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

CHAMBER ACTION

Senate		House
	.	

ORIGINAL STAMP BELOW

Representative(s) Berfield offered the following:

Amendment (with title amendment)

remove from the bill: everything after the enacting clause,

and insert in lieu thereof:

Section 1. Paragraph (a) of subsection (6) of section 627.410, Florida Statutes, is amended, and paragraph (f) is added to subsection (7) of said section, to read:

627.410 Filing, approval of forms.--

(6)(a) An insurer shall not deliver or issue for delivery or renew in this state any health insurance policy form until it has filed with the department a copy of every applicable rating manual, rating schedule, change in rating manual, and change in rating schedule; if rating manuals and rating schedules are not applicable, the insurer must file with the department applicable premium rates and any change in applicable premium rates. This paragraph does not apply to group health insurance policies insuring groups of 51 or more persons, except for Medicare supplement insurance, long-term care insurance, and any coverage under which the increase in

1 claims costs over the lifetime of the contract due to
2 advancing age or duration is prefunded in the premium.
3 (7)
4 (f) Insurers with fewer than 1,000 nationwide
5 policyholders or insured group members or subscribers covered
6 under any form or pooled group of forms with health insurance
7 coverage, as described in s. 627.6561(5)(a)2., excluding
8 Medicare supplement insurance coverage under part VIII, at the
9 time of a rate filing made pursuant to subparagraph (b)1., may
10 file for an annual rate increase limited to medical trend as
11 adopted by the department pursuant to s. 627.411(5). The
12 filing is in lieu of the actuarial memorandum required for a
13 rate filing prescribed by paragraph (6)(b). The filing must
14 include forms adopted by the department and a certification by
15 an officer of the company that the filing includes all similar
16 forms.
17 Section 2. Section 627.411, Florida Statutes, is
18 amended to read:
19 627.411 Grounds for disapproval.--
20 (1) The department shall disapprove any form filed
21 under s. 627.410, or withdraw any previous approval thereof,
22 only if the form:
23 (a) Is in any respect in violation of, or does not
24 comply with, this code.
25 (b) Contains or incorporates by reference, where such
26 incorporation is otherwise permissible, any inconsistent,
27 ambiguous, or misleading clauses, or exceptions and conditions
28 which deceptively affect the risk purported to be assumed in
29 the general coverage of the contract.
30 (c) Has any title, heading, or other indication of its
31 provisions which is misleading.

1 (d) Is printed or otherwise reproduced in such manner
2 as to render any material provision of the form substantially
3 illegible.
4 (e) Is for health insurance, and:
5 1. Provides benefits that ~~which~~ are unreasonable in
6 relation to the premium charged;~~,~~
7 2. Contains provisions that ~~which~~ are unfair or
8 inequitable or contrary to the public policy of this state or
9 that ~~which~~ encourage misrepresentation;~~, or~~
10 3. Contains provisions that ~~which~~ apply rating
11 practices that ~~which result in premium escalations that are~~
12 ~~not viable for the policyholder market or~~ result in unfair
13 discrimination pursuant to s. 626.9541(1)(g)2.;~~in sales~~
14 ~~practices.~~
15 4. Results in an actuarially justified rate increase
16 that includes the insurer reducing the portion of the premium
17 used to pay claims from the loss-ratio standard certified in
18 the last actuarial certification filed by the insurer, which
19 rate increase is in excess of the actuarially justified rate
20 increase without such loss-ratio change, by an amount
21 exceeding the greater of 50 percent of annual medical trend or
22 5 percent;
23 5. Results in an actuarially justified rate increase
24 that includes the insurer changing established rate
25 relationships between insureds or types of coverage, which
26 rate increase is in excess of the actuarially justified rate
27 increase without such relationship change, to any insured by
28 an amount exceeding the greater of 50 percent of annual
29 medical trend or 5 percent;
30 6. Results in an actuarially justified rate increase
31 that is in excess of the greater of 150 percent of annual

