HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1573 w/CS Health Insurance
SPONSOR(S): Farkas
TIED BILLS: None. **IDEN./SIM. BILLS:** HB 723 (c), HB 1657 (c), SB 1796 (c)

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Insurance	14 Y, 0 N w/CS	Cooper	Schulte
2) Health Care	18 Y, 0 N w/CS	Chavis	Collins
3)			
4)			
5)			

SUMMARY ANALYSIS

HB 1573 amends various provisions of law relating to health insurance including:

- Requires certain licensed facilities to make certain information public electronically on a monthly basis, to provide notice in public areas that such information is available electronically, and to provide an electronic link to the Agency for Health Care Administration's website;
- Expands the definition of "health flex plan" to include enrollees who purchase coverage directly from the plan or through a small business purchasing arrangement by a local government subject, authorizing such plans to limit the term of coverage, and extending the program's expiration date;
- Exempts individuals and certain groups from laws restricting or limiting coinsurance, copayments, or annual or lifetime maximum payments in conformance with other sections of the code;
- Provides for mandatory offering of optional coverage of individual health insurance policies for certain speech, language, swallowing and hearing disorders, and provides certain exclusion, exception, and limitation;
- Revises the definition of "eligible individual" for the purposes of availability of individual health insurance coverage and authorizes insurers to impose certain surcharges or premium charges for creditable coverage earned in certain states;
- Requires additional information in a certification relating to certain creditable coverage for purposes of eligibility for exclusion from preexisting condition requirements;
- Provides for mandatory offering of optional coverage of group health insurance policies for certain speech, language, swallowing and hearing disorders, and provides certain exclusion, exception, and limitation;
- Extends the time period for continuation of certain coverage under group health plans;
- Amends the Employee Health Care Access Act, revises definitions, revises open enrollment period for one-life groups to twice a year, requires small employers to provide certain health benefit plan information specifying limitation; revises modified community rating adjustment criteria, authorizes separation of experience of certain small employer groups using approved health reimbursement arrangements
- Corrects scrivener's errors;
- Specifies nonapplication of certain health maintenance contract filing requirement to certain group health insurance policies, with exceptions, and provides for mandatory offering of optional coverage for health maintenance subscribers for certain specified benefits subject to limits;
- Provides compliance requirements for health maintenance organizations replacing certain coverages;
- Provides additional requirements for extension of benefits under group health maintenance contracts;
- Creates s. 641.54, F.S., to require health maintenance organizations to provide specific information to subscribers; and
- Provides severability.

The act takes effect upon becoming law.

State agencies should not experience any fiscal impact with this bill.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. DOES THE BILL:

1. Reduce government?	Yes[]	No[X]	N/A[]
2. Lower taxes?	Yes[]	No[]	N/A[X]
3. Expand individual freedom?	Yes[X]	No[]	N/A[]
4. Increase personal responsibility?	Yes[]	No[]	N/A[X]
5. Empower families?	Yes[]	No[]	N/A[X]

For any principle that received a "no" above, please explain:

1. The bill requires both hospitals and health maintenance organizations to make certain information available to prospective patients and subscribers relating to charges, copay, co-insurance or deductibles.

B. EFFECT OF PROPOSED CHANGES:

HB 1573 amends various provisions of law relating to health insurance as follows:

- Amends s. 395.301, F.S., relating to itemized patient billing.
  - Requires certain licensed facilities to make certain information public electronically on a quarterly basis.
  - Requires such facilities to provide notice in public areas that such information is available electronically.
  - Requires such facilities to provide an electronic link to the Agency for Health Care Administrations' website.
- Amends s. 408.909, F.S., relating to health flex plans.
  - Expands the definition of "health flex plan" to include enrollees who purchase coverage directly from the plan or through a small business purchasing arrangement by a local government subject.
  - Authorizes such plans to limit the term of coverage.
  - Extends the program's expiration date.
- Amends s. 627.410, F.S., relating to filing and approval of forms.
  - Exempts individuals and certain groups from laws restricting or limiting coinsurance, copayments, or annual or lifetime maximum payments in conformance with other sections of the code.
- Creates s. 627.6410, F.S., relating to optional coverage for speech, language, swallowing and hearing disorders.
  - Requires mandatory offering of optional coverage of individual health insurance policies for certain speech, language, swallowing and hearing disorders.
  - Specifies the levels of benefits.
  - Provides certain exclusions and limitations.
- Amends s. 627.6487, F.S., relating to guaranteed availability of individual health insurance coverage to eligible individuals.
  - Revises the definition of "eligible individual" for the purposes of availability of individual health insurance coverage.
  - Authorizes insurers to impose certain surcharges or premium charges for creditable coverage earned in certain states.
- Amends s. 627.6561, F.S., relating to preexisting conditions.
  - Requires additional information relating to the type of coverage the individual had previously.

