Amendment No. ___ (for drafter's use only)

CHAMBER ACTION

Senate		House
	.	

ORIGINAL STAMP BELOW

Representative(s) Farkas offered the following:

Amendment to Amendment (843101) (with title amendment)

On page 18, between lines 20 and 21,

insert:

Section 10. Health flex plans.--

(1) INTENT.--The Legislature finds that a significant portion of the residents of this state are not able to obtain affordable health insurance coverage. Therefore it is the intent of the Legislature to expand the availability of health care options for lower income uninsured state residents by encouraging health insurers, health maintenance organizations, health care provider-sponsored organizations, local governments, health care districts, or other public or private community-based organizations to develop alternative approaches to traditional health insurance which emphasize coverage for basic and preventive health care services. To the maximum extent possible, such options should be coordinated with existing governmental or community-based health services programs in a manner which is consistent with

1 the objectives and requirements of such programs.
2 (2) DEFINITIONS.--As used in this section:
3 (a) "Agency" means the Agency for Health Care
4 Administration.
5 (b) "Approved plan" means a health flex plan approved
6 under subsection (3) which guarantees payment by the health
7 plan entity for specified health care services provided to the
8 enrollee.
9 (c) "Enrollee" means an individual who has been
10 determined eligible for and is receiving health benefits under
11 a health flex plan approved under this section.
12 (d) "Health care coverage" means payment for health
13 care services covered as benefits under an approved plan or
14 that otherwise provides, either directly or through
15 arrangements with other persons, covered health care services
16 on a prepaid per capita basis or on a prepaid aggregate
17 fixed-sum basis.
18 (e) "Health plan entity" means a health insurer,
19 health maintenance organization, health care
20 provider-sponsored organization, local government, health care
21 districts, or other public or private community-based
22 organization which develops and implements an approved plan,
23 and is responsible for financing and paying all claims by
24 enrollees of the plan.
25 (3) PILOT PROGRAM.--The agency and the Department of
26 Insurance shall jointly approve or disapprove health flex
27 plans which provide health care coverage for eligible
28 participants residing in the three areas of the state having
29 the highest number of uninsured residents as determined by the
30 agency. A plan may limit or exclude benefits otherwise
31 required by law for insurers offering coverage in this state,

1 cap the total amount of claims paid in 1 year per enrollee, or
2 limit the number of enrollees covered. The agency and the
3 Department of Insurance shall not approve or shall withdraw
4 approval of a plan which:
5 (a) Contains any ambiguous, inconsistent, or
6 misleading provisions, or exceptions or conditions that
7 deceptively affect or limit the benefits purported to be
8 assumed in the general coverage provided by the plan;
9 (b) Provides benefits that are unreasonable in
10 relation to the premium charged, contains provisions that are
11 unfair or inequitable or contrary to the public policy of this
12 state or that encourage misrepresentation, or result in unfair
13 discrimination in sales practices; or
14 (c) Cannot demonstrate that the plan is financially
15 sound and the applicant has the ability to underwrite or
16 finance the benefits provided.
17 (4) LICENSE NOT REQUIRED.--A health flex plan approved
18 under this section shall not be subject to the licensing
19 requirements of the Florida Insurance Code or chapter 641,
20 Florida Statutes, relating to health maintenance
21 organizations, unless expressly made applicable. However, for
22 the purposes of prohibiting unfair trade practices, health
23 flex plans shall be considered insurance subject to the
24 applicable provisions of part IX of chapter 626, Florida
25 Statutes, except as otherwise provided in this section.
26 (5) ELIGIBILITY.--Eligibility to enroll in an approved
27 health flex plan is limited to residents of this state who:
28 (a) Are 64 years of age or younger.
29 (b) Have a family income equal to or less than 200
30 percent of the federal poverty level.
31 (c) Are not covered by a private insurance policy and

