements set forth in
 625 subsection (9) ~~(10)~~.

626 (q)~~(u)~~ "Self-employed individual" means an individual or
 627 sole proprietor who derives his or her income from a trade or
 628 business carried on by the individual or sole proprietor which
 629 results in taxable income as indicated on IRS Form 1040,
 630 schedule C or F, and which generated taxable income in one of
 631 the 2 previous years.

632 (r)~~(v)~~ "Small employer" means, in connection with a health
 633 benefit plan with respect to a calendar year and a plan year,
 634 any person, sole proprietor, self-employed individual,
 635 independent contractor, firm, corporation, partnership, or
 636 association that is actively engaged in business, has its
 637 principal place of business in this state, employed an average
 638 of at least 1 but not more than 50 eligible employees on
 639 business days during the preceding calendar year the majority of
 640 whom were employed in this state, employs at least 1 employee on
 641 the first day of the plan year, and is not formed primarily for
 642 purposes of purchasing insurance. In determining the number of
 643 eligible employees, companies that are an affiliated group as
 644 defined in s. 1504(a) of the Internal Revenue Code of 1986, as

645 amended, are considered a single employer. For purposes of this
 646 section, a sole proprietor, an independent contractor, or a
 647 self-employed individual is considered a small employer only if
 648 all of the conditions and criteria established in this section
 649 are met.

650 (s)~~(w)~~ "Small employer carrier" means a carrier that
 651 offers health benefit plans covering eligible employees of one
 652 or more small employers.

653 ~~(9) SMALL EMPLOYER CARRIER'S ELECTION TO BECOME A RISK-~~
 654 ~~ASSUMING CARRIER OR A REINSURING CARRIER.~~

655 ~~(a) A small employer carrier must elect to become either a~~
 656 ~~risk-assuming carrier or a reinsuring carrier. By October 31,~~
 657 ~~1993, all small employer carriers must file a final election,~~
 658 ~~which is binding for 2 years, from January 1, 1994, through~~
 659 ~~December 31, 1995, after which an election shall be binding for~~
 660 ~~a period of 5 years. Any carrier that is not a small employer~~
 661 ~~carrier and intends to become a small employer carrier must file~~
 662 ~~its designation when it files the forms and rates it intends to~~
 663 ~~use for small employer group health insurance; such designation~~
 664 ~~shall be binding for 2 years after the date of approval of the~~
 665 ~~forms and rates, and any subsequent designation is binding for 5~~
 666 ~~years. The office may permit a carrier to modify its election at~~
 667 ~~any time for good cause shown, after a hearing.~~

668 ~~(b) The commission shall establish an application process~~
 669 ~~for small employer carriers seeking to change their status under~~
 670 ~~this subsection.~~

671 ~~(c) An election to become a risk-assuming carrier is~~
 672 ~~subject to approval under subsection (10).~~

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673 ~~(d) A small employer carrier that elects to cease~~
674 ~~participating as a reinsuring carrier and to become a risk-~~
675 ~~assuming carrier is prohibited from reinsuring or continuing to~~
676 ~~reinsure any small employer health benefits plan under~~
677 ~~subsection (11) as soon as the carrier becomes a risk-assuming~~
678 ~~carrier and must pay a prorated assessment based upon business~~
679 ~~issued as a reinsuring carrier for any portion of the year that~~
680 ~~the business was reinsured. A small employer carrier that elects~~
681 ~~to cease participating as a risk-assuming carrier and to become~~
682 ~~a reinsuring carrier is permitted to reinsure small employer~~
683 ~~health benefit plans under the terms set forth in subsection~~
684 ~~(11) and must pay a prorated assessment based upon business~~
685 ~~issued as a reinsuring carrier for any portion of the year that~~
686 ~~the business was reinsured.~~

687 (9)~~(10)~~ ELECTION PROCESS TO BECOME A RISK-ASSUMING
688 CARRIER.—

689 (a)1. ~~A small employer carrier may become a risk-assuming~~
690 ~~carrier by filing with the office a designation of election~~
691 ~~under subsection (9) in a format and manner prescribed by the~~
692 ~~commission. The office shall approve the election of a small~~
693 ~~employer carrier to become a risk-assuming carrier if the office~~
694 ~~finds that the carrier is capable of assuming that status~~
695 ~~pursuant to the criteria set forth in paragraph (b).~~

696 2. The office must approve or disapprove any designation
697 as a risk-assuming carrier within 60 days after filing.

