HOUSE AMENDMENT

Bill No. CS/HB 1253

Amendment No. 1 (for drafter's use only)

CHAMBER ACTION

Senate | House

ORIGINAL STAMP BELOW

The Council for Healthy Communities offered the following:

Amendment (with title amendment)

On page 2, line 17,

remove from the bill: everything after the enacting clause,

and insert in lieu thereof:

Section 1. 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 the objectives and requirements of such programs.

(2) DEFINITIONS.--As used in this section:

(a) "Agency" means the Agency for Health Care Administration.

(b) "Approved plan" means a health flex plan approved under subsection (3) which guarantees payment by the health plan entity for specified health care services provided to the enrollee.

(c) "Enrollee" means an individual who has been determined eligible for and is receiving health benefits under a health flex plan approved under this section.

(d) "Health care coverage" means payment for health care services covered as benefits under an approved plan or that otherwise provides, either directly or through arrangements with other persons, covered health care services on a prepaid per capita basis or on a prepaid aggregate fixed-sum basis.

(e) "Health plan entity" means a health insurer, health maintenance organization, health care provider-sponsored organization, local government, health care districts, or other public or private community-based organization which develops and implements an approved plan, and is responsible for financing and paying all claims by enrollees of the plan.

(3) PILOT PROGRAM.--The agency and the Department of Insurance shall jointly approve or disapprove health flex plans which provide health care coverage for eligible participants residing in the three areas of the state having the highest number of uninsured residents as determined by the agency. A plan may limit or exclude benefits otherwise

required by law for insurers offering coverage in this state, cap the total amount of claims paid in 1 year per enrollee, or limit the number of enrollees covered. The agency and the Department of Insurance shall not approve or shall withdraw approval of a plan which:

(a) Contains any ambiguous, inconsistent, or misleading provisions, or exceptions or conditions that deceptively affect or limit the benefits purported to be assumed in the general coverage provided by the plan;

(b) Provides benefits that are unreasonable in relation to the premium charged, contains provisions that are unfair or inequitable or contrary to the public policy of this state or that encourage misrepresentation, or result in unfair discrimination in sales practices; or

(c) Cannot demonstrate that the plan is financially sound and the applicant has the ability to underwrite or finance the benefits provided.

(4) LICENSE NOT REQUIRED.--A health flex plan approved under this section shall not be subject to the licensing requirements of the Florida Insurance Code or chapter 641, Florida Statutes, relating to health maintenance organizations, unless expressly made applicable. However, for the purposes of prohibiting unfair trade practices, health flex plans shall be considered insurance subject to the applicable provisions of part IX of chapter 626, Florida Statutes, except as otherwise provided in 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 200 percent of the federal poverty level.

(c) 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, or other public health care program, including, but not limited to, Kidcare, and have not been covered at any time during the past 6 months.

(d) Have applied for health care benefits through an approved health flex plan and agree to make any payments required for participation, including, but not limited to, periodic payments and payments due at the time health care services are provided.

(6) RECORDS.--Every health flex plan provider shall maintain reasonable records of its loss, expense, and claims experience and shall make such records reasonably available to enable the agency and the Department of Insurance to monitor and determine the financial viability of the plan, as necessary.

(7) NOTICE.--The denial of coverage by the health plan entity shall be accompanied by the specific reasons for denial, nonrenewal, or cancellation. Notice of nonrenewal or cancellation shall be provided at least 45 days in advance of such nonrenewal or cancellation except that 10 days' written notice shall be given for cancellation due to nonpayment of premiums. If the health plan entity fails to give the required notice, the plan shall remain in effect until notice is appropriately given.

(8) NONENTITLEMENT.--Coverage under an approved health flex plan is not an entitlement and no cause of action shall arise against the state, local governmental entity, or other political subdivision of this state or the agency for failure to make coverage available to eligible persons under this

section.

(9) CIVIL ACTIONS.--In addition to an administrative action initiated under subsection (4), the agency may seek any remedy provided by law, including, but not limited to, the remedies provided in s. 812.035, Florida Statutes, if the agency finds that a health plan entity has engaged in any act resulting in injury to an enrollee covered by a plan approved under this section.

Section 2. Paragraph (m) of subsection (3), paragraphs (a), (d), and (e) of subsection (12), and paragraph (a) of subsection (15) of section 627.6699, Florida Statutes, are amended to read:

627.6699 Employee Health Care Access Act.--

(3) DEFINITIONS.--As used in this section, the term:

(m) "Limited benefit policy or contract" means a policy or contract that provides coverage for each person insured under the policy for a specifically named disease or diseases, a specifically named accident, or ~~a specifically named limited market~~ that fulfills a ~~an experimental or~~ reasonable need by providing more affordable health insurance~~, such as the small group market~~.

