1 A bill to be entitled
2 An act relating to health insurance; amending ss.
3 626.9541, 641.3903, and 641.441, F.S.; specifying
4 mandatory arbitration as an unfair method of competition
5 and unfair or deceptive act or practice for certain
6 insurers, managed care providers, prepaid limited health
7 service organizations, or prepaid health clinics; amending
8 s. 627.4091, F.S.; including certain additional contracts
9 and plans under a requirement to provide specific reasons
10 for denial of an application for insurance; creating s.
11 627.4303, F.S.; requiring policies, contracts, and plans
12 providing benefits for prescription drug coverage to cover
13 all federally approved drugs without a waiting period;
14 requiring prescription drug formularies to be limited to
15 three tiers of coverage; creating s. 627.6042, F.S.;
16 requiring policies of insurers offering coverage of
17 dependent children to maintain such coverage until the
18 child reaches age 25, under certain circumstances;
19 providing application; amending s. 627.6415, F.S.;
20 deleting an 18th birthday age limitation on application of
21 certain dependent coverage requirements; amending s.
22 627.6475, F.S.; revising risk-assuming carrier election
23 requirements and procedures; revising certain criteria and
24 limitations under the individual health reinsurance
25 program; amending s. 627.6617, F.S.; increasing a minimum
26 reimbursement limitation amount for home health care
27 services; amending s. 627.662, F.S.; revising a list of
28 provisions applicable to group, blanket, or franchise
29 health insurance to include use of specific methodology
30 for payment of claims provisions; amending s. 627.667,

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31 F.S.; deleting a limitation on application of certain
32 extension of benefits provisions; amending s. 627.6692,
33 F.S.; increasing a time period for payment of premium to
34 continue coverage under a group health plan; amending s.
35 627.6699, F.S.; revising certain definitions; revising
36 certain coverage enrollment eligibility criteria for small
37 employers; deleting a premium rate restriction on charging
38 for certain rate adjustments; revising small employer
39 carrier election requirements and procedures; revising
40 certain criteria and limitations under the small employer
41 health reinsurance program; amending ss. 627.911 and
42 627.9175, F.S.; applying certain information reporting
43 requirements to health maintenance organizations; revising
44 health insurance information requirements and criteria;
45 deleting an annual report requirement; amending s.
46 627.9403, F.S.; deleting an exemption for limited benefit
47 policies from a long-term care insurance restriction
48 relating to nursing home care; amending ss. 636.016 and
49 641.31, F.S.; requiring prepaid limited health service
50 organizations and health maintenance organizations
51 offering coverage of dependent children to maintain such
52 coverage until the child reaches age 25, under certain
53 circumstances; providing application; providing
54 requirements for contract termination and denial of a
55 claim related to limiting age attainment; amending s.
56 641.3101, F.S.; providing a compliance requirement for
57 health maintenance contracts using a specific payment of
58 claims methodology; creating s. 641.31075, F.S.; imposing
59 compliance requirements upon health maintenance
60 organization replacements of other group or individual

61 health coverage with organization coverage; amending s.
62 641.3111, F.S.; deleting a limitation on certain extension
63 of benefits provisions upon group health maintenance
64 contract termination; imposing additional extension of
65 benefits requirements upon such termination; amending ss.
66 627.651, 641.2018, 641.3107, and 641.513, F.S.; correcting
67 cross references; providing an effective date.
68
69 Be It Enacted by the Legislature of the State of Florida:
70
71 Section 1. Paragraph (bb) is added to subsection (1) of
72 section 626.9541, Florida Statutes, to read:
73 626.9541 Unfair methods of competition and unfair or
74 deceptive acts or practices defined.--
75 (1) UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE
76 ACTS.--The following are defined as unfair methods of
77 competition and unfair or deceptive acts or practices:
78 (bb) Mandatory arbitration.--For a life insurer, health
79 insurer, or disability insurer, issuing a policy which requires
80 the submission of disputes between the parties to the policy or
81 contract to arbitration.
82 Section 2. Subsection (1) of section 627.4091, Florida
83 Statutes, is amended to read:
84 627.4091 Specific reasons for denial, cancellation, or
85 nonrenewal.--
86 (1) The denial of an application for an insurance policy,
87 health maintenance organization contract, or prepaid limited
88 health service organization plan must be accompanied by the
89 specific reasons for denial, including the specific underwriting
90 reasons, if applicable.

91 Section 3. Section 627.4303, Florida Statutes, is created
92 to read:
93 627.4303 Prescription drug formularies.--Notwithstanding
94 any other provision of law, any individual, blanket, or group
95 health insurance policy, health maintenance organization
96 contract, or prepaid limited health organization plan, or any
97 health insurance policy or certificate delivered or issued for
98 delivery to any person in this state, including out-of-state
99 group plans pursuant to s. 627.6515 covering residents of this
100 state, that provides benefits for prescription drug coverage
101 shall cover all prescription drugs approved by the United States
102 Food and Drug Administration without any waiting period.
103 Prescription drug formularies shall be limited to no more than
104 three tiers of coverage, including generic and nongeneric
105 prescription drugs.
106 Section 4. Section 627.6042, Florida Statutes, is created
107 to read:
108 627.6042 Dependent coverage.--
109 (1) If an insurer offers coverage that insures dependent
110 children of the policyholder or certificateholder, the policy
111 must insure a dependent child of the policyholder or
112 certificateholder at least until the end of the calendar year in
113 which the child reaches the age of 25, if:
114 (a) The child is dependent upon the policyholder or
115 certificateholder for support.
116 (b) The child is living in the household of the
117 policyholder or certificateholder or the child is a full-time or
118 part-time student.
119 (2) Nothing in this section affects or preempts an
120 insurer's right to medically underwrite or charge the

121 appropriate premium.
122 Section 5. Subsections (1) and (4) of section 627.6415,
123 Florida Statutes, are amended to read:
124 627.6415 Coverage for natural-born, adopted, and foster
125 children; children in insured's custodial care.--
126 (1) A health insurance policy that provides coverage for a
127 member of the family of the insured shall, as to the family
128 member's coverage, provide that the health insurance benefits
129 applicable to children of the insured also apply to an adopted
130 child or a foster child of the insured placed in compliance with
131 chapter 63~~, prior to the child's 18th birthday,~~ from the moment
132 of placement in the residence of the insured. Except in the case
133 of a foster child, the policy may not exclude coverage for any
134 preexisting condition of the child. In the case of a newborn
135 child, coverage begins at the moment of birth if a written
136 agreement to adopt the child has been entered into by the
137 insured prior to the birth of the child, whether or not the
138 agreement is enforceable. This section does not require coverage
139 for an adopted child who is not ultimately placed in the
140 residence of the insured in compliance with chapter 63.
141 (4) In order to increase access to postnatal, infant, and
142 pediatric health care for all children placed in court-ordered
143 custody, including foster children, all health insurance
144 policies that provide coverage for a member of the family of the
145 insured shall, as to such family member's coverage, also provide
146 that the health insurance benefits applicable for children shall
147 be payable with respect to a foster child or other child in
148 court-ordered temporary or other custody of the insured~~, prior~~
149 ~~to the child's 18th birthday~~.

150 Section 6. Paragraph (a) of subsection (5), paragraph (c)
151 of subsection (6), and paragraphs (b), (c), and (e) of
152 subsection (7) of section 627.6475, Florida Statutes, are
153 amended to read:
154 627.6475 Individual reinsurance pool.--
155 (5) ISSUER'S ELECTION TO BECOME A RISK-ASSUMING CARRIER.--
156 (a) Each health insurance issuer that offers individual
157 health insurance must elect to become a risk-assuming carrier or
158 a reinsuring carrier for purposes of this section. Each such
159 issuer must make ~~an initial election, binding through December~~
160 ~~31, 1999. The issuer's initial election must be made no later~~
161 ~~than October 31, 1997. By October 31, 1997, all issuers must~~
162 ~~file a final election, which is binding for 2 years, from~~
163 ~~January 1, 1998, through December 31, 1999, after which~~ an
164 election <u>which</u> shall be binding <u>indefinitely or until modified</u>
165 <u>or withdrawn</u> ~~for a period of 5 years~~. The department may permit
166 an issuer to modify its election at any time for good cause
167 shown~~, after a hearing~~.
168 (6) ELECTION PROCESS TO BECOME A RISK-ASSUMING CARRIER.--
169 (c) The department shall provide public notice of an
170 issuer's <u>filing a</u> designation of election under this subsection
171 to become a risk-assuming carrier and shall provide at least a
172 21-day period for public comment <u>upon receipt of such filing</u>
173 ~~prior to making a decision on the election~~. ~~The department shall~~
174 ~~hold a hearing on the election at the request of the issuer.~~
175 (7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.--
176 (b) A reinsuring carrier may reinsure with the program
177 coverage of an eligible individual, subject to each of the
178 following provisions:

