CHAMBER ACTION

Senate		House
	.	

Senator Latvala moved the following amendment:

Senate Amendment (with title amendment)

Delete everything after the enacting clause

and insert:

Section 1. Health flex plans.--

(1) INTENT.--The Legislature finds that a significant proportion of the residents of this state are unable to obtain affordable health insurance coverage. Therefore, it is the intent of the Legislature to expand the availability of health care options for low-income uninsured state residents by encouraging health insurers, health maintenance organizations, health-care-provider-sponsored organizations, local governments, health care districts, or other public or private community-based organizations to develop alternative approaches to traditional health insurance which emphasize coverage for basic and preventive health care services. To the maximum extent possible, these options should be coordinated with existing governmental or community-based health services programs in a manner that is consistent with the objectives

1 and requirements of such programs.
2 (2) DEFINITIONS.--As used in this section, the term:
3 (a) "Agency" means the Agency for Health Care
4 Administration.
5 (b) "Department" means the Department of Insurance.
6 (c) "Enrollee" means an individual who has been
7 determined to be eligible for and is receiving health care
8 coverage under a health flex plan approved under this section.
9 (d) "Health care coverage" or "health flex plan
10 coverage" means health care services that are covered as
11 benefits under an approved health flex plan or that are
12 otherwise provided, either directly or through arrangements
13 with other persons, via a health flex plan on a prepaid
14 per-capita basis or on a prepaid aggregate fixed-sum basis.
15 (e) "Health flex plan" means a health plan approved
16 under subsection (3) which guarantees payment for specified
17 health care coverage provided to the enrollee.
18 (f) "Health flex plan entity" means a health insurer,
19 health maintenance organization, health care
20 provider-sponsored organization, local government, health care
21 district, or other public or private community-based
22 organization that develops and implements an approved health
23 flex plan and is responsible for administering the health flex
24 plan and paying all claims for health flex plan coverage by
25 enrollees of the health flex plan.
26 (3) PILOT PROGRAM.--The agency and the department
27 shall each approve or disapprove health flex plans that
28 provide health care coverage for eligible participants who
29 reside in the three areas of the state that have the highest
30 number of uninsured persons, as identified in the Florida
31 Health Insurance Study conducted by the agency and in Indian

1 River County. A health flex plan may limit or exclude benefits
2 otherwise required by law for insurers offering coverage in
3 this state, may cap the total amount of claims paid per year
4 per enrollee, may limit the number of enrollees, or may take
5 any combination of those actions.
6 (a) The agency shall develop guidelines for the review
7 of applications for health flex plans and shall disapprove or
8 withdraw approval of plans that do not meet or no longer meet
9 minimum standards for quality of care and access to care.
10 (b) The department shall develop guidelines for the
11 review of health flex plan applications and shall disapprove
12 or shall withdraw approval of plans that:
13 1. Contain any ambiguous, inconsistent, or misleading
14 provisions or any exceptions or conditions that deceptively
15 affect or limit the benefits purported to be assumed in the
16 general coverage provided by the health flex plan;
17 2. Provide benefits that are unreasonable in relation
18 to the premium charged or contain provisions that are unfair
19 or inequitable or contrary to the public policy of this state,
20 that encourage misrepresentation, or that result in unfair
21 discrimination in sales practices; or
22 3. Cannot demonstrate that the health flex plan is
23 financially sound and that the applicant is able to underwrite
24 or finance the health care coverage provided.
25 (c) The agency and the department may adopt rules as
26 needed to administer this section.
27 (4) LICENSE NOT REQUIRED.--Neither the licensing
28 requirements of the Florida Insurance Code nor chapter 641,
29 Florida Statutes, relating to health maintenance
30 organizations, is applicable to a health flex plan approved
31 under this section, unless expressly made applicable. However,

1 for the purpose of prohibiting unfair trade practices, health
2 flex plans are considered to be insurance subject to the
3 applicable provisions of part IX of chapter 626, Florida
4 Statutes, except as otherwise provided in this section.
5 (5) ELIGIBILITY.--Eligibility to enroll in an approved
6 health flex plan is limited to residents of this state who:
7 (a) Are 64 years of age or younger;
8 (b) Have a family income equal to or less than 200
9 percent of the federal poverty level;
10 (c) Are not covered by a private insurance policy and
11 are not eligible for coverage through a public health
12 insurance program, such as Medicare or Medicaid, or another
13 public health care program, such as KidCare, and have not been
14 covered at any time during the past 6 months; and
15 (d) Have applied for health care coverage through an
16 approved health flex plan and have agreed to make any payments
17 required for participation, including periodic payments or
18 payments due at the time health care services are provided.
19 (6) RECORDS.--Each health flex plan shall maintain
20 enrollment data and reasonable records of its losses,
21 expenses, and claims experience and shall make those records
22 reasonably available to enable the department to monitor and
23 determine the financial viability of the health flex plan, as
24 necessary. Provider networks and total enrollment by area
25 shall be reported to the agency biannually to enable the
26 agency to monitor access to care.
27 (7) NOTICE.--The denial of coverage by a health flex
28 plan, or the nonrenewal or cancellation of coverage, must be
29 accompanied by the specific reasons for denial, nonrenewal, or
30 cancellation. Notice of nonrenewal or cancellation must be
31 provided at least 45 days in advance of the nonrenewal or

1 cancellation, except that 10 days' written notice must be
2 given for cancellation due to nonpayment of premiums. If the
3 health flex plan fails to give the required notice, the health
4 flex plan coverage must remain in effect until notice is
5 appropriately given.
6 (8) NONENTITLEMENT.--Coverage under an approved health
7 flex plan is not an entitlement, and a cause of action does
8 not arise against the state, a local government entity, or any
9 other political subdivision of this state, or against the
10 agency, for failure to make coverage available to eligible
11 persons under this section.
12 (9) PROGRAM EVALUATION.--The agency and the department
13 shall evaluate the pilot program and its effect on the
14 entities that seek approval as health flex plans, on the
15 number of enrollees, and on the scope of the health care
16 coverage offered under a health flex plan; shall provide an
17 assessment of the health flex plans and their potential
18 applicability in other settings; and shall, by January 1,
19 2004, jointly submit a report to the Governor, the President
20 of the Senate, and the Speaker of the House of
21 Representatives.
22 (10) EXPIRATION.--This section expires July 1, 2004.
23 Section 2. Section 408.7057, Florida Statutes, is
24 amended to read:
25 408.7057 Statewide provider and health plan ~~managed~~
26 ~~care organization~~ claim dispute resolution program.--
27 (1) As used in this section, the term:
28 (a) "Agency" means the Agency for Health Care
29 Administration.
30 (b)~~(a)~~ "Health plan ~~Managed care organization~~" means a
31 health maintenance organization or a prepaid health clinic

certified under chapter 641, a prepaid health plan authorized under s. 409.912, ~~or~~ an exclusive provider organization certified under s. 627.6472<u>, or a major medical expense health insurance policy as defined in s. 627.643(2)(e) offered by a group or an individual health insurer licensed pursuant to chapter 624, including a preferred provider organization under s. 627.6471</u>.

<u>(c)</u>~~(b)~~ "Resolution organization" means a qualified independent third-party claim-dispute-resolution entity selected by and contracted with the Agency for Health Care Administration.

(2)(a) The agency ~~for Health Care Administration~~ shall establish a program ~~by January 1, 2001,~~to provide assistance to contracted and noncontracted providers and <u>health plans</u> ~~managed care organizations~~ for resolution of claim disputes that are not resolved by the provider and the <u>health plan</u> ~~managed care organization~~. The agency shall contract with a resolution organization to timely review and consider claim disputes submitted by providers and <u>health plans</u> ~~managed care organizations~~ and recommend to the agency an appropriate resolution of those disputes. The agency shall establish by rule jurisdictional amounts and methods of aggregation for claim disputes that may be considered by the resolution organization.

(b) The resolution organization shall review claim disputes filed by contracted and noncontracted providers and <u>health plans</u> ~~managed care organizations~~ unless the disputed claim:

1. Is related to interest payment;

2. Does not meet the jurisdictional amounts or the methods of aggregation established by agency rule, as provided

1 in paragraph (a);
2 3. Is part of an internal grievance in a Medicare
3 managed care organization or a reconsideration appeal through
4 the Medicare appeals process;
5 4. Is related to a health plan that is not regulated
6 by the state;
7 5. Is part of a Medicaid fair hearing pursued under 42
8 C.F.R. ss. 431.220 et seq.;
9 6. Is the basis for an action pending in state or
10 federal court; or
11 7. Is subject to a binding claim-dispute-resolution
12 process provided by contract entered into prior to October 1,
13 2000, between the provider and the managed care organization.
14 (c) Contracts entered into or renewed on or after
15 October 1, 2000, may require exhaustion of an internal
16 dispute-resolution process as a prerequisite to the submission
17 of a claim by a provider or a health plan ~~maintenance~~
18 ~~organization~~ to the resolution organization ~~when the~~
19 ~~dispute-resolution program becomes effective~~.
20 (d) A contracted or noncontracted provider or health
21 maintenance organization may not file a claim dispute with the
22 resolution organization more than 12 months after a final
23 determination has been made on a claim by a health maintenance
24 organization.
25 (e) The resolution organization shall require the
26 health plan or provider submitting the claim dispute to submit
27 any supporting documentation to the resolution organization
28 within 15 days after receipt by the health plan or provider of
29 a request from the resolution organization for documentation
30 in support of the claim dispute. The resolution organization
31 may extend the time if appropriate. Failure to submit the

1 supporting documentation within such time period shall result
2 in the dismissal of the submitted claim dispute.
3 (f) The resolution organization shall require the
4 respondent in the claim dispute to submit all documentation in
5 support of its position within 15 days after receiving a
6 request from the resolution organization for supporting
7 documentation. The resolution organization may extend the time
8 if appropriate. Failure to submit the supporting documentation
9 within such time period shall result in a default against the
10 health plan or provider. In the event of such a default, the
11 resolution organization shall issue its written recommendation
12 to the agency that a default be entered against the defaulting
13 entity. The written recommendation shall include a
14 recommendation to the agency that the defaulting entity shall
15 pay the entity submitting the claim dispute the full amount of
16 the claim dispute, plus all accrued interest, and shall be
17 considered a nonprevailing party for the purposes of this
18 section.
19 (g)1. If on an ongoing basis during the preceding 12
20 months, the agency has reason to believe that a pattern of
21 noncompliance with ss. 627.6131 and 641.3155 exists on the
22 part of a particular health plan or provider, the agency shall
23 evaluate the information contained in these cases to determine
24 whether the information evidences a pattern and report its
25 findings, together with substantiating evidence, to the
26 appropriate licensure or certification entity for the health
27 plan or provider.
28 2. In addition, the agency shall prepare an annual
29 report to the Governor and the Legislature by February 1 of
30 each year, enumerating the claims dismissed, the defaults
31 issued, and the failures to comply with agency final orders

issued under this section.

(3) The agency shall adopt rules to establish a process to be used by the resolution organization in considering claim disputes submitted by a provider or health plan ~~managed care organization~~ which must include the issuance by the resolution organization of a written recommendation, supported by findings of fact, to the agency within 60 days after the requested information is received by the resolution organization within the timeframes specified by the resolution organization. In no event shall the review time exceed 90 days following receipt of the initial claim dispute submission by the resolution organization receipt of the claim dispute submission.

(4) Within 30 days after receipt of the recommendation of the resolution organization, the agency shall adopt the recommendation as a final order.

(5) The agency shall notify within 7 days the appropriate licensure or certification entity whenever there is a violation of a final order issued by the agency pursuant to this section.

(6)~~(5)~~ The entity that does not prevail in the agency's order must pay a review cost to the review organization, as determined by agency rule. Such rule must provide for an apportionment of the review fee in any case in which both parties prevail in part. If the nonprevailing party fails to pay the ordered review cost within 35 days after the agency's order, the nonpaying party is subject to a penalty of not more than $500 per day until the penalty is paid.

(7)~~(6)~~ The agency ~~for Health Care Administration~~ may adopt rules to administer this section.

Section 3. Effective July 1, 2002, paragraph (o) of

1 subsection (3) of section 456.053, Florida Statutes, is
2 amended to read:
3 456.053 Financial arrangements between referring
4 health care providers and providers of health care services.--
5 (3) DEFINITIONS.--For the purpose of this section, the
6 word, phrase, or term:
7 (o) "Referral" means any referral of a patient by a
8 health care provider for health care services, including,
9 without limitation:
10 1. The forwarding of a patient by a health care
11 provider to another health care provider or to an entity which
12 provides or supplies designated health services or any other
13 health care item or service; or
14 2. The request or establishment of a plan of care by a
15 health care provider, which includes the provision of
16 designated health services or other health care item or
17 service.
18 3. The following orders, recommendations, or plans of
19 care shall not constitute a referral by a health care
20 provider:
21 a. By a radiologist for diagnostic-imaging services.
22 b. By a physician specializing in the provision of
23 radiation therapy services for such services.
24 c. By a medical oncologist for drugs and solutions to
25 be prepared and administered intravenously to such
26 oncologist's patient, as well as for the supplies and
27 equipment used in connection therewith to treat such patient
28 for cancer and the complications thereof.
29 d. By a cardiologist for cardiac catheterization
30 services.
31 e. By a pathologist for diagnostic clinical laboratory

tests and pathological examination services, if furnished by or under the supervision of such pathologist pursuant to a consultation requested by another physician.

f. By a health care provider who is the sole provider or member of a group practice for designated health services or other health care items or services that are prescribed or provided solely for such referring health care provider's or group practice's own patients, and that are provided or performed by or under the direct supervision of such referring health care provider or group practice; provided, however, that effective July 1, 1999, a physician licensed pursuant to chapter 458, chapter 459, chapter 460, or chapter 461 may refer a patient to a sole provider or group practice for diagnostic imaging services, excluding radiation therapy services, for which the sole provider or group practice billed both the technical and the professional fee for or on behalf of the patient, if the referring physician has no investment interest in the practice. The diagnostic imaging service referred to a group practice or sole provider must be a diagnostic imaging service normally provided within the scope of practice to the patients of the group practice or sole provider. The group practice or sole provider may accept no more that 15 percent of their patients receiving diagnostic imaging services from outside referrals, excluding radiation therapy services.

g. By a health care provider for services provided by an ambulatory surgical center licensed under chapter 395.

