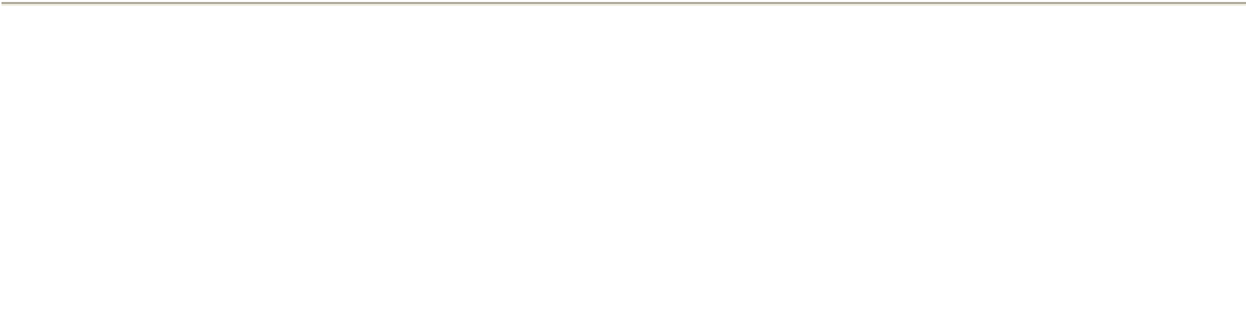
CHAMBER ACTION



1 Representative(s) Farkas offered the following:

2

3 **Amendment (with title amendment)**

4 Between lines 58 and 59, insert:

5 Section 3. Paragraph (l) of subsection (3) of section
6 408.05, Florida Statutes, is amended to read:

7 408.05 State Center for Health Statistics.--

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

11 (l) Develop, in conjunction with the State Comprehensive
12 Health Information System Advisory Council, and implement a
13 long-range plan for making available performance outcome and
14 financial data that will allow consumers to compare health care
15 services. The performance outcomes and financial data the agency

16 must make available shall include, but is not limited to,
17 pharmaceuticals, physicians, health care facilities, and health
18 plans and managed care entities. The agency shall submit the
19 initial plan to the Governor, the President of the Senate, and
20 the Speaker of the House of Representatives by January ~~March~~ 1,
21 2006 ~~2005~~, and shall update the plan and report on the status of
22 its implementation annually thereafter. The agency shall also
23 make the plan and status report available to the public on its
24 Internet website. As part of the plan, the agency shall identify
25 the process and timeframes for implementation, any barriers to
26 implementation, and recommendations of changes in the law that
27 may be enacted by the Legislature to eliminate the barriers. As
28 preliminary elements of the plan, the agency shall:

29 1. Make available performance outcome and patient charge
30 data collected from health care facilities pursuant to s.
31 408.061(1)(a) and (2). The agency shall determine which
32 conditions and procedures, performance outcomes, and patient
33 charge data to disclose based upon input from the council. When
34 determining which conditions and procedures are to be disclosed,
35 the council and the agency shall consider variation in costs,
36 variation in outcomes, and magnitude of variations and other
37 relevant information. When determining which performance
38 outcomes to disclose, the agency:

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

43 b. May consider such additional measures that are adopted
44 by the Centers for Medicare and Medicaid Studies, National
45 Quality Forum, the Joint Commission on Accreditation of
46 Healthcare Organizations, the Agency for Healthcare Research and
47 Quality, or a similar national entity that establishes standards
48 to measure the performance of health care providers, or by other
49 states.
50
51 When determining which patient charge data to disclose, the
52 agency shall consider such measures as average charge, average
53 net revenue per adjusted patient day, average cost per adjusted
54 patient day, and average cost per admission, among others.
55 2. Make available performance measures, benefit design,
56 and premium cost data from health plans licensed pursuant to
57 chapter 627 or chapter 641. The agency shall determine which
58 performance outcome and member and subscriber cost data to
59 disclose, based upon input from the council. When determining
60 which data to disclose, the agency shall consider information
61 that may be required by either individual or group purchasers to
62 assess the value of the product, which may include membership
63 satisfaction, quality of care, current enrollment or membership,
64 coverage areas, accreditation status, premium costs, plan costs,
65 premium increases, range of benefits, copayments and
66 deductibles, accuracy and speed of claims payment, credentials
67 of physicians, number of providers, names of network providers,
68 and hospitals in the network. Health plans shall make available

69 to the agency any such data or information that is not currently
70 reported to the agency or the office.
71 3. Determine the method and format for public disclosure
72 of data reported pursuant to this paragraph. The agency shall
73 make its determination based upon input from the Comprehensive
74 Health Information System Advisory Council. At a minimum, the
75 data shall be made available on the agency's Internet website in
76 a manner that allows consumers to conduct an interactive search
77 that allows them to view and compare the information for
78 specific providers. The website must include such additional
79 information as is determined necessary to ensure that the
80 website enhances informed decisionmaking among consumers and
81 health care purchasers, which shall include, at a minimum,
82 appropriate guidance on how to use the data and an explanation
83 of why the data may vary from provider to provider. The data
84 specified in subparagraph 1. shall be released no later than
85 January 1, 2006, for the reporting of infection rates, and no
86 later than October ~~March~~ 1, 2005, for mortality rates and
87 complication rates. The data specified in subparagraph 2. shall
88 be released no later than October ~~March~~ 1, 2006.
89 Section 4. Paragraph (b) of subsection (3) of section
90 408.909, Florida Statutes, is amended to read:
91 408.909 Health flex plans.--
92 (3) PROGRAM.--The agency and the office shall each approve
93 or disapprove health flex plans that provide health care
94 coverage for eligible participants. A health flex plan may limit
95 or exclude benefits otherwise required by law for insurers

