CHAMBER ACTION

The Insurance Committee recommends the following:

**Council/Committee Substitute**

Remove the entire bill and insert:

A bill to be entitled

An act relating to health insurance; amending s. 408.05, F.S.; changing the due date for a report from the Agency for Health Care Administration regarding the State Center for Health Statistics; amending s. 408.909, F.S.; providing an additional criterion for the Office of Insurance Regulation to disapprove or withdraw approval of health flex plans; amending s. 627.413, F.S.; authorizing insurers and health maintenance organizations to offer policies or contracts providing for a high deductible plan meeting federal requirements and in conjunction with a health savings account; amending s. 627.638, F.S.; providing certain contract and claim form requirements for direct payment to certain providers of emergency services and care; amending s. 627.6487, F.S.; revising the definition of the term "eligible individual" for purposes of obtaining coverage in the Florida Health Insurance Plan; amending s. 627.64872, F.S.; revising definitions; changing references to the Director of the Office of

Insurance Regulation to the Commissioner of Insurance Regulation; deleting obsolete language; providing additional eligibility criteria; reducing premium rate limitations; revising requirements for sources of additional revenue; authorizing the board to cancel policies under inadequate funding conditions; providing a limitation; specifying a maximum provider reimbursement rate; requiring licensed providers to accept assignment of plan benefits and consider certain payments as payments in full; amending s. 627.6692, F.S.; extending a time period within which eligible employees may apply for continuation of coverage; amending s. 627.6699, F.S.; revising availability of coverage provision of the Employee Health Care Access Act; including high deductible plans meeting federal health savings account plan requirements; revising membership of the board of the small employer health reinsurance program; revising certain reporting dates relating to program losses and assessments; requiring the board to advise executive and legislative entities on health insurance issues; providing requirements; amending s. 641.27, F.S.; increasing the interval at which the office examines health maintenance organizations; deleting authorization for the office to accept an audit report from a certified public accountant in lieu of conducting its own examination; increasing an expense limitation; repealing s. 627.6402, F.S.; relating to authorized insurance rebates for healthy lifestyles; providing application; providing an effective date.

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

Section 1. Paragraph (l) of subsection (3) of section 408.05, Florida Statutes, is amended to read:

408.05 State Center for Health Statistics.--

(3) COMPREHENSIVE HEALTH INFORMATION SYSTEM.--In order to produce comparable and uniform health information and statistics, the agency shall perform the following functions:

(l) Develop, in conjunction with the State Comprehensive Health Information System Advisory Council, and implement a long-range plan for making available performance outcome and financial data that will allow consumers to compare health care services. The performance outcomes and financial data the agency must make available shall include, but is not limited to, pharmaceuticals, physicians, health care facilities, and health plans and managed care entities. The agency shall submit the initial plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January ~~March~~ 1, 2006 ~~2005~~, and shall update the plan and report on the status of its implementation annually thereafter. The agency shall also make the plan and status report available to the public on its Internet website. As part of the plan, the agency shall identify the process and timeframes for implementation, any barriers to implementation, and recommendations of changes in the law that may be enacted by the Legislature to eliminate the barriers. As preliminary elements of the plan, the agency shall:

1. Make available performance outcome and patient charge data collected from health care facilities pursuant to s. 408.061(1)(a) and (2). The agency shall determine which conditions and procedures, performance outcomes, and patient charge data to disclose based upon input from the council. When determining which conditions and procedures are to be disclosed, the council and the agency shall consider variation in costs, variation in outcomes, and magnitude of variations and other relevant information. When determining which performance outcomes to disclose, the agency:

a. Shall consider such factors as volume of cases; average patient charges; average length of stay; complication rates; mortality rates; and infection rates, among others, which shall be adjusted for case mix and severity, if applicable.

b. May consider such additional measures that are adopted by the Centers for Medicare and Medicaid Studies, National Quality Forum, the Joint Commission on Accreditation of Healthcare Organizations, the Agency for Healthcare Research and Quality, or a similar national entity that establishes standards to measure the performance of health care providers, or by other states.