698 (b) In determining whether to approve an application by a
699 small employer carrier to become a risk-assuming carrier, the
700 office shall consider:

701 1. The carrier's financial ability to support the
702 assumption of the risk of small employer groups.

703 2. The carrier's history of rating and underwriting small
704 employer groups.

705 3. The carrier's commitment to market fairly to all small
706 employers in the state or its service area, as applicable.

707 ~~4. The carrier's ability to assume and manage the risk of~~
708 ~~enrolling small employer groups without the protection of the~~
709 ~~reinsurance program provided in subsection (11).~~

710 ~~(c) A small employer carrier that becomes a risk-assuming~~
711 ~~carrier pursuant to this subsection is not subject to the~~
712 ~~assessment provisions of subsection (11).~~

713 ~~(d) The office shall provide public notice of a small~~
714 ~~employer carrier's designation of election under subsection (9)~~
715 ~~to become a risk-assuming carrier and shall provide at least a~~
716 ~~21-day period for public comment prior to making a decision on~~
717 ~~the election. The office shall hold a hearing on the election at~~
718 ~~the request of the carrier.~~

719 (c)(e) The office may rescind the approval granted to a
720 risk-assuming carrier under this subsection if the office finds
721 that the carrier no longer meets the criteria of paragraph (b).

722 ~~(11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.—~~

723 ~~(a) There is created a nonprofit entity to be known as the~~
724 ~~"Florida Small Employer Health Reinsurance Program."~~

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

727 ~~2. Effective upon this act becoming a law, the board shall~~
728 ~~consist of the director of the office or his or her designee,~~

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729 ~~who shall serve as the chairperson, and 13 additional members~~
730 ~~who are representatives of carriers and insurance agents and are~~
731 ~~appointed by the director of the office and serve as follows:~~

732 ~~a. Five members shall be representatives of health~~
733 ~~insurers licensed under chapter 624 or chapter 641. Two members~~
734 ~~shall be agents who are actively engaged in the sale of health~~
735 ~~insurance. Four members shall be employers or representatives of~~
736 ~~employers. One member shall be a person covered under an~~
737 ~~individual health insurance policy issued by a licensed insurer~~
738 ~~in this state. One member shall represent the Agency for Health~~
739 ~~Care Administration and shall be recommended by the Secretary of~~
740 ~~Health Care Administration.~~

741 ~~b. A member appointed under this subparagraph shall serve~~
742 ~~a term of 4 years and shall continue in office until the~~
743 ~~member's successor takes office, except that, in order to~~
744 ~~provide for staggered terms, the director of the office shall~~
745 ~~designate two of the initial appointees under this subparagraph~~
746 ~~to serve terms of 2 years and shall designate three of the~~
747 ~~initial appointees under this subparagraph to serve terms of 3~~
748 ~~years.~~

749 ~~3. The director of the office may remove a member for~~
750 ~~cause.~~

751 ~~4. Vacancies on the board shall be filled in the same~~
752 ~~manner as the original appointment for the unexpired portion of~~
753 ~~the term.~~

754 ~~(c)1. The board shall submit to the office a plan of~~
755 ~~operation to assure the fair, reasonable, and equitable~~
756 ~~administration of the program. The board may at any time submit~~

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757 ~~to the office any amendments to the plan that the board finds to~~
758 ~~be necessary or suitable.~~

759 ~~2. The office shall, after notice and hearing, approve the~~
760 ~~plan of operation if it determines that the plan submitted by~~
761 ~~the board is suitable to assure the fair, reasonable, and~~
762 ~~equitable administration of the program and provides for the~~
763 ~~sharing of program gains and losses equitably and~~
764 ~~proportionately in accordance with paragraph (j).~~

765 ~~3. The plan of operation, or any amendment thereto,~~
766 ~~becomes effective upon written approval of the office.~~

767 ~~(d) The plan of operation must, among other things:~~

768 ~~1. Establish procedures for handling and accounting for~~
769 ~~program assets and moneys and for an annual fiscal reporting to~~
770 ~~the office.~~

771 ~~2. Establish procedures for selecting an administering~~
772 ~~carrier and set forth the powers and duties of the administering~~
773 ~~carrier.~~

774 ~~3. Establish procedures for reinsuring risks.~~

775 ~~4. Establish procedures for collecting assessments from~~
776 ~~participating carriers to provide for claims reinsured by the~~
777 ~~program and for administrative expenses, other than amounts~~
778 ~~payable to the administrative carrier, incurred or estimated to~~
779 ~~be incurred during the period for which the assessment is made.~~