96 offering coverage in this state, may cap the total amount of
97 claims paid per year per enrollee, may limit the number of
98 enrollees, or may take any combination of those actions. A
99 health flex plan offering may include the option of a
100 catastrophic plan supplementing the health flex plan.
101 (b) The office shall develop guidelines for the review of
102 health flex plan applications and provide regulatory oversight
103 of health flex plan advertisement and marketing procedures. The
104 office shall disapprove or shall withdraw approval of plans
105 that:
106 1. Contain any ambiguous, inconsistent, or misleading
107 provisions or any exceptions or conditions that deceptively
108 affect or limit the benefits purported to be assumed in the
109 general coverage provided by the health flex plan;
110 2. Provide benefits that are unreasonable in relation to
111 the premium charged or contain provisions that are unfair or
112 inequitable or contrary to the public policy of this state, that
113 encourage misrepresentation, or that result in unfair
114 discrimination in sales practices; ~~or~~
115 3. Cannot demonstrate that the health flex plan is
116 financially sound and that the applicant is able to underwrite
117 or finance the health care coverage provided; or
118 4. Cannot demonstrate that the applicant and its
119 management are in compliance with the standards required
120 pursuant to s. 624.404(3).
121 Section 5. Subsection (6) is added to section 627.413,
122 Florida Statutes, to read:

123 627.413 Contents of policies, in general;
124 identification.--
125 (6) Notwithstanding any other provision of the Florida
126 Insurance Code that is in conflict with federal requirements for
127 a health savings account qualified high deductible health plan,
128 an insurer, or a health maintenance organization subject to part
129 I of chapter 641, which is authorized to issue health insurance
130 in this state may offer for sale an individual or group policy
131 or contract that provides for a high deductible plan that meets
132 the federal requirements of a health savings account plan and
133 which is offered in conjunction with a health savings account.
134 Section 6. Subsection (2) of section 627.638, Florida
135 Statutes, is amended to read:
136 627.638 Direct payment for hospital, medical services.--
137 (2) Whenever, in any health insurance claim form, an
138 insured specifically authorizes payment of benefits directly to
139 any recognized hospital, ~~or~~ physician, or dentist, the insurer
140 shall make such payment to the designated provider of such
141 services, unless otherwise provided in the insurance contract.
142 The insurance contract may not prohibit, and claims forms must
143 provide option for, the payment of benefits directly to a
144 licensed hospital, physician, or dentist for care provided
145 pursuant to s. 395.1041. The insurer may require written
146 attestation of assignment of benefits. Payment to the provider
147 from the insurer shall be no more than the amount that the
148 insurer would otherwise have paid without the assignment.

149 Section 7. Section 627.6402, Florida Statutes, is amended
150 to read:
151 627.6402 Insurance rebates for healthy lifestyles.--
152 (1) Any rate, rating schedule, or rating manual for an
153 individual health insurance policy filed with the office may
154 ~~shall~~ provide for an appropriate rebate of premiums paid in the
155 last ~~calendar~~ year when the individual covered by such plan is
156 enrolled in and maintains participation in any health wellness,
157 maintenance, or improvement program approved by the health plan.
158 The rebate may be based on premiums paid in the last calendar
159 year or the last policy year. The individual must provide
160 evidence of demonstrative maintenance or improvement of the
161 individual's health status as determined by assessments of
162 agreed-upon health status indicators between the individual and
163 the health insurer, including, but not limited to, reduction in
164 weight, body mass index, and smoking cessation. Any rebate
165 provided by the health insurer is presumed to be appropriate
166 unless credible data demonstrates otherwise, or unless such
167 rebate program requires the insured to incur costs to qualify
168 for the rebate which equal or exceed the value of the rebate,
169 but in no event shall the rebate ~~not~~ exceed 10 percent of paid
170 premiums.
171 (2) The premium rebate authorized by this section shall be
172 effective for an insured on an annual basis, unless the
173 individual fails to maintain or improve his or her health status
174 while participating in an approved wellness program, or credible