~~h. By a health care provider for diagnostic clinical laboratory services where such services are directly related to renal dialysis.~~

h.~~i.~~ By a urologist for lithotripsy services.

1 i.~~j.~~ By a dentist for dental services performed by an
2 employee of or health care provider who is an independent
3 contractor with the dentist or group practice of which the
4 dentist is a member.
5 j.~~k.~~ By a physician for infusion therapy services to a
6 patient of that physician or a member of that physician's
7 group practice.
8 k.~~l.~~ By a nephrologist for renal dialysis services and
9 supplies, except laboratory services.
10 l. By a health care provider whose principal
11 professional practice consists of treating patients in their
12 private residences for services to be rendered in such private
13 residences. For purposes of this sub-subparagraph, the term
14 "private residences" includes patient's private homes,
15 independent living centers, and assisted living facilities,
16 but does not include skilled nursing facilities.
17 Section 4. Subsection (1) of section 626.88, Florida
18 Statutes, is amended to read:
19 626.88 Definitions of "administrator" and "insurer".--
20 (1) For the purposes of this part, an "administrator"
21 is any person who directly or indirectly solicits or effects
22 coverage of, collects charges or premiums from, or adjusts or
23 settles claims on residents of this state in connection with
24 authorized commercial self-insurance funds or with insured or
25 self-insured programs which provide life or health insurance
26 coverage or coverage of any other expenses described in s.
27 624.33(1) or any person who, through a health care risk
28 contract as defined in s. 641.234 with an insurer or health
29 maintenance organization, provides billing and collection
30 services to health insurers and health maintenance
31 organizations on behalf of health care providers, other than

1 any of the following persons:
2 (a) An employer on behalf of such employer's employees
3 or the employees of one or more subsidiary or affiliated
4 corporations of such employer.
5 (b) A union on behalf of its members.
6 (c) An insurance company which is either authorized to
7 transact insurance in this state or is acting as an insurer
8 with respect to a policy lawfully issued and delivered by such
9 company in and pursuant to the laws of a state in which the
10 insurer was authorized to transact an insurance business.
11 (d) A health care services plan, health maintenance
12 organization, professional service plan corporation, or person
13 in the business of providing continuing care, possessing a
14 valid certificate of authority issued by the department, and
15 the sales representatives thereof, if the activities of such
16 entity are limited to the activities permitted under the
17 certificate of authority.
18 (e) An insurance agent licensed in this state whose
19 activities are limited exclusively to the sale of insurance.
20 (f) An adjuster licensed in this state whose
21 activities are limited to the adjustment of claims.
22 (g) A creditor on behalf of such creditor's debtors
23 with respect to insurance covering a debt between the creditor
24 and its debtors.
25 (h) A trust and its trustees, agents, and employees
26 acting pursuant to such trust established in conformity with
27 29 U.S.C. s. 186.
28 (i) A trust exempt from taxation under s. 501(a) of
29 the Internal Revenue Code, a trust satisfying the requirements
30 of ss. 624.438 and 624.439, or any governmental trust as
31 defined in s. 624.33(3), and the trustees and employees acting

1 pursuant to such trust, or a custodian and its agents and
2 employees, including individuals representing the trustees in
3 overseeing the activities of a service company or
4 administrator, acting pursuant to a custodial account which
5 meets the requirements of s. 401(f) of the Internal Revenue
6 Code.
7 (j) A financial institution which is subject to
8 supervision or examination by federal or state authorities or
9 a mortgage lender licensed under chapter 494 who collects and
10 remits premiums to licensed insurance agents or authorized
11 insurers concurrently or in connection with mortgage loan
12 payments.
13 (k) A credit card issuing company which advances for
14 and collects premiums or charges from its credit card holders
15 who have authorized such collection if such company does not
16 adjust or settle claims.
17 (l) A person who adjusts or settles claims in the
18 normal course of such person's practice or employment as an
19 attorney at law and who does not collect charges or premiums
20 in connection with life or health insurance coverage.
21 (m) A person approved by the Division of Workers'
22 Compensation of the Department of Labor and Employment
23 Security who administers only self-insured workers'
24 compensation plans.
25 (n) A service company or service agent and its
26 employees, authorized in accordance with ss. 626.895-626.899,
27 serving only a single employer plan, multiple-employer welfare
28 arrangements, or a combination thereof.
29 (o) Any provider or group practice, as defined in s.
30 456.053, providing services under the scope of the license of
31 the provider or the member of the group practice.

1

2 A person who provides billing and collection services to
3 health insurers and health maintenance organizations on behalf
4 of health care providers shall comply with the provisions of
5 ss. 627.6131, 641.3155, and 641.51(4).
6 Section 5. Paragraph (a) of subsection (6) of section
7 627.410, Florida Statutes, is amended, paragraphs (f) and (g)
8 are added to subsection (6) of that section, and paragraph (f)
9 is added to subsection (7) of that section, to read:
10 627.410 Filing, approval of forms.--
11 (6)(a) An insurer shall not deliver or issue for
12 delivery or renew in this state any health insurance policy
13 form until it has filed with the department a copy of every
14 applicable rating manual, rating schedule, change in rating
15 manual, and change in rating schedule; if rating manuals and
16 rating schedules are not applicable, the insurer must file
17 with the department applicable premium rates and any change in
18 applicable premium rates. This paragraph does not apply to
19 group health insurance policies, effectuated and delivered in
20 this state, insuring groups of 51 or more persons, except for
21 Medicare supplement insurance, long-term care insurance, and
22 any coverage under which the increase in claim costs over the
23 lifetime of the contract due to advancing age or duration is
24 prefunded in the premium.
25 (f) Notwithstanding the requirements of subsection
26 (2), an insurer that files changes in rates, rating manuals,
27 or rating schedules with the department for individual health
28 policies as described in s. 627.6561(5)(a)2., but excluding
29 Medicare supplement policies, according to this paragraph may
30 begin providing required notice to policyholders and charging
31 corresponding adjusted rates in accordance with s. 627.6043,

1 upon filing, if the insurer certifies that it has met the
2 criteria of subparagraphs 1., 2., and 3. Filings submitted
3 under this paragraph must contain the same information and
4 demonstrations and must meet the same requirements as rate
5 filings submitted for approval under this section, including
6 the requirements of s. 627.411, except as indicated in this
7 paragraph.
8 1. The insurer must have complied with annual
9 rate-filing requirements then in effect pursuant to subsection
10 (7) since October 1, 2002, or for the previous 2 years,
11 whichever is less, and must have filed and implemented
12 actuarially justifiable rate adjustments at least annually
13 during this period. This subparagraph does not prevent an
14 insurer from filing rate adjustments more often than annually.
15 2. The insurer must have pooled experience for
16 applicable individual health policy forms in accordance with
17 the requirements of subparagraph (6)(e)3. Rate changes used on
18 a form must not vary by the experience of that form or the
19 health status of covered individuals on that form but must be
20 based on the experience of all forms, including rating
21 characteristics as defined in this paragraph.
22 3. Rates for the policy form are anticipated to meet a
23 minimum loss ratio of 65 percent over the expected life of the
24 form.
25
26 Rates for all individual health policy forms issued on or
27 after October 1, 2002, must be based upon the same factors for
28 each rating characteristic. As used in this paragraph, the
29 term "rating characteristics" means demographic
30 characteristics of individuals, including, but not limited to,
31 geographic area factors, benefit design, smoking status, and

health status at issue.

(g) After filing a change of rates for an individual health policy under paragraph (f), an insurer may be required to furnish additional information to demonstrate compliance with this section and s. 627.411. If the department finds that the adjusted rates are not reasonable in relation to premiums charged under the standards of this section and s. 627.411, the department may order appropriate corrective action.

(7)

(f) Insurers with fewer than 1,000 nationwide policyholders or insured group members or subscribers covered under any form or pooled group of forms with health insurance coverage, as described in s. 627.6561(5)(a)2., excluding Medicare supplement insurance coverage under part VIII, at the time of a rate filing made under subparagraph (b)1., may file for an annual rate increase limited to medical trend as adopted by the department under s. 627.411(4). The filing is in lieu of the actuarial memorandum required for a rate filing prescribed by paragraph (b). The filing must include forms adopted by the department and a certification by an officer of the company that the filing includes all similar forms.

Section 6. Paragraph (e) of subsection (1) of section 627.411, Florida Statutes, is amended, and subsections (3), (4), and (5) are added to that section, to read:

627.411 Grounds for disapproval.--

(1) The department shall disapprove any form filed under s. 627.410, or withdraw any previous approval thereof, only if the form:

(e) Is for health insurance, and:

1. Provides benefits that ~~which~~ are unreasonable in relation to the premium charged based on the original filed

1 and approved loss ratio for the form and rules adopted by the
2 department under s. 627.410(6)(b);,
3 2. Contains provisions that which are unfair or
4 inequitable or contrary to the public policy of this state or
5 that which encourage misrepresentation;, or
6 3. Contains provisions that which apply rating
7 practices that which result in premium escalations that are
8 not viable for the policyholder market or result in unfair
9 discrimination under s. 626.9541(1)(g)2.; or in sales
10 practices.
11 4. Results in actuarially justified annual rate
12 increases:
13 a. Which includes a reduction by the insurer of its
14 loss ratio that affects the rate by more than the greater of
15 50 percent of trend or 5 percent. At its option, the insurer
16 may file for approval of the actuarially justified rate
17 schedule for new insureds and a rate increase for existing
18 insureds where the increase due to the loss ratio reduction is
19 limited to the greater of 50 percent of medical trend or 5
20 percent. Future annual rate increases for existing insureds
21 must be limited to the greater of 150 percent of the rate
22 increase approved for new insureds or 10 percent until the two
23 rate schedules converge;
24 b. In excess of the greater of 150 percent of annual
25 medical trend or 10 percent and the company did not comply
26 with the annual filing requirements of s. 627.410(7) or
27 department rule for health maintenance organizations pursuant
28 to s. 641.31. At its option, the insurer may file for approval
29 of an actuarially justified new business rate schedule for new
30 insureds and a rate increase for existing insureds which is
31 equal to the rate increase otherwise allowed by this

1 sub-subparagraph. Future annual rate increases for existing
2 insureds are limited to the greater of 150 percent of the rate
3 increase approved for new insureds or 10 percent until the two
4 rate schedules converge; or
5 c. In excess of the greater of 150 percent of annual
6 medical trend or 10 percent on a form or block of pooled forms
7 in which no form is currently available for sale. This
8 sub-subparagraph does not apply to prestandardized Medicare
9 supplement forms.
10 (3) If a health insurance rate filing changes the
11 established rate relationships between insureds, the aggregate
12 effect of such a change must be revenue-neutral. The change to
13 the new relationship must be phased-in over a period approved
14 by the department. The department may not require the phase-in
15 period to exceed 3 years in duration. The rate filing may also
16 include increases based on overall experience or annual
17 medical trend, or both, which portions are not to be phased-in
18 pursuant to this subsection.
19 (4) Individual health insurance policies that are
20 subject to renewability requirements of s. 627.6425 are
21 guaranteed renewable for purposes of establishing loss ratio
22 standards and must comply with the same loss ratio standards
23 as other guaranteed renewable forms.
24 (5) In determining medical trend for application of
25 subparagraph (1)(e)4., the department shall semiannually
26 determine medical trend for each health care market, using
27 reasonable actuarial techniques and standards. The trend must
28 be adopted by the department by rule and determined as
29 follows:
30 (a) Trend must be determined separately for medical
31 expense, preferred provider organization, Medicare supplement,

1 health maintenance organization, and other coverage for
2 individual, small group, and large group, where applicable.
3 (b) The department shall survey insurers and health
4 maintenance organizations currently issuing products and
5 representing at least an 80-percent market share based on
6 premiums earned in the state for the most recent calendar year
7 for each of the categories specified in paragraph (a).
8 (c) Trend must be computed as the average annual
9 medical trend approved for the carriers surveyed, giving
10 appropriate weight to each carrier's statewide market share of
11 earned premiums.
12 (d) The annual trend is the annual change in claims
13 cost per unit of exposure. Trend includes the combined effect
14 of medical provider price changes, changes in utilization, new
15 medical procedures, and technology and cost shifting.
16 Section 7. Section 627.6131, Florida Statutes, is
17 created to read:
18 627.6131 Payment of claims.--
19 (1) The contract shall include the following
20 provision:
21
22 "Time of Payment of Claims: After receiving
23 written proof of loss, the insurer will pay
24 monthly all benefits then due for ...(type of
25 benefit).... Benefits for any other loss
26 covered by this policy will be paid as soon as
27 the insurer receives proper written proof."
28
29 (2) As used in this section, the term "claim" for a
30 noninstitutional provider means a paper or electronic billing
31 instrument submitted to the insurer's designated location that

1 consists of the HCFA 1500 data set, or its successor, that has
2 all mandatory entries for a physician licensed under chapter
3 458, chapter 459, chapter 460, chapter 461, or chapter 463; a
4 psychologist licensed under chapter 490; or any appropriate
5 billing instrument that has all mandatory entries for any
6 other noninstitutional provider. For institutional providers,
7 "claim" means a paper or electronic billing instrument
8 submitted to the insurer's designated location that consists
9 of the UB-92 data set or its successor, with entries stated as
10 mandatory by the National Uniform Billing Committee.
11 (3) All claims for payment, whether electronic or
12 nonelectronic:
13 (a) Are considered received on the date the claim is
14 received by the insurer at its designated claims receipt
15 location.
16 (b) Must be mailed or electronically transferred to an
17 insurer within 6 months after completion of the service and
18 the provider is furnished with the correct name and address of
19 the patient's health insurer. If a provider's claim is
20 submitted electronically, it is considered made on the date it
21 is electronically transferred.
22 (c) Must not duplicate a claim previously submitted
23 unless it is determined that the original claim was not
24 received or is otherwise lost.
25 (4) For all electronically submitted claims, a health
26 insurer shall:
27 (a) Within 24 hours after the beginning of the next
28 business day after receipt of the claim, provide electronic
29 acknowledgment of the receipt of the claim to the electronic
30 source submitting the claim.
31 (b) Within 20 days after receipt of the claim, pay the