When determining which patient charge data to disclose, the agency shall consider such measures as average charge, average net revenue per adjusted patient day, average cost per adjusted patient day, and average cost per admission, among others.

2. Make available performance measures, benefit design, and premium cost data from health plans licensed pursuant to

chapter 627 or chapter 641. The agency shall determine which performance outcome and member and subscriber cost data to disclose, based upon input from the council. When determining which data to disclose, the agency shall consider information that may be required by either individual or group purchasers to assess the value of the product, which may include membership satisfaction, quality of care, current enrollment or membership, coverage areas, accreditation status, premium costs, plan costs, premium increases, range of benefits, copayments and deductibles, accuracy and speed of claims payment, credentials of physicians, number of providers, names of network providers, and hospitals in the network. Health plans shall make available to the agency any such data or information that is not currently reported to the agency or the office.

3. Determine the method and format for public disclosure of data reported pursuant to this paragraph. The agency shall make its determination based upon input from the Comprehensive Health Information System Advisory Council. At a minimum, the data shall be made available on the agency's Internet website in a manner that allows consumers to conduct an interactive search that allows them to view and compare the information for specific providers. The website must include such additional information as is determined necessary to ensure that the website enhances informed decisionmaking among consumers and health care purchasers, which shall include, at a minimum, appropriate guidance on how to use the data and an explanation of why the data may vary from provider to provider. The data specified in subparagraph 1. shall be released no later than

March 1, 2005. The data specified in subparagraph 2. shall be released no later than March 1, 2006.

Section 2. Paragraph (b) of subsection (3) of section 408.909, Florida Statutes, is amended to read:

408.909 Health flex plans.--

(3) PROGRAM.--The agency and the office shall each approve or disapprove health flex plans that provide health care coverage for eligible participants. A health flex plan may limit or exclude benefits otherwise required by law for insurers offering coverage in this state, may cap the total amount of claims paid per year per enrollee, may limit the number of enrollees, or may take any combination of those actions. A health flex plan offering may include the option of a catastrophic plan supplementing the health flex plan.

(b) The office shall develop guidelines for the review of health flex plan applications and provide regulatory oversight of health flex plan advertisement and marketing procedures. The office shall disapprove or shall withdraw approval of plans that:

1. Contain any ambiguous, inconsistent, or misleading provisions or any exceptions or conditions that deceptively affect or limit the benefits purported to be assumed in the general coverage provided by the health flex plan;

2. Provide benefits that are unreasonable in relation to the premium charged or contain provisions that are unfair or inequitable or contrary to the public policy of this state, that encourage misrepresentation, or that result in unfair discrimination in sales practices; ~~or~~

3. Cannot demonstrate that the health flex plan is financially sound and that the applicant is able to underwrite or finance the health care coverage provided; or

4. Cannot demonstrate that the applicant and its management are in compliance with the standards required pursuant to s. 624.404(3).

Section 3. Subsection (6) is added to section 627.413, Florida Statutes, to read:

627.413 Contents of policies, in general; identification.--

(6) Notwithstanding any other provision of the Florida Insurance Code that is in conflict with federal requirements for a health savings account qualified high deductible health plan, an insurer, or a health maintenance organization subject to part I of chapter 641, which is authorized to issue health insurance in this state may offer for sale an individual or group policy or contract that provides for a high deductible plan that meets the federal requirements of a health savings account plan and which is offered in conjunction with a health savings account.

Section 4. Subsection (2) of section 627.638, Florida Statutes, is amended to read:

627.638 Direct payment for hospital, medical services.--

(2) Whenever, in any health insurance claim form, an insured specifically authorizes payment of benefits directly to any recognized hospital or physician, the insurer shall make such payment to the designated provider of such services, unless otherwise provided in the insurance contract. The insurance contract cannot prohibit, and claims forms must provide option

for, the payment of benefits directly to a recognized hospital or physician for care provided pursuant to s. 395.1041.