780 ~~5. Provide for any additional matters at the discretion of~~
781 ~~the board.~~

782 ~~(e) The board shall recommend to the office market conduct~~
783 ~~requirements and other requirements for carriers and agents,~~
784 ~~including requirements relating to:~~

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- 785 1. ~~Registration by each carrier with the office of its~~
786 ~~intention to be a small employer carrier under this section;~~
- 787 2. ~~Publication by the office of a list of all small~~
788 ~~employer carriers, including a requirement applicable to agents~~
789 ~~and carriers that a health benefit plan may not be sold by a~~
790 ~~carrier that is not identified as a small employer carrier;~~
- 791 3. ~~The availability of a broadly publicized, toll-free~~
792 ~~telephone number for access by small employers to information~~
793 ~~concerning this section;~~
- 794 4. ~~Periodic reports by carriers and agents concerning~~
795 ~~health benefit plans issued; and~~
- 796 5. ~~Methods concerning periodic demonstration by small~~
797 ~~employer carriers and agents that they are marketing or issuing~~
798 ~~health benefit plans to small employers.~~
- 799 (f) ~~The program has the general powers and authority~~
800 ~~granted under the laws of this state to insurance companies and~~
801 ~~health maintenance organizations licensed to transact business,~~
802 ~~except the power to issue health benefit plans directly to~~
803 ~~groups or individuals. In addition thereto, the program has~~
804 ~~specific authority to:~~
- 805 1. ~~Enter into contracts as necessary or proper to carry~~
806 ~~out the provisions and purposes of this act, including the~~
807 ~~authority to enter into contracts with similar programs of other~~
808 ~~states for the joint performance of common functions or with~~
809 ~~persons or other organizations for the performance of~~
810 ~~administrative functions.~~
- 811 2. ~~Sue or be sued, including taking any legal action~~
812 ~~necessary or proper for recovering any assessments and penalties~~

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813 ~~for, on behalf of, or against the program or any carrier.~~
814 ~~3. Take any legal action necessary to avoid the payment of~~
815 ~~improper claims against the program.~~
816 ~~4. Issue reinsurance policies, in accordance with the~~
817 ~~requirements of this act.~~
818 ~~5. Establish rules, conditions, and procedures for~~
819 ~~reinsurance risks under the program participation.~~
820 ~~6. Establish actuarial functions as appropriate for the~~
821 ~~operation of the program.~~
822 ~~7. Assess participating carriers in accordance with~~
823 ~~paragraph (j), and make advance interim assessments as may be~~
824 ~~reasonable and necessary for organizational and interim~~
825 ~~operating expenses. Interim assessments shall be credited as~~
826 ~~offsets against any regular assessments due following the close~~
827 ~~of the calendar year.~~
828 ~~8. Appoint appropriate legal, actuarial, and other~~
829 ~~committees as necessary to provide technical assistance in the~~
830 ~~operation of the program, and in any other function within the~~
831 ~~authority of the program.~~
832 ~~9. Borrow money to effect the purposes of the program. Any~~
833 ~~notes or other evidences of indebtedness of the program which~~
834 ~~are not in default constitute legal investments for carriers and~~
835 ~~may be carried as admitted assets.~~
836 ~~10. To the extent necessary, increase the \$5,000~~
837 ~~deductible reinsurance requirement to adjust for the effects of~~
838 ~~inflation.~~
839 ~~(g) A reinsuring carrier may reinsure with the program~~
840 ~~coverage of an eligible employee of a small employer, or any~~

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841 ~~dependent of such an employee, subject to each of the following~~
842 ~~provisions:~~

843 ~~1. With respect to a standard and basic health care plan,~~
844 ~~the program must reinsure the level of coverage provided; and,~~
845 ~~with respect to any other plan, the program must reinsure the~~
846 ~~coverage up to, but not exceeding, the level of coverage~~
847 ~~provided under the standard and basic health care plan.~~

848 ~~2. Except in the case of a late enrollee, a reinsuring~~
849 ~~carrier may reinsure an eligible employee or dependent within 60~~
850 ~~days after the commencement of the coverage of the small~~
851 ~~employer. A newly employed eligible employee or dependent of a~~
852 ~~small employer may be reinsured within 60 days after the~~
853 ~~commencement of his or her coverage.~~

