By Senator Peaden

1-856-02

A bill to be entitled

An act relating to health flex plans; providing legislative findings and intent; defining terms; providing for a pilot program for health flex plans for certain uninsured persons; providing criteria for approval of health flex plans; delineating the responsibilities of the Agency for Health Care Administration and the Department of Insurance; exempting approved health flex plans from certain regulatory requirements; providing criteria for eligibility to enroll in a health flex plan; requiring health flex plan entities to maintain certain records; providing requirements for denial, nonrenewal, or cancellation of coverage; specifying that coverage under an approved health flex plan is not an entitlement; requiring an evaluation and report; providing for expiration; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Health flex plans.--

(1) INTENT.--The Legislature finds that a significant proportion of the residents of this state are unable to obtain affordable health insurance coverage. Therefore, it is the intent of the Legislature to expand the availability of health care options for low-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, these options should be coordinated with existing governmental or community-based health services programs in a manner that is consistent with the objectives and requirements of such programs.

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

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

(b) "Department" means the Department of Insurance.

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

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

(e) "Health flex plan" means a health plan approved under subsection (3) which guarantees payment for specified health care coverage provided to the enrollee.

(f) "Health flex plan entity" means a health insurer, health maintenance organization, health care provider-sponsored organization, local government, health care district, or other public or private community-based organization that develops and implements an approved health flex plan and is responsible for administering the health flex

plan and paying all claims for health flex plan coverage by enrollees of the health flex plan.

(3) PILOT PROGRAM.--The agency and the department shall each approve or disapprove health flex plans that provide health care coverage for eligible participants in the three areas of the state which the agency designates as having the highest number of uninsured persons, as determined by the Florida Health Insurance Study. A health flex plan may limit or exclude benefits otherwise required by law for insurers offering coverage in this state, may cap the total amount of claims paid per year per enrollee, may limit the number of enrollees, or may take any combination of those actions.

(a) The agency shall develop guidelines for the review of applications for health flex plans and shall disapprove or withdraw approval of plans that do not meet or no longer meet minimum standards for quality of care and access to care.

(b) The department shall develop guidelines for the review of health flex plan applications and shall disapprove or shall withdraw approval of plans that:

1. Contain any ambiguous, inconsistent, or misleading provisions or any exceptions or conditions that deceptively affect or limit the benefits purported to be assumed in the general coverage provided by the health flex plan;

2. Provide benefits that are unreasonable in relation to the premium charged or contain provisions that are unfair or inequitable or contrary to the public policy of this state, that encourage misrepresentation, or that result in unfair discrimination in sales practices; or

3. Cannot demonstrate that the health flex plan is financially sound and that the applicant is able to underwrite or finance the health care coverage provided.

(c) The agency and the department may adopt rules as needed to implement this section.

(4) LICENSE NOT REQUIRED.--Neither the licensing requirements of the Florida Insurance Code nor chapter 641, Florida Statutes, relating to health maintenance organizations, is applicable to a health flex plan approved under this section, unless expressly made applicable. However, for the purpose of prohibiting unfair trade practices, health flex plans are considered to be 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 another public health care program, such as KidCare, and have not been covered at any time during the past 6 months; and

(d) Have applied for health care coverage through an approved health flex plan and have agreed to make any payments required for participation, including periodic payments or payments due at the time health care services are provided.

(6) RECORDS.--Each health flex plan shall maintain enrollment data and reasonable records of its losses, expenses, and claims experience and shall make those records reasonably available to enable the department to monitor and determine the financial viability of the health flex plan, as necessary. Provider networks and total enrollment by area

shall be reported to the agency biannually to enable the agency to monitor access to care.

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

(8) NONENTITLEMENT.--Coverage under an approved health flex plan is not an entitlement, and a cause of action does not arise against the state, a local government entity, or any other political subdivision of this state, or against the agency, for failure to make coverage available to eligible persons under this section.

(9) PROGRAM EVALUATION.--The agency and the department shall evaluate the pilot program and its effect on the entities that seek approval as health flex plans, the number of enrollees, the scope of health care coverage offered under a health flex plan, and an assessment of the health flex plans and their potential applicability in other settings and shall, by January 1, 2004, jointly submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

(10) EXPIRATION.--This section expires July 1, 2004.

Section 2. This act shall take effect July 1, 2002.

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SENATE SUMMARY

Provides for a pilot program for health flex plans for certain uninsured persons. Provides legislative findings and intent and defines terms. Provides criteria for approval of health flex plans. Delineates the responsibilities of the Agency for Health Care Administration and the Department of Insurance. Exempts approved health flex plans from certain regulatory requirements. Provides criteria for eligibility to enroll in a health flex plan. Requires health flex plan entities to maintain certain records. Provides requirements for denial, nonrenewal, or cancellation of coverage. Specifies that coverage under an approved health flex plan is not an entitlement or a basis for legal action. Requires an evaluation of the pilot program and a report to the Governor and to legislative leaders.