Section 5. Paragraph (b) of subsection (3) of section 627.6487, Florida Statutes, is amended to read:

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

(3) For the purposes of this section, the term "eligible individual" means an individual:

(b) Who is not eligible for coverage under:

1. A group health plan, as defined in s. 2791 of the Public Health Service Act;

2. A conversion policy or contract issued by an authorized insurer or health maintenance organization under s. 627.6675 or s. 641.3921, respectively, offered to an individual who is no longer eligible for coverage under either an insured or self-insured employer plan;

3. Part A or part B of Title XVIII of the Social Security Act; ~~or~~

4. A state plan under Title XIX of such act, or any successor program, and does not have other health insurance coverage; or

5. The Florida Health Insurance Plan as specified in s. 627.64872 and such plan is accepting new enrollments. However, a person whose previous coverage was under the Florida Health Insurance Plan as specified in s. 627.64872 is not an eligible individual as defined in s. 627.6487(3)(a);

Section 6. Paragraphs (b), (c), and (n) of subsection (2) and subsections (3), (6), (9), and (15) of section 627.64872,

Florida Statutes, are amended, subsection (20) of said section is renumbered as subsection (21), and a new subsection (20) is added to said section, to read:

627.64872 Florida Health Insurance Plan.--

(2) DEFINITIONS.--As used in this section:

(b) "Commissioner" means the Commissioner of Insurance Regulation.

(c) "Dependent" means a resident spouse or resident unmarried child under the age of 19 years, a child who is a student under the age of 25 years and who is financially dependent upon the parent, or a child of any age who is disabled and dependent upon the parent.

~~(c) "Director" means the Director of the Office of Insurance Regulation.~~

(n) "Resident" means an individual who has been legally domiciled in this state for a period of at least 6 months and who physically resides in this state not less than 185 days per year.

(3) BOARD OF DIRECTORS.--

(a) The plan shall operate subject to the supervision and control of the board. The board shall consist of the commissioner ~~director~~ or his or her designated representative, who shall serve as a member of the board and shall be its chair, and an additional eight members, five of whom shall be appointed by the Governor, at least two of whom shall be individuals not representative of insurers or health care providers, one of whom shall be appointed by the President of the Senate, one of whom shall be appointed by the Speaker of the House of

Representatives, and one of whom shall be appointed by the Chief Financial Officer.

(b) The term to be served on the board by the commissioner ~~Director of the Office of Insurance Regulation~~ shall be determined by continued employment in such position. The remaining initial board members shall serve for a period of time as follows: two members appointed by the Governor and the members appointed by the President of the Senate and the Speaker of the House of Representatives shall serve a term of 2 years; and three members appointed by the Governor and the Chief Financial Officer shall serve a term of 4 years. Subsequent board members shall serve for a term of 3 years. A board member's term shall continue until his or her successor is appointed.

(c) Vacancies on the board shall be filled by the appointing authority, such authority being the Governor, the President of the Senate, the Speaker of the House of Representatives, or the Chief Financial Officer. The appointing authority may remove board members for cause.

(d) The commissioner ~~director~~, or his or her recognized representative, shall be responsible for any organizational requirements necessary for the initial meeting of the board which shall take place no later than September 1, 2004.

(e) Members shall not be compensated in their capacity as board members but shall be reimbursed for reasonable expenses incurred in the necessary performance of their duties in accordance with s. 112.061.

(f) The board shall submit to the Financial Services Commission a plan of operation for the plan and any amendments thereto necessary or suitable to ensure the fair, reasonable, and equitable administration of the plan. The plan of operation shall ensure that the plan qualifies to apply for any available funding from the Federal Government that adds to the financial viability of the plan. The plan of operation shall become effective upon approval in writing by the Financial Services Commission consistent with the date on which the coverage under this section must be made available. If the board fails to submit a suitable plan of operation within 1 year after implementation ~~the appointment of the board of directors~~, or at any time thereafter fails to submit suitable amendments to the plan of operation, the Financial Services Commission shall adopt such rules as are necessary or advisable to effectuate the provisions of this section. Such rules shall continue in force until modified by the office or superseded by a plan of operation submitted by the board and approved by the Financial Services Commission.