1 medical trend or 10 percent attributed to the insurer not
2 complying with the annual filing requirements of s. 627.410(7)
3 or department rule adopted under s. 641.31; or
4 7. Results in an actuarially justified rate increase
5 that is in excess of the greater of 150 percent of annual
6 medical trend or 10 percent on a form or block of pooled forms
7 in which no form is currently available for sale. This
8 provision does not apply to prestandardized Medicare
9 supplement forms.
10 (f) Excludes coverage for human immunodeficiency virus
11 infection or acquired immune deficiency syndrome or contains
12 limitations in the benefits payable, or in the terms or
13 conditions of such contract, for human immunodeficiency virus
14 infection or acquired immune deficiency syndrome which are
15 different than those which apply to any other sickness or
16 medical condition.
17 (2) In determining whether the benefits are reasonable
18 in relation to the premium charged, the department, in
19 accordance with reasonable actuarial techniques, shall
20 consider:
21 (a) Past loss experience and prospective loss
22 experience within and without this state.
23 (b) Allocation of expenses.
24 (c) Risk and contingency margins, along with
25 justification of such margins.
26 (d) Acquisition costs.
27 (3) If the renewal rate increase to existing insureds
28 at the time of the rate filing would exceed the indicated
29 levels based on the conditions in subparagraph (1)(e)4.,
30 subparagraph (1)(e)5., or subparagraph (1)(e)6., the insurer
31 may file for approval of a higher new business rate schedule

1 for new insureds and a rate increase of the amount that is
2 actuarially justified by the aggregate data without such
3 condition, plus the greater of 50 percent of annual medical
4 trend or 5 percent for existing insureds. Future annual rate
5 increases for the existing insureds at the time of the
6 exercise of this provision is limited to the greater of 150
7 percent of the rate increase approved for new insureds, the
8 greater of 150 percent of medical trend, or 10 percent, until
9 the rate schedules converge. The application of this
10 subsection is not a violation of s. 627.410(6)(d).
11 (4) If a rate filing changes the established rate
12 relationship between insureds, the aggregate effect of such
13 change shall be revenue neutral. The change to the new
14 relationship shall be phased in under this subsection over a
15 period not to exceed 3 years, as approved by the department.
16 (5) In determining medical trend for application of
17 subparagraphs (1)(e)4., 5., 6., and 7., the department shall
18 semiannually determine medical trend for each health care
19 market, using reasonable actuarial techniques and standards.
20 The trend must be adopted by the department by rule and
21 determined as follows:
22 (a) Trend must be determined separately for medical
23 expense; preferred provider organization; Medicare supplement;
24 health maintenance organization; and other coverage for
25 individual, small group, and large group, where applicable.
26 (b) The department shall survey insurers and health
27 maintenance organizations currently issuing products and
28 representing at least an 80-percent market share based on
29 premiums earned in the state for the most recent calendar year
30 for each of the categories specified in paragraph (a).
31 (c) Trend must be computed as the average annual

1 medical trend approved for the carriers surveyed, giving
2 appropriate weight to each carrier's statewide market share of
3 earned premiums.
4 (d) The annual trend is the annual change in claims
5 cost per unit of exposure. Trend includes the combined effect
6 of medical provider price changes, new medical procedures, and
7 technology and cost shifting.
8 Section 3. Subsection (9) is added to section
9 627.6515, Florida Statutes, to read:
10 627.6515 Out-of-state groups.--
11 (9) For purposes of this section, any insurer that
12 issues any group health insurance policy or group certificate
13 for health insurance to a resident of this state and requires
14 individual underwriting to determine coverage eligibility or
15 premium rates to be charged shall combine the experience of
16 all association-based group policies or association-based
17 group certificates which are substantially similar with
18 respect to type and level of benefits and marketing method
19 issued in this state after the policy form has been in force
20 for a period of 5 years to calculate uniform percentage rate
21 increases. For purposes of this section, policy forms that
22 have different cost-sharing arrangements or different riders
23 are considered to be different policy forms. Nothing in this
24 subsection shall be construed to require uniform rates for
25 policies or certificates after their fifth duration, it being
26 the intent and purpose of this law to require uniform
27 percentage rate increases for such policies or certificates.
28 Furthermore, nothing in this subsection shall be construed to
29 eliminate changes in rates by age for attained age policies or
30 certificates. The provisions of this subsection shall apply to
31 policies or certificates issued after July 1, 2001. For