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179 1. A reinsuring carrier may reinsure an eligible
180 individual within 90 ~~60~~ days after commencement of the coverage
181 of the eligible individual.
182 2. The program may not reimburse a participating carrier
183 with respect to the claims of a reinsured eligible individual
184 until the carrier has paid incurred claims of an amount equal to
185 the participating carrier’s selected deductible level ~~at least~~
186 ~~$5,000~~ in a calendar year for benefits covered by the program.
187 ~~In addition, the reinsuring carrier is responsible for 10~~
188 ~~percent of the next $50,000 and 5 percent of the next $100,000~~
189 ~~of incurred claims during a calendar year, and the program shall~~
190 ~~reinsure the remainder.~~
191 3. The board shall annually adjust the initial level of
192 claims and the maximum limit to be retained by the carrier to
193 reflect increases in costs and utilization within the standard
194 market for health benefit plans within the state. The adjustment
195 may not be less than the annual change in the medical component
196 of the "Commerce Price Index for All Urban Consumers" of the
197 Bureau of Labor Statistics of the United States Department of
198 Labor, unless the board proposes and the department approves a
199 lower adjustment factor.
200 4. A reinsuring carrier may terminate reinsurance for all
201 reinsured eligible individuals on any plan anniversary.
202 5. The premium rate charged for reinsurance by the program
203 to a health maintenance organization that is approved by the
204 Secretary of Health and Human Services as a federally qualified
205 health maintenance organization pursuant to 42 U.S.C. s.
206 300e(c)(2)(A) and that, as such, is subject to requirements that
207 limit the amount of risk that may be ceded to the program, which
208 requirements are more restrictive than subparagraph 2., shall be

209 reduced by an amount equal to that portion of the risk, if any,
210 which exceeds the amount set forth in subparagraph 2., which may
211 not be ceded to the program.
212 6. The board may consider adjustments to the premium rates
213 charged for reinsurance by the program or carriers that use
214 effective cost-containment measures, including high-cost case
215 management, as defined by the board.
216 7. A reinsuring carrier shall apply its case-management
217 and claims-handling techniques, including, but not limited to,
218 utilization review, individual case management, preferred
219 provider provisions, other managed-care provisions, or methods
220 of operation consistently with both reinsured business and
221 nonreinsured business.
222 (c)1. The board, as part of the plan of operation, shall
223 establish a methodology for determining premium rates to be
224 charged by the program for reinsuring eligible individuals
225 pursuant to this section. The methodology must include a system
226 for classifying individuals which reflects the types of case
227 characteristics commonly used by carriers in this state. The
228 methodology must provide for the development of basic
229 reinsurance premium rates, which shall be multiplied by the
230 factors set for them in this paragraph to determine the premium
231 rates for the program. The basic reinsurance premium rates shall
232 be established by the board, subject to the approval of the
233 department, and shall be set at levels that reasonably
234 approximate gross premiums charged to eligible individuals for
235 individual health insurance by health insurance issuers. The
236 premium rates set by the board may vary by geographical area, as
237 determined under this section, to reflect differences in cost.

238 ~~An eligible individual may be reinsured for a rate that is five~~
239 ~~times the rate established by the board.~~
240 2. The board shall periodically review the methodology
241 established, including the system of classification and any
242 rating factors, to ensure that it reasonably reflects the claims
243 experience of the program. The board may propose changes to the
244 rates that are subject to the approval of the department.
245 (e)1. Before September ~~March~~ 1 of each calendar year, the
246 board shall determine and report to the department the program
247 net loss in the individual account for the previous year,
248 including administrative expenses for that year and the incurred
249 losses for that year, taking into account investment income and
250 other appropriate gains and losses.
251 2. Any net loss in the individual account for the year
252 shall be recouped by assessing the carriers as follows:
253 a. The operating losses of the program shall be assessed
254 in the following order subject to the specified limitations. The
255 first tier of assessments shall be made against reinsuring
256 carriers in an amount that may not exceed 5 percent of each
257 reinsuring carrier's premiums for individual health insurance.
258 If such assessments have been collected and additional moneys
259 are needed, the board shall make a second tier of assessments in
260 an amount that may not exceed 0.5 percent of each carrier's
261 health benefit plan premiums.
262 b. Except as provided in paragraph (f), risk-assuming
263 carriers are exempt from all assessments authorized pursuant to
264 this section. The amount paid by a reinsuring carrier for the
265 first tier of assessments shall be credited against any
266 additional assessments made.

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267 c. The board shall equitably assess reinsuring carriers
268 for operating losses of the individual account based on market
269 share. The board shall annually assess each carrier a portion of
270 the operating losses of the individual account. The first tier
271 of assessments shall be determined by multiplying the operating
272 losses by a fraction, the numerator of which equals the
273 reinsuring carrier's earned premium pertaining to direct
274 writings of individual health insurance in the state during the
275 calendar year for which the assessment is levied, and the
276 denominator of which equals the total of all such premiums
277 earned by reinsuring carriers in the state during that calendar
278 year. The second tier of assessments shall be based on the
279 premiums that all carriers, except risk-assuming carriers,
280 earned on all health benefit plans written in this state. The
281 board may levy interim assessments against reinsuring carriers
282 to ensure the financial ability of the plan to cover claims
283 expenses and administrative expenses paid or estimated to be
284 paid in the operation of the plan for the calendar year prior to
285 the association's anticipated receipt of annual assessments for
286 that calendar year. Any interim assessment is due and payable
287 within 30 days after receipt by a carrier of the interim
288 assessment notice. Interim assessment payments shall be credited
289 against the carrier's annual assessment. Health benefit plan
290 premiums and benefits paid by a carrier that are less than an
291 amount determined by the board to justify the cost of collection
292 may not be considered for purposes of determining assessments.
293 d. Subject to the approval of the department, the board
294 shall adjust the assessment formula for reinsuring carriers that
295 are approved as federally qualified health maintenance
296 organizations by the Secretary of Health and Human Services

297 pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent, if any,
298 that restrictions are placed on them which are not imposed on
299 other carriers.
300 3. Before September ~~March~~ 1 of each year, the board shall
301 determine and file with the department an estimate of the
302 assessments needed to fund the losses incurred by the program in
303 the individual account for the previous calendar year.
304 4. If the board determines that the assessments needed to
305 fund the losses incurred by the program in the individual
306 account for the previous calendar year will exceed the amount
307 specified in subparagraph 2., the board shall evaluate the
308 operation of the program and report its findings and
309 recommendations to the department in the format established in
310 s. 627.6699(11) for the comparable report for the small employer
311 reinsurance program.
312 Section 7. Subsection (2) of section 627.6617, Florida
313 Statutes, is amended to read:
314 627.6617 Coverage for home health care services.--
315 (2) Carriers providing coverage pursuant to this section
316 may establish a maximum length of care for any policy year, but
317 in no event shall reimbursement be limited to an amount less
318 than $15,000 ~~$1,000~~ per year.
319 Section 8. Section 627.662, Florida Statutes, is amended
320 to read:
321 627.662 Other provisions applicable.--The following
322 provisions apply to group health insurance, blanket health
323 insurance, and franchise health insurance:
324 (1) Section 627.569, relating to use of dividends,
325 refunds, rate reductions, commissions, and service fees.

326 (2) Section 627.602(1)(f) and (2), relating to
327 identification numbers and statement of deductible provisions.
328 (3) Section 627.6044, relating to the use of specific
329 methodology for payment of claims.
330 (4)~~(3)~~ Section 627.635, relating to excess insurance.
331 (5)~~(4)~~ Section 627.638, relating to direct payment for
332 hospital or medical services.
333 (6)~~(5)~~ Section 627.640, relating to filing and
334 classification of rates.
335 (7)~~(6)~~ Section 627.613, relating to timely payment of
336 claims, or s. 627.6131, relating to payment of claims, whichever
337 is applicable.
338 (8)~~(7)~~ Section 627.645(1), relating to denial of claims.
339 (9)~~(8)~~ Section 627.6471, relating to preferred provider
340 organizations.
341 (10)~~(9)~~ Section 627.6472, relating to exclusive provider
342 organizations.
343 (11)~~(10)~~ Section 627.6473, relating to combined preferred
344 provider and exclusive provider policies.
345 (12)~~(11)~~ Section 627.6474, relating to provider contracts.
346 Section 9. Subsection (6) of section 627.667, Florida
347 Statutes, is amended to read:
348 627.667 Extension of benefits.--
349 (6) This section also applies to holders of group
350 certificates which are renewed, delivered, or issued for
351 delivery to residents of this state under group policies
352 effectuated or delivered outside this state~~, unless a succeeding~~
353 ~~carrier under a group policy has agreed to assume liability for~~
354 ~~the benefits~~.

