CHAMBER ACTION

The Health Care Regulation Committee recommends the following:

Council/Committee Substitute

Remove the entire bill and insert:

A bill to be entitled

An act relating to plans, policies, contracts, and programs for the provision of health care services; amending s. 408.909, F.S.; revising eligibility requirements for participation in health flex plans; amending s. 627.642, F.S.; requiring an identification card containing specified information to be given to insureds who have health and accident insurance; amending s. 627.657, F.S.; requiring an identification card containing specified information to be given to insureds under group health insurance policies; amending s. 641.31, F.S.; requiring an identification card to be given to persons having health care services through a health maintenance contract; amending ss. 383.145, 641.185, 641.2018, 641.3107, 641.3922, and 641.513, F.S.; conforming cross-references to changes made by the act; providing application; providing effective dates.

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

Section 1. Effective July 1, 2006, subsection (5) of section 408.909, Florida Statutes, is amended to read:

408.909 Health flex plans.--

(5) ELIGIBILITY.--Eligibility to enroll in an approved health flex plan is limited to residents of this state who meet all of the following requirements:

(a) Are 64 years of age or younger.~~,~~

(b) Have a family income equal to or less than 250 ~~200~~ percent of the federal poverty level.~~,~~

(c) Are eligible under a federally approved Medicaid demonstration waiver and reside in Palm Beach County or Miami-Dade County.~~,~~

(d) Are not covered by a private insurance policy and are not eligible for coverage through a public health insurance program, such as Medicare or Medicaid, unless specifically authorized under paragraph (c), or another public health care program, such as KidCare, and have not been covered at any time during the past 6 months.~~; and~~

(e) Have applied for health care coverage through an approved health flex plan and have agreed to make any payments required for participation, including periodic payments or payments due at the time health care services are provided.

(f) Are part of an employer group where at least 75 percent of the employees have a family income equal to or less than 250 percent of the federal poverty level.

Section 2. Subsection (3) is added to section 627.642, Florida Statutes, to read:

627.642 Outline of coverage.--

(3) In addition to the outline of coverage, a policy as specified in s. 627.6699(3)(k) must be accompanied by an identification card that contains, at a minimum:

(a) The name of the organization issuing the policy or name of the organization administering the policy, whichever applies.

(b) The name of the contract holder.

(c) Type of plan or name of network, but only health plans filed with the state may be identified on the card.

(d) The member identification number, contract number, and policy or group number, if applicable.

(e) A contact phone number or electronic address for authorizations.

(f) A phone number or electronic address whereby the covered person or hospital, physician, or other person rendering services covered by the policy may determine if the plan is insured and may obtain a benefits verification in order to estimate patient financial responsibility, in compliance with privacy rules under the Health Insurance Portability and Accountability Act.

(g) The national plan identifier, in accordance with the compliance date set forth by the federal Department of Health and Human Services.

The identification card must present the information in a readily identifiable manner or, alternatively, the information may be embedded on the card and available through magnetic

stripe or smart card. The information may also be provided through other electronic technology.

Section 3. Present subsection (2) of section 627.657, Florida Statutes, is renumbered as subsection (3), and a new subsection (2) is added to that section, to read:

627.657 Provisions of group health insurance policies.--

(2) The medical policy as specified in s. 627.6699(3)(k) must be accompanied by an identification card that contains, at a minimum:

(a) The name of the organization issuing the policy or name of the organization administering the policy, whichever applies.

(b) The name of the certificateholder.

(c) Type of plan or name of network, but only health plans filed with the state may be identified on the card.

(d) The member identification number, contract number, and policy or group number, if applicable.

(e) A contact phone number or electronic address for authorizations.

(f) A phone number or electronic address whereby the covered person or hospital, physician, or other person rendering services covered by the policy may determine if the plan is insured and may obtain a benefits verification in order to estimate patient financial responsibility, in compliance with privacy rules under the Health Insurance Portability and Accountability Act.

(g) The national plan identifier, in accordance with the compliance date set forth by the federal Department of Health and Human Services.

The identification card must present the information in a readily identifiable manner or, alternatively, the information may be embedded on the card and available through magnetic stripe or smart card. The information may also be provided through other electronic technology.

Section 4. Present subsections (5) through (40) of section 641.31, Florida Statutes, are renumbered as subsections (6) through (41), respectively, and a new subsection (5) is added to that section, to read:

641.31 Health maintenance contracts.--

(5) The contract, certificate, or member handbook must be accompanied by an identification card that contains, at a minimum:

(a) The name of the organization offering the contract or name of the organization administering the contract, whichever applies.

(b) The name of the subscriber.

(c) A statement that the health plan is a health maintenance organization. Only a health plan with a certificate of authority issued under this chapter may be identified as a health maintenance organization.

(d) The member identification number, contract number, and group number, if applicable.

(e) A contact phone number or electronic address for authorizations.

(f) A phone number or electronic address whereby the covered person or hospital, physician, or other person rendering services covered by the contract may determine if the plan is insured and may obtain a benefits verification in order to estimate patient financial responsibility, in compliance with privacy rules under the Health Insurance Portability and Accountability Act.