1 are not eligible for coverage through a public health
2 insurance program such as Medicare or Medicaid, or other
3 public health care program, including, but not limited to,
4 Kidcare, and have not been covered at any time during the past
5 6 months.
6 (d) Have applied for health care benefits through an
7 approved health flex plan and agree to make any payments
8 required for participation, including, but not limited to,
9 periodic payments and payments due at the time health care
10 services are provided.
11 (6) RECORDS.--Every health flex plan provider shall
12 maintain reasonable records of its loss, expense, and claims
13 experience and shall make such records reasonably available to
14 enable the agency and the Department of Insurance to monitor
15 and determine the financial viability of the plan, as
16 necessary.
17 (7) NOTICE.--The denial of coverage by the health plan
18 entity shall be accompanied by the specific reasons for
19 denial, nonrenewal, or cancellation. Notice of nonrenewal or
20 cancellation shall be provided at least 45 days in advance of
21 such nonrenewal or cancellation except that 10 days' written
22 notice shall be given for cancellation due to nonpayment of
23 premiums. If the health plan entity fails to give the
24 required notice, the plan shall remain in effect until notice
25 is appropriately given.
26 (8) NONENTITLEMENT.--Coverage under an approved health
27 flex plan is not an entitlement and no cause of action shall
28 arise against the state, local governmental entity, or other
29 political subdivision of this state or the agency for failure
30 to make coverage available to eligible persons under this
31 section.

1 (9) CIVIL ACTIONS.--In addition to an administrative
2 action initiated under subsection (4), the agency may seek any
3 remedy provided by law, including, but not limited to, the
4 remedies provided in s. 812.035, Florida Statutes, if the
5 agency finds that a health plan entity has engaged in any act
6 resulting in injury to an enrollee covered by a plan approved
7 under this section.
8 Section 11. Paragraph (a) of subsection (6) of section
9 627.410, Florida Statutes, is amended to read:
10 627.410 Filing, approval of forms.--
11 (6)(a) An insurer shall not deliver or issue for
12 delivery or renew in this state any health insurance policy
13 form until it has filed with the department a copy of every
14 applicable rating manual, rating schedule, change in rating
15 manual, and change in rating schedule; if rating manuals and
16 rating schedules are not applicable, the insurer must file
17 with the department applicable premium rates and any change in
18 applicable premium rates. This paragraph does not apply to
19 group health insurance policies insuring groups of 51 or more
20 persons, except for Medicare supplement insurance, long-term
21 care insurance, and any coverage under which the increase in
22 claims costs over the lifetime of the contract due to
23 advancing age or duration is prefunded in the premium.
24 Section 12. Paragraphs (m) and (n) of subsection (3),
25 paragraph (b) of subsection (6), paragraphs (a), (d), and (e)
26 of subsection (12), and paragraph (a) of subsection (15) of
27 section 627.6699, Florida Statutes, are amended to read:
28 627.6699 Employee Health Care Access Act.--
29 (3) DEFINITIONS.--As used in this section, the term:
30 (m) "Limited benefit policy or contract" means a
31 policy or contract that provides coverage for each person

Amendment No. ___ (for drafter's use only)

1 insured under the policy for a specifically named disease or
2 diseases, a specifically named accident, or ~~a specifically~~
3 ~~named limited market~~ that fulfills a ~~an experimental or~~
4 reasonable need by providing more affordable health insurance~~,~~
5 ~~such as the small group market~~.
6 (n) "Modified community rating" means a method used to
7 develop carrier premiums which spreads financial risk across a
8 large population; allows the use of separate rating factors
9 for age, gender, family composition, tobacco usage, and
10 geographic area as determined under paragraph (5)(j); and
11 allows adjustments for: claims experience, health status, or
12 credits based on the duration that the ~~of~~ coverage has been in
13 force as permitted under subparagraph (6)(b)6.~~5.~~; and
14 administrative and acquisition expenses as permitted under
15 subparagraph (6)(b)5. A carrier may separate the experience of
16 small employer groups with less than 2 eligible employees from
17 the experience of small employer groups with 2 through 50
18 eligible employees.
19 (6) RESTRICTIONS RELATING TO PREMIUM RATES.--
20 (b) For all small employer health benefit plans that
21 are subject to this section and are issued by small employer
22 carriers on or after January 1, 1994, premium rates for health
23 benefit plans subject to this section are subject to the
24 following:
25 1. Small employer carriers must use a modified
26 community rating methodology in which the premium for each
27 small employer must be determined solely on the basis of the
28 eligible employee's and eligible dependent's gender, age,
29 family composition, tobacco use, or geographic area as
30 determined under paragraph (5)(j) and in which the premium may
31 be adjusted as permitted by subparagraphs 6.~~5.~~and 7.~~6.~~