355 Section 10. Paragraph (e) of subsection (5) of section
356 627.6692, Florida Statutes, is amended to read:
357 627.6692 Florida Health Insurance Coverage Continuation
358 Act.--
359 (5) CONTINUATION OF COVERAGE UNDER GROUP HEALTH PLANS.--
360 (e)1. A covered employee or other qualified beneficiary
361 who wishes continuation of coverage must pay the initial premium
362 and elect such continuation in writing to the insurance carrier
363 issuing the employer's group health plan within 63 ~~30~~ days after
364 receiving notice from the insurance carrier under paragraph (d).
365 Subsequent premiums are due by the grace period expiration date.
366 The insurance carrier or the insurance carrier's designee shall
367 process all elections promptly and provide coverage
368 retroactively to the date coverage would otherwise have
369 terminated. The premium due shall be for the period beginning on
370 the date coverage would have otherwise terminated due to the
371 qualifying event. The first premium payment must include the
372 coverage paid to the end of the month in which the first payment
373 is made. After the election, the insurance carrier must bill the
374 qualified beneficiary for premiums once each month, with a due
375 date on the first of the month of coverage and allowing a 30-day
376 grace period for payment.
377 2. Except as otherwise specified in an election, any
378 election by a qualified beneficiary shall be deemed to include
379 an election of continuation of coverage on behalf of any other
380 qualified beneficiary residing in the same household who would
381 lose coverage under the group health plan by reason of a
382 qualifying event. This subparagraph does not preclude a
383 qualified beneficiary from electing continuation of coverage on
384 behalf of any other qualified beneficiary.

385 Section 11. Paragraphs (h), (i), (n), and (u) of
386 subsection (3), paragraph (c) of subsection (5), paragraph (b)
387 of subsection (6), paragraph (a) of subsection (9), paragraph
388 (d) of subsection (10), and paragraphs (f), (g), (h), and (j) of
389 subsection (11) of section 627.6699, Florida Statutes, are
390 amended to read:
391 627.6699 Employee Health Care Access Act.--
392 (3) DEFINITIONS.--As used in this section, the term:
393 (h) "Eligible employee" means an employee who works full
394 time, having a normal workweek of 25 or more hours, who is paid
395 wages or a salary at least equal to the federal minimum hourly
396 wage applicable to such employee, and who has met any applicable
397 waiting-period requirements or other requirements of this act.
398 The term includes a self-employed individual, a sole proprietor,
399 a partner of a partnership, or an independent contractor, if the
400 sole proprietor, partner, or independent contractor is included
401 as an employee under a health benefit plan of a small employer,
402 but does not include a part-time, temporary, or substitute
403 employee.
404 (i) "Established geographic area" means the county or
405 counties, or any portion of a county or counties, within which
406 the carrier provides or arranges for health care services to be
407 available to its insureds, members, or subscribers.
408 (n) "Modified community rating" means a method used to
409 develop carrier premiums which spreads financial risk across a
410 large population; allows the use of separate rating factors for
411 age, gender, family composition, tobacco usage, and geographic
412 area as determined under paragraph (5)(j); and allows
413 adjustments for: claims experience, health status, or duration
414 of coverage as permitted under subparagraph (6)(b)5.; and

415 administrative and acquisition expenses as permitted under
416 subparagraph (6)(b)5.
417 (u) "Self-employed individual" means an individual or sole
418 proprietor who derives his or her income from a trade or
419 business carried on by the individual or sole proprietor which
420 necessitates that the individual file with the Internal Revenue
421 Service for the most recent tax year federal income tax forms
422 with supporting schedules and accompanying income reporting
423 forms or federal income tax extensions of time to file forms
424 ~~results in taxable income as indicated on IRS Form 1040,~~
425 ~~schedule C or F, and which generated taxable income in one of~~
426 ~~the 2 previous years~~.
427 (5) AVAILABILITY OF COVERAGE.--
428 (c) Every small employer carrier must, as a condition of
429 transacting business in this state:
430 1. Beginning July 1, 2000, offer and issue all small
431 employer health benefit plans on a guaranteed-issue basis to
432 every eligible small employer, with 2 to 50 eligible employees,
433 that elects to be covered under such plan, agrees to make the
434 required premium payments, and satisfies the other provisions of
435 the plan. A rider for additional or increased benefits may be
436 medically underwritten and may only be added to the standard
437 health benefit plan. The increased rate charged for the
438 additional or increased benefit must be rated in accordance with
439 this section.
440 2. Beginning July 1, 2000, and until July 31, 2001, offer
441 and issue basic and standard small employer health benefit plans
442 on a guaranteed-issue basis to every eligible small employer
443 which is eligible for guaranteed renewal, has less than two
444 eligible employees, is not formed primarily for the purpose of

445 buying health insurance, elects to be covered under such plan,
446 agrees to make the required premium payments, and satisfies the
447 other provisions of the plan. A rider for additional or
448 increased benefits may be medically underwritten and may be
449 added only to the standard benefit plan. The increased rate
450 charged for the additional or increased benefit must be rated in
451 accordance with this section. For purposes of this subparagraph,
452 a person, his or her spouse, and his or her dependent children
453 shall constitute a single eligible employee if that person and
454 spouse are employed by the same small employer and either one
455 has a normal work week of less than 25 hours.

456 3.a. Beginning August 1, 2001, offer and issue basic and
457 standard small employer health benefit plans on a guaranteed-
458 issue basis, during a 31-day open enrollment period of August 1
459 through August 31 of each year, to every eligible small
460 employer, with fewer than two eligible employees, which small
461 employer is not formed primarily for the purpose of buying
462 health insurance and which elects to be covered under such plan,
463 agrees to make the required premium payments, and satisfies the
464 other provisions of the plan. Coverage provided under this sub-
465 subparagraph ~~subparagraph~~ shall begin on October 1 of the same
466 year as the date of enrollment, unless the small employer
467 carrier and the small employer agree to a different date. A
468 rider for additional or increased benefits may be medically
469 underwritten and may only be added to the standard health
470 benefit plan. The increased rate charged for the additional or
471 increased benefit must be rated in accordance with this section.
472 For purposes of this sub-subparagraph ~~subparagraph~~, a person,
473 his or her spouse, and his or her dependent children constitute
474 a single eligible employee if that person and spouse are

475 employed by the same small employer and either that person or
476 his or her spouse has a normal work week of less than 25 hours.
477 b. Notwithstanding the restrictions set forth in sub-
478 subparagraph a., when a small employer group is losing coverage
479 because a carrier is exercising the provisions of s.
480 627.6571(3)(b) or s. 641.31074(3)(b), the eligible small
481 employer, as defined in sub-subparagraph a., shall be entitled
482 to enroll with another carrier offering small employer coverage
483 within 63 days after the notice of termination or the
484 termination date of the prior coverage, whichever is later.
485 Coverage provided under this sub-subparagraph shall begin
486 immediately upon enrollment unless the small employer carrier
487 and the small employer agree to a different date.
488 4. This paragraph does not limit a carrier's ability to
489 offer other health benefit plans to small employers if the
490 standard and basic health benefit plans are offered and
491 rejected.
492 (6) RESTRICTIONS RELATING TO PREMIUM RATES.--
493 (b) For all small employer health benefit plans that are
494 subject to this section and are issued by small employer
495 carriers on or after January 1, 1994, premium rates for health
496 benefit plans subject to this section are subject to the
497 following:
498 1. Small employer carriers must use a modified community
499 rating methodology in which the premium for each small employer
500 must be determined solely on the basis of the eligible
501 employee's and eligible dependent's gender, age, family
502 composition, tobacco use, or geographic area as determined under
503 paragraph (5)(j) and in which the premium may be adjusted as
504 permitted by this paragraph.

505 2. Rating factors related to age, gender, family
506 composition, tobacco use, or geographic location may be
507 developed by each carrier to reflect the carrier's experience.
508 The factors used by carriers are subject to department review
509 and approval.
510 3. Small employer carriers may not modify the rate for a
511 small employer for 12 months from the initial issue date or
512 renewal date, unless the composition of the group changes or
513 benefits are changed. However, a small employer carrier may
514 modify the rate one time prior to 12 months after the initial
515 issue date for a small employer who enrolls under a previously
516 issued group policy that has a common anniversary date for all
517 employers covered under the policy if:
518 a. The carrier discloses to the employer in a clear and
519 conspicuous manner the date of the first renewal and the fact
520 that the premium may increase on or after that date.
521 b. The insurer demonstrates to the department that
522 efficiencies in administration are achieved and reflected in the
523 rates charged to small employers covered under the policy.
524 4. A carrier may issue a group health insurance policy to
525 a small employer health alliance or other group association with
526 rates that reflect a premium credit for expense savings
527 attributable to administrative activities being performed by the
528 alliance or group association if such expense savings are
529 specifically documented in the insurer's rate filing and are
530 approved by the department. Any such credit may not be based on
531 different morbidity assumptions or on any other factor related
532 to the health status or claims experience of any person covered
533 under the policy. Nothing in this subparagraph exempts an
534 alliance or group association from licensure for any activities