175 evidence demonstrates that the individual is not participating
176 in the approved wellness program.
177 (3) The program shall be available for all policies issued
178 on or after July 1, 2005.
179 Section 8. Paragraph (b) of subsection (3) of section
180 627.6487, Florida Statutes, is amended to read:
181 627.6487 Guaranteed availability of individual health
182 insurance coverage to eligible individuals.--
183 (3) For the purposes of this section, the term "eligible
184 individual" means an individual:
185 (b) Who is not eligible for coverage under:
186 1. A group health plan, as defined in s. 2791 of the
187 Public Health Service Act;
188 2. A conversion policy or contract issued by an authorized
189 insurer or health maintenance organization under s. 627.6675 or
190 s. 641.3921, respectively, offered to an individual who is no
191 longer eligible for coverage under either an insured or self-
192 insured employer plan;
193 3. Part A or part B of Title XVIII of the Social Security
194 Act; ~~or~~
195 4. A state plan under Title XIX of such act, or any
196 successor program, and does not have other health insurance
197 coverage; or
198 5. The Florida Health Insurance Plan as specified in s.
199 627.64872 and such plan is accepting new enrollments. However, a
200 person whose previous coverage was under the Florida Health

201 Insurance Plan as specified in s. 627.64872 is not an eligible
202 individual as defined in s. 627.6487(3)(a);
203 Section 9. Paragraphs (b), (c), and (n) of subsection (2)
204 and subsections (3), (6), (9), and (15) of section 627.64872,
205 Florida Statutes, are amended, subsection (20) of said section
206 is renumbered as subsection (21), and a new subsection (20) is
207 added to said section, to read:
208 627.64872 Florida Health Insurance Plan.--
209 (2) DEFINITIONS.--As used in this section:
210 (b) "Commissioner" means the Commissioner of Insurance
211 Regulation.
212 (c) "Dependent" means a resident spouse or resident
213 unmarried child under the age of 19 years, a child who is a
214 student under the age of 25 years and who is financially
215 dependent upon the parent, or a child of any age who is disabled
216 and dependent upon the parent.
217 (c) "Director" means the Director of the Office of
218 Insurance Regulation.
219 (n) "Resident" means an individual who has been legally
220 domiciled in this state for a period of at least 6 months and
221 who physically resides in this state not less than 185 days per
222 year.
223 (3) BOARD OF DIRECTORS.--
224 (a) The plan shall operate subject to the supervision and
225 control of the board. The board shall consist of the
226 commissioner director or his or her designated representative,
227 who shall serve as a member of the board and shall be its chair,

228 and an additional eight members, five of whom shall be appointed
229 by the Governor, at least two of whom shall be individuals not
230 representative of insurers or health care providers, one of whom
231 shall be appointed by the President of the Senate, one of whom
232 shall be appointed by the Speaker of the House of
233 Representatives, and one of whom shall be appointed by the Chief
234 Financial Officer.

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

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

252 (d) The commissioner ~~director~~, or his or her recognized
253 representative, shall be responsible for any organizational

254 requirements necessary for the initial meeting of the board
255 which shall take place no later than September 1, 2004.
256 (e) Members shall not be compensated in their capacity as
257 board members but shall be reimbursed for reasonable expenses
258 incurred in the necessary performance of their duties in
259 accordance with s. 112.061.
260 (f) The board shall submit to the Financial Services
261 Commission a plan of operation for the plan and any amendments
262 thereto necessary or suitable to ensure the fair, reasonable,
263 and equitable administration of the plan. The plan of operation
264 shall ensure that the plan qualifies to apply for any available
265 funding from the Federal Government that adds to the financial
266 viability of the plan. The plan of operation shall become
267 effective upon approval in writing by the Financial Services
268 Commission consistent with the date on which the coverage under
269 this section must be made available. If the board fails to
270 submit a suitable plan of operation within 1 year after
271 implementation ~~the appointment of the board of directors~~, or at
272 any time thereafter fails to submit suitable amendments to the
273 plan of operation, the Financial Services Commission shall adopt
274 such rules as are necessary or advisable to effectuate the
275 provisions of this section. Such rules shall continue in force
276 until modified by the office or superseded by a plan of
277 operation submitted by the board and approved by the Financial
278 Services Commission.
279 (6) ~~INTERIM REPORT;~~ ANNUAL REPORT.--

280 ~~(a) By no later than December 1, 2004, the board shall~~
281 ~~report to the Governor, the President of the Senate, and the~~
282 ~~Speaker of the House of Representatives the results of an~~
283 ~~actuarial study conducted by the board to determine, including,~~
284 ~~but not limited to:~~
285 ~~1. The impact the creation of the plan will have on the~~
286 ~~small group insurance market and the individual market on~~
287 ~~premiums paid by insureds. This shall include an estimate of the~~
288 ~~total anticipated aggregate savings for all small employers in~~
289 ~~the state.~~
290 ~~2. The number of individuals the pool could reasonably~~
291 ~~cover at various funding levels, specifically, the number of~~
292 ~~people the pool may cover at each of those funding levels.~~
293 ~~3. A recommendation as to the best source of funding for~~
294 ~~the anticipated deficits of the pool.~~
295 ~~4. The effect on the individual and small group market by~~
296 ~~including in the Florida Health Insurance Plan persons eligible~~
297 ~~for coverage under s. 627.6487, as well as the cost of including~~
298 ~~these individuals.~~
299
300 ~~The board shall take no action to implement the Florida Health~~
301 ~~Insurance Plan, other than the completion of the actuarial study~~
302 ~~authorized in this paragraph, until funds are appropriated for~~
303 ~~startup cost and any projected deficits.~~
304 ~~(b)~~ No later than December 1, 2005, and annually
305 thereafter, the board shall submit to the Governor, the
306 President of the Senate, the Speaker of the House of