1 purposes of this subsection, a group health policy or group
2 certificate for health insurance means any hospital or medical
3 policy or certificate, hospital or medical service plan
4 contract, or health maintenance organization subscriber
5 contract. The term does not include accident-only, specified
6 disease, individual hospital indemnity, credit, dental-only,
7 vision-only, Medicare supplement, long-term care, or
8 disability income insurance; similar supplemental plans
9 provided under a separate policy, certificate, or contract of
10 insurance, which cannot duplicate coverage under an underlying
11 health plan and are specifically designed to fill gaps in the
12 underlying health plan, coinsurance, or deductibles; coverage
13 issued as a supplement to liability insurance; workers'
14 compensation or similar insurance; or automobile
15 medical-payment insurance.
16 Section 4. Paragraphs (i) and (n) of subsection (3)
17 and paragraph (b) of subsection (6) of section 627.6699,
18 Florida Statutes, are amended to read:
19 627.6699 Employee Health Care Access Act.--
20 (3) DEFINITIONS.--As used in this section, the term:
21 (i) "Established geographic area" means the county or
22 counties~~, or any portion of a county or counties,~~within which
23 the carrier provides or arranges for health care services to
24 be available to its insureds, members, or subscribers.
25 (n) "Modified community rating" means a method used to
26 develop carrier premiums which spreads financial risk across a
27 large population; allows the use of separate rating factors
28 for age, gender, family composition, tobacco usage, and
29 geographic area as determined under paragraph (5)(j); and
30 allows adjustments for: claims experience, health status, or
31 credits based on the duration that the ~~of~~ coverage has been in

1 force as permitted under subparagraph (6)(b)6.~~subparagraph~~
2 ~~(6)(b)5.~~; and administrative and acquisition expenses as
3 permitted under subparagraph (6)(b)5. A carrier may separate
4 the experience of small employer groups with less than two
5 eligible employees from the experience of small employer
6 groups with two through 50 eligible employees.
7 (6) RESTRICTIONS RELATING TO PREMIUM RATES.--
8 (b) For all small employer health benefit plans that
9 are subject to this section and are issued by small employer
10 carriers on or after January 1, 1994, premium rates for health
11 benefit plans subject to this section are subject to the
12 following:
13 1. Small employer carriers must use a modified
14 community rating methodology in which the premium for each
15 small employer must be determined solely on the basis of the
16 eligible employee's and eligible dependent's gender, age,
17 family composition, tobacco use, or geographic area as
18 determined under paragraph (5)(j) and in which the premium may
19 be adjusted as permitted by subparagraphs 5., ~~and~~ 6., and 7.
20 2. Rating factors related to age, gender, family
21 composition, tobacco use, or geographic location may be
22 developed by each carrier to reflect the carrier's experience.
23 The factors used by carriers are subject to department review
24 and approval.
25 3. If the modified community rate is determined from
26 two experience pools as authorized by paragraph (5)(n), the
27 rate to be charged to small employer groups of less than two
28 eligible employees may not exceed 150 percent of the rate
29 determined for groups of two through 50 eligible employees;
30 however, the carrier may charge excess losses of the
31 less-than-two-eligible-employee experience pool to the

experience pool of the two through 50 eligible employees so that all losses are allocated and the 150-percent rate limit on the less-than-two-eligible-employee experience pool is maintained. Notwithstanding the provisions of s. 627.411(1)(e)4. and (3), the rate to be charged to a small employer group of fewer than 2 eligible employees insured as of July 1, 2001, may be up to 125 percent of the rate determined for groups of 2 through 50 eligible employees for the first annual renewal and 150 percent for subsequent annual renewals.

4.~~3.~~ Small employer carriers may not modify the rate for a small employer for 12 months from the initial issue date or renewal date, unless the composition of the group changes or benefits are changed. However, a small employer carrier may modify the rate one time prior to 12 months after the initial issue date for a small employer who enrolls under a previously issued group policy that has a common anniversary date for all employers covered under the policy if:

a. The carrier discloses to the employer in a clear and conspicuous manner the date of the first renewal and the fact that the premium may increase on or after that date.

b. The insurer demonstrates to the department that efficiencies in administration are achieved and reflected in the rates charged to small employers covered under the policy.

5.~~4.~~ A carrier may issue a group health insurance policy to a small employer health alliance or other group association with rates that reflect a premium credit for expense savings attributable to administrative activities being performed by the alliance or group association if such expense savings are specifically documented in the insurer's rate filing and are approved by the department. Any such