535 that require licensure under the insurance code. A carrier
536 issuing a group health insurance policy to a small employer
537 health alliance or other group association shall allow any
538 properly licensed and appointed agent of that carrier to market
539 and sell the small employer health alliance or other group
540 association policy. Such agent shall be paid the usual and
541 customary commission paid to any agent selling the policy.
542 5. ~~Any adjustments in rates for claims experience, health~~
543 ~~status, or duration of coverage may not be charged to individual~~
544 ~~employees or dependents. For a small employer's policy, such~~
545 ~~adjustments may not result in a rate for the small employer~~
546 ~~which deviates more than 15 percent from the carrier's approved~~
547 ~~rate. Any such adjustment must be applied uniformly to the rates~~
548 ~~charged for all employees and dependents of the small employer.~~
549 ~~A small employer carrier may make an adjustment to a small~~
550 ~~employer's renewal premium, not to exceed 10 percent annually,~~
551 ~~due to the claims experience, health status, or duration of~~
552 ~~coverage of the employees or dependents of the small employer.~~
553 ~~Semiannually, small group carriers shall report information on~~
554 ~~forms adopted by rule by the department, to enable the~~
555 ~~department to monitor the relationship of aggregate adjusted~~
556 ~~premiums actually charged policyholders by each carrier to the~~
557 ~~premiums that would have been charged by application of the~~
558 ~~carrier's approved modified community rates. If the aggregate~~
559 ~~resulting from the application of such adjustment exceeds the~~
560 ~~premium that would have been charged by application of the~~
561 ~~approved modified community rate by 5 percent for the current~~
562 ~~reporting period, the carrier shall limit the application of~~
563 ~~such adjustments only to minus adjustments beginning not more~~
564 ~~than 60 days after the report is sent to the department. For any~~

565 ~~subsequent reporting period, if the total aggregate adjusted~~
566 ~~premium actually charged does not exceed the premium that would~~
567 ~~have been charged by application of the approved modified~~
568 ~~community rate by 5 percent, the carrier may apply both plus and~~
569 ~~minus adjustments.~~ A small employer carrier may provide a credit
570 to a small employer's premium based on administrative and
571 acquisition expense differences resulting from the size of the
572 group. Group size administrative and acquisition expense factors
573 may be developed by each carrier to reflect the carrier's
574 experience and are subject to department review and approval.
575 6. A small employer carrier rating methodology may include
576 separate rating categories for one dependent child, for two
577 dependent children, and for three or more dependent children for
578 family coverage of employees having a spouse and dependent
579 children or employees having dependent children only. A small
580 employer carrier may have fewer, but not greater, numbers of
581 categories for dependent children than those specified in this
582 subparagraph.
583 7. Small employer carriers may not use a composite rating
584 methodology to rate a small employer with fewer than 10
585 employees. For the purposes of this subparagraph, a "composite
586 rating methodology" means a rating methodology that averages the
587 impact of the rating factors for age and gender in the premiums
588 charged to all of the employees of a small employer.
589 8.a. A carrier may separate the experience of small
590 employer groups with less than 2 eligible employees from the
591 experience of small employer groups with 2-50 eligible employees
592 for purposes of determining an alternative modified community
593 rating.

594 b. If a carrier separates the experience of small employer
595 groups as provided in sub-subparagraph a., the rate to be
596 charged to small employer groups of less than 2 eligible
597 employees may not exceed 150 percent of the rate determined for
598 small employer groups of 2-50 eligible employees. However, the
599 carrier may charge excess losses of the experience pool
600 consisting of small employer groups with less than 2 eligible
601 employees to the experience pool consisting of small employer
602 groups with 2-50 eligible employees so that all losses are
603 allocated and the 150-percent rate limit on the experience pool
604 consisting of small employer groups with less than 2 eligible
605 employees is maintained. Notwithstanding s. 627.411(1), the rate
606 to be charged to a small employer group of fewer than 2 eligible
607 employees, insured as of July 1, 2002, may be up to 125 percent
608 of the rate determined for small employer groups of 2-50
609 eligible employees for the first annual renewal and 150 percent
610 for subsequent annual renewals.
611 (9) SMALL EMPLOYER CARRIER'S ELECTION TO BECOME A RISK-
612 ASSUMING CARRIER OR A REINSURING CARRIER.--
613 (a) A small employer carrier must elect to become either a
614 risk-assuming carrier or a reinsuring carrier. ~~Each small~~
615 ~~employer carrier must make an initial election, binding through~~
616 ~~January 1, 1994. The carrier's initial election must be made no~~
617 ~~later than October 31, 1992. By October 31, 1993, all small~~
618 ~~employer carriers must file a final election, which is binding~~
619 ~~for 2 years, from January 1, 1994, through December 31, 1995,~~
620 ~~after which an election shall be binding for a period of 5~~
621 ~~years.~~ Any carrier that is not a small employer carrier on
622 October 31, 1992, and intends to become a small employer carrier
623 after October 31, 1992, must file its designation when it files

624 the forms and rates it intends to use for small employer group
625 health insurance; such designation shall be binding indefinitely
626 or until modified or withdrawn ~~for 2 years after the date of~~
627 ~~approval of the forms and rates, and any subsequent designation~~
628 ~~is binding for 5 years~~. The department may permit a carrier to
629 modify its election at any time for good cause shown~~, after a~~
630 ~~hearing~~.
631 (10) ELECTION PROCESS TO BECOME A RISK-ASSUMING CARRIER.--
632 (d) The department shall provide public notice of a small
633 employer carrier's filing a designation of election under
634 subsection (9) to become a risk-assuming carrier and shall
635 provide at least a 21-day period for public comment upon receipt
636 of such filing ~~prior to making a decision on the election~~. ~~The~~
637 ~~department shall hold a hearing on the election at the request~~
638 ~~of the carrier.~~
639 (11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.--
640 (f) The program has the general powers and authority
641 granted under the laws of this state to insurance companies and
642 health maintenance organizations licensed to transact business,
643 except the power to issue health benefit plans directly to
644 groups or individuals. In addition thereto, the program has
645 specific authority to:
646 1. Enter into contracts as necessary or proper to carry
647 out the provisions and purposes of this act, including the
648 authority to enter into contracts with similar programs of other
649 states for the joint performance of common functions or with
650 persons or other organizations for the performance of
651 administrative functions.

652 2. Sue or be sued, including taking any legal action
653 necessary or proper for recovering any assessments and penalties
654 for, on behalf of, or against the program or any carrier.
655 3. Take any legal action necessary to avoid the payment of
656 improper claims against the program.
657 4. Issue reinsurance policies, in accordance with the
658 requirements of this act.
659 5. Establish rules, conditions, and procedures for
660 reinsurance risks under the program participation.
661 6. Establish actuarial functions as appropriate for the
662 operation of the program.
663 7. Assess participating carriers in accordance with
664 paragraph (j), and make advance interim assessments as may be
665 reasonable and necessary for organizational and interim
666 operating expenses. Interim assessments shall be credited as
667 offsets against any regular assessments due following the close
668 of the calendar year.
669 8. Appoint appropriate legal, actuarial, and other
670 committees as necessary to provide technical assistance in the
671 operation of the program, and in any other function within the
672 authority of the program.
673 9. Borrow money to effect the purposes of the program. Any
674 notes or other evidences of indebtedness of the program which
675 are not in default constitute legal investments for carriers and
676 may be carried as admitted assets.
677 10. To the extent necessary, increase the $5,000
678 deductible reinsurance requirement to adjust for the effects of
679 inflation. The program may evaluate the desirability of
680 establishing different levels of deductibles. If different

681 levels of deductibles are established, such levels and the
682 resulting premiums shall be approved by the department.
683 (g) A reinsuring carrier may reinsure with the program
684 coverage of an eligible employee of a small employer, or any
685 dependent of such an employee, subject to each of the following
686 provisions:
687 1. With respect to a standard and basic health care plan,
688 the program may ~~must~~ reinsure the level of coverage provided;
689 and, with respect to any other plan, the program may ~~must~~
690 reinsure the coverage up to, but not exceeding, the level of
691 coverage provided under the standard and basic health care plan.
692 As an alternative to reinsuring the level of coverage provided
693 under the standard and basic health care plan, the program may
694 develop alternate levels of reinsurance designed to coordinate
695 with a reinsuring carrier's existing reinsurance. The levels of
696 reinsurance and resulting premiums must be approved by the
697 department.
698 2. Except in the case of a late enrollee, a reinsuring
699 carrier may reinsure an eligible employee or dependent within 60
700 days after the commencement of the coverage of the small
701 employer. A newly employed eligible employee or dependent of a
702 small employer may be reinsured within 60 days after the
703 commencement of his or her coverage.
704 3. A small employer carrier may reinsure an entire
705 employer group within 60 days after the commencement of the
706 group's coverage under the plan. The carrier may choose to
707 reinsure newly eligible employees and dependents of the
708 reinsured group pursuant to subparagraph 1.
709 4. The program may evaluate the option of allowing a small
710 employer carrier to reinsure an entire employer group or an