307 Representatives, and the substantive legislative committees of
308 the Legislature a report which includes an independent actuarial
309 study to determine, including, but not be limited to:
310 (a)~~1.~~ The impact the creation of the plan has on the small
311 group and individual insurance market, specifically on the
312 premiums paid by insureds. This shall include an estimate of the
313 total anticipated aggregate savings for all small employers in
314 the state.
315 (b)~~2.~~ The actual number of individuals covered at the
316 current funding and benefit level, the projected number of
317 individuals that may seek coverage in the forthcoming fiscal
318 year, and the projected funding needed to cover anticipated
319 increase or decrease in plan participation.
320 ~~3. A recommendation as to the best source of funding for~~
321 ~~the anticipated deficits of the pool.~~
322 (c)~~4.~~ A summarization of the activities of the plan in the
323 preceding calendar year, including the net written and earned
324 premiums, plan enrollment, the expense of administration, and
325 the paid and incurred losses.
326 (d)~~5.~~ A review of the operation of the plan as to whether
327 the plan has met the intent of this section.
328 (9) ELIGIBILITY.--
329 (a) Any individual person who is and continues to be a
330 resident of this state shall be eligible for coverage under the
331 plan if:
332 1. Evidence is provided that the person received notices
333 of rejection or refusal to issue substantially similar coverage

334 for health reasons from at least two health insurers or health
335 maintenance organizations. A rejection or refusal by an insurer
336 offering only stop-loss, excess of loss, or reinsurance coverage
337 with respect to the applicant shall not be sufficient evidence
338 under this paragraph;.

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

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

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

346 (c) Except for individuals made eligible under
347 subparagraph (a)3., a person shall not be eligible for coverage
348 under the plan if:

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

358 2. The person is determined to be eligible for health care
359 benefits under Medicaid, Medicare, the state's children's health

360 insurance program, or any other federal, state, or local
361 government program that provides health benefits;
362 3. The person voluntarily terminated plan coverage unless
363 12 months have elapsed since such termination;
364 4. The person is an inmate or resident of a public
365 institution; or
366 5. The person's premiums are paid for or reimbursed under
367 any government-sponsored program or by any government agency or
368 health care provider or by any health care provider sponsored or
369 affiliated organization.
370 (d) Coverage shall cease:
371 1. On the date a person is no longer a resident of this
372 state;
373 2. On the date a person requests coverage to end;
374 3. Upon the death of the covered person;
375 4. On the date state law requires cancellation or
376 nonrenewal of the policy; ~~or~~
377 5. At the option of the plan, 30 days after the plan makes
378 any inquiry concerning the person's eligibility or place of
379 residence to which the person does not reply; or~~.~~
380 6. Upon failure of the insured to pay for continued
381 coverage.
382 (e) Except under the circumstances described in this
383 subsection, coverage of a person who ceases to meet the
384 eligibility requirements of this subsection shall be terminated
385 at the end of the policy period for which the necessary premiums
386 have been paid.

387 (15) FUNDING OF THE PLAN.--
388 (a) Premiums.--
389 1. The plan shall establish premium rates for plan
390 coverage as provided in this section. Separate schedules of
391 premium rates based on age, sex, and geographical location may
392 apply for individual risks. Premium rates and schedules shall be
393 submitted to the office for approval prior to use.
394 2. Initial rates for plan coverage shall be limited to no
395 more than 200 percent ~~300 percent~~ of rates established for
396 individual standard risks as specified in s. 627.6675(3)(c).
397 Subject to the limits provided in this paragraph, subsequent
398 rates shall be established to provide fully for the expected
399 costs of claims, including recovery of prior losses, expenses of
400 operation, investment income of claim reserves, and any other
401 cost factors subject to the limitations described herein, but in
402 no event shall premiums exceed the 200-percent ~~300-percent~~ rate
403 limitation provided in this section. Notwithstanding the 200-
404 percent ~~300-percent~~ rate limitation, sliding scale premium
405 surcharges based upon the insured's income may apply to all
406 enrollees, except those made eligible for coverage by
407 subparagraph (9)(a)3.
408 3. For the purposes of determining assessments under this
409 section, the term "health insurance" means any hospital and
410 medical expense incurred policy, minimum premium plan, stop-loss
411 coverage, health maintenance organization contract, prepaid
412 health clinic contract, multiple-employer welfare arrangement
413 contract, or fraternal benefit society health benefits contract,

414 whether sold as an individual or group policy or contract. The
415 term does not include a policy covering medical payment coverage
416 or personal injury protection coverage in a motor vehicle
417 policy, coverage issued as a supplement to liability insurance,
418 or workers' compensation.
419 (b) Sources of additional revenue.--Any deficit incurred
420 by the plan may ~~shall~~ be ~~primarily~~ funded through amounts
421 appropriated by the Legislature from general revenue and other
422 appropriate sources, including, but not limited to, a portion of
423 the ~~annual growth in~~ existing net insurance premium taxes in an
424 amount not less than the anticipated losses and reserve
425 requirements for existing policyholders. General revenue sources
426 for the plan shall not exceed $5 million per year and are
427 subject to annual appropriation by the Legislature. The board
428 shall operate the plan in such a manner that the estimated cost
429 of providing health insurance during any fiscal year will not
430 exceed total income the plan expects to receive from policy
431 premiums and funds appropriated by the Legislature, including
432 any interest on investments. After determining the amount of
433 funds appropriated to the board for a fiscal year, the board
434 shall estimate the number of new policies it believes the plan
435 has the financial capacity to insure during that year so that
436 costs do not exceed income. The board shall take steps necessary
437 to ensure that plan enrollment does not exceed the number of
438 residents it has estimated it has the financial capacity to
439 insure.