(6) ~~INTERIM REPORT;~~ ANNUAL REPORT.--

~~(a) By no later than December 1, 2004, the board shall report to the Governor, the President of the Senate, and the Speaker of the House of Representatives the results of an actuarial study conducted by the board to determine, including, but not limited to:~~

~~1. The impact the creation of the plan will have on the small group insurance market and the individual market on premiums paid by insureds. This shall include an estimate of the~~

~~total anticipated aggregate savings for all small employers in the state.~~

~~2. The number of individuals the pool could reasonably cover at various funding levels, specifically, the number of people the pool may cover at each of those funding levels.~~

~~3. A recommendation as to the best source of funding for the anticipated deficits of the pool.~~

~~4. The effect on the individual and small group market by including in the Florida Health Insurance Plan persons eligible for coverage under s. 627.6487, as well as the cost of including these individuals.~~

~~The board shall take no action to implement the Florida Health Insurance Plan, other than the completion of the actuarial study authorized in this paragraph, until funds are appropriated for startup cost and any projected deficits.~~

~~(b)~~ No later than December 1, 2005, and annually thereafter, the board shall submit to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the substantive legislative committees of the Legislature a report which includes an independent actuarial study to determine, including, but not be limited to:

(a)~~1.~~ The impact the creation of the plan has on the small group and individual insurance market, specifically on the premiums paid by insureds. This shall include an estimate of the total anticipated aggregate savings for all small employers in the state.

(b)~~2.~~ The actual number of individuals covered at the current funding and benefit level, the projected number of individuals that may seek coverage in the forthcoming fiscal year, and the projected funding needed to cover anticipated increase or decrease in plan participation.

~~3. A recommendation as to the best source of funding for the anticipated deficits of the pool.~~

(c)~~4.~~ A summarization of the activities of the plan in the preceding calendar year, including the net written and earned premiums, plan enrollment, the expense of administration, and the paid and incurred losses.

(d)~~5.~~ A review of the operation of the plan as to whether the plan has met the intent of this section.

(9) ELIGIBILITY.--

(a) Any individual person who is and continues to be a resident of this state shall be eligible for coverage under the plan if:

1. Evidence is provided that the person received notices of rejection or refusal to issue substantially similar coverage for health reasons from at least two health insurers or health maintenance organizations. A rejection or refusal by an insurer offering only stop-loss, excess of loss, or reinsurance coverage with respect to the applicant shall not be sufficient evidence under this paragraph.

2. The person is enrolled in the Florida Comprehensive Health Association as of the date the plan is implemented.

3. Is an eligible individual as defined in s. 627.6487(3), excluding s. 627.6487(3)(b)5.

(b) Each resident dependent of a person who is eligible for coverage under the plan shall also be eligible for such coverage.

(c) A person shall not be eligible for coverage under the plan if:

1. The person has or obtains health insurance coverage substantially similar to or more comprehensive than a plan policy, or would be eligible to obtain such coverage, unless a person may maintain other coverage for the period of time the person is satisfying any preexisting condition waiting period under a plan policy or may maintain plan coverage for the period of time the person is satisfying a preexisting condition waiting period under another health insurance policy intended to replace the plan policy;~~.~~

2. The person is determined to be eligible for health care benefits under Medicaid, Medicare, the state's children's health insurance program, or any other federal, state, or local government program that provides health benefits;

3. The person voluntarily terminated plan coverage unless 12 months have elapsed since such termination;

4. The person is an inmate or resident of a public institution; or

5. The person's premiums are paid for or reimbursed under any government-sponsored program or by any government agency or health care provider or by any health care provider sponsored or affiliated organization.

(d) Coverage shall cease:

1. On the date a person is no longer a resident of this state;

2. On the date a person requests coverage to end;

3. Upon the death of the covered person;

4. On the date state law requires cancellation or nonrenewal of the policy; ~~or~~

5. At the option of the plan, 30 days after the plan makes any inquiry concerning the person's eligibility or place of residence to which the person does not reply; or~~.~~

6. Upon failure of the insured to pay for continued coverage.

(e) Except under the circumstances described in this subsection, coverage of a person who ceases to meet the eligibility requirements of this subsection shall be terminated at the end of the policy period for which the necessary premiums have been paid.