711 eligible employee at the first or subsequent renewal date. Any
712 such option and the resulting premium must be approved by the
713 department.
714 5.~~4.~~ The program may not reimburse a participating carrier
715 with respect to the claims of a reinsured employee or dependent
716 until the carrier has paid incurred claims of an amount equal to
717 the participating carrier's selected deductible level ~~at least~~
718 ~~$5,000~~ in a calendar year for benefits covered by the program.
719 ~~In addition, the reinsuring carrier shall be responsible for 10~~
720 ~~percent of the next $50,000 and 5 percent of the next $100,000~~
721 ~~of incurred claims during a calendar year and the program shall~~
722 ~~reinsure the remainder.~~
723 6.~~5.~~ The board annually shall adjust the initial level of
724 claims and the maximum limit to be retained by the carrier to
725 reflect increases in costs and utilization within the standard
726 market for health benefit plans within the state. The adjustment
727 shall not be less than the annual change in the medical
728 component of the "Consumer Price Index for All Urban Consumers"
729 of the Bureau of Labor Statistics of the Department of Labor,
730 unless the board proposes and the department approves a lower
731 adjustment factor.
732 7.~~6.~~ A small employer carrier may terminate reinsurance
733 for all reinsured employees or dependents on any plan
734 anniversary.
735 8.~~7.~~ The premium rate charged for reinsurance by the
736 program to a health maintenance organization that is approved by
737 the Secretary of Health and Human Services as a federally
738 qualified health maintenance organization pursuant to 42 U.S.C.
739 s. 300e(c)(2)(A) and that, as such, is subject to requirements
740 that limit the amount of risk that may be ceded to the program,

741 which requirements are more restrictive than subparagraph 5. ~~4.~~,
742 shall be reduced by an amount equal to that portion of the risk,
743 if any, which exceeds the amount set forth in subparagraph 5. ~~4.~~
744 which may not be ceded to the program.
745 9.~~8.~~ The board may consider adjustments to the premium
746 rates charged for reinsurance by the program for carriers that
747 use effective cost containment measures, including high-cost
748 case management, as defined by the board.
749 10.~~9.~~ A reinsuring carrier shall apply its case-management
750 and claims-handling techniques, including, but not limited to,
751 utilization review, individual case management, preferred
752 provider provisions, other managed care provisions or methods of
753 operation, consistently with both reinsured business and
754 nonreinsured business.
755 (h)1. The board, as part of the plan of operation, shall
756 establish a methodology for determining premium rates to be
757 charged by the program for reinsuring small employers and
758 individuals pursuant to this section. The methodology shall
759 include a system for classification of small employers that
760 reflects the types of case characteristics commonly used by
761 small employer carriers in the state. The methodology shall
762 provide for the development of basic reinsurance premium rates,
763 which shall be multiplied by the factors set for them in this
764 paragraph to determine the premium rates for the program. The
765 basic reinsurance premium rates shall be established by the
766 board, subject to the approval of the department, and shall be
767 set at levels which reasonably approximate gross premiums
768 charged to small employers by small employer carriers for health
769 benefit plans with benefits similar to the standard and basic
770 health benefit plan. The premium rates set by the board may vary

771 by geographical area, as determined under this section, to
772 reflect differences in cost. ~~The multiplying factors must be~~
773 ~~established as follows:~~
774 ~~a. The entire group may be reinsured for a rate that is~~
775 ~~1.5 times the rate established by the board.~~
776 ~~b. An eligible employee or dependent may be reinsured for~~
777 ~~a rate that is 5 times the rate established by the board.~~
778 2. The board periodically shall review the methodology
779 established, including the system of classification and any
780 rating factors, to assure that it reasonably reflects the claims
781 experience of the program. The board may propose changes to the
782 rates which shall be subject to the approval of the department.
783 (j)1. Before <u>September</u> ~~March~~ 1 of each calendar year, the
784 board shall determine and report to the department the program
785 net loss for the previous year, including administrative
786 expenses for that year, and the incurred losses for the year,
787 taking into account investment income and other appropriate
788 gains and losses.
789 2. Any net loss for the year shall be recouped by
790 assessment of the carriers, as follows:
791 a. The operating losses of the program shall be assessed
792 in the following order subject to the specified limitations. The
793 first tier of assessments shall be made against reinsuring
794 carriers in an amount which shall not exceed 5 percent of each
795 reinsuring carrier's premiums from health benefit plans covering
796 small employers. If such assessments have been collected and
797 additional moneys are needed, the board shall make a second tier
798 of assessments in an amount which shall not exceed 0.5 percent
799 of each carrier's health benefit plan premiums. Except as
800 provided in paragraph (n), risk-assuming carriers are exempt

801 from all assessments authorized pursuant to this section. The
802 amount paid by a reinsuring carrier for the first tier of
803 assessments shall be credited against any additional assessments
804 made.
805 b. The board shall equitably assess carriers for operating
806 losses of the plan based on market share. The board shall
807 annually assess each carrier a portion of the operating losses
808 of the plan. The first tier of assessments shall be determined
809 by multiplying the operating losses by a fraction, the numerator
810 of which equals the reinsuring carrier's earned premium
811 pertaining to direct writings of small employer health benefit
812 plans in the state during the calendar year for which the
813 assessment is levied, and the denominator of which equals the
814 total of all such premiums earned by reinsuring carriers in the
815 state during that calendar year. The second tier of assessments
816 shall be based on the premiums that all carriers, except risk-
817 assuming carriers, earned on all health benefit plans written in
818 this state. The board may levy interim assessments against
819 carriers to ensure the financial ability of the plan to cover
820 claims expenses and administrative expenses paid or estimated to
821 be paid in the operation of the plan for the calendar year prior
822 to the association's anticipated receipt of annual assessments
823 for that calendar year. Any interim assessment is due and
824 payable within 30 days after receipt by a carrier of the interim
825 assessment notice. Interim assessment payments shall be credited
826 against the carrier's annual assessment. Health benefit plan
827 premiums and benefits paid by a carrier that are less than an
828 amount determined by the board to justify the cost of collection
829 may not be considered for purposes of determining assessments.

830 c. Subject to the approval of the department, the board
831 shall make an adjustment to the assessment formula for
832 reinsuring carriers that are approved as federally qualified
833 health maintenance organizations by the Secretary of Health and
834 Human Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the
835 extent, if any, that restrictions are placed on them that are
836 not imposed on other small employer carriers.
837 3. Before <u>September</u> ~~March~~ 1 of each year, the board shall
838 determine and file with the department an estimate of the
839 assessments needed to fund the losses incurred by the program in
840 the previous calendar year.
841 4. If the board determines that the assessments needed to
842 fund the losses incurred by the program in the previous calendar
843 year will exceed the amount specified in subparagraph 2., the
844 board shall evaluate the operation of the program and report its
845 findings, including any recommendations for changes to the plan
846 of operation, to the department within <u>240</u> ~~90~~ days following the
847 end of the calendar year in which the losses were incurred. The
848 evaluation shall include an estimate of future assessments, the
849 administrative costs of the program, the appropriateness of the
850 premiums charged and the level of carrier retention under the
851 program, and the costs of coverage for small employers. If the
852 board fails to file a report with the department within <u>240</u> ~~90~~
853 days following the end of the applicable calendar year, the
854 department may evaluate the operations of the program and
855 implement such amendments to the plan of operation the
856 department deems necessary to reduce future losses and
857 assessments.
858 5. If assessments exceed the amount of the actual losses
859 and administrative expenses of the program, the excess shall be

860 held as interest and used by the board to offset future losses
861 or to reduce program premiums. As used in this paragraph, the
862 term "future losses" includes reserves for incurred but not
863 reported claims.
864 6. Each carrier's proportion of the assessment shall be
865 determined annually by the board, based on annual statements and
866 other reports considered necessary by the board and filed by the
867 carriers with the board.
868 7. Provision shall be made in the plan of operation for
869 the imposition of an interest penalty for late payment of an
870 assessment.
871 8. A carrier may seek, from the commissioner, a deferment,
872 in whole or in part, from any assessment made by the board. The
873 department may defer, in whole or in part, the assessment of a
874 carrier if, in the opinion of the department, the payment of the
875 assessment would place the carrier in a financially impaired
876 condition. If an assessment against a carrier is deferred, in
877 whole or in part, the amount by which the assessment is deferred
878 may be assessed against the other carriers in a manner
879 consistent with the basis for assessment set forth in this
880 section. The carrier receiving such deferment remains liable to
881 the program for the amount deferred and is prohibited from
882 reinsuring any individuals or groups in the program if it fails
883 to pay assessments.
884 Section 12. Section 627.911, Florida Statutes, is amended
885 to read:
886 627.911 Scope of this part.--Any insurer <u>or health</u>
887 <u>maintenance organization</u> transacting insurance in this state
888 shall report information as required by this part.