440 (c) In the event of inadequate funding, the board may
441 cancel existing policies on a nondiscriminatory basis as
442 necessary to remedy the situation. No policy may be canceled if
443 a covered individual is currently making a claim.
444 (20) PROVIDER REIMBURSEMENT.--Notwithstanding any other
445 provision of law, the maximum reimbursement rate to health care
446 providers for all covered, medically necessary services shall be
447 100 percent of Medicare's allowed payment amount for that
448 particular provider and service. All licensed providers in this
449 state shall accept assignment of plan benefits and consider the
450 Medicare allowed payment amount as payment in full. By no later
451 than December 1, 2005, the board shall update the actuarial
452 study required by s. 627.64872(6), to include the impact of
453 alternative methods of actuarially sound risk adjusted provider
454 reimbursement methodologies, including capitated prepaid
455 arrangements, that take into account such factors as age, sex,
456 geographic variations, case mix, and access to specialty medical
457 care. The board shall submit the updated actuarial study to the
458 Governor, the President of the Senate, and the Speaker of the
459 House no later than December 1, 2005.
460 Section 10. Section 627.65626, Florida Statutes, is
461 amended to read:
462 627.65626 Insurance rebates for healthy lifestyles.--
463 (1) Any rate, rating schedule, or rating manual for a
464 health insurance policy, which provides creditable coverage as
465 defined in s. 627.6561(5), filed with the office shall provide
466 for an appropriate rebate of premiums paid in the last policy

467 year, contract year, or calendar year when the majority of
468 members of a health plan have enrolled and maintained
469 participation in any health wellness, maintenance, or
470 improvement program offered by the group policyholder and the
471 health plan ~~employer~~. The rebate may be based upon premiums paid
472 in the last calendar year or policy year. The group ~~employer~~
473 must provide evidence of demonstrative maintenance or
474 improvement of the enrollees' health status as determined by
475 assessments of agreed-upon health status indicators between the
476 policyholder ~~employer~~ and the health insurer, including, but not
477 limited to, reduction in weight, body mass index, and smoking
478 cessation. The group or health insurer may contract with an
479 independent third-party administrator to assemble and report the
480 health status required in this subsection between the
481 policyholder and the health insurer. Any rebate provided by the
482 health insurer is presumed to be appropriate unless credible
483 data demonstrates otherwise or unless such rebate program
484 requires the insured to incur costs to qualify for the rebate
485 which equal or exceed the value of the rebate, but in no event
486 shall the rebate ~~not~~ exceed 10 percent of paid premiums.
487 (2) The premium rebate authorized by this section shall be
488 effective for an insured on an annual basis unless the number of
489 participating employees or members on the policy renewal
490 anniversary becomes less than the majority of the employees or
491 members eligible for participation in the wellness program.
492 (3) The program shall be available for all policies issued
493 on or after July 1, 2005.

494 Section 11. Paragraphs (d) and (j) of subsection (5) of
495 section 627.6692, Florida Statutes, are amended to read:
496 627.6692 Florida Health Insurance Coverage Continuation
497 Act.--
498 (5) CONTINUATION OF COVERAGE UNDER GROUP HEALTH PLANS.--
499 (d)1. A qualified beneficiary must give written notice to
500 the insurance carrier within 63 ~~30~~ days after the occurrence of
501 a qualifying event. Unless otherwise specified in the notice, a
502 notice by any qualified beneficiary constitutes notice on behalf
503 of all qualified beneficiaries. The written notice must inform
504 the insurance carrier of the occurrence and type of the
505 qualifying event giving rise to the potential election by a
506 qualified beneficiary of continuation of coverage under the
507 group health plan issued by that insurance carrier, except that
508 in cases where the covered employee has been involuntarily
509 discharged, the nature of such discharge need not be disclosed.
510 The written notice must, at a minimum, identify the employer,
511 the group health plan number, the name and address of all
512 qualified beneficiaries, and such other information required by
513 the insurance carrier under the terms of the group health plan
514 or the commission by rule, to the extent that such information
515 is known by the qualified beneficiary.
516 2. Within 14 days after the receipt of written notice
517 under subparagraph 1., the insurance carrier shall send each
518 qualified beneficiary by certified mail an election and premium
519 notice form, approved by the office, which form must provide for
520 the qualified beneficiary's election or nonelection of

521 continuation of coverage under the group health plan and the
522 applicable premium amount due after the election to continue
523 coverage. This subparagraph does not require separate mailing of
524 notices to qualified beneficiaries residing in the same
525 household, but requires a separate mailing for each separate
526 household.