(15) FUNDING OF THE PLAN.--

(a) Premiums.--

1. The plan shall establish premium rates for plan coverage as provided in this section. Separate schedules of premium rates based on age, sex, and geographical location may apply for individual risks. Premium rates and schedules shall be submitted to the office for approval prior to use.

2. Initial rates for plan coverage shall be limited to no more than 200 percent ~~300 percent~~ of rates established for individual standard risks as specified in s. 627.6675(3)(c). Subject to the limits provided in this paragraph, subsequent rates shall be established to provide fully for the expected

costs of claims, including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein, but in no event shall premiums exceed the 200-percent ~~300-percent~~ rate limitation provided in this section. Notwithstanding the 200-percent ~~300-percent~~ rate limitation, sliding scale premium surcharges based upon the insured's income may apply to all enrollees.

(b) Sources of additional revenue.--Any deficit incurred by the plan shall be ~~primarily~~ funded through amounts appropriated by the Legislature from general revenue sources, including, but not limited to, a portion of the ~~annual growth in~~ existing net insurance premium taxes in an amount not less than the anticipated losses and reserve requirements for existing policyholders. The board shall operate the plan in such a manner that the estimated cost of providing health insurance during any fiscal year will not exceed total income the plan expects to receive from policy premiums and funds appropriated by the Legislature, including any interest on investments. After determining the amount of funds appropriated to the board for a fiscal year, the board shall estimate the number of new policies it believes the plan has the financial capacity to insure during that year so that costs do not exceed income. The board shall take steps necessary to ensure that plan enrollment does not exceed the number of residents it has estimated it has the financial capacity to insure.

(c) In the event of inadequate funding, the board may cancel existing policies on a nondiscriminatory basis as

necessary to remedy the situation. No policy may be canceled if a covered individual is currently making a claim.

(20) PROVIDER REIMBURSEMENT.--Notwithstanding any other provision of law, the maximum reimbursement rate to health care providers for all covered, medically necessary services shall be 100 percent of Medicare's allowed payment amount for that particular provider and service. All licensed providers in this state shall accept assignment of plan benefits and consider the Medicare allowed payment amount as payment in full.

Section 7. Paragraphs (d) and (j) of subsection (5) of section 627.6692, Florida Statutes, are amended to read:

627.6692 Florida Health Insurance Coverage Continuation Act.--

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

(d)1. A qualified beneficiary must give written notice to the insurance carrier within 63 ~~30~~ days after the occurrence of a qualifying event. Unless otherwise specified in the notice, a notice by any qualified beneficiary constitutes notice on behalf of all qualified beneficiaries. The written notice must inform the insurance carrier of the occurrence and type of the qualifying event giving rise to the potential election by a qualified beneficiary of continuation of coverage under the group health plan issued by that insurance carrier, except that in cases where the covered employee has been involuntarily discharged, the nature of such discharge need not be disclosed. The written notice must, at a minimum, identify the employer, the group health plan number, the name and address of all qualified beneficiaries, and such other information required by

the insurance carrier under the terms of the group health plan or the commission by rule, to the extent that such information is known by the qualified beneficiary.

2. Within 14 days after the receipt of written notice under subparagraph 1., the insurance carrier shall send each qualified beneficiary by certified mail an election and premium notice form, approved by the office, which form must provide for the qualified beneficiary's election or nonelection of continuation of coverage under the group health plan and the applicable premium amount due after the election to continue coverage. This subparagraph does not require separate mailing of notices to qualified beneficiaries residing in the same household, but requires a separate mailing for each separate household.

(j) Notwithstanding paragraph (b), if a qualified beneficiary in the military reserve or National Guard has elected to continue coverage and is thereafter called to active duty and the coverage under the group plan is terminated by the beneficiary or the carrier due to the qualified beneficiary becoming eligible for TRICARE (the health care program provided by the United States Defense Department), the 18-month period or such other applicable maximum time period for which the qualified beneficiary would otherwise be entitled to continue coverage is tolled during the time that he or she is covered under the TRICARE program. Within 63 ~~30~~ days after the federal TRICARE coverage terminates, the qualified beneficiary may elect to continue coverage under the group health plan, retroactively to the date coverage terminated under TRICARE, for the remainder

of the 18-month period or such other applicable time period, subject to termination of coverage at the earliest of the conditions specified in paragraph (b).