1 2. Rating factors related to age, gender, family
2 composition, tobacco use, or geographic location may be
3 developed by each carrier to reflect the carrier's experience.
4 The factors used by carriers are subject to department review
5 and approval.
6 3. If the modified community rate is determined from
7 two experience pools as authorized by paragraph (3)(n), the
8 rate to be charged to small employer groups of less than 2
9 eligible employees may not exceed 150 percent of the rate
10 determined for groups of 2 through 50 eligible employees;
11 however, the carrier may charge excess losses of the less than
12 2 eligible employee experience pool to the experience pool of
13 the 2 through 50 eligible employees so that all losses are
14 allocated and the 150-percent rate limit on the less than 2
15 eligible employee experience pool is maintained.
16 4.~~3.~~ Small employer carriers may not modify the rate
17 for a small employer for 12 months from the initial issue date
18 or renewal date, unless the composition of the group changes
19 or benefits are changed. However, a small employer carrier may
20 modify the rate one time prior to 12 months after the initial
21 issue date for a small employer who enrolls under a previously
22 issued group policy that has a common anniversary date for all
23 employers covered under the policy if:
24 a. The carrier discloses to the employer in a clear
25 and conspicuous manner the date of the first renewal and the
26 fact that the premium may increase on or after that date.
27 b. The insurer demonstrates to the department that
28 efficiencies in administration are achieved and reflected in
29 the rates charged to small employers covered under the policy.
30 5.~~4.~~ A carrier may issue a group health insurance
31 policy to a small employer health alliance or other group

1 association with rates that reflect a premium credit for
2 expense savings attributable to administrative activities
3 being performed by the alliance or group association if such
4 expense savings are specifically documented in the insurer's
5 rate filing and are approved by the department. Any such
6 credit may not be based on different morbidity assumptions or
7 on any other factor related to the health status or claims
8 experience of any person covered under the policy. Nothing in
9 this subparagraph exempts an alliance or group association
10 from licensure for any activities that require licensure under
11 the insurance code. A carrier issuing a group health insurance
12 policy to a small employer health alliance or other group
13 association shall allow any properly licensed and appointed
14 agent of that carrier to market and sell the small employer
15 health alliance or other group association policy. Such agent
16 shall be paid the usual and customary commission paid to any
17 agent selling the policy.
18 6.~~5.~~ Any adjustments in rates for claims experience,
19 health status, or duration of coverage may not be charged to
20 individual employees or dependents. For a small employer's
21 policy, such adjustments may not result in a rate for the
22 small employer which deviates more than 15 percent from the
23 carrier's approved rate. Any such adjustment must be applied
24 uniformly to the rates charged for all employees and
25 dependents of the small employer. A small employer carrier may
26 make an adjustment to a small employer's renewal premium, not
27 to exceed 10 percent annually, due to the claims experience,
28 health status, or duration of coverage of the employees or
29 dependents of the small employer. Semiannually, small group
30 carriers shall report information on forms adopted by rule by
31 the department, to enable the department to monitor the

relationship of aggregate adjusted premiums actually charged policyholders by each carrier to the premiums that would have been charged by application of the carrier's approved modified community rates. If the aggregate resulting from the application of such adjustment exceeds the premium that would have been charged by application of the approved modified community rate by 5 percent for the current reporting period, the carrier shall limit the application of such adjustments only to minus adjustments beginning not more than 60 days after the report is sent to the department. For any subsequent reporting period, if the total aggregate adjusted premium actually charged does not exceed the premium that would have been charged by application of the approved modified community rate by 5 percent, the carrier may apply both plus and minus adjustments. A small employer carrier may provide a credit to a small employer's premium based on administrative and acquisition expense differences resulting from the size of the group. Group size administrative and acquisition expense factors may be developed by each carrier to reflect the carrier's experience and are subject to department review and approval.

7.~~6.~~ A small employer carrier rating methodology may include separate rating categories for one dependent child, for two dependent children, and for three or more dependent children for family coverage of employees having a spouse and dependent children or employees having dependent children only. A small employer carrier may have fewer, but not greater, numbers of categories for dependent children than those specified in this subparagraph.