889 Section 13. Section 627.9175, Florida Statutes, is amended
890 to read:
891 627.9175 Reports of information on health insurance.--
892 (1) Each authorized health insurer or health maintenance
893 organization shall submit annually to the department information
894 concerning ~~as to policies of individual~~ health insurance
895 coverage being issued or currently in force in this state. The
896 information shall include information related to premium, number
897 of policies, and covered lives for such policies and other
898 information necessary to analyze trends in enrollment, premiums,
899 and claim costs.
900 (2) The required information shall be broken down by
901 market segment, to include:
902 (a) Health insurance issuer, company, or contact person or
903 agent.
904 (b) All health insurance products issued or in force,
905 including, but not limited to:
906 1. Direct premiums earned.
907 2. Direct losses incurred.
908 3. Direct premiums earned for new business issued during
909 the year.
910 4. Number of policies.
911 5. Number of certificates.
912 6. Number of total covered lives.
913 ~~(a) A summary of typical benefits, exclusions, and~~
914 ~~limitations for each type of individual policy form currently~~
915 ~~being issued in the state. The summary shall include, as~~
916 ~~appropriate:~~
917 ~~1. The deductible amount;~~
918 ~~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) 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 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.~~

(3) The department shall publish annually a consumer's guide ~~which summarizes and compares the information required to be reported under this subsection~~.

~~(2)(a) 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~~

949 ~~and shall utilize such forms to analyze the effects of health~~
950 ~~care cost containment programs used by health insurers in this~~
951 ~~state.~~
952 <u>(4)</u>~~(c)~~ The department shall analyze the data reported
953 under ~~this~~ subsection <u>(2)</u> and shall annually make available to
954 the public a summary of its findings as to the types of cost
955 containment measures reported and the estimated effect of these
956 measures.
957 Section 14. Section 627.9403, Florida Statutes, is amended
958 to read:
959 627.9403 Scope.--The provisions of this part shall apply
960 to long-term care insurance policies delivered or issued for
961 delivery in this state, and to policies delivered or issued for
962 delivery outside this state to the extent provided in s.
963 627.9406, by an insurer, a fraternal benefit society as defined
964 in s. 632.601, a health maintenance organization as defined in
965 s. 641.19, a prepaid health clinic as defined in s. 641.402, or
966 a multiple-employer welfare arrangement as defined in s.
967 624.437. A policy which is advertised, marketed, or offered as a
968 long-term care policy and as a Medicare supplement policy shall
969 meet the requirements of this part and the requirements of ss.
970 627.671-627.675 and, to the extent of a conflict, be subject to
971 the requirement that is more favorable to the policyholder or
972 certificateholder. The provisions of this part shall not apply
973 to a continuing care contract issued pursuant to chapter 651 and
974 shall not apply to guaranteed renewable policies issued prior to
975 October 1, 1988. Any limited benefit policy that limits coverage
976 to care in a nursing home or to one or more lower levels of care
977 required or authorized to be provided by this part or by
978 department rule must meet all requirements of this part that

979 apply to long-term care insurance policies, except ss.
980 627.9407(3)(c), (9), (10)(f), and (12) and 627.94073(2). ~~If the~~
981 ~~limited benefit policy does not provide coverage for care in a~~
982 ~~nursing home, but does provide coverage for one or more lower~~
983 ~~levels of care, the policy shall also be exempt from the~~
984 ~~requirements of s. 627.9407(3)(d).~~
985 Section 15. Subsection (5) of section 636.016, Florida
986 Statutes, is amended to read:
987 636.016 Prepaid limited health service contracts.--For any
988 entity licensed prior to October 1, 1993, all subscriber
989 contracts in force at such time shall be in compliance with this
990 section upon renewal of such contract.
991 (5)<u>(a)1. If a prepaid limited health service organization</u>
992 <u>offers coverage for dependent children of the contract holder,</u>
993 <u>the policy must insure a dependent child of the contract holder</u>
994 <u>at least until the end of the calendar year in which the child</u>
995 <u>reaches the age of 25, if:</u>
996 <u>a. The child is dependent upon the contract holder for</u>
997 <u>support.</u>
998 <u>b. The child is living in the household of the contract</u>
999 <u>holder or the child is a full-time or part-time student.</u>
1000 <u>2. Nothing in this section affects or preempts a prepaid</u>
1001 <u>limited health service organization's right to medically</u>
1002 <u>underwrite or charge the appropriate premium.</u>
1003 <u>(b)1. A contract that provides coverage for a family</u>
1004 <u>member of the contract holder shall, as to such family member's</u>
1005 <u>coverage, provide that benefits applicable to children of the</u>
1006 <u>contract holder also apply to an adopted child or a foster child</u>
1007 <u>of the contract holder placed in compliance with chapter 63 from</u>
1008 <u>the moment of placement in the residence of the contract holder.</u>

1009 Except in the case of a foster child, the policy may not exclude
1010 coverage for any preexisting condition of the child. In the case
1011 of a newborn child, coverage begins at the moment of birth if a
1012 written agreement to adopt such child has been entered into by
1013 the contract holder prior to the birth of the child, whether or
1014 not the agreement is enforceable. This section does not require
1015 coverage for an adopted child who is not ultimately placed in
1016 the residence of the contract holder in compliance with chapter
1017 63.
1018 2. A contract may require the contract holder to notify
1019 the insurer of the birth or placement of an adopted child within
1020 a specified time period of not less than 30 days after the birth
1021 or placement in the residence of a child adopted by the contract
1022 holder. If timely notice is given, the insurer may not charge an
1023 additional premium for coverage of the child for the duration of
1024 the notice period. If timely notice is not given, the insurer
1025 may charge an additional premium from the date of birth or
1026 placement. If notice is given within 60 days after the birth or
1027 placement of the child, the insurer may not deny coverage for
1028 the child due to the failure of the contract holder to timely
1029 notify the insurer of the birth or placement of the child.
1030 3. If the policy does not require the contract holder to
1031 notify the insurer of the birth or placement of an adopted child
1032 within a specified time period, the insurer may not deny
1033 coverage for such child or retroactively charge the contract
1034 holder an additional premium for such child. However, the
1035 insurer may prospectively charge the contract holder an
1036 additional premium for the child if the insurer provides at
1037 least 45 days' notice of the additional premium required.
1038 4. In order to increase access to postnatal, infant, and

1039 pediatric health care for all children placed in court-ordered
1040 custody, including foster children, all health insurance
1041 policies that provide coverage for a family member of the
1042 contract holder shall, as to such family member's coverage,
1043 provide that benefits applicable for children shall be payable
1044 with respect to a foster child or other child in court-ordered
1045 temporary or other custody of the contract holder.
1046 (c) A contract that provides that coverage of a dependent
1047 child shall terminate upon attainment of the limiting age for
1048 dependent children specified in the contract shall also provide
1049 in substance that attainment of the limiting age does not
1050 terminate the coverage of the child while the child continues to
1051 be:
1052 1. Incapable of self-sustaining employment by reason of
1053 mental retardation or physical handicap.
1054 2. Chiefly dependent upon the contract holder or
1055 subscriber for support and maintenance.
1056
1057 If a claim is denied under a contract for the stated reason that
1058 the child has attained the limiting age for dependent children
1059 specified in the contract, the notice of denial must state that
1060 the contract holder has the burden of establishing that the
1061 child continues to meet the criteria specified in subparagraphs
1062 1. and 2. All prepaid limited health service coverage, benefits,
1063 or services for a member of the family of the subscriber must,
1064 as to such family member's coverage, benefits, or services,
1065 provide also that the coverage, benefits, or services applicable
1066 for children will be provided with respect to a preenrolled
1067 newborn child of the subscriber, or covered family member of the

1068 ~~subscriber, from the moment of birth, or adoption pursuant to~~
1069 ~~chapter 63.~~
1070 Section 16. Subsections (9) through (17) of section
1071 641.31, Florida Statutes, are amended to read:
1072 641.31 Health maintenance contracts.--
1073 (9)<u>(a)1. If a health maintenance organization offers</u>
1074 <u>coverage for dependent children of the subscriber, the policy</u>
1075 <u>must cover a dependent child of the subscriber at least until</u>
1076 <u>the end of the calendar year in which the child reaches the age</u>
1077 <u>of 25, if:</u>
1078 <u>a. The child is dependent upon the subscriber for support.</u>
1079 <u>b. The child is living in the household of the subscriber,</u>
1080 <u>or the child is a full-time or part-time student.</u>
1081 <u>2. Nothing in this paragraph affects or preempts a health</u>
1082 <u>maintenance organization's right to medically underwrite or</u>
1083 <u>charge the appropriate premium.</u>
1084 <u>(b)1. A contract that provides coverage for a family</u>
1085 <u>member of the subscriber shall, as to such family member's</u>
1086 <u>coverage, provide that benefits applicable to children of the</u>
1087 <u>subscriber also apply to an adopted child or a foster child of</u>
1088 <u>the subscriber placed in compliance with chapter 63 from the</u>
1089 <u>moment of placement in the residence of the subscriber. Except</u>
1090 <u>in the case of a foster child, the policy may not exclude</u>
1091 <u>coverage for any preexisting condition of the child. In the case</u>
1092 <u>of a newborn child, coverage begins at the moment of birth if a</u>
1093 <u>written agreement to adopt such child has been entered into by</u>
1094 <u>the subscriber prior to the birth of the child, whether or not</u>
1095 <u>the agreement is enforceable. This section does not require</u>
1096 <u>coverage for an adopted child who is not ultimately placed in</u>
1097 <u>the residence of the subscriber in compliance with chapter 63.</u>

CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

1098 2. A contract may require the subscriber to notify the
1099 health maintenance organization of the birth or placement of an
1100 adopted child within a specified time period of not less than 30
1101 days after the birth or placement in the residence of a child
1102 adopted by the subscriber. If timely notice is given, the health
1103 maintenance organization may not charge an additional premium
1104 for coverage of the child for the duration of the notice period.
1105 If timely notice is not given, the health maintenance
1106 organization may charge an additional premium from the date of
1107 birth or placement. If notice is given within 60 days after the
1108 birth or placement of the child, the health maintenance
1109 organization may not deny coverage for the child due to the
1110 failure of the subscriber to timely notify the health
1111 maintenance organization of the birth or placement of the child.
1112 3. If the policy does not require the subscriber to notify
1113 the health maintenance organization of the birth or placement of
1114 an adopted child within a specified time period, the health
1115 maintenance organization may not deny coverage for such child or
1116 retroactively charge the subscriber an additional premium for
1117 such child. However, the health maintenance organization may
1118 prospectively charge the subscriber an additional premium for
1119 the child if the health maintenance organization provides at
1120 least 45 days' notice of the additional premium required.
1121 4. In order to increase access to postnatal, infant, and
1122 pediatric health care for all children placed in court-ordered
1123 custody, including foster children, all health insurance
1124 policies that provide coverage for a family member of the
1125 subscriber shall, as to such family member's coverage, provide
1126 that benefits applicable for children shall be payable with
1127 respect to a foster child or other child in court-ordered

1128 temporary or other custody of the subscriber.
1129 (10) A contract that provides that coverage of a dependent
1130 child shall terminate upon attainment of the limiting age for
1131 dependent children specified in the contract shall also provide
1132 in substance that attainment of the limiting age does not
1133 terminate the coverage of the child while the child continues to
1134 be:
1135 (a) Incapable of self-sustaining employment by reason of
1136 mental retardation or physical handicap.
1137 (b) Chiefly dependent upon the subscriber for support and
1138 maintenance.
1139
1140 If a claim is denied under a contract for the stated reason that
1141 the child has attained the limiting age for dependent children
1142 specified in the contract, the notice of denial must state that
1143 the subscriber has the burden of establishing that the child
1144 continues to meet the criteria specified in paragraphs (a) and
1145 (b). ~~All health maintenance contracts that provide coverage,~~
1146 ~~benefits, or services for a member of the family of the~~
1147 ~~subscriber must, as to such family member's coverage, benefits,~~
1148 ~~or services, provide also that the coverage, benefits, or~~
1149 ~~services applicable for children must be provided with respect~~
1150 ~~to a newborn child of the subscriber, or covered family member~~
1151 ~~of the subscriber, from the moment of birth. However, with~~
1152 ~~respect to a newborn child of a covered family member other than~~
1153 ~~the spouse of the insured or subscriber, the coverage for the~~
1154 ~~newborn child terminates 18 months after the birth of the~~
1155 ~~newborn child. The coverage, benefits, or services for newborn~~
1156 ~~children must consist of coverage for injury or sickness,~~
1157 ~~including the necessary care or treatment of medically diagnosed~~

1158 ~~congenital defects, birth abnormalities, or prematurity, and~~
1159 ~~transportation costs of the newborn to and from the nearest~~
1160 ~~appropriate facility appropriately staffed and equipped to treat~~
1161 ~~the newborn's condition, when such transportation is certified~~
1162 ~~by the attending physician as medically necessary to protect the~~
1163 ~~health and safety of the newborn child.~~
1164 ~~(a) A contract may require the subscriber to notify the~~
1165 ~~plan of the birth of a child within a time period, as specified~~
1166 ~~in the contract, of not less than 30 days after the birth, or a~~
1167 ~~contract may require the preenrollment of a newborn prior to~~
1168 ~~birth. However, if timely notice is given, a plan may not charge~~
1169 ~~an additional premium for additional coverage of the newborn~~
1170 ~~child for not less than 30 days after the birth of the child. If~~
1171 ~~timely notice is not given, the plan may charge an additional~~
1172 ~~premium from the date of birth. If notice is given within 60~~
1173 ~~days of the birth of the child, the contract may not deny~~
1174 ~~coverage of the child due to failure of the subscriber to timely~~
1175 ~~notify the plan of the birth of the child or to preenroll the~~
1176 ~~child.~~
1177 ~~(b) If the contract does not require the subscriber to~~
1178 ~~notify the plan of the birth of a child within a specified time~~
1179 ~~period, the plan may not deny coverage of the child nor may it~~
1180 ~~retroactively charge the subscriber an additional premium for~~
1181 ~~the child; however, the contract may prospectively charge the~~
1182 ~~member an additional premium for the child if the plan provides~~
1183 ~~at least 45 days' notice of the additional charge.~~
1184 (11)~~(10)~~ No alteration of any written application for any
1185 health maintenance contract shall be made by any person other
1186 than the applicant without his or her written consent, except
1187 that insertions may be made by the health maintenance

1188 organization, for administrative purposes only, in such manner
1189 as to indicate clearly that such insertions are not to be
1190 ascribed to the applicant.

1191 (12) ~~(11)~~ No contract shall contain any waiver of rights or
1192 benefits provided to or available to subscribers under the
1193 provisions of any law or rule applicable to health maintenance
1194 organizations.

1195 (13) ~~(12)~~ Each health maintenance contract, certificate, or
1196 member handbook shall state that emergency services and care
1197 shall be provided to subscribers in emergency situations not
1198 permitting treatment through the health maintenance
1199 organization's providers, without prior notification to and
1200 approval of the organization. Not less than 75 percent of the
1201 reasonable charges for covered services and supplies shall be
1202 paid by the organization, up to the subscriber contract benefit
1203 limits. Payment also may be subject to additional applicable
1204 copayment provisions, not to exceed $100 per claim. The health
1205 maintenance contract, certificate, or member handbook shall
1206 contain the definitions of "emergency services and care" and
1207 "emergency medical condition" as specified in s. 641.19(7) and
1208 (8), shall describe procedures for determination by the health
1209 maintenance organization of whether the services qualify for
1210 reimbursement as emergency services and care, and shall contain
1211 specific examples of what does constitute an emergency. In
1212 providing for emergency services and care as a covered service,
1213 a health maintenance organization shall be governed by s.
1214 641.513.

1215 (14) ~~(13)~~ In addition to the requirements of this section,
1216 with respect to a person who is entitled to have payments for

1217 health care costs made under Medicare, Title XVIII of the Social
1218 Security Act ("Medicare"), parts A and/or B:
1219 (a) The health maintenance organization shall mail or
1220 deliver notification to the Medicare beneficiary of the date of
1221 enrollment in the health maintenance organization within 10 days
1222 after receiving notification of enrollment approval from the
1223 United States Department of Health and Human Services, Health
1224 Care Financing Administration. When a Medicare beneficiary who
1225 is a subscriber of the health maintenance organization requests
1226 disenrollment from the organization, the organization shall mail
1227 or deliver to the beneficiary notice of the effective date of
1228 the disenrollment within 10 days after receipt of the written
1229 disenrollment request. The health maintenance organization shall
1230 forward the disenrollment request to the United States
1231 Department of Health and Human Services, Health Care Financing
1232 Administration, in a timely manner so as to effectuate the next
1233 available disenrollment date, as prescribed by such federal
1234 agency.
1235 (b) The health maintenance contract, certificate, or
1236 member handbook shall be delivered to the subscriber no later
1237 than the earlier of 10 working days after the health maintenance
1238 organization and the Health Care Financing Administration of the
1239 United States Department of Health and Human Services approve
1240 the subscriber's enrollment application or the effective date of
1241 coverage of the subscriber under the health maintenance
1242 contract. However, if notice from the Health Care Financing
1243 Administration of its approval of the subscriber's enrollment
1244 application is received by the health maintenance organization
1245 after the effective coverage date prescribed by the Health Care
1246 Financing Administration, the health maintenance organization

1247 shall deliver the contract, certificate, or member handbook to
1248 the subscriber within 10 days after receiving such notice. When
1249 a Medicare recipient is enrolled in a health maintenance
1250 organization program, the contract, certificate, or member
1251 handbook shall be accompanied by a health maintenance
1252 organization identification sticker with instruction to the
1253 Medicare beneficiary to place the sticker on the Medicare
1254 identification card.