    - Requires that when the individual's most recent period of creditable coverage was earned out-of-state than an insurer issuing a policy that complies with certain requirements may impose a surcharge or charge a premium for the policy equal to that permitted in the state where the creditable coverage was earned for purposes of eligibility of exclusion from preexisting condition requirements.
- Amends 627.667, F.S., removing a limitation of certain application of extension of benefits provisions;
- Creates s. 627.66912, F.S., relating to optional coverage for speech, language, swallowing and hearing disorders.
    - Provides for mandatory offering of optional coverage of group health insurance policies for certain speech, language, swallowing and hearing disorders for an appropriate additional premium.
    - Specifies the levels of benefits.
    - Provides certain exclusions.
- Amends s. 627.6692, F.S., relating to the Florida Health Insurance Coverage Continuation Act.
    - Extends the time period for continuation of certain coverage under group health plans to be identical to that provided under COBRA (The Consolidated Omnibus Reconciliation Act).
- Amends s. 627.6699, F.S., relating to the Employee Health Care Access Act.
    - Revises definitions to make the definition of eligibility in the small group market more specific.
    - Revises the open enrollment period for one-life groups to twice a year.
    - Requires small employers to provide certain health benefit plan information to their employees on an annual basis.
    - Specifies that such information does not require the employer to provide or contribute to such plans.
    - Specifies that such plans are not required to be issued on a guaranteed-issue basis.
    - Revises the modified community rating adjustment of plus or minus 15 percent underwriting in small group from the current benchmark of 5 percent maximum deviation from the modified community rate to a maximum of 3 percent.
    - Allows a separate rating pool for plans that utilize an IRS approved health reimbursement account.
- Amends s. 627.410,F.S. and s. 641.31, F.S., corrects scrivener's errors.
- Amends s. 641.31, F.S., relating to health maintenance contracts.
    - Specifies nonapplication of certain health maintenance contract filing requirements an individual subscriber or to a group of 51 or more persons that provides coverage as specified.
    - Provides for mandatory offering of optional coverage for health maintenance subscribers for an appropriate additional premium, for genetic or congenital disorders or conditions involving speech, language, swallowing, and hearing and a hearing aide and earmolds at the benefit levels as specified.
- Creates s. 641.31075, F.S., relating to requirements for replacing health coverage.
    - Provides compliance requirements for health maintenance organizations replacing any other group health coverage with its group health maintenance coverage subjecting them to the same replacement requirements insurance policies.
- Amends s. 641.3111, F.S.
    - Provides additional requirements for extension of benefits under group health maintenance contracts.
    - Provides that such extension is required regardless of whether the group contract holder or other entity secures replacement coverage from a new insurer or HMO or foregoes the provision of coverage.
    - Requires that the provision of coverage must provide for the continuation of contract benefits in connection with the treatment of a specific accident or illness that incurred while the contract was in effect.
- Creates s. 641.54, F.S., relating to information disclosure for health maintenance organizations.

    - Requires health maintenance organizations to make available to subscribers the estimated co-pay, co-insurance or deductible for any covered service, the status of the subscriber's maximum annual out of pocket payments for a covered individual or family, and the status of the subscriber's maximum lifetime benefit.
    - Requires the health maintenance organization to provide, upon the request of the subscriber, an estimate of the amount the health maintenance organization will pay for a particular medical procedure or services.
    - Authorizes the estimate to be n the form of a range of payments or an average payment.
    - Provides that the health maintenance organization providing such an estimate in good faith is not bound by the estimate.
- Provides severability.

The act takes effect upon becoming law.

Information to Health Care Consumers

Currently, pursuant to s. 408.061, F.S., the Agency for Health Care Administration (agency) may require the submission by health care facilities, health care providers, and health insurers of data "necessary to carry out the agency's duties." Specifications for data to be collected is required to be developed by the agency with the assistance of technical advisory panels including representatives of affected entities, consumers, purchasers, and other interested parties.