854 ~~3. A small employer carrier may reinsure an entire~~
855 ~~employer group within 60 days after the commencement of the~~
856 ~~group's coverage under the plan. The carrier may choose to~~
857 ~~reinsure newly eligible employees and dependents of the~~
858 ~~reinsured group pursuant to subparagraph 1.~~

859 ~~4. The program may not reimburse a participating carrier~~
860 ~~with respect to the claims of a reinsured employee or dependent~~
861 ~~until the carrier has paid incurred claims of at least \$5,000 in~~
862 ~~a calendar year for benefits covered by the program. In~~
863 ~~addition, the reinsuring carrier shall be responsible for 10~~
864 ~~percent of the next \$50,000 and 5 percent of the next \$100,000~~
865 ~~of incurred claims during a calendar year and the program shall~~
866 ~~reinsure the remainder.~~

867 ~~5. The board annually shall adjust the initial level of~~
868 ~~claims and the maximum limit to be retained by the carrier to~~

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869 ~~reflect increases in costs and utilization within the standard~~
870 ~~market for health benefit plans within the state. The adjustment~~
871 ~~shall not be less than the annual change in the medical~~
872 ~~component of the "Consumer Price Index for All Urban Consumers"~~
873 ~~of the Bureau of Labor Statistics of the Department of Labor,~~
874 ~~unless the board proposes and the office approves a lower~~
875 ~~adjustment factor.~~

876 ~~6. A small employer carrier may terminate reinsurance for~~
877 ~~all reinsured employees or dependents on any plan anniversary.~~

878 ~~7. The premium rate charged for reinsurance by the program~~
879 ~~to a health maintenance organization that is approved by the~~
880 ~~Secretary of Health and Human Services as a federally qualified~~
881 ~~health maintenance organization pursuant to 42 U.S.C. s.~~
882 ~~300e(c)(2)(A) and that, as such, is subject to requirements that~~
883 ~~limit the amount of risk that may be ceded to the program, which~~
884 ~~requirements are more restrictive than subparagraph 4., shall be~~
885 ~~reduced by an amount equal to that portion of the risk, if any,~~
886 ~~which exceeds the amount set forth in subparagraph 4. which may~~
887 ~~not be ceded to the program.~~

888 ~~8. The board may consider adjustments to the premium rates~~
889 ~~charged for reinsurance by the program for carriers that use~~
890 ~~effective cost containment measures, including high-cost case~~
891 ~~management, as defined by the board.~~

892 ~~9. A reinsuring carrier shall apply its case-management~~
893 ~~and claims-handling techniques, including, but not limited to,~~
894 ~~utilization review, individual case management, preferred~~
895 ~~provider provisions, other managed care provisions or methods of~~
896 ~~operation, consistently with both reinsured business and~~

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897 nonreinsured business.

898 ~~(h)1. The board, as part of the plan of operation, shall~~
899 ~~establish a methodology for determining premium rates to be~~
900 ~~charged by the program for reinsuring small employers and~~
901 ~~individuals pursuant to this section. The methodology shall~~
902 ~~include a system for classification of small employers that~~
903 ~~reflects the types of case characteristics commonly used by~~
904 ~~small employer carriers in the state. The methodology shall~~
905 ~~provide for the development of basic reinsurance premium rates,~~
906 ~~which shall be multiplied by the factors set for them in this~~
907 ~~paragraph to determine the premium rates for the program. The~~
908 ~~basic reinsurance premium rates shall be established by the~~
909 ~~board, subject to the approval of the office, and shall be set~~
910 ~~at levels which reasonably approximate gross premiums charged to~~
911 ~~small employers by small employer carriers for health benefit~~
912 ~~plans with benefits similar to the standard and basic health~~
913 ~~benefit plan. The premium rates set by the board may vary by~~
914 ~~geographical area, as determined under this section, to reflect~~
915 ~~differences in cost. The multiplying factors must be established~~
916 ~~as follows:~~

917 ~~a. The entire group may be reinsured for a rate that is~~
918 ~~1.5 times the rate established by the board.~~

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

921 ~~2. The board periodically shall review the methodology~~
922 ~~established, including the system of classification and any~~
923 ~~rating factors, to assure that it reasonably reflects the claims~~
924 ~~experience of the program. The board may propose changes to the~~