1 credit may not be based on different morbidity assumptions or
2 on any other factor related to the health status or claims
3 experience of any person covered under the policy. Nothing in
4 this subparagraph exempts an alliance or group association
5 from licensure for any activities that require licensure under
6 the insurance code. A carrier issuing a group health insurance
7 policy to a small employer health alliance or other group
8 association shall allow any properly licensed and appointed
9 agent of that carrier to market and sell the small employer
10 health alliance or other group association policy. Such agent
11 shall be paid the usual and customary commission paid to any
12 agent selling the policy.
13 6.~~5.~~ Any adjustments in rates for claims experience,
14 health status, or credits based on the duration of coverage
15 may not be charged to individual employees or dependents. For
16 a small employer's policy, such adjustments may not result in
17 a rate for the small employer which deviates more than 15
18 percent from the carrier's approved rate. Any such adjustment
19 must be applied uniformly to the rates charged for all
20 employees and dependents of the small employer. A small
21 employer carrier may make an adjustment to a small employer's
22 renewal premium, not to exceed 10 percent annually, due to the
23 claims experience, health status, or credits based on the
24 duration of coverage of the employees or dependents of the
25 small employer. Semiannually, small group carriers shall
26 report information on forms adopted by rule by the department,
27 to enable the department to monitor the relationship of
28 aggregate adjusted premiums actually charged policyholders by
29 each carrier to the premiums that would have been charged by
30 application of the carrier's approved modified community
31 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 employees. For the purposes of this subparagraph, a "composite rating methodology" means a rating methodology that averages the impact of the rating factors for age and gender in the premiums charged to all of the employees of a small employer.

1 Section 5. Section 627.9408, Florida Statutes, is
2 amended to read:
3 627.9408 Rules.--
4 (1) The department may ~~has authority to~~ adopt rules
5 pursuant to ss. 120.536(1) and 120.54 to administer ~~implement~~
6 ~~the provisions of~~ this part.
7 (2) The department may adopt by rule the provisions of
8 the Long-Term Care Insurance Model Regulation adopted by the
9 National Association of Insurance Commissioners in the second
10 quarter of the year 2000 which are not in conflict with the
11 Florida Insurance Code.
12 Section 6. Paragraph (b) of subsection (3) of section
13 641.31, Florida Statutes, is amended, and paragraph (f) is
14 added to said subsection, to read:
15 641.31 Health maintenance contracts.--
16 (3)
17 (b) Any change in the rate is subject to paragraph (d)
18 and requires at least 30 days' advance written notice to the
19 subscriber. In the case of a group member, there may be a
20 contractual agreement with the health maintenance organization
21 to have the employer provide the required notice to the
22 individual members of the group. This paragraph does not apply
23 to a group contract covering 51 or more persons unless the
24 rate is for any coverage under which the increase in claim
25 costs over the lifetime of the contract due to advancing age
26 or duration is prefunded in the premium.
27 (f) A health maintenance organization with fewer than
28 1,000 covered subscribers under all individual or group
29 contracts, at the time of a rate filing, may file for an
30 annual rate increase limited to annual medical trend, as
31 adopted by the department. The filing is in lieu of the

1 actuarial memorandum otherwise required for the rate filing.
2 The filing must include forms adopted by the department and a
3 certification by an officer of the company that the filing
4 includes all similar forms.
5 Section 7. Paragraphs (a) and (b) of subsection (1) of
6 section 641.3155, Florida Statutes, are amended to read:
7 641.3155 Payment of claims.--
8 (1)(a) As used in this section, the term "clean claim"
9 for a noninstitutional provider means a claim submitted on a
10 HCFA 1500 form which has no defect or impropriety, including
11 lack of required substantiating documentation for
12 noncontracted providers and suppliers, or particular
13 circumstances requiring special treatment which prevent timely
14 payment from being made on the claim. A claim may not be
15 considered not clean solely because a health maintenance
16 organization refers the claim to a medical specialist within
17 the health maintenance organization for examination. If
18 additional substantiating documentation, such as the medical
19 record or encounter data, is required from a source outside
20 the health maintenance organization, the claim is considered
21 not clean. This paragraph does not apply to claims which
22 include potential coordination of benefits for third-party
23 liability or subrogation, as evidenced by the information
24 provided on the claim form related to coordination of
25 benefits.This definition of "clean claim" is repealed on the
26 effective date of rules adopted by the department which define
27 the term "clean claim."
28 (b) Absent a written definition that is agreed upon
29 through contract, the term "clean claim" for an institutional
30 claim is a properly and accurately completed paper or
31 electronic billing instrument that consists of the UB-92 data