527 (j) Notwithstanding paragraph (b), if a qualified
528 beneficiary in the military reserve or National Guard has
529 elected to continue coverage and is thereafter called to active
530 duty and the coverage under the group plan is terminated by the
531 beneficiary or the carrier due to the qualified beneficiary
532 becoming eligible for TRICARE (the health care program provided
533 by the United States Defense Department), the 18-month period or
534 such other applicable maximum time period for which the
535 qualified beneficiary would otherwise be entitled to continue
536 coverage is tolled during the time that he or she is covered
537 under the TRICARE program. Within 63 ~~30~~ days after the federal
538 TRICARE coverage terminates, the qualified beneficiary may elect
539 to continue coverage under the group health plan, retroactively
540 to the date coverage terminated under TRICARE, for the remainder
541 of the 18-month period or such other applicable time period,
542 subject to termination of coverage at the earliest of the
543 conditions specified in paragraph (b).

544 Section 12. Paragraph (c) of subsection (5) and paragraphs
545 (b) and (j) of subsection (11) of section 627.6699, Florida
546 Statutes, are amended, and paragraph (o) is added to subsection
547 (11) of said section, to read:

548 627.6699 Employee Health Care Access Act.--

549 (5) AVAILABILITY OF COVERAGE.--

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

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

561 2. In the absence of enrollment availability in the
562 Florida Health Insurance Plan, offer and issue basic and
563 standard small employer health benefit plans <u>and a high
564 deductible plan that meets the requirements of a health savings
565 account plan or health reimbursement account as defined by
566 federal law,</u> on a guaranteed-issue basis, during a 31-day open
567 enrollment period of August 1 through August 31 of each year, to
568 every eligible small employer, with fewer than two eligible
569 employees, which small employer is not formed primarily for the
570 purpose of buying health insurance and which elects to be
571 covered under such plan, agrees to make the required premium
572 payments, and satisfies the other provisions of the plan.
573 Coverage provided under this subparagraph shall begin on October
574 1 of the same year as the date of enrollment, unless the small

575 employer carrier and the small employer agree to a different
576 date. A rider for additional or increased benefits may be
577 medically underwritten and may only be added to the standard
578 health benefit plan. The increased rate charged for the
579 additional or increased benefit must be rated in accordance with
580 this section. For purposes of this subparagraph, a person, his
581 or her spouse, and his or her dependent children constitute a
582 single eligible employee if that person and spouse are employed
583 by the same small employer and either that person or his or her
584 spouse has a normal work week of less than 25 hours. Any right
585 to an open enrollment of health benefit coverage for groups of
586 fewer than two employees, pursuant to this section, shall remain
587 in full force and effect in the absence of the availability of
588 new enrollment into the Florida Health Insurance Plan.
589 3. This paragraph does not limit a carrier's ability to
590 offer other health benefit plans to small employers if the
591 standard and basic health benefit plans are offered and
592 rejected.
593 (11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.--
594 (b)1. The program shall operate subject to the supervision
595 and control of the board.
596 2. Effective upon this act becoming a law, the board shall
597 consist of the director of the office or his or her designee,
598 who shall serve as the chairperson, and 13 additional members
599 who are representatives of carriers and insurance agents and are
600 appointed by the director of the office and serve as follows:

601 a. Five members shall be representatives of health
602 insurers licensed under chapter 624 or chapter 641. Two members
603 shall be agents who are actively engaged in the sale of health
604 insurance. Four members shall be employers or representatives of
605 employers. One member shall be a person covered under an
606 individual health insurance policy issued by a licensed insurer
607 in this state. One member shall represent the Agency for Health
608 Care Administration and shall be recommended by the Secretary of
609 Health Care Administration. ~~The director of the office shall~~
610 ~~include representatives of small employer carriers subject to~~
611 ~~assessment under this subsection. If two or more carriers elect~~
612 ~~to be risk-assuming carriers, the membership must include at~~
613 ~~least two representatives of risk-assuming carriers; if one~~
614 ~~carrier is risk-assuming, one member must be a representative of~~
615 ~~such carrier. At least one member must be a carrier who is~~
616 ~~subject to the assessments, but is not a small employer carrier.~~
617 ~~Subject to such restrictions, at least five members shall be~~
618 ~~selected from individuals recommended by small employer carriers~~
619 ~~pursuant to procedures provided by rule of the commission. Three~~
620 ~~members shall be selected from a list of health insurance~~
621 ~~carriers that issue individual health insurance policies. At~~
622 ~~least two of the three members selected must be reinsuring~~
623 ~~carriers. Two members shall be selected from a list of insurance~~
624 ~~agents who are actively engaged in the sale of health insurance.~~
625 b. A member appointed under this subparagraph shall serve
626 a term of 4 years and shall continue in office until the
627 member's successor takes office, except that, in order to

628 provide for staggered terms, the director of the office shall
629 designate two of the initial appointees under this subparagraph
630 to serve terms of 2 years and shall designate three of the
631 initial appointees under this subparagraph to serve terms of 3
632 years.