925 ~~rates which shall be subject to the approval of the office.~~

926 ~~(i) If a health benefit plan for a small employer issued~~
927 ~~in accordance with this subsection is entirely or partially~~
928 ~~reinsured with the program, the premium charged to the small~~
929 ~~employer for any rating period for the coverage issued must be~~
930 ~~consistent with the requirements relating to premium rates set~~
931 ~~forth in this section.~~

932 ~~(j)1. Before July 1 of each calendar year, the board shall~~
933 ~~determine and report to the office the program net loss for the~~
934 ~~previous year, including administrative expenses for that year,~~
935 ~~and the incurred losses for the year, taking into account~~
936 ~~investment income and other appropriate gains and losses.~~

937 ~~2. Any net loss for the year shall be recouped by~~
938 ~~assessment of the carriers, as follows:~~

939 ~~a. The operating losses of the program shall be assessed~~
940 ~~in the following order subject to the specified limitations. The~~
941 ~~first tier of assessments shall be made against reinsuring~~
942 ~~carriers in an amount which shall not exceed 5 percent of each~~
943 ~~reinsuring carrier's premiums from health benefit plans covering~~
944 ~~small employers. If such assessments have been collected and~~
945 ~~additional moneys are needed, the board shall make a second tier~~
946 ~~of assessments in an amount which shall not exceed 0.5 percent~~
947 ~~of each carrier's health benefit plan premiums. Except as~~
948 ~~provided in paragraph (n), risk-assuming carriers are exempt~~
949 ~~from all assessments authorized pursuant to this section. The~~
950 ~~amount paid by a reinsuring carrier for the first tier of~~
951 ~~assessments shall be credited against any additional assessments~~
952 ~~made.~~

953 ~~b. The board shall equitably assess carriers for operating~~
954 ~~losses of the plan based on market share. The board shall~~
955 ~~annually assess each carrier a portion of the operating losses~~
956 ~~of the plan. The first tier of assessments shall be determined~~
957 ~~by multiplying the operating losses by a fraction, the numerator~~
958 ~~of which equals the reinsuring carrier's earned premium~~
959 ~~pertaining to direct writings of small employer health benefit~~
960 ~~plans in the state during the calendar year for which the~~
961 ~~assessment is levied, and the denominator of which equals the~~
962 ~~total of all such premiums earned by reinsuring carriers in the~~
963 ~~state during that calendar year. The second tier of assessments~~
964 ~~shall be based on the premiums that all carriers, except risk-~~
965 ~~assuming carriers, earned on all health benefit plans written in~~
966 ~~this state. The board may levy interim assessments against~~
967 ~~carriers to ensure the financial ability of the plan to cover~~
968 ~~claims expenses and administrative expenses paid or estimated to~~
969 ~~be paid in the operation of the plan for the calendar year prior~~
970 ~~to the association's anticipated receipt of annual assessments~~
971 ~~for that calendar year. Any interim assessment is due and~~
972 ~~payable within 30 days after receipt by a carrier of the interim~~
973 ~~assessment notice. Interim assessment payments shall be credited~~
974 ~~against the carrier's annual assessment. Health benefit plan~~
975 ~~premiums and benefits paid by a carrier that are less than an~~
976 ~~amount determined by the board to justify the cost of collection~~
977 ~~may not be considered for purposes of determining assessments.~~
978 ~~e. Subject to the approval of the office, the board shall~~
979 ~~make an adjustment to the assessment formula for reinsuring~~
980 ~~carriers that are approved as federally qualified health~~

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981 ~~maintenance organizations by the Secretary of Health and Human~~
982 ~~Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent,~~
983 ~~if any, that restrictions are placed on them that are not~~
984 ~~imposed on other small employer carriers.~~

985 ~~3. Before July 1 of each year, the board shall determine~~
986 ~~and file with the office an estimate of the assessments needed~~
987 ~~to fund the losses incurred by the program in the previous~~
988 ~~calendar year.~~

989 ~~4. If the board determines that the assessments needed to~~
990 ~~fund the losses incurred by the program in the previous calendar~~
991 ~~year will exceed the amount specified in subparagraph 2., the~~
992 ~~board shall evaluate the operation of the program and report its~~
993 ~~findings, including any recommendations for changes to the plan~~
994 ~~of operation, to the office within 180 days following the end of~~
995 ~~the calendar year in which the losses were incurred. The~~
996 ~~evaluation shall include an estimate of future assessments, the~~
997 ~~administrative costs of the program, the appropriateness of the~~
998 ~~premiums charged and the level of carrier retention under the~~
999 ~~program, and the costs of coverage for small employers. If the~~
1000 ~~board fails to file a report with the office within 180 days~~
1001 ~~following the end of the applicable calendar year, the office~~
1002 ~~may evaluate the operations of the program and implement such~~
1003 ~~amendments to the plan of operation the office deems necessary~~
1004 ~~to reduce future losses and assessments.~~

