By the Committee on Banking and Insurance; and Senators Latvala and King

311-1867-01

1 A bill to be entitled
2 An act relating to health care; making
3 legislative findings and providing legislative
4 intent; providing definitions; providing for a
5 pilot program for health flex plans for certain
6 uninsured persons; providing criteria;
7 exempting approved health flex plans from
8 certain licensing requirements; providing
9 criteria for eligibility to enroll in a health
10 flex plan; requiring health flex plan providers
11 to maintain certain records; providing
12 requirements for denial, nonrenewal, or
13 cancellation of coverage; specifying that
14 coverage under an approved health flex plan is
15 not an entitlement; providing for civil actions
16 against health plan entities by the Agency for
17 Health Care Administration under certain
18 circumstances; amending s. 627.410, F.S.;
19 requiring certain group certificates for health
20 insurance coverage to be subject to the
21 requirements for individual health insurance
22 policies; exempting group health insurance
23 policies insuring groups of a certain size from
24 rate filing requirements; providing alternative
25 rate filing requirements for insurers with less
26 than a specified number of nationwide
27 policyholders or members; amending s. 627.411,
28 F.S.; revising the grounds for the disapproval
29 of insurance policy forms; providing that a
30 health insurance policy form may be disapproved
31 if it results in certain rate increases;

1 specifying allowable new business rates and
2 renewal rates if rate increases exceed certain
3 levels; authorizing the Department of Insurance
4 to determine medical trend for purposes of
5 approving rate filings; amending s. 627.6487,
6 F.S.; revising the types of policies that
7 individual health insurers must offer to
8 persons eligible for guaranteed individual
9 health insurance coverage; prohibiting
10 individual health insurers from applying
11 discriminatory underwriting or rating practices
12 to eligible individuals; amending s. 627.6515,
13 F.S.; requiring that coverage issued to a state
14 resident under certain group health insurance
15 policies issued outside the state be subject to
16 the requirements for individual health
17 insurance policies; amending s. 627.6699, F.S.;
18 revising definitions used in the Employee
19 Health Care Access Act; allowing carriers to
20 separate the experience of small employer
21 groups with fewer than two employees; revising
22 the rating factors that may be used by small
23 employer carriers; requiring the Insurance
24 Commissioner to appoint a health benefit plan
25 committee to modify the standard, basic, and
26 limited health benefit plans; revising the
27 disclosure that a carrier must make to a small
28 employer upon offering certain policies;
29 prohibiting small employer carriers from using
30 certain policies, contracts, forms, or rates
31 unless filed with and approved by the

1 Department of Insurance pursuant to certain
2 provisions; restricting application of certain
3 laws to limited benefit policies under certain
4 circumstances; authorizing offering or
5 delivering limited benefit policies or
6 contracts to certain employers; providing
7 requirements for benefits in limited benefit
8 policies or contracts for small employers;
9 amending s. 627.9408, F.S.; authorizing the
10 department to adopt by rule certain provisions
11 of the Long-Term Care Insurance Model
12 Regulation, as adopted by the National
13 Association of Insurance Commissioners;
14 amending s. 641.31, F.S.; exempting contracts
15 of group health maintenance organizations
16 covering a specified number of persons from the
17 requirements of filing with the department;
18 specifying the standards for department
19 approval and disapproval of a change in rates
20 by a health maintenance organization; providing
21 alternative rate filing requirements for
22 organizations with less than a specified number
23 of subscribers; providing an effective date.
24
25 WHEREAS, the Legislature recognizes that the increasing
26 number of uninsured Floridians is due in part to small
27 employers' and their employees' inability to afford
28 comprehensive health insurance coverage, and
29 WHEREAS, the Legislature recognizes the need for small
30 employers and their employees to have the opportunity to
31