8.~~7.~~ Small employer carriers may not use a composite rating methodology to rate a small employer with fewer than 10

1 employees. For the purposes of this subparagraph, a "composite
2 rating methodology" means a rating methodology that averages
3 the impact of the rating factors for age and gender in the
4 premiums charged to all of the employees of a small employer.
5 (12) STANDARD, BASIC, AND LIMITED HEALTH BENEFIT
6 PLANS.--
7 (a)1. By May 15, 1993, the commissioner shall appoint
8 a health benefit plan committee composed of four
9 representatives of carriers which shall include at least two
10 representatives of HMOs, at least one of which is a staff
11 model HMO, two representatives of agents, four representatives
12 of small employers, and one employee of a small employer. The
13 carrier members shall be selected from a list of individuals
14 recommended by the board. The commissioner may require the
15 board to submit additional recommendations of individuals for
16 appointment.
17 2. The plans shall comply with all of the requirements
18 of this subsection.
19 3. The plans must be filed with and approved by the
20 department prior to issuance or delivery by any small employer
21 carrier.
22 4. Before October 1, 2001, and in every fourth year
23 thereafter, the commissioner shall appoint a new health
24 benefit plan committee in the manner provided in subparagraph
25 1. to determine if modifications to a plan might be
26 appropriate and to submit recommended modifications to the
27 department for approval. Such determination shall be based
28 upon prevailing industry standards regarding managed care and
29 cost containment provisions and shall be for the purpose of
30 ensuring that the benefit plans offered to small employers on
31 a guaranteed issue basis are consistent with the low-priced to

mid-priced benefit plans offered in the large group market. This determination shall be included in a report submitted to the President of the Senate and the Speaker of the House of Representatives annually by October 1. ~~After approval of the revised health benefit plans, if the department determines that modifications to a plan might be appropriate, the commissioner shall appoint a new health benefit plan committee in the manner provided in subparagraph 1. to submit recommended modifications to the department for approval.~~

(d)1. Upon offering coverage under a standard health benefit plan, a basic health benefit plan, or a limited benefit policy or contract for any small employer, the small employer carrier shall disclose in writing to the employer ~~provide such employer group with a written statement that contains, at a minimum~~:

~~a. An explanation of those mandated benefits and providers that are not covered by the policy or contract;~~

a.~~b.~~ An outline of coverage ~~An explanation of the managed care and cost control features of the policy or contract,~~along with all appropriate mailing addresses and telephone numbers to be used by insureds in seeking information.~~or authorization; and~~

b.~~c.~~ ~~An explanation of~~ The primary and preventive care features of the policy or contract.

~~Such disclosure statement must be presented in a clear and understandable form and format and must be separate from the policy or certificate or evidence of coverage provided to the employer group.~~

~~2. Before a small employer carrier issues a standard health benefit plan, a basic health benefit plan, or a limited~~

~~benefit policy or contract, it must obtain from the prospective policyholder a signed written statement in which the prospective policyholder:~~

~~a. Certifies as to eligibility for coverage under the standard health benefit plan, basic health benefit plan, or limited benefit policy or contract;~~

c.~~b.~~ ~~Acknowledges~~ The limited nature of the coverage and ~~an understanding of the managed care and~~ the cost control features of the policy or contract.~~;~~

~~c. Acknowledges that if misrepresentations are made regarding eligibility for coverage under a standard health benefit plan, a basic health benefit plan, or a limited benefit policy or contract, the person making such misrepresentations forfeits coverage provided by the policy or contract; and~~

2.~~d.~~ If a limited plan is requested, the prospective policyholder must acknowledge in writing ~~acknowledges~~ that he or she ~~the prospective policyholder~~ had been offered, at the time of application for the insurance policy or contract, the opportunity to purchase any health benefit plan offered by the carrier and that the prospective policyholder had rejected that coverage.

~~A copy of such written statement shall be provided to the prospective policyholder no later than at the time of delivery of the policy or contract, and the original of such written statement shall be retained in the files of the small employer carrier for the period of time that the policy or contract remains in effect or for 5 years, whichever period is longer.~~

~~3. Any material statement made by an applicant for coverage under a health benefit plan which falsely certifies~~