Section 8. Paragraph (c) of subsection (5) and paragraphs (b) and (j) of subsection (11) of section 627.6699, Florida Statutes, are amended, and paragraph (o) is added to subsection (11) of said section, to read:

627.6699 Employee Health Care Access Act.--

(5) AVAILABILITY OF COVERAGE.--

(c) Every small employer carrier must, as a condition of transacting business in this state:

1. Offer and issue all small employer health benefit plans on a guaranteed-issue basis to every eligible small employer, with 2 to 50 eligible employees, that elects to be covered under such plan, agrees to make the required premium payments, and satisfies the other provisions of the plan. A rider for additional or increased benefits may be medically underwritten and may only be added to the standard health benefit plan. The increased rate charged for the additional or increased benefit must be rated in accordance with this section.

2. In the absence of enrollment availability in the Florida Health Insurance Plan, offer and issue basic and standard small employer health benefit plans and a high deductible plan that meets the requirements of a health savings account plan or health reimbursement account as defined by federal law, on a guaranteed-issue basis, during a 31-day open enrollment period of August 1 through August 31 of each year, to every eligible small employer, with fewer than two eligible

employees, which small employer is not formed primarily for the purpose of buying health insurance and which elects to be covered under such plan, agrees to make the required premium payments, and satisfies the other provisions of the plan. Coverage provided under this subparagraph shall begin on October 1 of the same year as the date of enrollment, unless the small employer carrier and the small employer agree to a different date. A rider for additional or increased benefits may be medically underwritten and may only be added to the standard health benefit plan. The increased rate charged for the additional or increased benefit must be rated in accordance with this section. For purposes of this subparagraph, a person, his or her spouse, and his or her dependent children constitute a single eligible employee if that person and spouse are employed by the same small employer and either that person or his or her spouse has a normal work week of less than 25 hours. Any right to an open enrollment of health benefit coverage for groups of fewer than two employees, pursuant to this section, shall remain in full force and effect in the absence of the availability of new enrollment into the Florida Health Insurance Plan.

3. This paragraph does not limit a carrier's ability to offer other health benefit plans to small employers if the standard and basic health benefit plans are offered and rejected.

(11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.--

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

2. Effective upon this act becoming a law, the board shall consist of the director of the office or his or her designee, who shall serve as the chairperson, and 13 additional members who are representatives of carriers and insurance agents and are appointed by the director of the office and serve as follows:

a. Five members shall be representatives of health insurers licensed under chapter 624 or chapter 641. Two members shall be agents who are actively engaged in the sale of health insurance. Four members shall be employers or representatives of employers. One member shall be a person covered under an individual health insurance policy issued by a licensed insurer in this state. One member shall represent the Agency for Health Care Administration and shall be recommended by the Secretary of Health Care Administration. ~~The director of the office shall include representatives of small employer carriers subject to assessment under this subsection. If two or more carriers elect to be risk-assuming carriers, the membership must include at least two representatives of risk-assuming carriers; if one carrier is risk-assuming, one member must be a representative of such carrier. At least one member must be a carrier who is subject to the assessments, but is not a small employer carrier. Subject to such restrictions, at least five members shall be selected from individuals recommended by small employer carriers pursuant to procedures provided by rule of the commission. Three members shall be selected from a list of health insurance carriers that issue individual health insurance policies. At least two of the three members selected must be reinsuring~~

~~carriers. Two members shall be selected from a list of insurance agents who are actively engaged in the sale of health insurance.~~

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

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

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

~~5. The director of the office may require an entity that recommends persons for appointment to submit additional lists of recommended appointees.~~