1 choose more affordable and flexible health insurance plans,
2 and
3 WHEREAS, it is the intent of the Legislature that
4 insurers and health maintenance organizations have maximum
5 flexibility in health plan design or in developing a health
6 plan design to complement a medical savings account program
7 established by a small employer for the benefit of its
8 employees, NOW, THEREFORE,
9
10 Be It Enacted by the Legislature of the State of Florida:
11
12 Section 1. Health flex plans.--
13 (1) INTENT.--The Legislature finds that a significant
14 portion of state residents are not able to obtain affordable
15 health insurance coverage. Therefore, it is the intent of the
16 Legislature to expand the availability of health care options
17 for lower-income uninsured state residents by encouraging
18 health insurers, health maintenance organizations, health care
19 provider-sponsored organizations, local governments, health
20 care districts, and other public or private community-based
21 organizations to develop alternative approaches to traditional
22 health insurance which emphasize coverage for basic and
23 preventive health care services. To the maximum extent
24 possible, these options should be coordinated with existing
25 governmental or community-based health services programs in a
26 manner that is consistent with the objectives and requirements
27 of such programs.
28 (2) DEFINITIONS.--As used in this section, the term:
29 (a) "Agency" means the Agency for Health Care
30 Administration.
31

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

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

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

1 remedies provided in section 812.035, Florida Statutes, if the
2 agency finds that a health plan entity has engaged in any act
3 resulting in injury to an enrollee covered by a plan approved
4 under this section.
5 Section 2. Subsection (1) and paragraph (a) of
6 subsection (6) of section 627.410, Florida Statutes, are
7 amended, and paragraph (f) is added to subsection (7) of that
8 section, to read:
9 627.410 Filing, approval of forms.--
10 (1) No basic insurance policy or annuity contract
11 form, or application form where written application is
12 required and is to be made a part of the policy or contract,
13 or group certificates issued under a master contract delivered
14 in this state, or printed rider or endorsement form or form of
15 renewal certificate, shall be delivered or issued for delivery
16 in this state, unless the form has been filed with the
17 department at its offices in Tallahassee by or in behalf of
18 the insurer which proposes to use such form and has been
19 approved by the department. This provision does not apply to
20 surety bonds or to policies, riders, endorsements, or forms of
21 unique character which are designed for and used with relation
22 to insurance upon a particular subject (other than as to
23 health insurance), or which relate to the manner of
24 distribution of benefits or to the reservation of rights and
25 benefits under life or health insurance policies and are used
26 at the request of the individual policyholder, contract
27 holder, or certificateholder. As to group insurance policies
28 effectuated and delivered outside this state but covering
29 persons resident in this state, the group certificates to be
30 delivered or issued for delivery in this state shall be filed
31 with the department for information purposes only, except that

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1 group certificates for health insurance coverage, as described
2 in s. 627.6561(5)(a)2., which require individual underwriting
3 to determine coverage eligibility for an individual or premium
4 rates to be charged to an individual, shall be considered
5 policies issued on an individual basis and are subject to and
6 must comply with the Florida Insurance Code in the same manner
7 as individual health insurance policies issued in this state.
8 (6)(a) An insurer shall not deliver or issue for
9 delivery or renew in this state any health insurance policy
10 form until it has filed with the department a copy of every
11 applicable rating manual, rating schedule, change in rating
12 manual, and change in rating schedule; if rating manuals and
13 rating schedules are not applicable, the insurer must file
14 with the department applicable premium rates and any change in
15 applicable premium rates. This paragraph does not apply to
16 group health insurance policies insuring groups of 51 or more
17 persons, effectuated and delivered in this state, except for
18 Medicare supplement insurance, long-term care insurance, and
19 any coverage under which the increase in claim costs over the
20 lifetime of the contract due to advancing age or duration is
21 prefunded in the premium.
22 (7)
23 (f) Insurers with fewer than 1,000 nationwide
24 policyholders or insured group members or subscribers covered
25 under any form or pooled group of forms with health insurance
26 coverage, as described in s. 627.6561(5)(a)2., excluding
27 Medicare supplement insurance coverage under part VIII, at the
28 time of a rate filing made pursuant to subparagraph (b)1., may
29 file for an annual rate increase limited to medical trend as
30 adopted by the department pursuant to s. 627.411(4). The
31 filing is in lieu of the actuarial memorandum required for a