Data to be submitted by health care facilities may include, but are not limited to: case-mix data, patient admission or discharge data with patient and provider-specific identifiers included, actual charge data by diagnostic groups, financial data, accounting data, operating expenses, expenses incurred for rendering services to patients who cannot or do not pay, interest charges, depreciation expenses based on the expected useful life of the property and equipment involved, and demographic data. Data may be obtained from documents such as, but not limited to: leases, contracts, debt instruments, itemized patient bills, medical record abstracts, and related diagnostic information.

Pursuant to s. 408.062, F.S., the agency, relying on data collected, must establish a reliable, timely, and consistent information system that distributes information and serves as the basis for the agency's public education programs. The agency is required to seek advice from consumers, health care purchasers, health care providers, health care facilities, health insurers, and local health councils in the development and implementation of its information system. Also, the agency is to publish and disseminate information to the public which will enhance informed decision making in the selection of health care providers, facilities, and services. These publications may identify average charges for specified services, lengths of stay associated with established diagnostic groups, readmission rates, mortality rates, recommended guidelines for selection and use of health care providers, health care facilities, and health care services, and such other information as the agency deems appropriate.

The bill also requires a health care facility not operated by the state, to make available to the public on its internet website or by other electronic means a list of charges for the top 20 percent of the most frequently used charge item in each hospital's charge master for both inpatient and out patient services. The list is to be updated monthly. The facility must place a notice in the reception areas that such information is available electronically and provide the web address. The facilities' webpage must also provide an electronic link to the agency's website to determine what average charge per diagnosis-related groups is available. Each nonstate operated licensed facility, upon the request of a prospective patient and prior to the provision of medical services, must also provide a reasonable estimate of charges for the proposed service. However, such estimate does not preclude the actual charges from exceeding the estimate based on changes in the patient's medical condition or the treatment needs of the patient as determined by the attending and consulting physicians.

The estimate requirement is currently found in the "Florida Patient's Bill of Rights and Responsibilities," s. 381.026, F.S. The difference between the current law and the bill's requirement is that the current Patient's Bill of Rights has no enforcement attached to it so there is no liability for failure to comply. The bill places this requirement in the hospital licensure law, thereby making any violation subject to possible administrative sanction by the agency.

Health Flex Plan Pilot Program

In 2002, the Legislature created, in s. 408.909, F.S., the Health Flex Plan pilot program. The pilot program permits entities to develop alternative health care coverage plans, referred to as health flex plans, for uninsured persons who have a family income equal to or less than 200 percent of the federal poverty level. The goal of the program is to improve the affordability and availability of heath care coverage for low-income Floridians who are unable to obtain health coverage, by encouraging the development of alternative approaches to traditional health insurance that still provide basic and preventative health care services.

A health flex plan is permitted to take measures that are impermissible for regular care providers, including:

- Limiting or excluding benefits that are otherwise required by law for insurers offering coverage in Florida;
- Capping the total amount of claims paid per year per enrollee; and
- Limiting the number of enrollees

A health flex plan may be developed and implemented by health insurers, health maintenance organizations (HMOs), health care provider-sponsored organizations, local governments, heath care districts, or other community-based organizations. Current law specifies that the agency must develop guidelines for reviewing health flex plan applications and must disapprove or withdraw approval of plans that do not meet minimum standards for quality of care and access to care. The Office of Insurance Regulation (office) must also develop guidelines for reviewing health flex plan applications and must disapprove or withdraw approval of plans that:

- Contain any ambiguous, inconsistent, or misleading provisions, or exceptions or conditions that deceptively affect or limit the benefits purported to be assumed in the general coverage provided by the plan;
- Provide benefits that are unreasonable in relation to the premium charged, contain provisions that are unfair or inequitable or contrary to the public policy of this state or that encourage misrepresentation, or result in unfair discrimination in sales practices; or
- Cannot demonstrate the health flex plan is financially sound and that the applicant has the ability to underwrite or finance the benefits provided.

The statute attempts to target the pilot programs in areas of the state that have the greatest number of the uninsured poor. The statute authorizes the agency and the office to approve health flex plans in the three areas of the state having the highest number of uninsured persons. These areas are District 1 (Bay, Escambia, Gadsden, Leon, Okaloosa, and Santa Rosa Counties), District 16 (Broward County), and District 17 (Dade County). The statue also authorizes the issuance of health flex plans in Indian River County.