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

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

a. The operating losses of the program shall be assessed in the following order subject to the specified limitations. The

first tier of assessments shall be made against reinsuring carriers in an amount which shall not exceed 5 percent of each reinsuring carrier's premiums from health benefit plans covering small employers. If such assessments have been collected and additional moneys are needed, the board shall make a second tier of assessments in an amount which shall not exceed 0.5 percent of each carrier's health benefit plan premiums. Except as provided in paragraph (n), risk-assuming carriers are exempt from all assessments authorized pursuant to this section. The amount paid by a reinsuring carrier for the first tier of assessments shall be credited against any additional assessments made.

b. The board shall equitably assess carriers for operating losses of the plan based on market share. The board shall annually assess each carrier a portion of the operating losses of the plan. The first tier of assessments shall be determined by multiplying the operating losses by a fraction, the numerator of which equals the reinsuring carrier's earned premium pertaining to direct writings of small employer health benefit plans in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of all such premiums earned by reinsuring carriers in the state during that calendar year. The second tier of assessments shall be based on the premiums that all carriers, except risk-assuming carriers, earned on all health benefit plans written in this state. The board may levy interim assessments against carriers to ensure the financial ability of the plan to cover claims expenses and administrative expenses paid or estimated to

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

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

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

4. If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified in subparagraph 2., the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the office within 180 ~~90~~ days following the end of the calendar year in which the losses were incurred. The evaluation shall include an estimate of future assessments, the

administrative costs of the program, the appropriateness of the premiums charged and the level of carrier retention under the program, and the costs of coverage for small employers. If the board fails to file a report with the office within 180 ~~90~~ days following the end of the applicable calendar year, the office may evaluate the operations of the program and implement such amendments to the plan of operation the office deems necessary to reduce future losses and assessments.

5. If assessments exceed the amount of the actual losses and administrative expenses of the program, the excess shall be held as interest and used by the board to offset future losses or to reduce program premiums. As used in this paragraph, the term "future losses" includes reserves for incurred but not reported claims.

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

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

8. A carrier may seek, from the office, a deferment, in whole or in part, from any assessment made by the board. The office may defer, in whole or in part, the assessment of a carrier if, in the opinion of the office, the payment of the assessment would place the carrier in a financially impaired condition. If an assessment against a carrier is deferred, in whole or in part, the amount by which the assessment is deferred

may be assessed against the other carriers in a manner consistent with the basis for assessment set forth in this section. The carrier receiving such deferment remains liable to the program for the amount deferred and is prohibited from reinsuring any individuals or groups in the program if it fails to pay assessments.

(o) The board shall advise the office, the agency, the department, and other executive and legislative entities on health insurance issues. Specifically, the board shall:

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

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

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

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

5. By September 1 each year, issue a report to the office on the state of the health insurance market. The report shall include recommendations for changes in the health insurance market, results from implementation of previous recommendations and information on health insurance markets.

Section 9. Subsection (1) of section 641.27, Florida Statutes, is amended to read:

641.27 Examination by the department.--

(1) The office shall examine the affairs, transactions, accounts, business records, and assets of any health maintenance organization as often as it deems it expedient for the protection of the people of this state, but not less frequently than once every 5 ~~3~~ years. ~~In lieu of making its own financial examination, the office may accept an independent certified public accountant's audit report prepared on a statutory accounting basis consistent with this part.~~ However, except when the medical records are requested and copies furnished pursuant to s. 456.057, medical records of individuals and records of physicians providing service under contract to the health maintenance organization shall not be subject to audit, although they may be subject to subpoena by court order upon a showing of good cause. For the purpose of examinations, the office may administer oaths to and examine the officers and agents of a health maintenance organization concerning its business and affairs. The examination of each health maintenance organization by the office shall be subject to the same terms and conditions as apply to insurers under chapter 624. In no event shall expenses of all examinations exceed a maximum of $50,000 ~~$20,000~~ for any 1-year period. Any rehabilitation, liquidation, conservation, or dissolution of a health maintenance organization shall be conducted under the supervision of the department, which shall have all power with respect thereto granted to it under the laws governing the rehabilitation,

liquidation, reorganization, conservation, or dissolution of life insurance companies.

Section 10. Section 627.6402, Florida Statutes, is repealed.

Section 11. This act shall take effect July 1, 2005, and shall apply to all policies or contracts issued or renewed on or after July 1, 2005.