1 claim or notify a provider or designee if a claim is denied or
2 contested. Notice of the insurer's action on the claim and
3 payment of the claim is considered to be made on the date the
4 notice or payment was mailed or electronically transferred.
5 (c)1. Notification of the health insurer's
6 determination of a contested claim must be accompanied by an
7 itemized list of additional information or documents the
8 insurer can reasonably determine are necessary to process the
9 claim.
10 2. A provider must submit the additional information
11 or documentation, as specified on the itemized list, within 35
12 days after receipt of the notification. Failure of a provider
13 to submit by mail or electronically the additional information
14 or documentation requested within 35 days after receipt of the
15 notification may result in denial of the claim.
16 3. A health insurer may not make more than one request
17 for documents under this paragraph in connection with a claim,
18 unless the provider fails to submit all of the requested
19 documents to process the claim or if documents submitted by
20 the provider raise new additional issues not included in the
21 original written itemization, in which case the health insurer
22 may provide the provider with one additional opportunity to
23 submit the additional documents needed to process the claim.
24 In no case may the health insurer request duplicate documents.
25 (d) For purposes of this subsection, electronic means
26 of transmission of claims, notices, documents, forms, and
27 payments shall be used to the greatest extent possible by the
28 health insurer and the provider.
29 (e) A claim must be paid or denied within 90 days
30 after receipt of the claim. Failure to pay or deny a claim
31 within 120 days after receipt of the claim creates an

1 uncontestable obligation to pay the claim.
2 (5) For all nonelectronically submitted claims, a
3 health insurer shall:
4 (a) Effective November 1, 2003, provide acknowledgment
5 of receipt of the claim within 15 days after receipt of the
6 claim to the provider or provide a provider within 15 days
7 after receipt with electronic access to the status of a
8 submitted claim.
9 (b) Within 40 days after receipt of the claim, pay the
10 claim or notify a provider or designee if a claim is denied or
11 contested. Notice of the insurer's action on the claim and
12 payment of the claim is considered to be made on the date the
13 notice or payment was mailed or electronically transferred.
14 (c)1. Notification of the health insurer's
15 determination of a contested claim must be accompanied by an
16 itemized list of additional information or documents the
17 insurer can reasonably determine are necessary to process the
18 claim.
19 2. A provider must submit the additional information
20 or documentation, as specified on the itemized list, within 35
21 days after receipt of the notification. Failure of a provider
22 to submit by mail or electronically the additional information
23 or documentation requested within 35 days after receipt of the
24 notification may result in denial of the claim.
25 3. A health insurer may not make more than one request
26 for documents under this paragraph in connection with a claim
27 unless the provider fails to submit all of the requested
28 documents to process the claim or if documents submitted by
29 the provider raise new additional issues not included in the
30 original written itemization, in which case the health insurer
31 may provide the provider with one additional opportunity to

1 submit the additional documents needed to process the claim.
2 In no case may the health insurer request duplicate documents.
3 (d) For purposes of this subsection, electronic means
4 of transmission of claims, notices, documents, forms, and
5 payments shall be used to the greatest extent possible by the
6 health insurer and the provider.
7 (e) A claim must be paid or denied within 120 days
8 after receipt of the claim. Failure to pay or deny a claim
9 within 140 days after receipt of the claim creates an
10 uncontestable obligation to pay the claim.
11 (6) If a health insurer determines that it has made an
12 overpayment to a provider for services rendered to an insured,
13 the health insurer must make a claim for such overpayment to
14 the provider's designated location. A health insurer that
15 makes a claim for overpayment to a provider under this section
16 shall give the provider a written or electronic statement
17 specifying the basis for the retroactive denial or payment
18 adjustment. The insurer must identify the claim or claims, or
19 overpayment claim portion thereof, for which a claim for
20 overpayment is submitted.
21 (a) If an overpayment determination is the result of
22 retroactive review or audit of coverage decisions or payment
23 levels not related to fraud, a health insurer shall adhere to
24 the following procedures:
25 1. All claims for overpayment must be submitted to a
26 provider within 30 months after the health insurer's payment
27 of the claim. A provider must pay, deny, or contest the health
28 insurer's claim for overpayment within 40 days after the
29 receipt of the claim. All contested claims for overpayment
30 must be paid or denied within 120 days after receipt of the
31 claim. Failure to pay or deny overpayment and claim within 140

1 days after receipt creates an uncontestable obligation to pay
2 the claim.
3 2. A provider that denies or contests a health
4 insurer's claim for overpayment or any portion of a claim
5 shall notify the health insurer, in writing, within 35 days
6 after the provider receives the claim that the claim for
7 overpayment is contested or denied. The notice that the claim
8 for overpayment is denied or contested must identify the
9 contested portion of the claim and the specific reason for
10 contesting or denying the claim and, if contested, must
11 include a request for additional information. If the health
12 insurer submits additional information, the health insurer
13 must, within 35 days after receipt of the request, mail or
14 electronically transfer the information to the provider. The
15 provider shall pay or deny the claim for overpayment within 45
16 days after receipt of the information. The notice is
17 considered made on the date the notice is mailed or
18 electronically transferred by the provider.
19 3. Failure of a health insurer to respond to a
20 provider's contesting of claim or request for additional
21 information regarding the claim within 35 days after receipt
22 of such notice may result in denial of the claim.
23 4. The health insurer may not reduce payment to the
24 provider for other services unless the provider agrees to the
25 reduction in writing or fails to respond to the health
26 insurer's overpayment claim as required by this paragraph.
27 5. Payment of an overpayment claim is considered made
28 on the date the payment was mailed or electronically
29 transferred. An overdue payment of a claim bears simple
30 interest at the rate of 12 percent per year. Interest on an
31 overdue payment for a claim for an overpayment begins to

1 accrue when the claim should have been paid, denied, or
2 contested.
3 (b) A claim for overpayment shall not be permitted
4 beyond 30 months after the health insurer's payment of a
5 claim, except that claims for overpayment may be sought beyond
6 that time from providers convicted of fraud pursuant to s.
7 817.234.
8 (7) Payment of a claim is considered made on the date
9 the payment was mailed or electronically transferred. An
10 overdue payment of a claim bears simple interest of 12 percent
11 per year. Interest on an overdue payment for a claim or for
12 any portion of a claim begins to accrue when the claim should
13 have been paid, denied, or contested. The interest is payable
14 with the payment of the claim.
15 (8) For all contracts entered into or renewed on or
16 after October 1, 2002, a health insurer's internal dispute
17 resolution process related to a denied claim not under active
18 review by a mediator, arbitrator, or third-party dispute
19 entity must be finalized within 60 days after the receipt of
20 the provider's request for review or appeal.
21 (9) A provider or any representative of a provider,
22 regardless of whether the provider is under contract with the
23 health insurer, may not collect or attempt to collect money
24 from, maintain any action at law against, or report to a
25 credit agency an insured for payment of covered services for
26 which the health insurer contested or denied the provider's
27 claim. This prohibition applies during the pendency of any
28 claim for payment made by the provider to the health insurer
29 for payment of the services or internal dispute resolution
30 process to determine whether the health insurer is liable for
31 the services. For a claim, this pendency applies from the

1 date the claim or a portion of the claim is denied to the date
2 of the completion of the health insurer's internal dispute
3 resolution process, not to exceed 60 days.
4 (10) The provisions of this section may not be waived,
5 voided, or nullified by contract.
6 (11) A health insurer may not retroactively deny a
7 claim because of insured ineligibility more than 1 year after
8 the date of payment of the claim.
9 (12) A health insurer shall pay a contracted primary
10 care or admitting physician, pursuant to such physician's
11 contract, for providing inpatient services in a contracted
12 hospital to an insured if such services are determined by the
13 health insurer to be medically necessary and covered services
14 under the health insurer's contract with the contract holder.
15 (13) Upon written notification by an insured, an
16 insurer shall investigate any claim of improper billing by a
17 physician, hospital, or other health care provider. The
18 insurer shall determine if the insured was properly billed for
19 only those procedures and services that the insured actually
20 received. If the insurer determines that the insured has been
21 improperly billed, the insurer shall notify the insured and
22 the provider of its findings and shall reduce the amount of
23 payment to the provider by the amount determined to be
24 improperly billed. If a reduction is made due to such
25 notification by the insured, the insurer shall pay to the
26 insured 20 percent of the amount of the reduction up to $500.
27 (14) A permissible error ratio of 5 percent is
28 established for insurer's claims payment violations of s.
29 627.6131(4)(a), (b), (c), and (e) and (5)(a), (b), (c), and
30 (e). If the error ratio of a particular insurer does not
31 exceed the permissible error ratio of 5 percent for an audit

1 period, no fine shall be assessed for the noted claims
2 violations for the audit period. The error ratio shall be
3 determined by dividing the number of claims with violations
4 found on a statistically valid sample of claims for the audit
5 period by the total number of claims in the sample. If the
6 error ratio exceeds the permissible error ratio of 5 percent,
7 a fine may be assessed according to s. 624.4211 for those
8 claims payment violations which exceed the error ratio.
9 Notwithstanding the provisions of this section, the department
10 may fine a health insurer for claims payment violations of s.
11 627.6131(4)(e) and (5)(e) which create an uncontestable
12 obligation to pay the claim. The department shall not fine
13 insurers for violations which the department determines were
14 due to circumstances beyond the insurer's control.
15 (15) This section is applicable only to a major
16 medical expense health insurance policy as defined in s.
17 627.643(2)(e) offered by a group or an individual health
18 insurer licensed pursuant to chapter 624, including a
19 preferred provider policy under s. 627.6471 and an exclusive
20 provider organization under s. 627.6472.
21 (16) Notwithstanding s. 627.6131(4)(b), where an
22 electronic pharmacy claim is submitted to a pharmacy benefits
23 manager acting on behalf of a health insurer the pharmacy
24 benefits manager shall, within 30 days of receipt of the
25 claim, pay the claim or notify a provider or designee if a
26 claim is denied or contested. Notice of the insurer's action
27 on the claim and payment of the claim is considered to be made
28 on the date the notice or payment was mailed or electronically
29 transferred.
30 (17) Notwithstanding s. 627.6131(5)(a), effective
31 November 1, 2003, where a nonelectronic pharmacy claim is

1 submitted to a pharmacy benefits manager acting on behalf of a
2 health insurer the pharmacy benefits manager shall provide
3 acknowledgment of receipt of the claim within 30 days after
4 receipt of the claim to the provider or provide a provider
5 within 30 days after receipt with electronic access to the
6 status of a submitted claim.
7 Section 8. Paragraph (a) of subsection (2) of section
8 627.6425, Florida Statutes, is amended to read:
9 627.6425 Renewability of individual coverage.--
10 (2) An insurer may nonrenew or discontinue health
11 insurance coverage of an individual in the individual market
12 based only on one or more of the following:
13 (a) The individual has failed to pay premiums, ~~or~~
14 contributions, or a required copayment payable to the insurer
15 in accordance with the terms of the health insurance coverage
16 or the insurer has not received timely premium payments. When
17 the copayment is payable to the insurer and exceeds $300, the
18 insurer shall allow the insured up to 90 days after the date
19 of the procedure to pay the required copayment. The insurer
20 shall print in 10-point type on the declaration of benefits
21 page notification that the insured could be terminated for
22 failure to make any required copayment to the insurer.
23 Section 9. Paragraphs (b), (c), and (e) of subsection
24 (7) of section 627.6475, Florida Statutes, are amended to
25 read:
26 627.6475 Individual reinsurance pool.--
27 (7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.--
28 (b) A reinsuring carrier may reinsure with the program
29 coverage of an eligible individual, subject to each of the
30 following provisions:
31 1. A reinsuring carrier may reinsure an eligible

individual within 90 ~~60~~ days after commencement of the coverage of the eligible individual.