1005 ~~5. If assessments exceed the amount of the actual losses~~
1006 ~~and administrative expenses of the program, the excess shall be~~
1007 ~~held as interest and used by the board to offset future losses~~
1008 ~~or to reduce program premiums. As used in this paragraph, the~~

1009 ~~term "future losses" includes reserves for incurred but not~~
 1010 ~~reported claims.~~

1011 ~~6. Each carrier's proportion of the assessment shall be~~
 1012 ~~determined annually by the board, based on annual statements and~~
 1013 ~~other reports considered necessary by the board and filed by the~~
 1014 ~~carriers with the board.~~

1015 ~~7. Provision shall be made in the plan of operation for~~
 1016 ~~the imposition of an interest penalty for late payment of an~~
 1017 ~~assessment.~~

1018 ~~8. A carrier may seek, from the office, a deferment, in~~
 1019 ~~whole or in part, from any assessment made by the board. The~~
 1020 ~~office may defer, in whole or in part, the assessment of a~~
 1021 ~~carrier if, in the opinion of the office, the payment of the~~
 1022 ~~assessment would place the carrier in a financially impaired~~
 1023 ~~condition. If an assessment against a carrier is deferred, in~~
 1024 ~~whole or in part, the amount by which the assessment is deferred~~
 1025 ~~may be assessed against the other carriers in a manner~~
 1026 ~~consistent with the basis for assessment set forth in this~~
 1027 ~~section. The carrier receiving such deferment remains liable to~~
 1028 ~~the program for the amount deferred and is prohibited from~~
 1029 ~~reinsuring any individuals or groups in the program if it fails~~
 1030 ~~to pay assessments.~~

1031 ~~(k) Neither the participation in the program as reinsuring~~
 1032 ~~carriers, the establishment of rates, forms, or procedures, nor~~
 1033 ~~any other joint or collective action required by this act, may~~
 1034 ~~be the basis of any legal action, criminal or civil liability,~~
 1035 ~~or penalty against the program or any of its carriers either~~
 1036 ~~jointly or separately.~~

1037 ~~(l) The board, as part of the plan of operation, shall~~
 1038 ~~develop standards setting forth the manner and levels of~~
 1039 ~~compensation to be paid to agents for the sale of basic and~~
 1040 ~~standard health benefit plans. In establishing such standards,~~
 1041 ~~the board shall take into consideration the need to assure the~~
 1042 ~~broad availability of coverages, the objectives of the program,~~
 1043 ~~the time and effort expended in placing the coverage, the need~~
 1044 ~~to provide ongoing service to the small employer, the levels of~~
 1045 ~~compensation currently used in the industry, and the overall~~
 1046 ~~costs of coverage to small employers selecting these plans.~~

1047 ~~(m) The board shall monitor compliance with this section,~~
 1048 ~~including the market conduct of small employer carriers, and~~
 1049 ~~shall report to the office any unfair trade practices and~~
 1050 ~~misleading or unfair conduct by a small employer carrier that~~
 1051 ~~has been reported to the board by agents, consumers, or any~~
 1052 ~~other person. The office shall investigate all reports and, upon~~
 1053 ~~a finding of noncompliance with this section or of unfair or~~
 1054 ~~misleading practices, shall take action against the small~~
 1055 ~~employer carrier as permitted under the insurance code or~~
 1056 ~~chapter 641. The board is not given investigatory or regulatory~~
 1057 ~~powers, but must forward all reports of cases or abuse or~~
 1058 ~~misrepresentation to the office.~~

1059 ~~(n) Notwithstanding paragraph (j), the administrative~~
 1060 ~~expenses of the program shall be recouped by assessment of risk-~~
 1061 ~~assuming carriers and reinsuring carriers and such amounts shall~~
 1062 ~~not be considered part of the operating losses of the plan for~~
 1063 ~~the purposes of this paragraph. Each carrier's portion of such~~
 1064 ~~administrative expenses shall be determined by multiplying the~~