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

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

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

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

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

649 a. The operating losses of the program shall be assessed
650 in the following order subject to the specified limitations. The
651 first tier of assessments shall be made against reinsuring
652 carriers in an amount which shall not exceed 5 percent of each
653 reinsuring carrier's premiums from health benefit plans covering
654 small employers. If such assessments have been collected and

655 additional moneys are needed, the board shall make a second tier
656 of assessments in an amount which shall not exceed 0.5 percent
657 of each carrier's health benefit plan premiums. Except as
658 provided in paragraph (n), risk-assuming carriers are exempt
659 from all assessments authorized pursuant to this section. The
660 amount paid by a reinsuring carrier for the first tier of
661 assessments shall be credited against any additional assessments
662 made.

663 b. The board shall equitably assess carriers for operating
664 losses of the plan based on market share. The board shall
665 annually assess each carrier a portion of the operating losses
666 of the plan. The first tier of assessments shall be determined
667 by multiplying the operating losses by a fraction, the numerator
668 of which equals the reinsuring carrier's earned premium
669 pertaining to direct writings of small employer health benefit
670 plans in the state during the calendar year for which the
671 assessment is levied, and the denominator of which equals the
672 total of all such premiums earned by reinsuring carriers in the
673 state during that calendar year. The second tier of assessments
674 shall be based on the premiums that all carriers, except risk-
675 assuming carriers, earned on all health benefit plans written in
676 this state. The board may levy interim assessments against
677 carriers to ensure the financial ability of the plan to cover
678 claims expenses and administrative expenses paid or estimated to
679 be paid in the operation of the plan for the calendar year prior
680 to the association's anticipated receipt of annual assessments
681 for that calendar year. Any interim assessment is due and

682 payable within 30 days after receipt by a carrier of the interim
683 assessment notice. Interim assessment payments shall be credited
684 against the carrier's annual assessment. Health benefit plan
685 premiums and benefits paid by a carrier that are less than an
686 amount determined by the board to justify the cost of collection
687 may not be considered for purposes of determining assessments.

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

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

699 4. If the board determines that the assessments needed to
700 fund the losses incurred by the program in the previous calendar
701 year will exceed the amount specified in subparagraph 2., the
702 board shall evaluate the operation of the program and report its
703 findings, including any recommendations for changes to the plan
704 of operation, to the office within 180 ~~90~~ days following the end
705 of the calendar year in which the losses were incurred. The
706 evaluation shall include an estimate of future assessments, the
707 administrative costs of the program, the appropriateness of the
708 premiums charged and the level of carrier retention under the

709 program, and the costs of coverage for small employers. If the
710 board fails to file a report with the office within 180 ~~90~~ days
711 following the end of the applicable calendar year, the office
712 may evaluate the operations of the program and implement such
713 amendments to the plan of operation the office deems necessary
714 to reduce future losses and assessments.

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

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

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

728 8. A carrier may seek, from the office, a deferment, in
729 whole or in part, from any assessment made by the board. The
730 office may defer, in whole or in part, the assessment of a
731 carrier if, in the opinion of the office, the payment of the
732 assessment would place the carrier in a financially impaired
733 condition. If an assessment against a carrier is deferred, in
734 whole or in part, the amount by which the assessment is deferred
735 may be assessed against the other carriers in a manner

736 consistent with the basis for assessment set forth in this
737 section. The carrier receiving such deferment remains liable to
738 the program for the amount deferred and is prohibited from
739 reinsuring any individuals or groups in the program if it fails
740 to pay assessments.

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

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

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

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

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

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

763 Section 13. Subsection (1) of section 641.27, Florida
764 Statutes, is amended to read:
765 641.27 Examination by the department.--
766 (1) The office shall examine the affairs, transactions,
767 accounts, business records, and assets of any health maintenance
768 organization as often as it deems it expedient for the
769 protection of the people of this state, but not less frequently
770 than once every 5 ~~3~~ years. ~~In lieu of making its own financial~~
771 ~~examination, the office may accept an independent certified~~
772 ~~public accountant's audit report prepared on a statutory~~
773 ~~accounting basis consistent with this part.~~ However, except when
774 the medical records are requested and copies furnished pursuant
775 to s. 456.057, medical records of individuals and records of
776 physicians providing service under contract to the health
777 maintenance organization shall not be subject to audit, although
778 they may be subject to subpoena by court order upon a showing of
779 good cause. For the purpose of examinations, the office may
780 administer oaths to and examine the officers and agents of a
781 health maintenance organization concerning its business and
782 affairs. The examination of each health maintenance organization
783 by the office shall be subject to the same terms and conditions
784 as apply to insurers under chapter 624. In no event shall
785 expenses of all examinations exceed a maximum of $50,000 ~~$20,000~~
786 for any 1-year period. Any rehabilitation, liquidation,
787 conservation, or dissolution of a health maintenance
788 organization shall be conducted under the supervision of the
789 department, which shall have all power with respect thereto