2. The program may not reimburse a participating carrier with respect to the claims of a reinsured eligible individual until the carrier has paid incurred claims of an amount equal to the participating carrier's selected deductible level, as established by the board,~~at least $5,000~~ in a calendar year for benefits covered by the program. ~~In addition, the reinsuring carrier is responsible for 10 percent of the next $50,000 and 5 percent of the next $100,000 of incurred claims during a calendar year, and the program shall reinsure the remainder.~~

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

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

5. The premium rate charged for reinsurance by the program to a health maintenance organization that is approved by the Secretary of Health and Human Services as a federally qualified health maintenance organization pursuant to 42 U.S.C. s. 300e(c)(2)(A) and that, as such, is subject to requirements that limit the amount of risk that may be ceded to the program, which requirements are more restrictive than subparagraph 2., shall be reduced by an amount equal to that

1 portion of the risk, if any, which exceeds the amount set
2 forth in subparagraph 2., which may not be ceded to the
3 program.
4 6. The board may consider adjustments to the premium
5 rates charged for reinsurance by the program or carriers that
6 use effective cost-containment measures, including high-cost
7 case management, as defined by the board.
8 7. A reinsuring carrier shall apply its
9 case-management and claims-handling techniques, including, but
10 not limited to, utilization review, individual case
11 management, preferred provider provisions, other managed-care
12 provisions, or methods of operation consistently with both
13 reinsured business and nonreinsured business.
14 (c)1. The board, as part of the plan of operation,
15 shall establish a methodology for determining premium rates to
16 be charged by the program for reinsuring eligible individuals
17 pursuant to this section. The methodology must include a
18 system for classifying individuals which reflects the types of
19 case characteristics commonly used by carriers in this state.
20 The methodology must provide for the development of basic
21 reinsurance premium rates, which shall be multiplied by the
22 factors set for them in this paragraph to determine the
23 premium rates for the program. The basic reinsurance premium
24 rates shall be established by the board, subject to the
25 approval of the department, and shall be set at levels that
26 reasonably approximate gross premiums charged to eligible
27 individuals for individual health insurance by health
28 insurance issuers. The premium rates set by the board may vary
29 by geographical area, as determined under this section, to
30 reflect differences in cost. ~~An eligible individual may be~~
31 ~~reinsured for a rate that is five times the rate established~~

1 ~~by the board.~~
2 2. The board shall periodically review the methodology
3 established, including the system of classification and any
4 rating factors, to ensure that it reasonably reflects the
5 claims experience of the program. The board may propose
6 changes to the rates that are subject to the approval of the
7 department.
8 (e)1. Before September ~~March~~ 1 of each calendar year,
9 the board shall determine and report to the department the
10 program net loss in the individual account for the previous
11 year, including administrative expenses for that year and the
12 incurred losses for that year, taking into account investment
13 income and other appropriate gains and losses.
14 2. Any net loss in the individual account for the year
15 shall be recouped by assessing the carriers as follows:
16 a. The operating losses of the program shall be
17 assessed in the following order subject to the specified
18 limitations. The first tier of assessments shall be made
19 against reinsuring carriers in an amount that may not exceed 5
20 percent of each reinsuring carrier's premiums for individual
21 health insurance. If such assessments have been collected and
22 additional moneys are needed, the board shall make a second
23 tier of assessments in an amount that may not exceed 0.5
24 percent of each carrier's health benefit plan premiums.
25 b. Except as provided in paragraph (f), risk-assuming
26 carriers are exempt from all assessments authorized pursuant
27 to this section. The amount paid by a reinsuring carrier for
28 the first tier of assessments shall be credited against any
29 additional assessments made.
30 c. The board shall equitably assess reinsuring
31 carriers for operating losses of the individual account based

1 on market share. The board shall annually assess each carrier
2 a portion of the operating losses of the individual account.
3 The first tier of assessments shall be determined by
4 multiplying the operating losses by a fraction, the numerator
5 of which equals the reinsuring carrier's earned premium
6 pertaining to direct writings of individual health insurance
7 in the state during the calendar year for which the assessment
8 is levied, and the denominator of which equals the total of
9 all such premiums earned by reinsuring carriers in the state
10 during that calendar year. The second tier of assessments
11 shall be based on the premiums that all carriers, except
12 risk-assuming carriers, earned on all health benefit plans
13 written in this state. The board may levy interim assessments
14 against reinsuring carriers to ensure the financial ability of
15 the plan to cover claims expenses and administrative expenses
16 paid or estimated to be paid in the operation of the plan for
17 the calendar year prior to the association's anticipated
18 receipt of annual assessments for that calendar year. Any
19 interim assessment is due and payable within 30 days after
20 receipt by a carrier of the interim assessment notice. Interim
21 assessment payments shall be credited against the carrier's
22 annual assessment. Health benefit plan premiums and benefits
23 paid by a carrier that are less than an amount determined by
24 the board to justify the cost of collection may not be
25 considered for purposes of determining assessments.
26 d. Subject to the approval of the department, the
27 board shall adjust the assessment formula for reinsuring
28 carriers that are approved as federally qualified health
29 maintenance organizations by the Secretary of Health and Human
30 Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent,
31 if any, that restrictions are placed on them which are not

1 imposed on other carriers.
2 3. Before September ~~March~~ 1 of each year, the board
3 shall determine and file with the department an estimate of
4 the assessments needed to fund the losses incurred by the
5 program in the individual account for the previous calendar
6 year.
7 4. If the board determines that the assessments needed
8 to fund the losses incurred by the program in the individual
9 account for the previous calendar year will exceed the amount
10 specified in subparagraph 2., the board shall evaluate the
11 operation of the program and report its findings and
12 recommendations to the department in the format established in
13 s. 627.6699(11) for the comparable report for the small
14 employer reinsurance program.
15 Section 10. Subsection (4) of section 627.651, Florida
16 Statutes, is amended to read:
17 627.651 Group contracts and plans of self-insurance
18 must meet group requirements.--
19 (4) This section does not apply to any plan which is
20 established or maintained by an individual employer in
21 accordance with the Employee Retirement Income Security Act of
22 1974, Pub. L. No. 93-406, or to a multiple-employer welfare
23 arrangement as defined in s. 624.437(1), except that a
24 multiple-employer welfare arrangement shall comply with ss.
25 627.419, 627.657, 627.6575, 627.6578, 627.6579, 627.6612,
26 627.66121, 627.66122, 627.6615, 627.6616, and 627.662(7)
27 ~~627.662(6)~~. This subsection does not allow an authorized
28 insurer to issue a group health insurance policy or
29 certificate which does not comply with this part.
30 Section 11. Section 627.662, Florida Statutes, is
31 amended to read:

627.662 Other provisions applicable.--The following provisions apply to group health insurance, blanket health insurance, and franchise health insurance:

(1) Section 627.569, relating to use of dividends, refunds, rate reductions, commissions, and service fees.

(2) Section 627.602(1)(f) and (2), relating to identification numbers and statement of deductible provisions.

(3) Section 627.635, relating to excess insurance.

(4) Section 627.638, relating to direct payment for hospital or medical services.

(5) Section 627.640, relating to filing and classification of rates.

(6) Section 627.613, relating to timely payment of claims, or s. 627.6131, relating to payment of claims.

(7)~~(6)~~ Section 627.645(1), relating to denial of claims.

(8)~~(7)~~ Section 627.613, relating to time of payment of claims.

(9)~~(8)~~ Section 627.6471, relating to preferred provider organizations.

(10)~~(9)~~ Section 627.6472, relating to exclusive provider organizations.

(11)~~(10)~~ Section 627.6473, relating to combined preferred provider and exclusive provider policies.

(12)~~(11)~~ Section 627.6474, relating to provider contracts.

Section 12. Subsection (6) of section 627.667, Florida Statutes, is amended to read:

627.667 Extension of benefits.--

(6) This section also applies to holders of group certificates which are renewed, delivered, or issued for

delivery to residents of this state under group policies effectuated or delivered outside this state~~, unless a succeeding carrier under a group policy has agreed to assume liability for the benefits~~.

Section 13. Paragraph (e) of subsection (5) of section 627.6692, Florida Statutes, as amended by section 1 of chapter 2001-353, Laws of Florida, is amended to read:

627.6692 Florida Health Insurance Coverage Continuation Act.--

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

(e)1. A covered employee or other qualified beneficiary who wishes continuation of coverage must pay the initial premium and elect such continuation in writing to the insurance carrier issuing the employer's group health plan within 63 ~~30~~ days after receiving notice from the insurance carrier under paragraph (d). Subsequent premiums are due by the grace period expiration date. The insurance carrier or the insurance carrier's designee shall process all elections promptly and provide coverage retroactively to the date coverage would otherwise have terminated. The premium due shall be for the period beginning on the date coverage would have otherwise terminated due to the qualifying event. The first premium payment must include the coverage paid to the end of the month in which the first payment is made. After the election, the insurance carrier must bill the qualified beneficiary for premiums once each month, with a due date on the first of the month of coverage and allowing a 30-day grace period for payment.

2. Except as otherwise specified in an election, any election by a qualified beneficiary shall be deemed to include

an election of continuation of coverage on behalf of any other qualified beneficiary residing in the same household who would lose coverage under the group health plan by reason of a qualifying event. This subparagraph does not preclude a qualified beneficiary from electing continuation of coverage on behalf of any other qualified beneficiary.

Section 14. Paragraphs (i), (m), and (n) of subsection (3), paragraph (c) of subsection (5), paragraph (b) of subsection (6), paragraphs (f), (g), (h), and (j) of subsection (11), and subsections (12) and (15) of section 627.6699, Florida Statutes, are amended to read:

627.6699 Employee Health Care Access Act.--

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

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

(m) "Flexible ~~Limited~~ benefit policy or contract" means a policy or contract that provides coverage for each person insured under the policy and ~~for a specifically named disease or diseases, a specifically named accident, or a specifically named limited market~~ that fulfills a ~~an experimental or~~ reasonable need by providing more affordable health insurance to a small employer or a small employer health alliance under s. 627.654~~, such as the small group market~~.

(n) "Modified community rating" means a method used to develop carrier premiums which spreads financial risk across a large population; allows the use of separate rating factors for age, gender, family composition, tobacco usage, and geographic area as determined under paragraph (5)(j); and

1 allows adjustments for: claims experience, health status, or
2 duration of coverage as permitted under subparagraph (6)(b)5.;
3 and administrative and acquisition expenses as permitted under
4 subparagraph (6)(b)5.
5 (5) AVAILABILITY OF COVERAGE.--
6 (c) Every small employer carrier must, as a condition
7 of transacting business in this state:
8 1. Beginning July 1, 2000, offer and issue all small
9 employer health benefit plans on a guaranteed-issue basis to
10 every eligible small employer, with 2 to 50 eligible
11 employees, that elects to be covered under such plan, agrees
12 to make the required premium payments, and satisfies the other
13 provisions of the plan. A rider for additional or increased
14 benefits may be medically underwritten and may only be added
15 to the standard health benefit plan. The increased rate
16 charged for the additional or increased benefit must be rated
17 in accordance with this section.
18 2. Beginning July 1, 2000, and until July 31, 2001,
19 offer and issue basic and standard small employer health
20 benefit plans on a guaranteed-issue basis to every eligible
21 small employer which is eligible for guaranteed renewal, has
22 less than two eligible employees, is not formed primarily for
23 the purpose of buying health insurance, elects to be covered
24 under such plan, agrees to make the required premium payments,
25 and satisfies the other provisions of the plan. A rider for
26 additional or increased benefits may be medically underwritten
27 and may be added only to the standard benefit plan. The
28 increased rate charged for the additional or increased benefit
29 must be rated in accordance with this section. For purposes of
30 this subparagraph, a person, his or her spouse, and his or her
31 dependent children shall constitute a single eligible employee

1 if that person and spouse are employed by the same small
2 employer and either one has a normal work week of less than 25
3 hours.
4 3.a. Beginning August 1, 2001, offer and issue basic
5 and standard small employer health benefit plans on a
6 guaranteed-issue basis, during a 31-day open enrollment period
7 of August 1 through August 31 of each year, to every eligible
8 small employer, with fewer than two eligible employees, which
9 small employer is not formed primarily for the purpose of
10 buying health insurance and which elects to be covered under
11 such plan, agrees to make the required premium payments, and
12 satisfies the other provisions of the plan. Coverage provided
13 under this subparagraph shall begin on October 1 of the same
14 year as the date of enrollment, unless the small employer
15 carrier and the small employer agree to a different date. A
16 rider for additional or increased benefits may be medically
17 underwritten and may only be added to the standard health
18 benefit plan. The increased rate charged for the additional
19 or increased benefit must be rated in accordance with this
20 section. For purposes of this subparagraph, a person, his or
21 her spouse, and his or her dependent children constitute a
22 single eligible employee if that person and spouse are
23 employed by the same small employer and either that person or
24 his or her spouse has a normal work week of less than 25
25 hours.
26 b. Notwithstanding the restrictions set forth in
27 sub-subparagraph a., when a small employer group is losing
28 coverage because a carrier is exercising the provisions of s.
29 627.6571(3)(b) or s. 641.31074(3)(b), the eligible small
30 employer, as defined in sub-subparagraph a., is entitled to
31 enroll with another carrier offering small employer coverage

1 within 63 days after the notice of termination or the
2 termination date of the prior coverage, whichever is later.
3 Coverage provided under this sub-subparagraph begins
4 immediately upon enrollment, unless the small employer carrier
5 and the small employer agree to a different date.
6 4. This paragraph does not limit a carrier's ability
7 to offer other health benefit plans to small employers if the
8 standard and basic health benefit plans are offered and
9 rejected.
10 (6) RESTRICTIONS RELATING TO PREMIUM RATES.--
11 (b) For all small employer health benefit plans that
12 are subject to this section and are issued by small employer
13 carriers on or after January 1, 1994, premium rates for health
14 benefit plans subject to this section are subject to the
15 following:
16 1. Small employer carriers must use a modified
17 community rating methodology in which the premium for each
18 small employer must be determined solely on the basis of the
19 eligible employee's and eligible dependent's gender, age,
20 family composition, tobacco use, or geographic area as
21 determined under paragraph (5)(j) and in which the premium may
22 be adjusted as permitted by subparagraphs 5., ~~and~~ 6., and 7.
23 2. Rating factors related to age, gender, family
24 composition, tobacco use, or geographic location may be
25 developed by each carrier to reflect the carrier's experience.
26 The factors used by carriers are subject to department review
27 and approval.
28 3. Small employer carriers may not modify the rate for
29 a small employer for 12 months from the initial issue date or
30 renewal date, unless the composition of the group changes or
31 benefits are changed. However, a small employer carrier may

1 modify the rate one time prior to 12 months after the initial
2 issue date for a small employer who enrolls under a previously
3 issued group policy that has a common anniversary date for all
4 employers covered under the policy if:
5 a. The carrier discloses to the employer in a clear
6 and conspicuous manner the date of the first renewal and the
7 fact that the premium may increase on or after that date.
8 b. The insurer demonstrates to the department that
9 efficiencies in administration are achieved and reflected in
10 the rates charged to small employers covered under the policy.
11 4. A carrier may issue a group health insurance policy
12 to a small employer health alliance or other group association
13 with rates that reflect a premium credit for expense savings
14 attributable to administrative activities being performed by
15 the alliance or group association if such expense savings are
16 specifically documented in the insurer's rate filing and are
17 approved by the department. Any such credit may not be based
18 on different morbidity assumptions or on any other factor
19 related to the health status or claims experience of any
20 person covered under the policy. Nothing in this subparagraph
21 exempts an alliance or group association from licensure for
22 any activities that require licensure under the insurance
23 code. A carrier issuing a group health insurance policy to a
24 small employer health alliance or other group association
25 shall allow any properly licensed and appointed agent of that
26 carrier to market and sell the small employer health alliance
27 or other group association policy. Such agent shall be paid
28 the usual and customary commission paid to any agent selling
29 the policy.
30 5. ~~Any adjustments in rates for claims experience,~~
31 ~~health status, or duration of coverage may not be charged to~~