1065 ~~total of such administrative expenses by a fraction, the~~
 1066 ~~numerator of which equals the carrier's earned premium~~
 1067 ~~pertaining to direct writing of small employer health benefit~~
 1068 ~~plans in the state during the calendar year for which the~~
 1069 ~~assessment is levied, and the denominator of which equals the~~
 1070 ~~total of such premiums earned by all carriers in the state~~
 1071 ~~during such calendar year.~~

1072 ~~(e) The board shall advise the office, the Agency for~~
 1073 ~~Health Care Administration, the department, other executive~~
 1074 ~~departments, and the Legislature on health insurance issues.~~
 1075 ~~Specifically, the board shall:~~

1076 ~~1. Provide a forum for stakeholders, consisting of~~
 1077 ~~insurers, employers, agents, consumers, and regulators, in the~~
 1078 ~~private health insurance market in this state.~~

1079 ~~2. Review and recommend strategies to improve the~~
 1080 ~~functioning of the health insurance markets in this state with a~~
 1081 ~~specific focus on market stability, access, and pricing.~~

1082 ~~3. Make recommendations to the office for legislation~~
 1083 ~~addressing health insurance market issues and provide comments~~
 1084 ~~on health insurance legislation proposed by the office.~~

1085 ~~4. Meet at least three times each year. One meeting shall~~
 1086 ~~be held to hear reports and to secure public comment on the~~
 1087 ~~health insurance market, to develop any legislation needed to~~
 1088 ~~address health insurance market issues, and to provide comments~~
 1089 ~~on health insurance legislation proposed by the office.~~

1090 ~~5. Issue a report to the office on the state of the health~~
 1091 ~~insurance market by September 1 each year. The report shall~~
 1092 ~~include recommendations for changes in the health insurance~~

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1093 ~~market, results from implementation of previous recommendations,~~
 1094 ~~and information on health insurance markets.~~

1095 (10)~~(12)~~ STANDARD, BASIC, HIGH DEDUCTIBLE, AND LIMITED
 1096 HEALTH BENEFIT PLANS.—

1097 (a)1. The Chief Financial Officer shall appoint a health
 1098 benefit plan committee composed of four representatives of
 1099 carriers which shall include at least two representatives of
 1100 HMOs, at least one of which is a staff model HMO, two
 1101 representatives of agents, four representatives of small
 1102 employers, and one employee of a small employer. The carrier
 1103 members shall be selected from a list of individuals recommended
 1104 by the insurance commissioner ~~board~~. The Chief Financial Officer
 1105 may require the insurance commissioner ~~board~~ to submit
 1106 additional recommendations of individuals for appointment.

1107 2. The plans shall comply with all of the requirements of
 1108 this subsection.

1109 3. The plans must be filed with and approved by the office
 1110 prior to issuance or delivery by any small employer carrier.

1111 4. After approval of the revised health benefit plans, if
 1112 the office determines that modifications to a plan might be
 1113 appropriate, the Chief Financial Officer shall appoint a new
 1114 health benefit plan committee in the manner provided in
 1115 subparagraph 1. to submit recommended modifications to the
 1116 office for approval.

1117 (11)~~(13)~~ STANDARDS TO ASSURE FAIR MARKETING.—

1118 (e) A small employer carrier shall provide reasonable
 1119 compensation, ~~as provided under the plan of operation of the~~
 1120 ~~program,~~ to an agent, if any, for the sale of a basic or

1121 standard health benefit plan.

1122 (13)~~(15)~~ SMALL EMPLOYERS ACCESS PROGRAM.—

1123 (k) Benefits.—The benefits provided by the plan shall be
 1124 the same as the coverage required for small employers under
 1125 subsection (10) ~~(12)~~. Upon the approval of the office, the
 1126 insurer may also establish an optional mutually supported
 1127 benefit plan which is an alternative plan developed within a
 1128 defined geographic region of this state or any other such
 1129 alternative plan which will carry out the intent of this
 1130 subsection. Any small employer carrier issuing new health
 1131 benefit plans may offer a benefit plan with coverages similar
 1132 to, but not less than, any alternative coverage plan developed
 1133 pursuant to this subsection.