1 ~~as to the applicant's eligibility for coverage serves as the~~
2 ~~basis for terminating coverage under the policy or contract.~~
3 3.~~4.~~ Each marketing communication that is intended to
4 be used in the marketing of a health benefit plan in this
5 state must be submitted for review by the department prior to
6 use and must contain the disclosures stated in this
7 subsection.
8 4. The contract, policy, and certificates evidencing
9 coverage under a limited benefit policy or contract and the
10 application for coverage under such plans must state in not
11 less than 10 point type on the first page in contrasting color
12 the following: "The benefits provided by this health plan are
13 limited and may not cover all of your medical needs. You
14 should carefully review the benefits offered under this health
15 plan."
16 (d)~~(e)~~ A small employer carrier may not use any
17 policy, contract, form, or rate under this section, including
18 applications, enrollment forms, policies, contracts,
19 certificates, evidences of coverage, riders, amendments,
20 endorsements, and disclosure forms, until the insurer has
21 filed it with the department and the department has approved
22 it under ss. 627.410, ~~627.4106, and~~ 627.411, and 641.31.
23 (15) APPLICABILITY OF OTHER STATE LAWS.--
24 (a) Except as expressly provided in this section, a
25 law requiring coverage for a specific health care service or
26 benefit, or a law requiring reimbursement, utilization, or
27 consideration of a specific category of licensed health care
28 practitioner, does not apply to a standard or basic health
29 benefit plan policy or contract or a limited benefit policy or
30 contract offered or delivered to a small employer unless that
31 law is made expressly applicable to such policies or

1 contracts. A law restricting or limiting deductibles,
2 copayments, or annual or lifetime maximum payments does not
3 apply to a limited benefit policy or contract offered or
4 delivered to a small employer unless such law is made
5 expressly applicable to such policy or contract. A limited
6 benefit policy or contract which is offered or delivered to a
7 small employer may also be offered or delivered to an employer
8 with 51 or more eligible employees. Any covered disease or
9 condition may be treated by any physician, without
10 discrimination, licensed or certified to treat the disease or
11 condition.
12 Section 13. Paragraph (b) of subsection (3) of section
13 641.31, Florida Statutes, is amended to read:
14 641.31 Health maintenance contracts.--
15 (3)
16 (b) Any change in the rate is subject to paragraph (d)
17 and requires at least 30 days' advance written notice to the
18 subscriber. In the case of a group member, there may be a
19 contractual agreement with the health maintenance organization
20 to have the employer provide the required notice to the
21 individual members of the group. This paragraph does not apply
22 to a group contract covering 51 or more persons unless the
23 rate is for any coverage under which the increase in claim
24 costs over the lifetime of the contract due to advancing age
25 or duration is prefunded in the premium.
26 Section 14. It is hereby appropriated for State Fiscal
27 Year 2001-2002, $713,493 from the General Revenue Fund and
28 $924,837 from the Medical Care Trust Fund to increase the
29 pharmaceutical dispensing fee for prescriptions dispensed to
30 nursing home residents and other institutional residents from
31 $4.23 to $4.73 per prescription.

1 =============== T I T L E   A M E N D M E N T ===============
2 And the title is amended as follows:
3 On page 20, line 25,
4
5 after the semicolon insert:
6 making legislative findings and providing
7 legislative intent; providing definitions;
8 providing for a pilot program for health flex
9 plans for certain uninsured persons; providing
10 criteria; exempting approved health flex plans
11 from certain licensing requirements; providing
12 criteria for eligibility to enroll in a health
13 flex plan; requiring health flex plan providers
14 to maintain certain records; providing
15 requirements for denial, nonrenewal, or
16 cancellation of coverage; specifying coverage
17 under an approved health flex plan is not an
18 entitlement; providing for civil actions
19 against health plan entities by the Agency for
20 Health Care Administration under certain
21 circumstances; amending s. 627.410, F.S.;
22 exempting group health insurance policies
23 insuring groups of a certain size from rate
24 filing requirements; amending s. 627.6699,
25 F.S.; revising certain definitions; allowing
26 carriers to separate the experience of small
27 employer groups with fewer than two employees;
28 revising the rating factors that may be used by
29 small employer carriers; revising a definition;
30 requiring the Insurance Commissioner to appoint
31 a health benefit plan committee to modify the

1 standard, basic, and limited health benefit
2 plans; revising the disclosure that a carrier
3 must make to a small employer upon offering
4 certain policies; prohibiting small employer
5 carriers from using certain policies,
6 contracts, forms, or rates unless filed with
7 and approved by the Department of Insurance
8 pursuant to certain provisions; restricting
9 application of certain laws to limited benefit
10 policies under certain circumstances;
11 authorizing offering or delivering limited
12 benefit policies or contracts to certain
13 employers; providing requirements for benefits
14 in limited benefit policies or contracts for
15 small employers; amending s. 641.31, F.S.;
16 exempting contracts of group health maintenance
17 organizations covering a specified number of
18 persons from the requirements of filing with
19 the department; providing an appropriation;
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