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1 rate filing prescribed by paragraph (6)(b). The filing must
2 include forms adopted by the department and a certification by
3 an officer of the company that the filing includes all similar
4 forms.
5 Section 3. Section 627.411, Florida Statutes, is
6 amended to read:
7 627.411 Grounds for disapproval.--
8 (1) The department shall disapprove any form filed
9 under s. 627.410, or withdraw any previous approval thereof,
10 only if the form:
11 (a) Is in any respect in violation of, or does not
12 comply with, this code.
13 (b) Contains or incorporates by reference, where such
14 incorporation is otherwise permissible, any inconsistent,
15 ambiguous, or misleading clauses, or exceptions and conditions
16 which deceptively affect the risk purported to be assumed in
17 the general coverage of the contract.
18 (c) Has any title, heading, or other indication of its
19 provisions which is misleading.
20 (d) Is printed or otherwise reproduced in such manner
21 as to render any material provision of the form substantially
22 illegible.
23 (e) Is for health insurance, and:
24 1. Provides benefits that ~~which~~ are unreasonable in
25 relation to the premium charged;~~,~~
26 2. Contains provisions that ~~which~~ are unfair or
27 inequitable or contrary to the public policy of this state or
28 that ~~which~~ encourage misrepresentation;~~, or~~
29 3. Contains provisions that ~~which~~ apply rating
30 practices that ~~which result in premium escalations that are~~
31 ~~not viable for the policyholder market or~~ result in unfair

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discrimination pursuant to s. 626.9541(1)(g)2.;~~in sales practices.~~

4. Results in actuarially justified rate increases on an annual basis:

a. Attributed to the insurer reducing the portion of the premium used to pay claims from the loss ratio standard certified in the last actuarial certification filed by the insurer, in excess of the greater of 50 percent of annual medical trend or 5 percent. At its option, the insurer may file for approval of an actuarially justified new business rate schedule for new insureds and a rate increase for existing insureds that is equal to the greater of 150 percent of annual medical trend or 10 percent. Future annual rate increases for existing insureds shall be limited to the greater of 150 percent of the rate increase approved for new insureds or 10 percent until the two rate schedules converge;

b. In excess of the greater of 150 percent of annual medical trend or 10 percent and the company did not comply with the annual filing requirements of s. 627.410(7) or department rule for health maintenance organizations pursuant to s. 641.31. At its option the insurer may file for approval of an actuarially justified new business rate schedule for new insureds and a rate increase for existing insureds that is equal to the rate increase allowed by the preceding sentence. Future annual rate increases for existing insureds shall be limited to the greater of 150 percent of the rate increase approved for new insureds or 10 percent until the two rate schedules converge; or

c. In excess of the greater of 150 percent of annual medical trend or 10 percent on a form or block of pooled forms in which no form is currently available for sale. This

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1 sub-subparagraph does not apply to pre-standardized Medicare
2 supplement forms.
3 (f) Excludes coverage for human immunodeficiency virus
4 infection or acquired immune deficiency syndrome or contains
5 limitations in the benefits payable, or in the terms or
6 conditions of such contract, for human immunodeficiency virus
7 infection or acquired immune deficiency syndrome which are
8 different than those which apply to any other sickness or
9 medical condition.
10 (2) In determining whether the benefits are reasonable
11 in relation to the premium charged, the department, in
12 accordance with reasonable actuarial techniques, shall
13 consider:
14 (a) Past loss experience and prospective loss
15 experience within and without this state.
16 (b) Allocation of expenses.
17 (c) Risk and contingency margins, along with
18 justification of such margins.
19 (d) Acquisition costs.
20 (3) If a health insurance rate filing changes the
21 established rate relationships between insureds, the aggregate
22 effect of such change shall be revenue-neutral. The change to
23 the new relationship shall be phased-in over a period not to
24 exceed 3 years as approved by the department. The rate filing
25 may also include increases based on overall experience or
26 annual medical trend, or both, which portions shall not be
27 phased-in pursuant to this paragraph.
28 (4) In determining medical trend for application of
29 subparagraph (1)(e)4., the department shall semiannually
30 determine medical trend for each health care market, using
31 reasonable actuarial techniques and standards. The trend must

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1 be adopted by the department by rule and determined as
2 follows:
3 (a) Trend must be determined separately for medical
4 expense; preferred provider organization; Medicare supplement;
5 health maintenance organization; and other coverage for
6 individual, small group, and large group, where applicable.
7 (b) The department shall survey insurers and health
8 maintenance organizations currently issuing products and
9 representing at least an 80-percent market share based on
10 premiums earned in the state for the most recent calendar year
11 for each of the categories specified in paragraph (a).
12 (c) Trend must be computed as the average annual
13 medical trend approved for the carriers surveyed, giving
14 appropriate weight to each carrier's statewide market share of
15 earned premiums.
16 (d) The annual trend is the annual change in claims
17 cost per unit of exposure. Trend includes the combined effect
18 of medical provider price changes, changes in utilization, new
19 medical procedures, and technology and cost shifting.
20 Section 4. Subsections (4) and (8) of section
21 627.6487, Florida Statutes, are amended to read:
22 627.6487 Guaranteed availability of individual health
23 insurance coverage to eligible individuals.--
24 (4)(a) The health insurance issuer may elect to limit
25 the coverage offered under subsection (1) if the issuer offers
26 at least two different policy forms of health insurance
27 coverage, both of which:
28 1. Are designed for, made generally available to,
29 actively marketed to, and enroll both eligible and other
30 individuals by the issuer; and
31 2. Meet the requirement of paragraph (b).