(12) STANDARD, BASIC, AND LIMITED HEALTH BENEFIT PLANS.--

(a)1. By May 15, 1993, the commissioner shall appoint a health benefit plan committee composed of four representatives of carriers which shall include at least two representatives of HMOs, at least one of which is a staff model HMO, two representatives of agents, four representatives of small employers, and one employee of a small employer. The carrier members shall be selected from a list of individuals recommended by the board. The commissioner may require the

board to submit additional recommendations of individuals for appointment.

2. The plans shall comply with all of the requirements of this subsection.

3. The plans must be filed with and approved by the department prior to issuance or delivery by any small employer carrier.

4. Before October 1, 2001, and in every fourth year thereafter, the commissioner shall appoint a new health benefit plan committee in the manner provided in subparagraph 1. to determine if modifications to a plan might be appropriate and to submit recommended modifications to the department for approval. Such determination shall be based upon prevailing industry standards regarding managed care and cost containment provisions and shall be for the purpose of ensuring that the benefit plans offered to small employers on 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 as to the applicant's eligibility for coverage serves as the basis for terminating coverage under the policy or contract.~~

3.~~4.~~ Each marketing communication that is intended to be used in the marketing of a health benefit plan in this state must be submitted for review by the department prior to use and must contain the disclosures stated in this subsection.

4. The contract, policy, and certificates evidencing coverage under a limited benefit policy or contract and the application for coverage under such plans must state in not less than 10 point type on the first page in contrasting color the following: "The benefits provided by this health plan are limited and may not cover all of your medical needs. You should carefully review the benefits offered under this health

plan."

(d)~~(c)~~ A small employer carrier may not use any policy, contract, form, or rate under this section, including applications, enrollment forms, policies, contracts, certificates, evidences of coverage, riders, amendments, endorsements, and disclosure forms, until the insurer has filed it with the department and the department has approved it under ss. 627.410, ~~627.4106, and~~ 627.411, and 641.31.

(15) APPLICABILITY OF OTHER STATE LAWS.--

(a) Except as expressly provided in this section, a law requiring coverage for a specific health care service or benefit, or a law requiring reimbursement, utilization, or consideration of a specific category of licensed health care practitioner, does not apply to a standard or basic health benefit plan policy or contract or a limited benefit policy or contract offered or delivered to a small employer unless that law is made expressly applicable to such policies or contracts. A law restricting or limiting deductibles, copayments, or annual or lifetime maximum payments does not apply to a limited benefit policy or contract offered or delivered to a small employer unless such law is made expressly applicable to such policy or contract. A limited benefit policy or contract which is offered or delivered to a small employer may also be offered or delivered to an employer with 51 or more eligible employees. Any covered disease or condition may be treated by any physician, without discrimination, licensed or certified to treat the disease or condition.

Section 3. This act shall take effect October 1, 2001.

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========== T I T L E A M E N D M E N T ==========
And the title is amended as follows:

On page 1, line 2, through page 2, line 14, remove from the title of the bill: all of said lines,

and insert in lieu thereof:

An act relating to health care; making legislative findings and providing legislative intent; providing definitions; providing for a pilot program for health flex plans for certain uninsured persons; providing criteria; exempting approved health flex plans from certain licensing requirements; providing criteria for eligibility to enroll in a health flex plan; requiring health flex plan providers to maintain certain records; providing requirements for denial, nonrenewal, or cancellation of coverage; specifying coverage under an approved health flex plan is not an entitlement; providing for civil actions against health plan entities by the Agency for Health Care Administration under certain circumstances; amending s. 627.6699, F.S.; revising a definition; requiring the Insurance Commissioner to appoint a health benefit plan committee to modify the standard, basic, and limited health benefit plans; revising the disclosure that a carrier must make to a small employer upon offering certain policies; prohibiting small employer carriers from using certain policies, contracts, forms, or rates

unless filed with and approved by the Department of Insurance pursuant to certain provisions; restricting application of certain laws to limited benefit policies under certain circumstances; authorizing offering or delivering limited benefit policies or contracts to certain employers; providing requirements for benefits in limited benefit policies or contracts for small employers; providing an effective date.

WHEREAS, the Legislature recognizes that the increasing number of uninsured Floridians is due in part to small employers' and their employees' inability to afford comprehensive health insurance coverage, and

WHEREAS, the Legislature recognizes the need for small employers and their employees to have the opportunity to choose more affordable and flexible health insurance plans, and

WHEREAS, it is the intent of the Legislature that insurers and health maintenance organizations have maximum flexibility in health plan design or in developing a health plan design to complement a medical savings account program established by a small employer for the benefit of its employees, NOW, THEREFORE,