Eligibility to enroll in a health flex plan is limited to Florida residents who are under 65 years of age and have a family income equal to or less than 200 percent of the federal poverty level. The enrollee must not be covered by a private insurance policy, must not be eligible for coverage through a public health insurance program such as Medicare, Medicaid, or Kidcare, and must not have been covered at any time during the past 6 months. The enrollee must also have applied for health care coverage through

an approved plan and agree to make any payments required for participation, including periodic payments or payments due at the time health care services are provided.

The agency must evaluate the pilot program and its effects on the entities that seek approval as health flex plans, as well as the number of enrollees and the scope of the coverage afforded. The agency and the office are mandated to assess the health flex plans and their potential applicability in other settings. By January 1, 2004, the agency and the office are to submit their findings in a report to the Governor, President of the Senate, and the Speaker of the House of Representatives. Each approved health flex plan is required to maintain records of enrollment, finances, and claims experience to enable the agency and the department to monitor the plan. The statute authorizing the creation of the health flex pilot program expires on July 1, 2004.

According to the agency, two health flex plans have been approved, in Dade County. One plan is physician group based; the other is HMO based. No other applications have been received by the agency, and no health flex programs have been created other than the two in Dade County.

The agency has also reported they have conducted a survey to assess the interest of health plan providers in the health flex plan pilot program. Of the 145 surveys that were mailed electronically to potential providers, 76 (52%) responded. Forty-one respondents knew about the program. Two indicated an interest in applying. Forty-seven were not interested in expanding their product line; one indicated that the 200 percent poverty line was too restrictive; one was interested in other areas of the state; five believed the plan would not be profitable; and 15 indicated they did not have the resources to market the plan. The agency is implementing an informational and marketing plan to encourage more program participation.

The bill expands health flex plans to include approved plans purchased by enrollees directly from the plan or through a small business purchasing arrangement sponsored by a local government. It also authorizes a plan sponsored by a local government made available to residents who have not been covered by any health insurance plan or coverage through a public health insurance program for 12 months to limit the term of coverage. The bill extends the pilot project to July 1, 2008, from the current expiration of July 1, 2004.

Health Insurance Rate and Form Filing Requirements

Pursuant to ss. 627.410 and 627.411, F.S., insurers that issue health insurance policies in Florida are required to file their forms and rates for approval with the office These requirements of these sections apply to individual and group health insurance policies (groups of 50 or less), Medicare Supplement policies, and long-term care policies. Similar requirements are established in s. 641.31(3), F.S., for HMO contracts.

The bill provides that any law restricting or limiting deductibles, coinsurance, copayments, or annual or lifetime maximum payments does not apply to any health plan policy offered or delivered to an individual or to a group of 51 or more persons that provides coverage as described in s. 627.6561(5)(a)2., F.S., relating to preexisting conditions.[1]

Coverage for Speech, Language, Swallowing and Hearing disorders

According to the National Information Center for Children and Youth with Disabilities, speech and language disorders refer to problems in communication and related areas such as oral motor function.

[1] s. 627.6561(5)(a)2., F.S., states that the term "creditable coverage," means, with respect to an individual, coverage of the individual under health insurance coverage consisting of medical care, provided directly, through insurance or reimbursement, or otherwise and including terms and services paid for as medical care, under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance contract offered by a health insurance issurer.

These delays and disorders range from simple sound substitutions to the inability to understand or use language or use the oral-motor mechanism for functional speech and feeding. Some causes of speech and language disorders include hearing loss, neurological disorders, brain injury, mental retardation, drug abuse, physical impairments such as cleft lip or palate, and vocal abuse or misuse. Frequently, however, the cause is unknown.[2] Typically, services or benefits for speech, language, swallowing and hearing disorders under health insurance policies or health maintenance contracts are only available to policy or contract holders who have experienced a trauma related event, such as falling off a ladder or a stroke.