1134 (14)~~(16)~~ APPLICABILITY OF OTHER STATE LAWS.—

1135 (a) Except as expressly provided in this section, a law
 1136 requiring coverage for a specific health care service or
 1137 benefit, or a law requiring reimbursement, utilization, or
 1138 consideration of a specific category of licensed health care
 1139 practitioner, does not apply to a standard or basic health
 1140 benefit plan policy or contract or a limited benefit policy or
 1141 contract offered or delivered to a small employer unless that
 1142 law is made expressly applicable to such policies or contracts.
 1143 A law restricting or limiting deductibles, coinsurance,
 1144 copayments, or annual or lifetime maximum payments does not
 1145 apply to any health plan policy, including a standard or basic
 1146 health benefit plan policy or contract, offered or delivered to
 1147 a small employer unless such law is made expressly applicable to
 1148 such policy or contract. However, every small employer carrier

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1149 must offer to eligible small employers the standard benefit plan
 1150 and the basic benefit plan, as required by subsection (5), as
 1151 such plans have been approved by the office pursuant to
 1152 subsection (10) ~~(12)~~.

1153 ~~(c) Any second tier assessment paid by a carrier pursuant~~
 1154 ~~to paragraph (11) (j) may be credited against assessments levied~~
 1155 ~~against the carrier pursuant to s. 627.6494.~~

1156 (c) ~~(d)~~ Notwithstanding chapter 641, a health maintenance
 1157 organization is authorized to issue contracts providing benefits
 1158 equal to the standard health benefit plan, the basic health
 1159 benefit plan, and the limited benefit policy authorized by this
 1160 section.

1161 Section 16. Subsection (10) of section 641.3922, Florida
 1162 Statutes, is amended to read:

1163 641.3922 Conversion contracts; conditions.—Issuance of a
 1164 converted contract shall be subject to the following conditions:

1165 (10) ALTERNATE PLANS.—The health maintenance organization
 1166 shall offer a standard health benefit plan as established
 1167 pursuant to s. 627.6699 (10) ~~(12)~~. The health maintenance
 1168 organization may, at its option, also offer alternative plans
 1169 for group health conversion in addition to those required by
 1170 this section, provided any alternative plan is approved by the
 1171 office or is a converted policy, approved under s. 627.6675 and
 1172 issued by an insurance company authorized to transact insurance
 1173 in this state. Approval by the office of an alternative plan
 1174 shall be based on compliance by the alternative plan with the
 1175 provisions of this part and the rules promulgated thereunder,
 1176 applicable provisions of the Florida Insurance Code and rules

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1177 promulgated thereunder, and any other applicable law.

1178 Section 17. Subsections (10) through (15) of section
 1179 945.603, Florida Statutes, are renumbered as subsections (9)
 1180 through (14), respectively, and present subsection (10) of that
 1181 section is amended to read:

1182 945.603 Powers and duties of authority.—The purpose of the
 1183 authority is to assist in the delivery of health care services
 1184 for inmates in the Department of Corrections by advising the
 1185 Secretary of Corrections on the professional conduct of primary,
 1186 convalescent, dental, and mental health care and the management
 1187 of costs consistent with quality care, by advising the Governor
 1188 and the Legislature on the status of the Department of
 1189 Corrections' health care delivery system, and by assuring that
 1190 adequate standards of physical and mental health care for
 1191 inmates are maintained at all Department of Corrections
 1192 institutions. For this purpose, the authority has the authority
 1193 to:

1194 ~~(10) Coordinate the development of prospective payment~~
 1195 ~~arrangements as described in s. 408.50 when appropriate for the~~
 1196 ~~acquisition of inmate health care services.~~

1197 Section 18. Paragraph (e) of subsection (2) of section
 1198 1011.52, Florida Statutes, is amended to read:

1199 1011.52 Appropriation to first accredited medical school.—

1200 (2) In order for a medical school to qualify under the
 1201 provisions of this section and to be entitled to the benefits
 1202 herein, such medical school:

1203 (e) Must have in place an operating agreement with a
 1204 government-owned hospital that is located in the same county as

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1205 the medical school and that is a statutory teaching hospital as
1206 defined in s. 408.07 (44) ~~(45)~~. The operating agreement shall
1207 provide for the medical school to maintain the same level of
1208 affiliation with the hospital, including the level of services
1209 to indigent and charity care patients served by the hospital,
1210 which was in place in the prior fiscal year. Each year,
1211 documentation demonstrating that an operating agreement is in
1212 effect shall be submitted jointly to the Department of Education
1213 by the hospital and the medical school prior to the payment of
1214 moneys from the annual appropriation.

1215 Section 19. Except as otherwise expressly provided in this
1216 act, this act shall take effect July 1, 2011.