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For purposes of this subsection, policy forms that have different cost-sharing arrangements or different riders are considered to be different policy forms.

(b) The requirement of this subsection is met for health insurance coverage policy forms offered by an issuer in the individual market if the issuer offers the basic and standard health benefit plans as established pursuant to s. 627.6699(12) or policy forms for individual health insurance coverage with the largest, and next to largest, premium volume of all such policy forms offered by the issuer in this state or applicable marketing or service area, as prescribed in rules adopted by the department, in the individual market in the period involved. To the greatest extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.

(8) This section does not:

(a) Restrict the issuer from applying the same nondiscriminatory underwriting and rating practices that are applied by the issuer to other individuals applying for coverage ~~amount of the premium rates that an issuer may charge an individual for individual health insurance coverage~~; or

(b) Prevent a health insurance issuer that offers individual health insurance coverage from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

Section 5. Subsection (9) is added to section 627.6515, Florida Statutes, to read:

627.6515 Out-of-state groups.--

(9) Notwithstanding any other provision of this section, any group health insurance policy or group certificate for health insurance, as described in s. 627.6561(5)(a)2., which is issued to a resident of this state and requires individual underwriting to determine coverage eligibility for an individual or premium rates to be charged to an individual shall be considered a policy issued on an individual basis and is subject to and must comply with the Florida Insurance Code in the same manner as individual insurance policies issued in this state.

Section 6. Paragraphs (i), (m), and (n) of subsection (3), paragraph (b) of subsection (6), 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:

(i) "Established geographic area" means the county or counties~~, or any portion of a county or counties,~~ within which the carrier provides or arranges for health care services to be available to its insureds, members, or subscribers.

(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 or~~,~~ 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~~.

(n) "Modified community rating" means a method used to develop carrier premiums which spreads financial risk across a large population; allows the use of separate rating factors for age, gender, family composition, tobacco usage, and

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

determined for groups of two through 50 eligible employees; however, the carrier may charge excess losses of the 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

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

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1 each carrier to the premiums that would have been charged by
2 application of the carrier's approved modified community
3 rates. If the aggregate resulting from the application of such
4 adjustment exceeds the premium that would have been charged by
5 application of the approved modified community rate by 5
6 percent for the current reporting period, the carrier shall
7 limit the application of such adjustments only to minus
8 adjustments beginning not more than 60 days after the report
9 is sent to the department. For any subsequent reporting
10 period, if the total aggregate adjusted premium actually
11 charged does not exceed the premium that would have been
12 charged by application of the approved modified community rate
13 by 5 percent, the carrier may apply both plus and minus
14 adjustments. A small employer carrier may provide a credit to
15 a small employer's premium based on administrative and
16 acquisition expense differences resulting from the size of the
17 group. Group size administrative and acquisition expense
18 factors may be developed by each carrier to reflect the
19 carrier's experience and are subject to department review and
20 approval.
21 7.~~6.~~ A small employer carrier rating methodology may
22 include separate rating categories for one dependent child,
23 for two dependent children, and for three or more dependent
24 children for family coverage of employees having a spouse and
25 dependent children or employees having dependent children
26 only. A small employer carrier may have fewer, but not
27 greater, numbers of categories for dependent children than
28 those specified in this subparagraph.
29 8.~~7.~~ Small employer carriers may not use a composite
30 rating methodology to rate a small employer with fewer than 10
31 employees. For the purposes of this subparagraph, a "composite

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

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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 ~~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; and~~.~~

~~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 the ~~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~~

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~~

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~~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)~~(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. 627.31,627.410, 627.4106, and 627.411.