The bill requires a "mandatory offering" for "an appropriate additional premium" for purchases of individual or group health benefit insurance policies, at the "benefits or levels of benefits specified in the December 1999 Florida Medicaid Therapy Services Handbook" for genetic or congenital disorders or conditions involving speech, language, swallowing, and hearing and hearing aid and earmolds benefit, "at the level of benefits specified in the January 2001 Florida Medicaid Hearing Services Handbook." The bill specifically excludes specified-accident, specified-disease, hospital indemnity, limited benefit, disability income, or long-term care insurance policies. The bill also requires health maintenance organizations to make available to the contract holder as part of the application for any contract, "for an appropriate additional premium" the same benefits at the same level as previously listed.

Guaranteed Availability of Individual Health Insurance Coverage

Pursuant to s.627.6487 F.S., each health insurance issuer that offers individual health insurance coverage in Florida may not, with respect to an eligible individual who desires to enroll in individual health insurance coverage decline to offer such coverage to, or deny enrollment of, such individual; or impose any preexisting condition exclusion with respect to such coverage. However, certain persons are not eligible including those who were eligible for coverage under a conversion policy after covered under an insured "employer" plan.

This bill replaces "employer" with "group health" plan to specify eligibility for conversion policies. The bill also provides that if an individual's most recent period of creditable coverage was earned in a state other than Florida, an insurer issuing a policy may impose a surcharge or charge a premium for such a policy equal to that permitted in the state in which the creditable coverage was earned. Creditable coverage, as defined by the Centers for Medicare & Medicaid, is any previous health insurance coverage that can be used to shorten the pre-existing condition waiting period. The bill also requires that additional information be tendered regarding the underlying health plan that provided the creditable coverage to assist the insurer in determining eligibility.

Preexisting Conditions

Section 627.6561, F.S., relating to preexisting conditions, limits the time individuals under group health insurance policies can be denied coverage for a preexisting condition. This time can be reduced or eliminated if the individual or dependent was covered by previous health insurance (which qualifies under HIPAA as creditable coverage) and if there was not a break in coverage between the plans of more than 63 days. Determination of eligibility for the preexisting condition exclusion is based on the "Certificate of Creditable Coverage" obtained by the individual from the group health plan or employer under which the individual was previously covered.[3]

The bill requires that certificates of creditable coverage must include a statement whether the creditable coverage was a group or individual plan and indicate the state in which the creditable coverage was earned.

[2] National Information Center for Children and Youth with Disabilities. http://www.nichcy.org/index.html

[3] Creditable coverage includes most health coverages, including COBRA, a health insurance policy or an HMO, Medicaid, Medicare, the Indian Health Service, TRICARE, the Peace Corps, a state high-risk pool (ICHIP) or a state or local governmental public health plan.

Continuation of Coverage Under Group Plans

The "Florida Health Insurance Coverage Continuation Act," sometimes referred to as “Florida’s Mini-COBRA,” is intended to ensure continued access to affordable health insurance coverage for employees of small employers and their dependents and other qualified beneficiaries not currently protected by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).[4] Florida’s law requires that a group health plan issued to a small employer must provide that each qualified beneficiary who would lose coverage under the group health plan because of a qualifying event is entitled, without evidence of insurability, to elect, within a designated election period, continuation coverage under the employer's group health plan. A qualified beneficiary who elects continuation coverage is subject to all the terms and conditions applicable under the group health plan.

Currently, the law requires that 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 30 days after receiving notice from the insurance carrier. The bill replaces 30 days with 63 days, as provided by COBRA.

The Employee Health Care Access Act

In 1992, the Legislature enacted s. 627.6699, F.S., the Employee Health Care Access Act (act). An express purpose of the act is to promote the availability of health insurance coverage to small employers (i.e., under the act, at least one but not more than 50 eligible employees) regardless of their claims experience or their employees' health status.

In 2002, the Legislature revised the act to authorize less expensive health insurance coverage to small employers. The law now allows small group carriers to rate one-life groups, separate from the rating pool for groups with 2 to 50 employees, but not to exceed 150 percent of the rate determined for groups of 2 to 50 employees, with an interim rate cap of 125 percent effective July 1, 2002. The law also exempts all health plan policies offered to small employers from laws limiting deductibles, coinsurance, co-payments, and maximum lifetime and annual benefits.