1 ~~individual employees or dependents. For a small employer's~~
2 ~~policy, such adjustments may not result in a rate for the~~
3 ~~small employer which deviates more than 15 percent from the~~
4 ~~carrier's approved rate. Any such adjustment must be applied~~
5 ~~uniformly to the rates charged for all employees and~~
6 ~~dependents of the small employer. A small employer carrier may~~
7 ~~make an adjustment to a small employer's renewal premium, not~~
8 ~~to exceed 10 percent annually, due to the claims experience,~~
9 ~~health status, or duration of coverage of the employees or~~
10 ~~dependents of the small employer. Semiannually, small group~~
11 ~~carriers shall report information on forms adopted by rule by~~
12 ~~the department, to enable the department to monitor the~~
13 ~~relationship of aggregate adjusted premiums actually charged~~
14 ~~policyholders by each carrier to the premiums that would have~~
15 ~~been charged by application of the carrier's approved modified~~
16 ~~community rates. If the aggregate resulting from the~~
17 ~~application of such adjustment exceeds the premium that would~~
18 ~~have been charged by application of the approved modified~~
19 ~~community rate by 5 percent for the current reporting period,~~
20 ~~the carrier shall limit the application of such adjustments~~
21 ~~only to minus adjustments beginning not more than 60 days~~
22 ~~after the report is sent to the department. For any subsequent~~
23 ~~reporting period, if the total aggregate adjusted premium~~
24 ~~actually charged does not exceed the premium that would have~~
25 ~~been charged by application of the approved modified community~~
26 ~~rate by 5 percent, the carrier may apply both plus and minus~~
27 ~~adjustments.~~A small employer carrier may provide a credit to
28 a small employer's premium based on administrative and
29 acquisition expense differences resulting from the size of the
30 group. Group size administrative and acquisition expense
31 factors may be developed by each carrier to reflect the

1 carrier's experience and are subject to department review and
2 approval.
3 6. A small employer carrier rating methodology may
4 include separate rating categories for one dependent child,
5 for two dependent children, and for three or more dependent
6 children for family coverage of employees having a spouse and
7 dependent children or employees having dependent children
8 only. A small employer carrier may have fewer, but not
9 greater, numbers of categories for dependent children than
10 those specified in this subparagraph.
11 7. Small employer carriers may not use a composite
12 rating methodology to rate a small employer with fewer than 10
13 employees. For the purposes of this subparagraph, a "composite
14 rating methodology" means a rating methodology that averages
15 the impact of the rating factors for age and gender in the
16 premiums charged to all of the employees of a small employer.
17 8.a. A carrier may separate the experience of small
18 employer groups with less than 2 eligible employees from the
19 experience of small employer groups with 2-50 eligible
20 employees for purposes of determining an alternative modified
21 community rating.
22 b. If a carrier separates the experience of small
23 employer groups as provided in sub-subparagraph a., the rate
24 to be charged to small employer groups of less than 2 eligible
25 employees may not exceed 150 percent of the rate determined
26 for small employer groups of 2-50 eligible employees. However,
27 the carrier may charge excess losses of the experience pool
28 consisting of small employer groups with less than 2 eligible
29 employees to the experience pool consisting of small employer
30 groups with 2-50 eligible employees so that all losses are
31 allocated and the 150-percent rate limit on the experience

1 pool consisting of small employer groups with less than 2
2 eligible employees is maintained. Notwithstanding s.
3 627.411(1), the rate to be charged to a small employer group
4 of fewer than 2 eligible employees, insured as of July 1,
5 2002, may be up to 125 percent of the rate determined for
6 small employer groups of 2-50 eligible employees for the first
7 annual renewal and 150 percent for subsequent annual renewals.
8 (11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.--
9 (f) The program has the general powers and authority
10 granted under the laws of this state to insurance companies
11 and health maintenance organizations licensed to transact
12 business, except the power to issue health benefit plans
13 directly to groups or individuals. In addition thereto, the
14 program has specific authority to:
15 1. Enter into contracts as necessary or proper to
16 carry out the provisions and purposes of this act, including
17 the authority to enter into contracts with similar programs of
18 other states for the joint performance of common functions or
19 with persons or other organizations for the performance of
20 administrative functions.
21 2. Sue or be sued, including taking any legal action
22 necessary or proper for recovering any assessments and
23 penalties for, on behalf of, or against the program or any
24 carrier.
25 3. Take any legal action necessary to avoid the
26 payment of improper claims against the program.
27 4. Issue reinsurance policies, in accordance with the
28 requirements of this act.
29 5. Establish rules, conditions, and procedures for
30 reinsurance risks under the program participation.
31 6. Establish actuarial functions as appropriate for

the operation of the program.

7. Assess participating carriers in accordance with paragraph (j), and make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Interim assessments shall be credited as offsets against any regular assessments due following the close of the calendar year.

8. Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the program, and in any other function within the authority of the program.

9. Borrow money to effect the purposes of the program. Any notes or other evidences of indebtedness of the program which are not in default constitute legal investments for carriers and may be carried as admitted assets.

10. To the extent necessary, increase the $5,000 deductible reinsurance requirement to adjust for the effects of inflation. The program may evaluate the desirability of establishing differing levels of deductibles. If differing levels of deductibles are established, such levels and the resulting premiums must be approved by the department.

(g) A reinsuring carrier may reinsure with the program coverage of an eligible employee of a small employer, or any dependent of such an employee, subject to each of the following provisions:

1. With respect to a standard and basic health care plan, the program may ~~must~~ reinsure the level of coverage provided; and, with respect to any other plan, the program may ~~must~~ reinsure the coverage up to, but not exceeding, the level of coverage provided under the standard and basic health care plan. As an alternative to reinsuring the entire level of

coverage provided, the program may develop corridors of reinsurance designed to coordinate with a reinsuring carrier's existing reinsurance. The corridors of reinsurance and resulting premiums must be approved by the department.

2. Except in the case of a late enrollee, a reinsuring carrier may reinsure an eligible employee or dependent within 90 ~~60~~ days after the commencement of the coverage of the small employer. A newly employed eligible employee or dependent of a small employer may be reinsured within 90 ~~60~~ days after the commencement of his or her coverage.

3. A small employer carrier may reinsure an entire employer group within 90 ~~60~~ days after the commencement of the group's coverage under the plan. The carrier may choose to reinsure newly eligible employees and dependents of the reinsured group pursuant to subparagraph 1.

4. The program may evaluate the option of allowing a small employer carrier to reinsure an entire employer group or an eligible employee at the first or subsequent renewal date. Any such option and the resulting premium must be approved by the department.

5.~~4.~~ The program may not reimburse a participating carrier with respect to the claims of a reinsured employee or dependent until the carrier has paid incurred claims of an amount equal to the participating carrier's selected deductible level ~~at least $5,000~~ in a calendar year for benefits covered by the program. ~~In addition, the reinsuring carrier shall be responsible for 10 percent of the next $50,000 and 5 percent of the next $100,000 of incurred claims during a calendar year and the program shall reinsure the remainder.~~

6.~~5.~~ The board annually may ~~shall~~ adjust the initial

level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the "Consumer Price Index for All Urban Consumers" of the Bureau of Labor Statistics of the Department of Labor, unless the board proposes and the department approves a lower adjustment factor.

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

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

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

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

reinsured business and nonreinsured business.

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

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

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

2. The board periodically shall review the methodology established, including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the rates which shall be subject to the approval of the department.

(j)1. Before September ~~March~~ 1 of each calendar year,

1 the board shall determine and report to the department the
2 program net loss for the previous year, including
3 administrative expenses for that year, and the incurred losses
4 for the year, taking into account investment income and other
5 appropriate gains and losses.
6 2. Any net loss for the year shall be recouped by
7 assessment of the carriers, as follows:
8 a. The operating losses of the program shall be
9 assessed in the following order subject to the specified
10 limitations. The first tier of assessments shall be made
11 against reinsuring carriers in an amount which shall not
12 exceed 5 percent of each reinsuring carrier's premiums from
13 health benefit plans covering small employers. If such
14 assessments have been collected and additional moneys are
15 needed, the board shall make a second tier of assessments in
16 an amount which shall not exceed 0.5 percent of each carrier's
17 health benefit plan premiums. Except as provided in paragraph
18 (n), risk-assuming carriers are exempt from all assessments
19 authorized pursuant to this section. The amount paid by a
20 reinsuring carrier for the first tier of assessments shall be
21 credited against any additional assessments made.
22 b. The board shall equitably assess carriers for
23 operating losses of the plan based on market share. The board
24 shall annually assess each carrier a portion of the operating
25 losses of the plan. The first tier of assessments shall be
26 determined by multiplying the operating losses by a fraction,
27 the numerator of which equals the reinsuring carrier's earned
28 premium pertaining to direct writings of small employer health
29 benefit plans in the state during the calendar year for which
30 the assessment is levied, and the denominator of which equals
31 the total of all such premiums earned by reinsuring carriers

in the state during that calendar year. The second tier of assessments shall be based on the premiums that all carriers, except risk-assuming carriers, earned on all health benefit plans written in this state. The board may levy interim assessments against carriers to ensure the financial ability of the plan to cover claims expenses and administrative expenses paid or estimated to be paid in the operation of the plan for the calendar year prior to the association's anticipated receipt of annual assessments for that calendar year. Any interim assessment is due and payable within 30 days after receipt by a carrier of the interim assessment notice. Interim assessment payments shall be credited against the carrier's annual assessment. Health benefit plan premiums and benefits paid by a carrier that are less than an amount determined by the board to justify the cost of collection may not be considered for purposes of determining assessments.

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

3. Before September ~~March~~ 1 of each year, the board shall determine and file with the department an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.

4. If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified in subparagraph 2., the board shall evaluate the operation of the program and

1 report its findings, including any recommendations for changes
2 to the plan of operation, to the department within <u>240</u> ~~90~~ days
3 following the end of the calendar year in which the losses
4 were incurred. The evaluation shall include an estimate of
5 future assessments, the administrative costs of the program,
6 the appropriateness of the premiums charged and the level of
7 carrier retention under the program, and the costs of coverage
8 for small employers. If the board fails to file a report with
9 the department within <u>240</u> ~~90~~ days following the end of the
10 applicable calendar year, the department may evaluate the
11 operations of the program and implement such amendments to the
12 plan of operation the department deems necessary to reduce
13 future losses and assessments.
14 5. If assessments exceed the amount of the actual
15 losses and administrative expenses of the program, the excess
16 shall be held as interest and used by the board to offset
17 future losses or to reduce program premiums. As used in this
18 paragraph, the term "future losses" includes reserves for
19 incurred but not reported claims.
20 6. Each carrier's proportion of the assessment shall
21 be determined annually by the board, based on annual
22 statements and other reports considered necessary by the board
23 and filed by the carriers with the board.
24 7. Provision shall be made in the plan of operation
25 for the imposition of an interest penalty for late payment of
26 an assessment.
27 8. A carrier may seek, from the commissioner, a
28 deferment, in whole or in part, from any assessment made by
29 the board. The department may defer, in whole or in part, the
30 assessment of a carrier if, in the opinion of the department,
31 the payment of the assessment would place the carrier in a

1 financially impaired condition. If an assessment against a
2 carrier is deferred, in whole or in part, the amount by which
3 the assessment is deferred may be assessed against the other
4 carriers in a manner consistent with the basis for assessment
5 set forth in this section. The carrier receiving such
6 deferment remains liable to the program for the amount
7 deferred and is prohibited from reinsuring any individuals or
8 groups in the program if it fails to pay assessments.
9 (12) STANDARD, BASIC, AND FLEXIBLE ~~LIMITED~~ HEALTH
10 BENEFIT PLANS.--
11 (a)1. By May 15, 1993, the commissioner shall appoint
12 a health benefit plan committee composed of four
13 representatives of carriers which shall include at least two
14 representatives of HMOs, at least one of which is a staff
15 model HMO, two representatives of agents, four representatives
16 of small employers, and one employee of a small employer. The
17 carrier members shall be selected from a list of individuals
18 recommended by the board. The commissioner may require the
19 board to submit additional recommendations of individuals for
20 appointment.
21 2. The plans shall comply with all of the requirements
22 of this subsection.
23 3. The plans must be filed with and approved by the
24 department prior to issuance or delivery by any small employer
25 carrier.
26 4. Before October 1, 2002, and in every 4th year
27 thereafter, the commissioner shall appoint a new health
28 benefit plan committee in the manner provided in subparagraph
29 1. to determine whether modifications to a plan might be
30 appropriate and to submit recommended modifications to the
31 department for approval. Such a determination must be based

upon prevailing industry standards regarding managed care and cost-containment provisions and is to serve the purpose of ensuring that the benefit plans offered to small employers on a guaranteed-issue basis are consistent with the low-priced to mid-priced benefit plans offered in the large-group market. Each new health benefit plan committee shall evaluate the implementation of this act and its impact on the entities that provide the plans, the number of enrollees, the participants covered by the plans and their access to care, the scope of health care coverage offered under the plans, the difference in premiums between these plans and standard or basic plans, and an assessment of the plans. This determination shall be included in a report submitted to the President of the Senate and the Speaker of the House of Representatives annually by October 1.~~After approval of the revised health benefit plans, if the department determines that modifications to a plan might be appropriate, the commissioner shall appoint a new health benefit plan committee in the manner provided in subparagraph 1. to submit recommended modifications to the department for approval.~~

(b)1. Each small employer carrier issuing new health benefit plans shall offer to any small employer, upon request, a standard health benefit plan and a basic health benefit plan that meets the criteria set forth in this section.