(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. <u>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 that is offered or delivered to a small employer may also be offered or delivered to an employer having 51 or more eligible employees.</u>

Section 7. Section 627.9408, Florida Statutes, is amended to read:

627.9408 Rules.--

<u>(1)</u> The department <u>may</u> ~~has authority to~~ adopt rules pursuant to ss. 120.536(1) and 120.54 to <u>administer</u> ~~implement the provisions of~~ this part.

<u>(2) The department may adopt by rule the provisions of the Long-Term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners in the second quarter of the year 2000 which are not in conflict with the Florida Insurance Code.</u>

Section 8. Paragraphs (b) and (d) of subsection (3) of section 641.31, Florida Statutes, are amended, and paragraph (f) is added to that subsection, to read:

641.31 Health maintenance contracts.--

(3)

(b) Any change in the rate is subject to paragraph (d) and requires at least 30 days' advance written notice to the subscriber. In the case of a group member, there may be a contractual agreement with the health maintenance organization to have the employer provide the required notice to the individual members of the group. <u>This paragraph does not apply to a group contract covering 51 or more persons unless the</u>

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rate is for any coverage under which the increase in claim costs over the lifetime of the contract due to advancing age or duration is prefunded in the premium.

(d) Any change in rates charged for the contract must be filed with the department not less than 30 days in advance of the effective date. At the expiration of such 30 days, the rate filing shall be deemed approved unless prior to such time the filing has been affirmatively approved or disapproved by ~~order of~~ the department pursuant to s. 627.411. The approval of the filing by the department constitutes a waiver of any unexpired portion of such waiting period. The department may extend by not more than an additional 15 days the period within which it may so affirmatively approve or disapprove any such filing, by giving notice of such extension before expiration of the initial 30-day period. At the expiration of any such period as so extended, and in the absence of such prior affirmative approval or disapproval, any such filing shall be deemed approved.

(f) A health maintenance organization with fewer than 1,000 covered subscribers under all individual or group contracts, at the time of a rate filing, may file for an annual rate increase limited to annual medical trend, as adopted by the department. The filing is in lieu of the actuarial memorandum otherwise required for the rate filing. The filing must include forms adopted by the department and a certification by an officer of the company that the filing includes all similar forms.

Section 9. This act shall take effect October 1, 2001.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR
SB's 1960 & 1760

1. Revises the pilot program for providing health care flex plans coverage for uninsured, low-income persons, to provide that the Agency for Health Care Administration and the Department of Insurance would jointly approve or disapprove such plans.

2. Expands the definition of a "limited benefit policy or contract" that could be offered to either small or large employers that would be exempt from mandatory benefits that normally apply to health insurance policies or HMO contracts.

3. Requires that the certificate of coverage issued to a resident in Florida under a group policy issued outside of Florida be subject to the same requirements of the Insurance Code that apply to individual health insurance policies issued in Florida, if the insurer requires individual underwriting to determine coverage eligibility or premium rates to be charged to the Florida resident.

4. Exempts from rate filing requirements group health insurance policies and HMO contracts insuring groups of 51 or more persons, with certain exceptions.

5. Exempts from annual rate filing requirements insurance policy forms with fewer than 1,000 nationwide policyholders or members and allows for an annual rate increase limited to medical trend.

6. Establishes specific actuarial criteria for rate disapproval and deletes the provision that allows for the department to disapprove health insurance rates "which result in premium escalations that are not viable for the policyholder market."

7. Allows carriers writing individual policies to offer "HIPAA-eligible" individuals the standard and basic policy that small group carriers are required to offer, as an option to offering the insurer's two most popular policy forms. The bill also prohibits individual carriers from applying discriminatory underwriting and rating practices to HIPAA-eligible individuals.

8. Allows small group carriers to separate the experience of their insured one-life groups (employers with one employee, sole proprietors, and self-employed individuals) into a separate rating pool, apart from the rating pool for their insured groups with 2-50 employees. But, the rate for one-life groups could not exceed 150 percent of the rate for groups of 2-50 employees. The bill also provides that small group carriers may only provide credits (not surcharges) due to duration of coverage (the time period that a small employer has been insured with the carrier).

1 9. Authorizes the department to adopt by rule the provisions of the Long-Term Care Insurance Model
2 Regulation adopted by the National Association of Insurance Commissioners. The provisions are designed to
3 prevent insurers from implementing large rate increases after a policy has been issued.
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