Among other aspects of the act, the act permits the use of “modified community rating” to allow for specified adjustments in the rates. Currently, pursuant to s 627.6699(6)(b)5., F.S., any adjustments in rates for claims experience, health status, or duration of coverage may not result in a rate for the small employer which deviates more than 15 percent from the carrier's approved rate. Any such adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer. A small employer carrier may make an adjustment to a small employer's renewal premium, not to exceed 10 percent annually. Semiannually, small group carriers must report information to the Office of Insurance Regulation, to enable the office to monitor the relationship of aggregate adjusted premiums actually charged policyholders by each carrier to the premiums that would have been charged by application of the carrier's approved modified community rates. If the aggregate adjustment exceeds the premium that would have been charged by application of the approved modified community rate by 5 percent for the current reporting period, the carrier must limit the application of such adjustments only to minus adjustments for a specified period of time. There are additional requirements relating to subsequent reporting periods.

The bill makes the following changes to s. 627.6699, F.S.:

[4] COBRA, or the Consolidated Omnibus Budget Reconciliation Act of 1985, is a federal law that guarantees employees and their families continued insurance coverage for a specified amount of time after termination of group health insurance coverage with the company.

- Amends the definition of "eligible employee" to include a minimum wage level along with the minimum number of hours worked. This change is intended to ensure that individuals who qualify for the coverage are actual workers.
- Amends the definition of "self-employed individual" to require additional verification (relevant Internal Revenue Service documentation) as to the actual status as being self-employed.
- Expands the 30-day open enrollment period from once to twice a year;
- Requires small employers are required to provide, on an annual basis, information on at least three different health benefit plans to their employees, specifies that employers are not required to provide the plan or contribute to the cost of the plan, and specifies that individual health plan benefits are not required to "guaranteed issue."
- Amends the restrictions relating to modified community rating from the current plus or minus 5 percent to plus or minus 3 percent; and
- Allows carriers to separate the experience of small employer groups of 1-50 eligible employees using a health reimbursement arrangement for determining an alternative modified community. Health reimbursement arrangements."[5]

Health Maintenance Contracts

Section 641.31, F.S., relating to health maintenance contracts, contains rate regulating provisions. Rates charged by health maintenance organizations are prohibited from being excessive, inadequate, or unfairly discriminatory. In addition they are prohibited from following a rating methodology that is inconsistent, indeterminate, ambiguous, or that encourages misrepresentation or misunderstanding.

The bill provides that any law restricting or limiting deductibles, coinsurance, copayments, or annual or lifetime maximum payments shall not apply to any health maintenance contract offered or delivered to an individual or group of 51 or more persons that provides coverage as described in s. 641.31071(5)(a)2., F.S., relating to preexisting conditions.

Section 641.31, F.S., also provides the office rulemaking authority to define by rule what constitutes the above listed rates or activities. In addition, changes in rates charged under the contract must be filed with the office not less than 30 days in advance of the effective date. The rates are deemed approved at the expiration of the 30 days unless the office has affirmatively approved or disapproved by order.

The bill provides that the requirements related to the change in rates does not apply to group health insurance policies effectuated and delivered in this state insuring groups of 51 or more persons, except for Medicare supplement insurance, long-term care insurance, and any coverage under which the increase in claims costs over the lifetime of the contract due to advancing age or duration is refunded in the premium. This change is makes provisions relating to health maintenance contracts consistent with a previous change in the law that exempted the large group indemnity plans.

Extension of Benefits

Florida's current extension of benefit laws differ from one line of insurance to another. Some require that for a person on claim at the time an employer changes carriers, the current carrier has the responsibility for the extension of benefits. In other cases, the new carrier assigned is responsible.

The bill creates s. 641.31075, F.S., relating to requirements for replacing health coverage. The bill provides that when a health maintenance organization is replacing any other group health coverage with its group health maintenance organization coverage that it must comply with s. 627.666, F.S., relating to liability of succeeding insurer on replacement of group, blanket, or franchise health insurance.

[5] Health reimbursement arrangements are employer-funded medical care expense reimbursement plans, approved by the Internal Revenue Service, in which reimbursements made from the plan are excludable from employee gross income.

The bill addresses two provisions relating to extension of benefits.

Currently, s. 627.667 F.S., provides that each group health policy must contain a reasonable provision for extension of benefits in the event of the total disability of a certificateholder at the date of discontinuance of the policy or contract. The extension is required regardless of whether the group policyholder or other entity secures replacement coverage from a new insurer or foregoes the provision of coverage. It also provides that requirement 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.