(g) The national plan identifier, in accordance with the compliance date set forth by the federal Department of Health and Human Services.

The identification card must present the information in a readily identifiable manner or, alternatively, the information may be embedded on the card and available through magnetic stripe or smart card. The information may also be provided through other electronic technology.

Section 5. Paragraph (j) of subsection (3) of section 383.145, Florida Statutes, is amended to read:

383.145 Newborn and infant hearing screening.--

(3) REQUIREMENTS FOR SCREENING OF NEWBORNS; INSURANCE COVERAGE; REFERRAL FOR ONGOING SERVICES.--

(j) The initial procedure for screening the hearing of the newborn or infant and any medically necessary followup reevaluations leading to diagnosis shall be a covered benefit, reimbursable under Medicaid as an expense compensated supplemental to the per diem rate for Medicaid patients enrolled

in MediPass or Medicaid patients covered by a fee for service program. For Medicaid patients enrolled in HMOs, providers shall be reimbursed directly by the Medicaid Program Office at the Medicaid rate. This service may not be considered a covered service for the purposes of establishing the payment rate for Medicaid HMOs. All health insurance policies and health maintenance organizations as provided under ss. 627.6416, 627.6579, and 641.31(31) ~~(30)~~, except for supplemental policies that only provide coverage for specific diseases, hospital indemnity, or Medicare supplement, or to the supplemental polices, shall compensate providers for the covered benefit at the contracted rate. Nonhospital-based providers shall be eligible to bill Medicaid for the professional and technical component of each procedure code.

Section 6. Paragraphs (b) and (i) of subsection (1) of section 641.185, Florida Statutes, are amended to read:

641.185 Health maintenance organization subscriber protections.--

(1) With respect to the provisions of this part and part III, the principles expressed in the following statements shall serve as standards to be followed by the commission, the office, the department, and the Agency for Health Care Administration in exercising their powers and duties, in exercising administrative discretion, in administrative interpretations of the law, in enforcing its provisions, and in adopting rules:

(b) A health maintenance organization subscriber should receive quality health care from a broad panel of providers, including referrals, preventive care pursuant to s. 641.402(1),

emergency screening and services pursuant to ss. 641.31(13) ~~(12)~~ and 641.513, and second opinions pursuant to s. 641.51.

(i) A health maintenance organization subscriber should receive timely and, if necessary, urgent grievances and appeals within the health maintenance organization pursuant to ss. 641.228, 641.31(6) ~~(5)~~, 641.47, and 641.511.

Section 7. Subsection (1) of section 641.2018, Florida Statutes, is amended to read:

641.2018 Limited coverage for home health care authorized.--

(1) Notwithstanding other provisions of this chapter, a health maintenance organization may issue a contract that limits coverage to home health care services only. The organization and the contract shall be subject to all of the requirements of this part that do not require or otherwise apply to specific benefits other than home care services. To this extent, all of the requirements of this part apply to any organization or contract that limits coverage to home care services, except the requirements for providing comprehensive health care services as provided in ss. 641.19(4), (11), and (12), and 641.31(1), except ss. 641.31(10) ~~(9)~~, (13) ~~(12), (17)~~, (18), (19), (20), (21), (22), and (25) ~~(24)~~ and 641.31095.

Section 8. Section 641.3107, Florida Statutes, is amended to read:

641.3107 Delivery of contract.--Unless delivered upon execution or issuance, a health maintenance contract, certificate of coverage, or member handbook shall be mailed or delivered to the subscriber or, in the case of a group health

maintenance contract, to the employer or other person who will hold the contract on behalf of the subscriber group within 10 working days from approval of the enrollment form by the health maintenance organization or by the effective date of coverage, whichever occurs first. However, if the employer or other person who will hold the contract on behalf of the subscriber group requires retroactive enrollment of a subscriber, the organization shall deliver the contract, certificate, or member handbook to the subscriber within 10 days after receiving notice from the employer of the retroactive enrollment. This section does not apply to the delivery of those contracts specified in s. 641.31(14) ~~(13)~~.

Section 9. Paragraph (a) of subsection (7) of section 641.3922, Florida Statutes, is amended to read:

641.3922 Conversion contracts; conditions.--Issuance of a converted contract shall be subject to the following conditions:

(7) REASONS FOR CANCELLATION; TERMINATION.--The converted health maintenance contract must contain a cancellation or nonrenewability clause providing that the health maintenance organization may refuse to renew the contract of any person covered thereunder, but cancellation or nonrenewal must be limited to one or more of the following reasons:

(a) Fraud or intentional misrepresentation, subject to the limitations of s. 641.31(24) ~~(23)~~, in applying for any benefits under the converted health maintenance contract.~~;~~

Section 10. Subsection (4) of section 641.513, Florida Statutes, is amended to read:

641.513 Requirements for providing emergency services and care.--

(4) A subscriber may be charged a reasonable copayment, as provided in s. 641.31(13) ~~(12)~~, for the use of an emergency room.

Section 11. Except as otherwise expressly provided in this act, this act shall take effect January 1, 2007, and shall apply to identification cards issued for policies or certificates issued or renewed on or after that date.