1 set or its successor with entries stated as mandatory by the
2 National Uniform Billing Committee. This paragraph does not
3 apply to claims which include potential coordination of
4 benefits for third-party liability or subrogation, as
5 evidenced by the information provided on the claim form
6 related to coordination of benefits.
7 Section 8. Health flex plans.--
8 (1) INTENT.--The Legislature finds that a significant
9 portion of the residents of this state are not able to obtain
10 affordable health insurance coverage. Therefore, it is the
11 intent of the Legislature to expand the availability of health
12 care options for lower income uninsured state residents by
13 encouraging health insurers, health maintenance organizations,
14 health care provider sponsored organizations, local
15 governments, health care districts, or other public or private
16 community-based organizations to develop alternative
17 approaches to traditional health insurance which emphasize
18 coverage for basic and preventive health care services. To
19 the maximum extent possible, such options should be
20 coordinated with existing governmental or community-based
21 health services programs in a manner that is consistent with
22 the objectives and requirements of such programs.
23 (2) DEFINITIONS.--As used in this section:
24 (a) "Agency" means the Agency for Health Care
25 Administration.
26 (b) "Approved plan" means a health flex plan approved
27 under subsection (3) which guarantees payment by the health
28 plan entity for specified health care services provided to the
29 enrollee.
30 (c) "Enrollee" means an individual who has been
31 determined eligible for and is receiving health benefits under

1 a health flex plan approved under this section.
2 (d) "Health care coverage" means payment for health
3 care services covered as benefits under an approved plan or
4 that otherwise provides, either directly or through
5 arrangements with other persons, covered health care services
6 on a prepaid per-capita basis or on a prepaid aggregate
7 fixed-sum basis.
8 (e) "Health plan entity" means a health insurer,
9 health maintenance organization, health care provider
10 sponsored organization, local government, health care
11 districts, or other public or private community-based
12 organization that develops and implements an approved plan and
13 is responsible for financing and paying all claims by
14 enrollees of the plan.
15 (3) PILOT PROGRAM.--The agency and the Department of
16 Insurance shall jointly approve or disapprove health flex
17 plans which provide health care coverage for eligible
18 participants residing in the three areas of the state having
19 the highest number of uninsured residents as determined by the
20 agency. A plan may limit or exclude benefits otherwise
21 required by law for insurers offering coverage in this state,
22 cap the total amount of claims paid in 1 year per enrollee, or
23 limit the number of enrollees covered. The agency and the
24 Department of Insurance shall not approve or shall withdraw
25 approval of a plan which:
26 (a) Contains any ambiguous, inconsistent, or
27 misleading provisions, or exceptions or conditions that
28 deceptively affect or limit the benefits purported to be
29 assumed in the general coverage provided by the plan;
30 (b) Provides benefits that are unreasonable in
31 relation to the premium charged, contains provisions that are

1 unfair or inequitable or contrary to the public policy of this
2 state or that encourage misrepresentation, or result in unfair
3 discrimination in sales practices; or
4 (c) Cannot demonstrate that the plan is financially
5 sound and the applicant has the ability to underwrite or
6 finance the benefits provided.
7 (4) LICENSE NOT REQUIRED.--A health flex plan approved
8 under this section shall not be subject to the licensing
9 requirements of the Florida Insurance Code or chapter 641,
10 Florida Statutes, relating to health maintenance
11 organizations, unless expressly made applicable. However, for
12 the purposes of prohibiting unfair trade practices, health
13 flex plans shall be considered insurance subject to the
14 applicable provisions of part IX of chapter 626, Florida
15 Statutes, except as otherwise provided in this section.
16 (5) ELIGIBILITY.--Eligibility to enroll in an approved
17 health flex plan is limited to residents of this state who:
18 (a) Are 64 years of age or younger;
19 (b) Have a family income equal to or less than 200
20 percent of the federal poverty level;
21 (c) Are not covered by a private insurance policy and
22 are not eligible for coverage through a public health
23 insurance program such as Medicare or Medicaid, or other
24 public health care program, including, but not limited to,
25 Kidcare, and have not been covered at any time during the past
26 6 months; and
27 (d) Have applied for health care benefits through an
28 approved health flex plan and agree to make any payments
29 required for participation, including, but not limited to,
30 periodic payments and payments due at the time health care
31 services are provided.