The bill applies this requirement to situations where a succeeding carrier under a group policy has agreed to assume liability for the benefits."

Section s. 641.3111, F.S., relating to extension of benefits for health maintenance organizations, provides that every group health maintenance contract must provide that termination of the contract shall be without prejudice to any continuous loss which commenced while the 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 bill strikes this latter limitation of payment and replaces it with a requirement that an extension must occur regardless of whether the contract holder secures replacement coverage. Continuation of contract benefits must be continued.

C. SECTION DIRECTORY:

Section 1. Amends s. 395.301, F.S., relating to itemized patient bills.

Section 2. Amends s. 408.909, F.S., relating to health flex plans.

Section 3. Amends s. 627.410, F.S., relating to filing and approval of health insurance forms.

Section 4. Creates s. 627.6410, F.S., relating to optional coverage for speech, language, swallowing and hearing disorders.

Section 5. Amends s. 627.6487, F.S., relating to guaranteed availability of individual health insurance coverage to eligible individuals.

Section 6. Amends s. 627.6561, F.S., relating to preexisting conditions.

Section 7. Amends s. 627.667, F.S., relating to extension of benefits.

Section 8. Creates s. 627.66912, F.S., relating to optional coverage for speech, language, swallowing and hearing disorders.

Section 9. Amends s. 627.6692, F.S., relating to the Florida Health Insurance Coverage Continuation Act.

Section 10. Amends s. 627.6699, F.S., relating to the Employee Health Care Access Act.

Section 11. Amends s. 641.31, F.S., relating to health maintenance contracts.

Section 12. Creates s. 641.31075, F.S., relating to requirements for replacing health coverage.

Section 13. Amends s. 641.3111, F.S., relating to extension of benefits.

Section 14. Amends s. 641.54, F.S., relating to information disclosure by health maintenance organizations.

Section 15. Provides severability.

Section 16. Provides an effective date of upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Section 1 requires that more information regarding treatment charges be provided to health care consumers. Hospitals and ambulatory surgery center will bear the cost of identifying and posting the required information on electronic media. No cost estimates are available.

Section 12 requires that more information regarding estimated co-pay, co-insurance or deductibles be made available to subscribers of health maintenance organizations. The health maintenance organizations will bear the costs of providing such information. No cost estimates are available.

Health care consumers will have further information available to assist in choosing a hospital or ambulatory surgery provider.

Health care consumers will have further information available to assist in choosing a hospital provider, thereby potentially stimulating competition among providers.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenues.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On April 10, 2003, the Insurance Committee adopted a "strike-everything" amendment and reported the bill favorably with a CS. The CS differs from the bill as filed, as follows:

- Makes clarification changes to s. 395.301, F.S., itemized patient bill;
- Adds language which amends s. 408.909, F.S., health flex plans; and
- Deletes language relating to s. 641.513, F.S., related to requirements for providing emergency services and care by health maintenance organizations.

On April 15, 2003, the Health Care Committee amended the CS as reported by the Insurance Committee and reported the bill favorably with a CS. The Health Care Committee's CS differs from the Insurance Committee's CS, as follows:

- Requires licensed facilities to make available to the public the top 20% of the most frequently used charge items in the hospital's charge master to be updated monthly, requires the facility to place a notice in reception areas that such information is available and provide a website, to provide on the facility's website a link to the agency's webpage, and requires the facilities to provide an estimate to prospective patients of charges for the proposed services, but not bind the facility to the estimate. This differs from the Insurance Committee's CS which required the facility to provide its master list of charges and codes and a description of services of the top 100 diagnosis charges and codes for both inpatient and outpatient services.
- Further amends s. 408.909, F.S., relating to health flex plans to limits on enrollments for small business purchasing arrangement plans sponsored by a local government to certain eligible residents.
- Adds mandated offering requirements for optional coverage for speech, language, swallowing and hearing disorders, subject to limits for certain insurance policies and health maintenance contracts. This language was not contained in the Insurance Committee's CS.
- Specifies that individual health benefit information provided by small business employers to their employees shall not be construed as requiring a small employer or individual carrier to offer the benefits on a guaranteed-issue basis. This language was not contained in the Insurance Committee's CS.

- Corrects scrivener's errors.
- Increases the aggregate adjustment of premium rates for the modified community rating under the Florida Health Care Access Act to 3%. The rate in the Insurance Committee's CS was 2%.