By the Committee on Insurance and Representative Farkas

1 A bill to be entitled
2 An act relating to health insurance; providing
3 legislative intent; providing definitions;
4 providing for a pilot program for health flex
5 plans for certain uninsured persons; providing
6 criteria; exempting approved health flex plans
7 from certain licensing requirements; providing
8 criteria for eligibility to enroll in a health
9 flex plan; requiring health flex plan providers
10 to maintain certain records; providing
11 requirements for denial, nonrenewal, or
12 cancellation of coverage; specifying coverage
13 under an approved health flex plan is not an
14 entitlement; providing for civil actions
15 against health plan entities by the Agency for
16 Health Care Administration under certain
17 circumstances; amending s. 627.6699, F.S.;
18 revising certain definitions; requiring the
19 Insurance Commissioner to appoint new health
20 benefit plan committees under certain
21 circumstances for certain purposes; revising
22 certain coverage disclosure requirements for
23 small employer carriers; including certain form
24 filing, approval, and disapproval requirements
25 and procedures relating to health maintenance
26 organizations within certain small employer
27 carrier proscriptions; providing certain notice
28 requirements; restricting application of
29 certain laws to limited benefit policies under
30 certain circumstances; authorizing offering or
31 delivering limited benefit policies or

1 contracts to certain employers; providing an
2 effective date.
3
4 WHEREAS, the Legislature recognizes that the increasing
5 number of uninsured Floridians is due in part to small
6 employers' and their employees' inability to afford
7 comprehensive health insurance coverage, and
8 WHEREAS, the Legislature recognizes the need for small
9 employers and their employees to have the opportunity to
10 choose more affordable and flexible health insurance plans,
11 and
12 WHEREAS, it is the intent of the Legislature that
13 insurers and health maintenance organizations have maximum
14 flexibility in health plan design, NOW, THEREFORE,
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16 Be It Enacted by the Legislature of the State of Florida:
17
18 Section 1. Health flex plans.--
19 (1) INTENT.--The Legislature finds that a significant
20 portion of the residents of this state are not able to obtain
21 affordable health insurance coverage. Therefore, it is the
22 intent of the Legislature to expand the availability of health
23 care options for uninsured, lower income state residents by
24 encouraging health insurers, health maintenance organizations,
25 health care provider-sponsored organizations, local
26 governments, health care districts, or other public or private
27 community-based organizations to develop alternative
28 approaches to traditional health insurance which emphasize
29 coverage for basic and preventive health care services. To
30 the maximum extent possible, such options should be
31 coordinated with existing governmental or community-based

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

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

1 (c) Are not covered by a private insurance policy and
2 are not eligible for coverage through a public health
3 insurance program such as Medicare or Medicaid, or other
4 public health care program, including, but not limited to,
5 Kidcare, and have not been covered at any time during the past
6 6 months; and
7 (d) Have applied for health care benefits through an
8 approved health flex plan and agree to make any payments
9 required for participation, including, but not limited to,
10 periodic payments and payments due at the time health care
11 services are provided.
12 (6) RECORDS.--Every health flex plan provider shall
13 maintain reasonable records of its loss, expense, and claims
14 experience and shall make such records reasonably available to
15 enable the agency and the Department of Insurance to monitor
16 and determine the financial viability of the plan, as
17 necessary.
18 (7) NOTICE.--The denial of coverage by the health plan
19 entity shall be accompanied by the specific reasons for
20 denial, nonrenewal, or cancellation. Notice of nonrenewal or
21 cancellation shall be provided at least 45 days in advance of
22 such nonrenewal or cancellation, except that 10 days' written
23 notice shall be given for cancellation due to nonpayment of
24 premiums. If the health plan entity fails to give the
25 required notice, the plan shall remain in effect until notice
26 is appropriately given.
27 (8) NONENTITLEMENT.--Coverage under an approved health
28 flex plan is not an entitlement and no cause of action shall
29 arise against the state, local governmental entity, or other
30 political subdivision of this state or the agency for failure
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1 to make coverage available to eligible persons under this
2 section.
3 (9) CIVIL ACTIONS.--In addition to an administrative
4 action initiated under subsection (4), the agency may seek any
5 remedy provided by law, including, but not limited to, the
6 remedies provided in s. 812.035, Florida Statutes, if the
7 agency finds that a health plan entity has engaged in any act
8 resulting in injury to an enrollee covered by a plan approved
9 under this section.
10 Section 2. Paragraphs (m) and (w) of subsection (3),
11 paragraphs (a), (d), and (e) of subsection (12), and paragraph
12 (a) of subsection (15) of section 627.6699, Florida Statutes,
13 are amended, and paragraph (f) is added to subsection (12) of
14 said section, to read:
15 627.6699 Employee Health Care Access Act.--
16 (3) DEFINITIONS.--As used in this section, the term:
17 (m) "Limited benefit policy or contract" means a
18 policy or contract that provides coverage for each person
19 insured under the policy for a specifically named disease or
20 diseases or~~,~~a specifically named accident~~,~~or coverages ~~a~~
21 ~~specifically named limited market~~ that fulfill a ~~fulfills an~~
22 ~~experimental or~~ reasonable need by providing more affordable
23 health insurance or complement a medical savings account
24 program established by a small employer for the benefit of its
25 employees~~, such as the small group market~~.
26 (w) "Small employer carrier" means a carrier that
27 offers health benefit plans covering eligible employees of one
28 or more small employers, but does not include a carrier that
29 issues only limited benefit policies or contracts to small
30 employers.
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(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 odd-numbered 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 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 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;~~

~~b. 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~~

a.~~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;~~

b. ~~Acknowledges~~ The limited nature of the coverage and ~~an understanding of~~ the ~~managed care and~~ 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~~

~~d. If a limited plan is requested, acknowledges that 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.~~

~~4. Each marketing communication that is intended to be used in the marketing of a health benefit plan in this state~~

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~~must be submitted for review by the department prior to use and must contain the disclosures stated in this subsection.~~

(e) 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.

(f) The contract, policy, and certificates evidencing coverage under a standard health benefit plan, a basic health benefit plan, or 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."

(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 for treatment of a specific disease or condition 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 limited benefit policy or contract shall comply with s. 627.419(1), (2), (3), and (4).

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

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