1 (6) RECORDS.--Every health flex plan provider shall
2 maintain reasonable records of its loss, expense, and claims
3 experience and shall make such records reasonably available to
4 enable the agency and the Department of Insurance to monitor
5 and determine the financial viability of the plan, as
6 necessary.
7 (7) NOTICE.--The denial of coverage by the health plan
8 entity shall be accompanied by the specific reasons for
9 denial, nonrenewal, or cancellation. Notice of nonrenewal or
10 cancellation shall be provided at least 45 days in advance of
11 such nonrenewal or cancellation except that 10 days' written
12 notice shall be given for cancellation due to nonpayment of
13 premiums. If the health plan entity fails to give the
14 required notice, the plan shall remain in effect until notice
15 is appropriately given.
16 (8) NONENTITLEMENT.--Coverage under an approved health
17 flex plan is not an entitlement and no cause of action shall
18 arise against the state, local governmental entity, or other
19 political subdivision of this state or the agency for failure
20 to make coverage available to eligible persons under this
21 section.
22 (9) CIVIL ACTIONS.--In addition to an administrative
23 action initiated under subsection (4), the agency may seek any
24 remedy provided by law, including, but not limited to, the
25 remedies provided in s. 812.035, Florida Statutes, if the
26 agency finds that a health plan entity has engaged in any act
27 resulting in injury to an enrollee covered by a plan approved
28 under this section.
29 Section 9. The Legislature finds that the
30 affordability and availability of health insurance is one of
31 the most important and complex issues in this state and that

1 coverage issued to a state resident under group health
2 insurance policies issued outside the state is an important
3 factor in meeting the needs of the citizens of this state.
4 The Legislature also finds that it is important to ensure that
5 those policies are adequately regulated in order to maintain
6 the quality of the coverage offered to citizens of this state.
7 Therefore, the Workgroup on Out of State Group Policies is
8 hereby created to study the regulatory environment in which
9 these policies are now offered and recommend any statutory
10 changes that may be necessary to maintain the quality of the
11 insurance offered in this state. There shall be four members
12 from the House of Representatives appointed by the Speaker of
13 the House of Representatives and four members from the Senate
14 appointed by the President of the Senate. The group shall
15 begin its meetings by July 1, 2001, and complete its meetings
16 by November 15, 2001. Recommendations for suggested
17 legislation shall be delivered to the Speaker of the House of
18 Representatives and the President of the Senate by December
19 15, 2001. At its first meeting, the group shall elect a chair
20 from among its members.
21 Section 10. This act shall take effect July 1, 2001.
22
23
24 =============== T I T L E A M E N D M E N T ===============
25 And the title is amended as follows:
26 remove from the title of the bill: the entire title
27
28 and insert in lieu thereof:
29 An act relating to health insurance; amending
30 s. 627.410, F.S.; exempting group health
31 insurance policies insuring groups of a certain

1 size from rate filing requirements; providing
2 alternative rate filing requirements for
3 insurers with less than a specified number of
4 nationwide policyholders or members; amending
5 s. 627.411, F.S.; revising the grounds for the
6 disapproval of insurance policy forms;
7 providing that a health insurance policy form
8 may be disapproved if it results in certain
9 rate increases; specifying allowable new
10 business rates and renewal rates if rate
11 increases exceed certain levels; authorizing
12 the Department of Insurance to determine
13 medical trend for purposes of approving rate
14 filings; amending s. 627.6515, F.S.; providing
15 additional experience requirements and
16 limitations for out-of-state groups; providing
17 construction; amending s. 627.6699, F.S.;
18 revising definitions; allowing carriers to
19 separate the experience of small employer
20 groups with fewer than two employees; revising
21 the rating factors that may be used by small
22 employer carriers; amending s. 627.9408, F.S.;
23 authorizing the department to adopt by rule
24 certain provisions of the Long-Term Care
25 Insurance Model Regulation, as adopted by the
26 National Association of Insurance
27 Commissioners; amending s. 641.31, F.S.;
28 exempting contracts of group health maintenance
29 organizations covering a specified number of
30 persons from the requirements of filing with
31 the department; providing alternative rate

1 filing requirements for organizations with less
2 than a specified number of subscribers;
3 amending s. 641.3155, F.S.; specifying
4 nonapplication of certain provisions to certain
5 claims; providing for certain health flex
6 plans; providing legislative intent; providing
7 definitions; providing for a pilot program for
8 health flex plans for certain uninsured
9 persons; providing criteria; exempting approved
10 health flex plans from certain licensing
11 requirements; providing criteria for
12 eligibility to enroll in a health flex plan;
13 requiring health flex plan providers to
14 maintain certain records; providing
15 requirements for denial, nonrenewal, or
16 cancellation of coverage; specifying that
17 coverage under an approved health flex plan is
18 not an entitlement; providing for civil actions
19 against health plan entities by the Agency for
20 Health Care Administration under certain
21 circumstances; providing legislative findings;
22 creating the Workgroup on Out of State Group
23 Policies; providing for membership; providing
24 purposes; requiring recommendations for
25 proposed legislation; providing an effective
26 date.
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