2. For purposes of this subsection, the terms "standard health benefit plan" and "basic health benefit 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

1 b. A procedure for preauthorization by the small
2 employer carrier, or its designees.
3 3. A small employer carrier may include the following
4 managed care provisions in the policy or contract to control
5 costs:
6 a. A preferred provider arrangement or exclusive
7 provider organization or any combination thereof, in which a
8 small employer carrier enters into a written agreement with
9 the provider to provide services at specified levels of
10 reimbursement or to provide reimbursement to specified
11 providers. Any such written agreement between a provider and a
12 small employer carrier must contain a provision under which
13 the parties agree that the insured individual or covered
14 member has no obligation to make payment for any medical
15 service rendered by the provider which is determined not to be
16 medically necessary. A carrier may use preferred provider
17 arrangements or exclusive provider arrangements to the same
18 extent as allowed in group products that are not issued to
19 small employers.
20 b. A procedure for utilization review by the small
21 employer carrier or its designees.
22
23 This subparagraph does not prohibit a small employer carrier
24 from including in its policy or contract additional managed
25 care and cost containment provisions, subject to the approval
26 of the department, which have potential for controlling costs
27 in a manner that does not result in inequitable treatment of
28 insureds or subscribers. The carrier may use such provisions
29 to the same extent as authorized for group products that are
30 not issued to small employers.
31 4. The standard health benefit plan and any flexible

1 benefit policy or contract shall include:
2 a. Coverage for inpatient hospitalization;
3 b. Coverage for outpatient services;
4 c. Coverage for newborn children pursuant to s.
5 627.6575;
6 d. Coverage for child care supervision services
7 pursuant to s. 627.6579;
8 e. Coverage for adopted children upon placement in the
9 residence pursuant to s. 627.6578;
10 f. Coverage for mammograms pursuant to s. 627.6613;
11 g. Coverage for handicapped children pursuant to s.
12 627.6615;
13 h. Emergency or urgent care out of the geographic
14 service area; and
15 i. Coverage for services provided by a hospice
16 licensed under s. 400.602 in cases where such coverage would
17 be the most appropriate and the most cost-effective method for
18 treating a covered illness.
19 5. The standard health benefit plan and the basic
20 health benefit plan may include a schedule of benefit
21 limitations for specified services and procedures. If the
22 committee develops such a schedule of benefits limitation for
23 the standard health benefit plan or the basic health benefit
24 plan, a small employer carrier offering the plan must offer
25 the employer an option for increasing the benefit schedule
26 amounts by 4 percent annually.
27 6. The basic health benefit plan shall include all of
28 the benefits specified in subparagraph 4.; however, the basic
29 health benefit plan shall place additional restrictions on the
30 benefits and utilization and may also impose additional cost
31 containment measures.

7. Sections 627.419(2), (3), and (4), 627.6574, 627.6612, 627.66121, 627.66122, 627.6616, 627.6618, 627.668, ~~and~~ 627.66911, 627.4239, 627.65755, 627.6691, 627.4232, 627.42395, 627.65745, 627.667, 627.6617, 627.669, 641.51(8), 627.6472(18), 627.662, 641.19(13)(e), 627.6471, 627.6472, 627.6045, 627.607, 641.31(27), 641.51(11), 627.6577, 627.6699(12)(b)(7), 627.6472(16), 627.662, 641.31(21), 627.6419, 627.6045, 627.667, 641.3111, 627.6617, 641.513(3), 641.32(12) and 627.6619 apply to the standard health benefit plan, to any flexible benefit policy or contract,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. 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.

(c) If a small employer rejects, in writing, the standard health benefit plan and the basic health benefit plan, the small employer carrier may offer the small employer a flexible ~~limited~~ benefit policy or contract.

(d)1. Upon offering coverage under a standard health benefit plan, a basic health benefit plan, or a flexible ~~limited~~ benefit policy or contract for any small employer, the small employer carrier shall disclose in writing to the ~~provide such~~ employer ~~group with a written statement that contains, at a minimum~~:

~~a. An explanation of those mandated benefits and~~

~~providers that are not covered by the policy or contract;~~

a.~~b.~~ An outline of coverage together ~~explanation of the managed care and cost control features of the policy or contract, along~~ with all appropriate mailing addresses and telephone numbers to be used by insureds in seeking information or authorization.~~; and~~

b.~~c.~~ ~~An explanation of~~ The primary and preventive care features of the policy or contract.

~~Such disclosure statement must be presented in a clear and understandable form and format and must be separate from the policy or certificate or evidence of coverage provided to the employer group.~~

~~2. Before a small employer carrier issues a standard health benefit plan, a basic health benefit plan, or a limited benefit policy or contract, it must obtain from the prospective policyholder a signed written statement in which the prospective policyholder:~~

~~a. Certifies as to eligibility for coverage under the standard health benefit plan, basic health benefit plan, or limited benefit policy or contract;~~

c.~~b.~~ ~~Acknowledges~~ The limited nature of the coverage and ~~an understanding of~~ the ~~managed care and~~ cost control features of the policy or contract.~~;~~

~~c. Acknowledges that if misrepresentations are made regarding eligibility for coverage under a standard health benefit plan, a basic health benefit plan, or a limited benefit policy or contract, the person making such misrepresentations forfeits coverage provided by the policy or contract; and~~

2.~~d.~~ If a flexible benefit policy or contract ~~limited~~

~~plan~~ is requested, the prospective policyholder must acknowledge in writing ~~acknowledges~~ that he or she ~~the prospective policyholder~~ had been offered, at the time of application for the insurance policy or contract, the opportunity to purchase any health benefit plan offered by the carrier and that the prospective policyholder had rejected that coverage.

~~A copy of such written statement shall be provided to the prospective policyholder no later than at the time of delivery of the policy or contract, and the original of such written statement shall be retained in the files of the small employer carrier for the period of time that the policy or contract remains in effect or for 5 years, whichever period is longer.~~

~~3. Any material statement made by an applicant for coverage under a health benefit plan which falsely certifies as to the applicant's eligibility for coverage serves as the basis for terminating coverage under the policy or contract.~~

3.~~4.~~ Each marketing communication that is intended to be used in the marketing of a health benefit plan in this state must be submitted for review by the department prior to use and must contain the disclosures stated in this subsection.

4. The contract, policy, and certificates evidencing coverage under a flexible benefit policy or contract and the application for coverage under such plans must state in not less than 12-point bold type on the first page in contrasting color the following: "The benefits provided by this health plan are limited and may not cover all of your medical needs. You should carefully review the benefits offered under this health plan."

1 (e) A small employer carrier may not use any policy,
2 contract, form, or rate under this section, including
3 applications, enrollment forms, policies, contracts,
4 certificates, evidences of coverage, riders, amendments,
5 endorsements, and disclosure forms, until the carrier ~~insurer~~
6 has filed it with the department and the department has
7 approved it under ss. 627.410, ~~and~~ 627.411, and 641.31 and
8 this section.
9 (f) A flexible benefit policy or contract must have an
10 annual maximum benefit of $50,000 or greater and a lifetime
11 benefit of $500,000 or greater and such benefit shall be
12 disclosed in 12-point bold type in contrasting color.
13 (15) APPLICABILITY OF OTHER STATE LAWS.--
14 (a) Except as expressly provided in this section, a
15 law requiring coverage for a specific health care service or
16 benefit, or a law requiring reimbursement, utilization, or
17 consideration of a specific category of licensed health care
18 practitioner, does not apply to a standard or basic health
19 benefit plan policy or contract or a flexible ~~limited~~ benefit
20 policy or contract offered or delivered to a small employer
21 unless that law is made expressly applicable to such policies
22 or contracts. A law restricting or limiting deductibles,
23 coinsurance, copayments, or annual or lifetime maximum
24 payments does not apply to any health plan policy, including a
25 standard or basic health benefit plan policy or contract or a
26 flexible benefit policy or contract, offered or delivered to a
27 small employer unless such law is made expressly applicable to
28 such policy or contract. When any flexible benefit health
29 insurance policy or flexible benefit contract provides for the
30 payment for medical expense benefits or procedures, such
31 policy or contract shall be construed to include payment to a

1 licensed physician or licensed dentist who provides the
2 medical service benefits or procedures which are within the
3 scope of a licensed physician's license or licensed dentist's
4 license. Any limitation or condition placed upon payment to,
5 or upon services, diagnosis, or treatment by, any licensed
6 physician shall or licensed dentist apply equally to all
7 licensed physicians without unfair discrimination to the usual
8 and customary treatment procedures of any class of physicians
9 or licensed dentist.
10 (b) Except as provided in this section, a standard or
11 basic health benefit plan policy or contract or flexible
12 ~~limited~~ benefit policy or contract offered to a small employer
13 is not subject to any provision of this code which:
14 1. Inhibits a small employer carrier from contracting
15 with providers or groups of providers with respect to health
16 care services or benefits;
17 2. Imposes any restriction on a small employer
18 carrier's ability to negotiate with providers regarding the
19 level or method of reimbursing care or services provided under
20 a health benefit plan; or
21 3. Requires a small employer carrier to either include
22 a specific provider or class of providers when contracting for
23 health care services or benefits or to exclude any class of
24 providers that is generally authorized by statute to provide
25 such care.
26 (c) Any second tier assessment paid by a carrier
27 pursuant to paragraph (11)(j) may be credited against
28 assessments levied against the carrier pursuant to s.
29 627.6494.
30 (d) Notwithstanding chapter 641, a health maintenance
31 organization is authorized to issue contracts providing

1 benefits to a small employer equal to the standard health
2 benefit plan, the basic health benefit plan, and the flexible
3 ~~limited~~ benefit policy authorized by this section. Flexible
4 benefit plans offered by health maintenance organizations
5 shall contain all group provisions required under chapter 641.
6 Section 15. Section 627.911, Florida Statutes, is
7 amended to read:
8 627.911 Scope of this part.--Any insurer or health
9 maintenance organization transacting insurance in this state
10 shall report information as required by this part.
11 Section 16. Section 627.9175, Florida Statutes, is
12 amended to read:
13 627.9175 Reports of information on health insurance.--
14 (1) Each authorized health insurer shall submit
15 annually to the department information concerning health
16 insurance coverage being issued or currently in force in this
17 state. The information must include information related to
18 premium, number of policies, and covered lives for such
19 policies and other information necessary for analyzing trends
20 in enrollment, premiums, and claim costs.~~as to policies of~~
21 ~~individual health insurance:~~
22 (a) The required information must be broken down by
23 market segment, to include:
24 1. Health insurance issuer company contact
25 information.
26 2. Information on all health insurance products issued
27 or in force. Such information must include:
28 a. Direct premiums earned.
29 b. Direct losses incurred.
30 c. Direct premiums earned for new business issued
31 during the year.

d. Number of policies.

e. Number of certificates.

f. Number of total covered lives.

~~A summary of typical benefits, exclusions, and limitations for each type of individual policy form currently being issued in the state. The summary shall include, as appropriate:~~

~~1. The deductible amount;~~

~~2. The coinsurance percentage;~~

~~3. The out-of-pocket maximum;~~

~~4. Outpatient benefits;~~

~~5. Inpatient benefits; and~~

~~6. Any exclusions for preexisting conditions.~~

~~The department shall determine other appropriate benefits, exclusions, and limitations to be reported for inclusion in the consumer's guide published pursuant to this section.~~

(b) The department may adopt rules to administer this section, including, but not limited to, rules governing compliance and provisions implementing electronic methodologies for use in furnishing such records or documents. ~~A schedule of rates for each type of individual policy form reflecting typical variations by age, sex, region of the state, or any other applicable factor which is in use and is determined to be appropriate for inclusion by the department.~~

The department may ~~shall~~ provide by rule a uniform format for the submission of this information in order to allow for meaningful comparisons ~~of premiums charged for comparable benefits. The department shall publish annually a consumer's guide which summarizes and compares the information required~~

~~to be reported under this subsection~~.

(2)~~(a)~~ The department shall publish annually a consumer's guide ~~Every insurer transacting health insurance in this state shall report annually to the department, not later than April 1, information relating to any measure the insurer has implemented or proposes to implement during the next calendar year for the purpose of containing health insurance costs or cost increases~~. ~~The reports shall identify each measure and the forms to which the measure is applied, shall provide an explanation as to how the measure is used, and shall provide an estimate of the cost effect of the measure.~~

~~(b) The department shall promulgate forms to be used by insurers in reporting information pursuant to this subsection and shall utilize such forms to analyze the effects of health care cost containment programs used by health insurers in this state.~~

~~(c) The department shall analyze the data reported under this subsection and shall annually make available to the public a summary of its findings as to the types of cost containment measures reported and the estimated effect of these measures.~~

Section 17. Section 627.9403, Florida Statutes, is amended to read:

627.9403 Scope.--The provisions of this part shall apply to long-term care insurance policies delivered or issued for delivery in this state, and to policies delivered or issued for delivery outside this state to the extent provided in s. 627.9406, by an insurer, a fraternal benefit society as defined in s. 632.601, a health maintenance organization as defined in s. 641.19, a prepaid health clinic as defined in s. 641.402, or a multiple-employer welfare arrangement as defined

1 in s. 624.437. A policy which is advertised, marketed, or
2 offered as a long-term care policy and as a Medicare
3 supplement policy shall meet the requirements of this part and
4 the requirements of ss. 627.671-627.675 and, to the extent of
5 a conflict, be subject to the requirement that is more
6 favorable to the policyholder or certificateholder. The
7 provisions of this part shall not apply to a continuing care
8 contract issued pursuant to chapter 651 and shall not apply to
9 guaranteed renewable policies issued prior to October 1, 1988.
10 Any limited benefit policy that limits coverage to care in a
11 nursing home or to one or more lower levels of care required
12 or authorized to be provided by this part or by department
13 rule must meet all requirements of this part that apply to
14 long-term care insurance policies, except ss. 627.9407(3)(c)
15 and (d), (9), (10)(f), and (12) and 627.94073(2). ~~If the~~
16 ~~limited benefit policy does not provide coverage for care in a~~
17 ~~nursing home, but does provide coverage for one or more lower~~
18 ~~levels of care, the policy shall also be exempt from the~~
19 ~~requirements of s. 627.9407(3)(d).~~
20 Section 18. Section 627.9408, Florida Statutes, is
21 amended to read:
22 627.9408 Rules.--
23 (1) The department may ~~has authority to~~ adopt rules
24 pursuant to ss. 120.536(1) and 120.54 to administer ~~implement~~
25 ~~the provisions of~~ this part.
26 (2) The department may adopt by rule the provisions of
27 the Long-Term Care Insurance Model Regulation adopted by the
28 National Association of Insurance Commissioners in the second
29 quarter of the year 2000 which are not in conflict with the
30 Florida Insurance Code.
31 Section 19. Paragraph (e) of subsection (1) of section