790 granted to it under the laws governing the rehabilitation,
791 liquidation, reorganization, conservation, or dissolution of
792 life insurance companies.
793 Section 14. Subsection (40) of section 641.31, Florida
794 Statutes, is amended to read:
795 641.31 Health maintenance contracts.--
796 (40)(a) Any group rate, rating schedule, or rating manual
797 for a health maintenance organization policy, which provides
798 creditable coverage as defined in s. 627.6561(5), filed with the
799 office shall provide for an appropriate rebate of premiums paid
800 in the last contract ~~calendar~~ year when the majority of the
801 members of a health ~~individual covered by such~~ plan are ~~is~~
802 enrolled in and maintain ~~maintains~~ participation in any health
803 wellness, maintenance, or improvement program offered by the
804 group contract holder ~~approved by the health plan~~. The group
805 ~~individual~~ must provide evidence of demonstrative maintenance or
806 improvement of ~~his or her~~ health status as determined by
807 assessments of agreed-upon health status indicators between the
808 group ~~individual~~ and the health insurer, including, but not
809 limited to, reduction in weight, body mass index, and smoking
810 cessation. Any rebate provided by the health maintenance
811 organization ~~insurer~~ is presumed to be appropriate unless
812 credible data demonstrates otherwise or unless such rebate
813 program requires the insured to incur costs to qualify for the
814 rebate which equal or exceed the value of the rebate, but in no
815 event shall the rebate ~~not~~ exceed 10 percent of paid premiums.

816 (b) The premium rebate authorized by this section shall be
817 effective for a subscriber ~~an insured~~ on an annual basis, unless
818 the number of participating members on the contract renewal
819 anniversary becomes less than the majority of the members
820 eligible for participation in the wellness program ~~individual~~
821 ~~fails to maintain or improve his or her health status while~~
822 ~~participating in an approved wellness program, or credible~~
823 ~~evidence demonstrates that the individual is not participating~~
824 ~~in the approved wellness program~~.
825 (c) The program shall be available for all contracts
826 issued on or after July 1, 2005.
827 Section 15. There is hereby appropriated $5 million from
828 the General Revenue Fund for fiscal year 2005-2006 to the
829 Florida Health Insurance Plan for the purposes of implementing
830 the plan.
831
832
833 ================ T I T L E A M E N D M E N T =============
834 Remove line 10 and insert:
835 circumstances; providing requirements; amending s. 408.05, F.S.;
836 changing the due date for a report from the Agency for Health
837 Care Administration regarding the State Center for Health
838 Statistics; changing the release dates for certain data
839 collected by the State Center for Health Statistics; amending s.
840 408.909, F.S.; providing an additional criterion for the Office
841 of Insurance Regulation to disapprove or withdraw approval of
842 health flex plans; amending s. 627.413, F.S.; authorizing

843 insurers and health maintenance organizations to offer policies
844 or contracts providing for a high deductible plan meeting
845 federal requirements and in conjunction with a health savings
846 account; amending s. 627.638, F.S.; providing certain contract
847 and claim form requirements for direct payment to certain
848 providers of emergency services and care; amending s. 627.6402,
849 F.S.; revising provisions for healthy lifestyle rebates for an
850 individual health insurance policy; providing exceptions;
851 providing application; amending s. 627.6487, F.S.; revising the
852 definition of the term "eligible individual" for purposes of
853 obtaining coverage in the Florida Health Insurance Plan;
854 amending s. 627.64872, F.S.; revising definitions; changing
855 references to the Director of the Office of Insurance Regulation
856 to the Commissioner of Insurance Regulation; deleting obsolete
857 language; providing additional eligibility criteria; reducing
858 premium rate limitations; revising requirements for sources of
859 additional revenue; authorizing the board to cancel policies
860 under inadequate funding conditions; providing a limitation;
861 defining the term "health insurance" for purposes of certain
862 assessments; providing an exclusion; specifying a maximum
863 provider reimbursement rate; requiring licensed providers to
864 accept assignment of plan benefits and consider certain payments
865 as payments in full; authorizing the board to update a required
866 actuarial study; providing study criteria; amending s.
867 627.65626, F.S.; revising criteria for healthy lifestyle rebates
868 for group and similar health insurance policies provided by
869 health insurers; authorizing group or health insurers to

870 contract with an independent third-party administrator for
871 certain purposes; providing exceptions; providing application;
872 amending s. 627.6692, F.S.; extending a time period within which
873 eligible employees may apply for continuation of coverage;
874 amending s. 627.6699, F.S.; revising availability of coverage
875 provision of the Employee Health Care Access Act; including high
876 deductible plans meeting federal health savings account plan
877 requirements; revising membership of the board of the small
878 employer health reinsurance program; revising certain reporting
879 dates relating to program losses and assessments; requiring the
880 board to advise executive and legislative entities on health
881 insurance issues; providing requirements; amending s. 641.27,
882 F.S.; increasing the interval at which the office examines
883 health maintenance organizations; deleting authorization for the
884 office to accept an audit report from a certified public
885 accountant in lieu of conducting its own examination; increasing
886 an expense limitation; amending s. 641.31, F.S.; revising
887 criteria for healthy lifestyle rebates for health maintenance
888 organizations; providing exceptions; providing application;
889 providing an appropriation; providing application; providing an