By the Committee on Banking and Insurance; and Senator Peaden

597-2328-07

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.; authorizing certain licensed entities to offer the health flex plan; revising criteria for eligibility for enrollment in a health flex plan; creating s. 445.015, F.S.; establishing a small business health insurance plan grant program; providing purposes of the grant program; providing conditions for use of grant funds; providing duties of the Agency for Workforce Innovation and the Office of Insurance Regulation; requiring a report to the Governor and Legislature; providing an appropriation; 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. 627.4236, F.S.; redefining the term "bone marrow transplant" for purposes of required coverage for certain procedures to include nonablative therapy having life-prolonging intent; 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, 2007, subsections (3) and (5) of section 408.909, Florida Statutes, are 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.

(a) The agency shall develop guidelines for the review of applications for health flex plans and shall disapprove or withdraw approval of plans that do not meet or no longer meet minimum standards for quality of care and access to care. The agency shall ensure that the health flex plans follow standardized grievance procedures similar to those required of health maintenance organizations.

(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;

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 under s. 624.404(3).

(c) In order to expedite financial determinations and immediately qualify a large base of eligible entities to offer the health flex program, entities licensed under chapter 627, chapter 632, chapter 636, or chapter 641 shall be deemed in compliance with the financial requirements for offering a health flex plan. In addition, any local government or health care district that has the initial operating funds and taxing authority to fulfill its obligations under the proposed health flex plan shall be deemed in compliance with the financial requirements for offering a health flex plan.

(d)~~(c)~~ The agency and the Financial Services Commission may adopt rules as needed to administer this section.

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

(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~~

(d)~~(c)~~ 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; and

(e) Are either:

1. Not covered by a private insurance policy and 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; or

2. Part of an employer group that is not covered by a private health insurance policy and has not been covered at any time during the past 6 months and in which at least 75 percent of the employees have a family income equal to or less than 250 percent of the federal poverty level. If the health flex plan entity is a properly licensed health insurer, health plan, or health maintenance organization, this subparagraph applies when only 50 percent of the employees have a family

income equal to or less than 250 percent of the federal poverty level.

Section 2. Effective July 1, 2007, section 445.015, Florida Statutes, is created to read:

445.015 Small business health insurance plan grant program.--

(1) The agency shall establish a small business health insurance plan grant program to award, administer, and monitor grants to small employers and small businesses to develop and offer cafeteria health plans that qualify under s. 125 of the Internal Revenue Code and include options such as prepaid health clinic services licensed under part II of chapter 641 for the purpose of improving access to health insurance for uninsured employees. The agency shall give priority to employer proposals that would improve access for previously uninsured employees or include long-term commitments to insure employees. Grant funds shall not be used for ongoing maintenance of the plans or for employer contributions. Health plans may identify and assist eligible small employers and small businesses in obtaining grants. The agency, in consultation with the Office of Insurance Regulation, shall evaluate each project funded by a grant to measure any increases in access to insurance and the long-term viability of such increases. The agency shall design materials and interactive programs to inform small employers and small businesses about such cafeteria health plans and shall provide training to assist small employers and small businesses in developing such plans. Training shall include technical assistance in establishing relationships with health plans and individualized guidance on operational methods and

infrastructure that will best support and ensure the long-term success of using these plans.

(2) The agency shall submit a report that documents the specific activities undertaken during the fiscal year pursuant to this section annually to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than February 1.

Section 3. Effective July 1, 2007, the sum of $250,000 in nonrecurring revenue is appropriated from the General Revenue Fund to the Agency for Workforce Innovation for the 2007-2008 fiscal year to award Small Business Health Insurance Plan Grants to eligible businesses.

Section 4. 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 the name of the organization administering the policy, whichever applies.

(b) The name of the contract holder.

(c) The type of plan only if the plan is filed in the state, an indication that the plan is self-funded, or the name of the network.

(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 5. Subsection (1) of section 627.4236, Florida Statutes, is amended to read:

627.4236 Coverage for bone marrow transplant procedures.--

(1) As used in this section, the term "bone marrow transplant" means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative or nonablative therapy with curative or life-prolonging intent. Human blood precursor cells may be obtained from the patient in an autologous transplant or from a medically acceptable related or unrelated donor, and may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "bone marrow transplant" includes both the transplantation and the chemotherapy.

Section 6. 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) The type of plan only if the plan is filed in the state, an indication that the plan is self-funded, or the name of the network.

(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 7. 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 8. 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) ~~641.31(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 9. 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) ~~641.31(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) ~~641.31(5)~~, 641.47, and 641.511.

Section 10. 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) ~~641.31(9)~~, (13)~~(12), (17)~~, (18), (19), (20), (21),(22), and (25)~~(24)~~ and 641.31095.

Section 11. 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) ~~s. 641.31(13)~~.

Section 12. 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) ~~s. 641.31(23)~~, in applying for any benefits under the converted health maintenance contract.~~;~~

Section 13. 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) ~~s. 641.31(12)~~, for the use of an emergency room.

Section 14. Except as otherwise expressly provided in this act and except for this section, which shall take effect July 1, 2007, this act shall take effect January 1, 2008, and shall apply to policies or certificates issued or renewed on or after that date.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN COMMITTEE SUBSTITUTE FOR Senate Bill 2094

The committee substitute makes the following changes:

1. Revises criteria for eligibility for participation in the Health Flex Plan.

2. Creates a small business health insurance grant program to be administered by the Agency for Workforce Innovation and provides a $250,000 nonrecurring general revenue appropriation to be awarded to eligible businesses.

3. Revises the definition of bone marrow transplant for purposes of insurance coverage.