1 641.185, Florida Statutes, is amended to read:
2 641.185 Health maintenance organization subscriber
3 protections.--
4 (1) With respect to the provisions of this part and
5 part III, the principles expressed in the following statements
6 shall serve as standards to be followed by the Department of
7 Insurance and the Agency for Health Care Administration in
8 exercising their powers and duties, in exercising
9 administrative discretion, in administrative interpretations
10 of the law, in enforcing its provisions, and in adopting
11 rules:
12 (e) A health maintenance organization subscriber
13 should receive timely, concise information regarding the
14 health maintenance organization's reimbursement to providers
15 and services pursuant to ss. 641.31 and 641.31015 and should
16 receive prompt payment from the organization pursuant to s.
17 641.3155.
18 Section 20. Subsection (4) is added to section
19 641.234, Florida Statutes, to read:
20 641.234 Administrative, provider, and management
21 contracts.--
22 (4)(a) If a health maintenance organization, through a
23 health care risk contract, transfers to any entity the
24 obligations to pay any provider for any claims arising from
25 services provided to or for the benefit of any subscriber of
26 the organization, the health maintenance organization shall
27 remain responsible for any violations of ss. 641.3155,
28 641.3156, and 641.51(4). The provisions of ss.
29 624.418-624.4211 and 641.52 shall apply to any such
30 violations.
31 (b) As used in this subsection, the term:

1 1. "Health care risk contract" means a contract under
2 which an entity receives compensation in exchange for
3 providing to the health maintenance organization a provider
4 network or other services, which may include administrative
5 services.
6 2. "Entity" means a person licensed as an
7 administrator under s. 626.88 and does not include any
8 provider or group practice, as defined in s. 456.053,
9 providing services under the scope of the license of the
10 provider or the members of the group practice.
11 Section 21. Subsection (1) of section 641.30, Florida
12 Statutes, is amended to read:
13 641.30 Construction and relationship to other laws.--
14 (1) Every health maintenance organization shall accept
15 the ~~standard health~~ claim form prescribed pursuant to s.
16 641.3155 ~~s. 627.647~~.
17 Section 22. Paragraphs (b) and (d) of subsection (3)
18 of section 641.31, Florida Statutes, are amended, and
19 paragraph (f) is added to that subsection, to read:
20 641.31 Health maintenance contracts.--
21 (3)
22 (b) Any change in the rate is subject to paragraph (d)
23 and requires at least 30 days' advance written notice to the
24 subscriber. In the case of a group member, there may be a
25 contractual agreement with the health maintenance organization
26 to have the employer provide the required notice to the
27 individual members of the group. This paragraph does not apply
28 to a group contract covering 51 or more persons unless the
29 rate is for any coverage under which the increase in claim
30 costs over the lifetime of the contract due to advancing age
31 or duration is prefunded in the premium.

1 (d) Any change in rates charged for the contract must
2 be filed with the department not less than 30 days in advance
3 of the effective date. At the expiration of such 30 days, the
4 rate filing shall be deemed approved unless prior to such time
5 the filing has been affirmatively approved or disapproved by
6 ~~order of~~ the department pursuant to s. 627.411. The approval
7 of the filing by the department constitutes a waiver of any
8 unexpired portion of such waiting period. The department may
9 extend by not more than an additional 15 days the period
10 within which it may so affirmatively approve or disapprove any
11 such filing, by giving notice of such extension before
12 expiration of the initial 30-day period. At the expiration of
13 any such period as so extended, and in the absence of such
14 prior affirmative approval or disapproval, any such filing
15 shall be deemed approved.
16 (f) A health maintenance organization that has fewer
17 than 1,000 covered subscribers under all individual or group
18 contracts at the time of a rate filing may file for an annual
19 rate increase limited to annual medical trend, as adopted by
20 the department. The filing is in lieu of the actuarial
21 memorandum otherwise required for the rate filing. The filing
22 must include forms adopted by the department and a
23 certification by an officer of the company that the filing
24 includes all similar forms.
25 Section 23. Subsections (1) and (3) of section
26 641.3111, Florida Statutes, are amended to read:
27 641.3111 Extension of benefits.--
28 (1) Every group health maintenance contract shall
29 provide that termination of the contract shall be without
30 prejudice to any continuous loss which commenced while the
31 contract was in force, but any extension of benefits beyond

the period the contract was in force may be predicated upon the continuous total disability of the subscriber ~~and may be limited to payment for the treatment of a specific accident or illness incurred while the subscriber was a member~~. The extension is required regardless of whether the group contract holder or other entity secures replacement coverage from a new insurer or health maintenance organization or foregoes the provision of coverage. The required provision must provide for continuation of contract benefits in connection with the treatment of a specific accident or illness incurred while the contract was in effect.Such extension of benefits may be limited to the occurrence of the earliest of the following events:

(a) The expiration of 12 months.

(b) Such time as the member is no longer totally disabled.

(c) A succeeding carrier elects to provide replacement coverage without limitation as to the disability condition.

(d) The maximum benefits payable under the contract have been paid.

(3) In the case of maternity coverage, ~~when not covered by the succeeding carrier,~~a reasonable extension of benefits or accrued liability provision is required, which provision provides for continuation of the contract benefits in connection with maternity expenses for a pregnancy that commenced while the policy was in effect. The extension shall be for the period of that pregnancy and shall not be based upon total disability.

Section 24. Subsection (4) of section 641.3154, Florida Statutes, is amended to read:

641.3154 Organization liability; provider billing

1 prohibited.--
2 (4) A provider or any representative of a provider,
3 regardless of whether the provider is under contract with the
4 health maintenance organization, may not collect or attempt to
5 collect money from, maintain any action at law against, or
6 report to a credit agency a subscriber of an organization for
7 payment of services for which the organization is liable, if
8 the provider in good faith knows or should know that the
9 organization is liable. This prohibition applies during the
10 pendency of any claim for payment made by the provider to the
11 organization for payment of the services and any legal
12 proceedings or dispute resolution process to determine whether
13 the organization is liable for the services if the provider is
14 informed that such proceedings are taking place. It is
15 presumed that a provider does not know and should not know
16 that an organization is liable unless:
17 (a) The provider is informed by the organization that
18 it accepts liability;
19 (b) A court of competent jurisdiction determines that
20 the organization is liable; ~~or~~
21 (c) The department or agency makes a final
22 determination that the organization is required to pay for
23 such services subsequent to a recommendation made by the
24 Statewide Provider and Subscriber Assistance Panel pursuant to
25 s. 408.7056; or
26 (d) The agency issues a final order that the
27 organization is required to pay for such services subsequent
28 to a recommendation made by a resolution organization pursuant
29 to s. 408.7057.
30 Section 25. Section 641.3155, Florida Statutes, is
31 amended to read:

1 (Substantial rewording of section. See
2 s. 641.3155, F.S., for present text.)
3 641.3155 Prompt payment of claims.--
4 (1) As used in this section, the term "claim" for a
5 noninstitutional provider means a paper or electronic billing
6 instrument submitted to the health maintenance organization's
7 designated location that consists of the HCFA 1500 data set,
8 or its successor, that has all mandatory entries for a
9 physician licensed under chapter 458, chapter 459, chapter
10 460, chapter 461, chapter 463, or chapter 490 or any
11 appropriate billing instrument that has all mandatory entries
12 for any other noninstitutional provider. For institutional
13 providers, "claim" means a paper or electronic billing
14 instrument submitted to the health maintenance organization's
15 designated location that consists of the UB-92 data set or its
16 successor, with entries stated as mandatory by the National
17 Uniform Billing Committee.
18 (2) All claims for payment, whether electronic or
19 nonelectronic:
20 (a) Are considered received on the date the claim is
21 received by the organization at its designated claims receipt
22 location.
23 (b) Must be mailed or electronically transferred to an
24 organization within 6 months after completion of the service
25 and the provider is furnished with the correct name and
26 address of the patient's health insurer. If a provider's claim
27 is submitted electronically, it is considered made on the date
28 it is electronically transferred.
29 (c) Must not duplicate a claim previously submitted
30 unless it is determined that the original claim was not
31 received or is otherwise lost.

1 (3) For all electronically submitted claims, a health
2 maintenance organization shall:
3 (a) Within 24 hours after the beginning of the next
4 business day after receipt of the claim, provide electronic
5 acknowledgment of the receipt of the claim to the electronic
6 source submitting the claim.
7 (b) Within 20 days after receipt of the claim, pay the
8 claim or notify a provider or designee if a claim is denied or
9 contested. Notice of the organization's action on the claim
10 and payment of the claim is considered to be made on the date
11 the notice or payment was mailed or electronically
12 transferred.
13 (c)1. Notification of the health maintenance
14 organization's determination of a contested claim must be
15 accompanied by an itemized list of additional information or
16 documents the insurer can reasonably determine are necessary
17 to process the claim.
18 2. A provider must submit the additional information
19 or documentation, as specified on the itemized list, within 35
20 days after receipt of the notification. Failure of a provider
21 to submit by mail or electronically the additional information
22 or documentation requested within 35 days after receipt of the
23 notification may result in denial of the claim.
24 3. A health maintenance organization may not make more
25 than one request for documents under this paragraph in
26 connection with a claim, unless the provider fails to submit
27 all of the requested documents to process the claim or if
28 documents submitted by the provider raise new additional
29 issues not included in the original written itemization, in
30 which case the health maintenance organization may provide the
31 provider with one additional opportunity to submit the

1 additional documents needed to process the claim. In no case
2 may the health maintenance organization request duplicate
3 documents.
4 (d) For purposes of this subsection, electronic means
5 of transmission of claims, notices, documents, forms, and
6 payment shall be used to the greatest extent possible by the
7 health maintenance organization and the provider.
8 (e) A claim must be paid or denied within 90 days
9 after receipt of the claim. Failure to pay or deny a claim
10 within 120 days after receipt of the claim creates an
11 uncontestable obligation to pay the claim.
12 (4) For all nonelectronically submitted claims, a
13 health maintenance organization shall:
14 (a) Effective November 1, 2003, provide
15 acknowledgement of receipt of the claim within 15 days after
16 receipt of the claim to the provider or designee or provide a
17 provider or designee within 15 days after receipt with
18 electronic access to the status of a submitted claim.
19 (b) Within 40 days after receipt of the claim, pay the
20 claim or notify a provider or designee if a claim is denied or
21 contested. Notice of the health maintenance organization's
22 action on the claim and payment of the claim is considered to
23 be made on the date the notice or payment was mailed or
24 electronically transferred.
25 (c)1. Notification of the health maintenance
26 organization's determination of a contested claim must be
27 accompanied by an itemized list of additional information or
28 documents the organization can reasonably determine are
29 necessary to process the claim.
30 2. A provider must submit the additional information
31 or documentation, as specified on the itemized list, within 35

1 days after receipt of the notification. Failure of a provider
2 to submit by mail or electronically the additional information
3 or documentation requested within 35 days after receipt of the
4 notification may result in denial of the claim.
5 3. A health maintenance organization may not make more
6 than one request for documents under this paragraph in
7 connection with a claim unless the provider fails to submit
8 all of the requested documents to process the claim or if
9 documents submitted by the provider raise new additional
10 issues not included in the original written itemization, in
11 which case the health maintenance organization may provide the
12 provider with one additional opportunity to submit the
13 additional documents needed to process the claim. In no case
14 may the health maintenance organization request duplicate
15 documents.
16 (d) For purposes of this subsection, electronic means
17 of transmission of claims, notices, documents, forms, and
18 payments shall be used to the greatest extent possible by the
19 health maintenance organization and the provider.
20 (e) A claim must be paid or denied within 120 days
21 after receipt of the claim. Failure to pay or deny a claim
22 within 140 days after receipt of the claim creates an
23 uncontestable obligation to pay the claim.
24 (5) If a health maintenance organization determines
25 that it has made an overpayment to a provider for services
26 rendered to a subscriber, the health maintenance organization
27 must make a claim for such overpayment to the provider's
28 designated location. A health maintenance organization that
29 makes a claim for overpayment to a provider under this section
30 shall give the provider a written or electronic statement
31 specifying the basis for the retroactive denial or payment

1 adjustment. The health maintenance organization must identify
2 the claim or claims, or overpayment claim portion thereof, for
3 which a claim for overpayment is submitted.
4 (a) If an overpayment determination is the result of
5 retroactive review or audit of coverage decisions or payment
6 levels not related to fraud, a health maintenance organization
7 shall adhere to the following procedures:
8 1. All claims for overpayment must be submitted to a
9 provider within 30 months after the health maintenance
10 organization's payment of the claim. A provider must pay,
11 deny, or contest the health maintenance organization's claim
12 for overpayment within 40 days after the receipt of the claim.
13 All contested claims for overpayment must be paid or denied
14 within 120 days after receipt of the claim. Failure to pay or
15 deny overpayment and claim within 140 days after receipt
16 creates an uncontestable obligation to pay the claim.
17 2. A provider that denies or contests a health
18 maintenance organization's claim for overpayment or any
19 portion of a claim shall notify the organization, in writing,
20 within 35 days after the provider receives the claim that the
21 claim for overpayment is contested or denied. The notice that
22 the claim for overpayment is denied or contested must identify
23 the contested portion of the claim and the specific reason for
24 contesting or denying the claim and, if contested, must
25 include a request for additional information. If the
26 organization submits additional information, the organization
27 must, within 35 days after receipt of the request, mail or
28 electronically transfer the information to the provider. The
29 provider shall pay or deny the claim for overpayment within 45
30 days after receipt of the information. The notice is
31 considered made on the date the notice is mailed or