1255 (15)~~(14)~~ Whenever a subscriber of a health maintenance
1256 organization is also a Medicaid recipient, the health
1257 maintenance organization's coverage shall be primary to the
1258 recipient's Medicaid benefits and the organization shall be a
1259 third party subject to the provisions of s. 409.910(4).

1260 (16)~~(15)~~(a) All health maintenance contracts,
1261 certificates, and member handbooks shall contain the following
1262 provision:

1263

1264 "Grace Period: This contract has a (insert a number not
1265 less than 10) day grace period. This provision means that if any
1266 required premium is not paid on or before the date it is due, it
1267 may be paid during the following grace period. During the grace
1268 period, the contract will stay in force."

1269

1270 (b) The required provision of paragraph (a) shall not
1271 apply to certificates or member handbooks delivered to
1272 individual subscribers under a group health maintenance contract
1273 when the employer or other person who will hold the contract on
1274 behalf of the subscriber group pays the entire premium for the
1275 individual subscribers. However, such required provision shall
1276 apply to the group health maintenance contract.

1277 (17)~~(16)~~ The contracts must clearly disclose the intent of
1278 the health maintenance organization as to the applicability or
1279 nonapplicability of coverage to preexisting conditions. If
1280 coverage of the contract is not to be applicable to preexisting
1281 conditions, the contract shall specify, in substance, that
1282 coverage pertains solely to accidental bodily injuries resulting
1283 from accidents occurring after the effective date of coverage
1284 and that sicknesses are limited to those which first manifest
1285 themselves subsequent to the effective date of coverage.
1286 ~~(17) All health maintenance contracts that provide~~
1287 ~~coverage for a member of the family of the subscriber, shall, as~~
1288 ~~to such family member's coverage, provide that coverage,~~
1289 ~~benefits, or services applicable for children shall be provided~~
1290 ~~with respect to an adopted child of the subscriber, which child~~
1291 ~~is placed in compliance with chapter 63, from the moment of~~
1292 ~~placement in the residence of the subscriber. Such contracts may~~
1293 ~~not exclude coverage for any preexisting condition of the child.~~
1294 ~~In the case of a newborn child, coverage shall begin from the~~
1295 ~~moment of birth if a written agreement to adopt such child has~~
1296 ~~been entered into by the subscriber prior to the birth of the~~
1297 ~~child, whether or not such agreement is enforceable. However,~~
1298 ~~coverage for such child shall not be required in the event that~~
1299 ~~the child is not ultimately placed in the residence of the~~
1300 ~~subscriber in compliance with chapter 63.~~
1301 Section 17. Section 641.3101, Florida Statutes, is amended
1302 to read:
1303 641.3101 Additional contract contents.--
1304 (1) A health maintenance contract may contain additional
1305 provisions not inconsistent with this part which are:

1306 (a)~~(1)~~ Necessary, on account of the manner in which the
1307 organization is constituted or operated, in order to state the
1308 rights and obligations of the parties to the contract; or
1309 (b)~~(2)~~ Desired by the organization and neither prohibited
1310 by law nor in conflict with any provisions required to be
1311 included therein.
1312 (2) A health maintenance contract that uses a specific
1313 methodology for payment of claims shall comply with s. 627.6044.
1314 Section 18. Section 641.31075, Florida Statutes, is
1315 created to read:
1316 641.31075 Replacement.--
1317 (1) Any health maintenance organization that is replacing
1318 any other group health coverage with its group health
1319 maintenance coverage shall comply with s. 627.666.
1320 (2) Any health maintenance organization that is replacing
1321 any other individual health coverage with its individual health
1322 maintenance coverage shall comply with s. 627.6045.
1323 Section 19. Subsection (1) of section 641.3111, Florida
1324 Statutes, is amended to read:
1325 641.3111 Extension of benefits.--
1326 (1) Every group health maintenance contract shall provide
1327 that termination of the contract shall be without prejudice to
1328 any continuous loss which commenced while the contract was in
1329 force, but any extension of benefits beyond the period the
1330 contract was in force may be predicated upon the continuous
1331 total disability of the subscriber ~~and may be limited to payment~~
1332 ~~for the treatment of a specific accident or illness incurred~~
1333 ~~while the subscriber was a member~~. The extension is required
1334 regardless of whether the group contract holder or other entity
1335 secures replacement coverage from a new insurer or health

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

1336 maintenance organization or foregoes the provision of coverage.
1337 The required provision must provide for continuation of contract
1338 benefits in connection with the treatment of a specific accident
1339 or illness incurred while the contract was in effect. Such
1340 extension of benefits may be limited to the occurrence of the
1341 earliest of the following events:
1342 (a) The expiration of 12 months.
1343 (b) Such time as the member is no longer totally disabled.
1344 (c) A succeeding carrier elects to provide replacement
1345 coverage without limitation as to the disability condition.
1346 (d) The maximum benefits payable under the contract have
1347 been paid.
1348 Section 20. Subsection (15) is added to section 641.3903,
1349 Florida Statutes, to read:
1350 641.3903 Unfair methods of competition and unfair or
1351 deceptive acts or practices defined.--The following are defined
1352 as unfair methods of competition and unfair or deceptive acts or
1353 practices:
1354 (15) MANDATORY ARBITRATION.--For a managed care provider
1355 or prepaid limited health service organization, issuing a
1356 contract or service agreement which requires the submission of
1357 disputes between the parties to the contract or service
1358 agreement to arbitration.
1359 Section 21. Subsection (9) is added to section 641.441,
1360 Florida Statutes, to read:
1361 641.441 Unfair methods of competition and unfair or
1362 deceptive acts or practices defined.--The following are defined
1363 as unfair methods of competition and unfair or deceptive acts or
1364 practices:
1365 (9) MANDATORY ARBITRATION.--For a prepaid health clinic,

1366 issuing a policy or a contract which requires the submission of
1367 disputes between the parties to the policy or contract to
1368 arbitration.
1369 Section 22. Subsection (4) of section 627.651, Florida
1370 Statutes, is amended to read:
1371 627.651 Group contracts and plans of self-insurance must
1372 meet group requirements.--
1373 (4) This section does not apply to any plan which is
1374 established or maintained by an individual employer in
1375 accordance with the Employee Retirement Income Security Act of
1376 1974, Pub. L. No. 93-406, or to a multiple-employer welfare
1377 arrangement as defined in s. 624.437(1), except that a multiple-
1378 employer welfare arrangement shall comply with ss. 627.419,
1379 627.657, 627.6575, 627.6578, 627.6579, 627.6612, 627.66121,
1380 627.66122, 627.6615, 627.6616, and 627.662(8)(7). This
1381 subsection does not allow an authorized insurer to issue a group
1382 health insurance policy or certificate which does not comply
1383 with this part.
1384 Section 23. Subsection (1) of section 641.2018, Florida
1385 Statutes, is amended to read:
1386 641.2018 Limited coverage for home health care
1387 authorized.--
1388 (1) Notwithstanding other provisions of this chapter, a
1389 health maintenance organization may issue a contract that limits
1390 coverage to home health care services only. The organization and
1391 the contract shall be subject to all of the requirements of this
1392 part that do not require or otherwise apply to specific benefits
1393 other than home care services. To this extent, all of the
1394 requirements of this part apply to any organization or contract
1395 that limits coverage to home care services, except the

1396 requirements for providing comprehensive health care services as
1397 provided in ss. 641.19(4), (12), and (13), and 641.31(1), except
1398 ss. 641.31~~(9),~~ (13)~~(12)~~, ~~(17),~~ (18), (19), (20), (21), and (24)
1399 and 641.31095.
1400 Section 24. Section 641.3107, Florida Statutes, is amended
1401 to read:
1402 641.3107 Delivery of contract.--Unless delivered upon
1403 execution or issuance, a health maintenance contract,
1404 certificate of coverage, or member handbook shall be mailed or
1405 delivered to the subscriber or, in the case of a group health
1406 maintenance contract, to the employer or other person who will
1407 hold the contract on behalf of the subscriber group within 10
1408 working days from approval of the enrollment form by the health
1409 maintenance organization or by the effective date of coverage,
1410 whichever occurs first. However, if the employer or other person
1411 who will hold the contract on behalf of the subscriber group
1412 requires retroactive enrollment of a subscriber, the
1413 organization shall deliver the contract, certificate, or member
1414 handbook to the subscriber within 10 days after receiving notice
1415 from the employer of the retroactive enrollment. This section
1416 does not apply to the delivery of those contracts specified in
1417 s. 641.31(14)~~(13)~~.
1418 Section 25. Subsection (4) of section 641.513, Florida
1419 Statutes, is amended to read:
1420 641.513 Requirements for providing emergency services and
1421 care.--
1422 (4) A subscriber may be charged a reasonable copayment, as
1423 provided in s. 641.31(13)~~(12)~~, for the use of an emergency room.
1424 Such reimbursement shall be net of any applicable copayment
1425 authorized pursuant to this subsection.

1426 Section 26. This act shall take effect upon becoming a
1427 law.