1 electronically transferred by the provider.
2 3. Failure of a health maintenance organization to
3 respond to a provider's contestment of claim or request for
4 additional information regarding the claim within 35 days
5 after receipt of such notice may result in denial of the
6 claim.
7 4. The health maintenance organization may not reduce
8 payment to the provider for other services unless the provider
9 agrees to the reduction in writing or fails to respond to the
10 health maintenance organization's overpayment claim as
11 required by this paragraph.
12 5. Payment of an overpayment claim is considered made
13 on the date the payment was mailed or electronically
14 transferred. An overdue payment of a claim bears simple
15 interest at the rate of 12 percent per year. Interest on an
16 overdue payment for a claim for an overpayment payment begins
17 to accrue when the claim should have been paid, denied, or
18 contested.
19 (b) A claim for overpayment shall not be permitted
20 beyond 30 months after the health maintenance organization's
21 payment of a claim, except that claims for overpayment may be
22 sought beyond that time from providers convicted of fraud
23 pursuant to s. 817.234.
24 (6) Payment of a claim is considered made on the date
25 the payment was mailed or electronically transferred. An
26 overdue payment of a claim bears simple interest of 12 percent
27 per year. Interest on an overdue payment for a claim or for
28 any portion of a claim begins to accrue when the claim should
29 have been paid, denied, or contested. The interest is payable
30 with the payment of the claim.
31 (7)(a) For all contracts entered into or renewed on or

1 after October 1, 2002, a health maintenance organization's
2 internal dispute resolution process related to a denied claim
3 not under active review by a mediator, arbitrator, or
4 third-party dispute entity must be finalized within 60 days
5 after the receipt of the provider's request for review or
6 appeal.
7 (b) All claims to a health maintenance organization
8 begun after October 1, 2000, not under active review by a
9 mediator, arbitrator, or third-party dispute entity, shall
10 result in a final decision on the claim by the health
11 maintenance organization by January 2, 2003, for the purpose
12 of the statewide provider and managed care organization claim
13 dispute resolution program pursuant to s. 408.7057.
14 (8) A provider or any representative of a provider,
15 regardless of whether the provider is under contract with the
16 health maintenance organization, may not collect or attempt to
17 collect money from, maintain any action at law against, or
18 report to a credit agency a subscriber for payment of covered
19 services for which the health maintenance organization
20 contested or denied the provider's claim. This prohibition
21 applies during the pendency of any claim for payment made by
22 the provider to the health maintenance organization for
23 payment of the services or internal dispute resolution process
24 to determine whether the health maintenance organization is
25 liable for the services. For a claim, this pendency applies
26 from the date the claim or a portion of the claim is denied to
27 the date of the completion of the health maintenance
28 organization's internal dispute resolution process, not to
29 exceed 60 days.
30 (9) The provisions of this section may not be waived,
31 voided, or nullified by contract.

1 (10) A health maintenance organization may not
2 retroactively deny a claim because of subscriber ineligibility
3 more than 1 year after the date of payment of the claim.
4 (11) A health maintenance organization shall pay a
5 contracted primary care or admitting physician, pursuant to
6 such physician's contract, for providing inpatient services in
7 a contracted hospital to a subscriber if such services are
8 determined by the health maintenance organization to be
9 medically necessary and covered services under the health
10 maintenance organization's contract with the contract holder.
11 (12) Upon written notification by a subscriber, a
12 health maintenance organization shall investigate any claim of
13 improper billing by a physician, hospital, or other health
14 care provider. The organization shall determine if the
15 subscriber was properly billed for only those procedures and
16 services that the subscriber actually received. If the
17 organization determines that the subscriber has been
18 improperly billed, the organization shall notify the
19 subscriber and the provider of its findings and shall reduce
20 the amount of payment to the provider by the amount determined
21 to be improperly billed. If a reduction is made due to such
22 notification by the insured, the insurer shall pay to the
23 insured 20 percent of the amount of the reduction up to $500.
24 (13) A permissible error ratio of 5 percent is
25 established for health maintenance organizations' claims
26 payment violations of s. 641.3155(3)(a), (b), (c), and (e) and
27 (4)(a), (b), (c), and (e). If the error ratio of a particular
28 insurer does not exceed the permissible error ratio of 5
29 percent for an audit period, no fine shall be assessed for the
30 noted claims violations for the audit period. The error ratio
31 shall be determined by dividing the number of claims with

1 violations found on a statistically valid sample of claims for
2 the audit period by the total number of claims in the sample.
3 If the error ratio exceeds the permissible error ratio of 5
4 percent, a fine may be assessed according to s. 624.4211 for
5 those claims payment violations which exceed the error ratio.
6 Notwithstanding the provisions of this section, the department
7 may fine a health maintenance organization for claims payment
8 violations of s. 641.3155(3)(e) and (4)(e) which create an
9 uncontestable obligation to pay the claim. The department
10 shall not fine organizations for violations which the
11 department determines were due to circumstances beyond the
12 organization's control.
13 (14) This section shall apply to all claims or any
14 portion of a claim submitted by a health maintenance
15 organization subscriber under a health maintenance
16 organization subscriber contract to the organization for
17 payment.
18 (15) Notwithstanding s. 641.3155(3)(b), where an
19 electronic pharmacy claim is submitted to a pharmacy benefits
20 manager acting on behalf of a health maintenance organization
21 the pharmacy benefits manager shall, within 30 days of receipt
22 of the claim, pay the claim or notify a provider or designee
23 if a claim is denied or contested. Notice of the
24 organization's action on the claim and payment of the claim is
25 considered to be made on the date the notice or payment was
26 mailed or electronically transferred.
27 (16) Notwithstanding s. 641.3155(4)(a), effective
28 November 1, 2003, where a nonelectronic pharmacy claim is
29 submitted to a pharmacy benefits manager acting on behalf of a
30 health maintenance organization the pharmacy benefits manager
31 shall provide acknowledgment of receipt of the claim within 30

1 days after receipt of the claim to the provider or provide a
2 provider within 30 days after receipt with electronic access
3 to the status of a submitted claim.
4 Section 26. Subsection (12) of section 641.51, Florida
5 Statutes, is amended to read:
6 641.51 Quality assurance program; second medical
7 opinion requirement.--
8 (12) If a contracted primary care physician, licensed
9 under chapter 458 or chapter 459, determines ~~and the~~
10 ~~organization determine~~ that a subscriber requires examination
11 by a licensed ophthalmologist for medically necessary,
12 contractually covered services, then the organization shall
13 authorize the contracted primary care physician to send the
14 subscriber to a contracted licensed ophthalmologist.
15 Section 27. Except as otherwise provided in this act,
16 this act shall take effect October 1, 2002, and shall apply to
17 claims for services rendered after such date.
18
19
20 =============== T I T L E A M E N D M E N T ===============
21 And the title is amended as follows:
22 Delete everything before the enacting clause
23
24 and insert:
25 A bill to be entitled
26 An act relating to health care providers and
27 insurers; providing legislative findings and
28 legislative intent; defining terms; providing
29 for a pilot program for health flex plans for
30 certain uninsured persons; providing criteria;
31 authorizing the Agency for Health Care

1 Administration and the Department of Insurance
2 to adopt rules; exempting approved health flex
3 plans from certain licensing requirements;
4 providing criteria for eligibility to enroll in
5 a health flex plan; requiring health flex plan
6 providers to maintain certain records;
7 providing requirements for denial, nonrenewal,
8 or cancellation of coverage; specifying that
9 coverage under an approved health flex plan is
10 not an entitlement; providing for civil actions
11 against health plan entities by the Agency for
12 Health Care Administration under certain
13 circumstances; amending s. 408.7057, F.S.;
14 redesignating a program title; revising
15 definitions; including preferred provider
16 organizations and health insurers in the claim
17 dispute resolution program; specifying
18 timeframes for submission of supporting
19 documentation necessary for dispute resolution;
20 providing consequences for failure to comply;
21 providing additional responsibilities for the
22 agency relating to patterns of claim disputes;
23 providing timeframes for review by the
24 resolution organization; directing the agency
25 to notify appropriate licensure and
26 certification entities as part of violation of
27 final orders; amending s. 456.053, F.S., the
28 "Patient Self-Referral Act of 1992"; redefining
29 the term "referral" by revising the list of
30 practices that constitute exceptions; amending
31 s. 626.88, F.S.; redefining the term

1 "administrator," with respect to regulation of
2 insurance administrators; amending s. 627.410,
3 F.S.; exempting group health insurance policies
4 insuring groups of a certain size from
5 rate-filing requirements; providing alternative
6 rate-filing requirements for insurers having
7 fewer than a specified number of nationwide
8 policyholders or members; amending s. 627.411,
9 F.S.; revising the grounds for the disapproval
10 of insurance policy forms; providing that a
11 health insurance policy form may be disapproved
12 if it results in certain rate increases;
13 specifying allowable new business rates and
14 renewal rates if rate increases exceed certain
15 levels; authorizing the Department of Insurance
16 to determine medical trend for purposes of
17 approving rate filings; creating s. 627.6131,
18 F.S.; specifying payment of claims provisions
19 applicable to certain health insurers;
20 providing a definition; providing requirements
21 and procedures for paying, denying, or
22 contesting claims; providing criteria and
23 limitations; requiring payment within specified
24 periods; specifying rate of interest charged on
25 overdue payments; providing for electronic and
26 nonelectronic transmission of claims; providing
27 procedures for overpayment recovery; specifying
28 timeframes for adjudication of claims,
29 internally and externally; prohibiting action
30 to collect payment from an insured under
31 certain circumstances; providing applicability;

1 prohibiting contractual modification of
2 provisions of law; specifying circumstances for
3 retroactive claim denial; specifying claim
4 payment requirements; providing for billing
5 review procedures; specifying claim content
6 requirements; establishing a permissible error
7 ratio, specifying its applicability, and
8 providing for fines; providing specified
9 exceptions from notice and acknowledgment
10 requirements for pharmacy benefit manager
11 claims; amending s. 627.6425, F.S., relating to
12 renewability of individual coverage; providing
13 for circumstances relating to nonrenewal or
14 discontinuance of coverage; amending s.
15 627.6475, F.S.; revising criteria for
16 reinsuring individuals under an individual
17 health reinsurance program; amending s.
18 627.651, F.S.; correcting a cross-reference, to
19 conform; amending s. 627.662, F.S.; specifying
20 application of certain additional provisions to
21 group, blanket, and franchise health insurance;
22 amending s. 627.667, F.S.; deleting an
23 exception to an extension-of-benefits
24 application provision for out-of-state group
25 policies; amending s. 627.6692, F.S.; extending
26 a time period for premium payment for
27 continuation of coverage; amending s. 627.6699,
28 F.S.; redefining terms; allowing carriers to
29 separate the experience of small-employer
30 groups having fewer than two employees;
31 authorizing certain small employers to enroll

1 with alternate carriers under certain
2 circumstances; revising certain criteria of the
3 small-employer health reinsurance program;
4 requiring the Insurance Commissioner to appoint
5 a health benefit plan committee to modify the
6 standard, basic, and flexible health benefit
7 plans; revising certain disclosure
8 requirements; providing additional notice
9 requirements; revising the disclosure that a
10 carrier must make to a small employer upon
11 offering certain policies; prohibiting
12 small-employer carriers from using certain
13 policies, contracts, forms, or rates unless
14 filed with and approved by the Department of
15 Insurance pursuant to certain provisions;
16 restricting application of certain laws to
17 flexible benefit policies under certain
18 circumstances; amending s. 627.6425, F.S.;
19 revising provisions permitting an insurer to
20 nonrenew or discontinue coverage; authorizing
21 offering or delivering flexible benefit
22 policies or contracts to certain employers;
23 providing requirements for benefits in flexible
24 benefit policies or contracts for small
25 employers; amending s. 627.911, F.S.; including
26 health maintenance organizations under certain
27 information-reporting requirements; amending s.
28 627.9175, F.S.; revising health insurance
29 reporting requirements for insurers; amending
30 s. 627.9403, F.S.; clarifying application of
31 exceptions to certain long-term-care insurance

1 policy requirements for certain limited-benefit
2 policies; amending s. 627.9408, F.S.;
3 authorizing the department to adopt by rule
4 certain provisions of the Long-Term Care
5 Insurance Model Regulation, as adopted by the
6 National Association of Insurance
7 Commissioners; amending s. 641.185, F.S.;
8 specifying that health maintenance organization
9 subscribers should receive prompt payment from
10 the organization; amending s. 641.234, F.S.;
11 specifying responsibility of a health
12 maintenance organization for certain violations
13 under certain circumstances; amending s.
14 641.30, F.S.; conforming a cross-reference;
15 amending s. 641.31, F.S.; exempting contracts
16 of group health maintenance organizations
17 covering a specified number of persons from the
18 requirements of filing with the department;
19 specifying the standards for department
20 approval and disapproval of a change in rates
21 by a health maintenance organization; providing
22 alternative rate-filing requirements for
23 organizations having fewer than a specified
24 number of subscribers; amending s. 641.3111,
25 F.S.; revising extension-of-benefits
26 requirements for group health maintenance
27 contracts; amending s. 641.3154, F.S.;
28 modifying the circumstances under which a
29 provider knows that an organization is liable
30 for service reimbursement; amending s.
31 641.3155, F.S.; revising payment of claims

1 provisions applicable to certain health
2 maintenance organizations; providing a
3 definition; providing requirements and
4 procedures for paying, denying, or contesting
5 claims; providing criteria and limitations;
6 requiring payment within specified periods;
7 revising rate of interest charged on overdue
8 payments; providing for electronic and
9 nonelectronic transmission of claims; providing
10 procedures for overpayment recovery; specifying
11 timeframes for adjudication of claims,
12 internally and externally; prohibiting action
13 to collect payment from a subscriber under
14 certain circumstances; prohibiting contractual
15 modification of provisions of law; specifying
16 circumstances for retroactive claim denial;
17 specifying claim payment requirements;
18 providing for billing review procedures;
19 specifying claim content requirements;
20 establishing a permissible error ratio,
21 specifying its applicability, and providing for
22 fines; providing specified exceptions from
23 notice and acknowledgment requirements for
24 pharmacy benefit manager claims; amending s.
25 641.51, F.S.; revising provisions governing
26 examinations by ophthalmologists; providing
27 effective dates.
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