By Representative Berfield

1 A bill to be entitled
2 An act relating to health insurance; 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; requiring the Agency for Health
19 Care Administration and the Department of
20 Insurance to review the pilot program and
21 submit a report to the Legislature; providing
22 for future repeal; amending s. 627.410, F.S.;
23 requiring certain group certificates for health
24 insurance coverage to be subject to the
25 requirements for individual health insurance
26 policies; exempting group health insurance
27 policies insuring groups of a certain size from
28 rate filing requirements; providing alternative
29 rate filing requirements for insurers with less
30 than a specified number of nationwide
31 policyholders or members; amending s. 627.411,

1 F.S.; revising the grounds for the disapproval
2 of insurance policy forms; providing that a
3 health insurance policy form may be disapproved
4 if it results in certain rate increases;
5 specifying allowable new business rates and
6 renewal rates if rate increases exceed certain
7 levels; authorizing the Department of Insurance
8 to determine medical trend for purposes of
9 approving rate filings; amending s. 627.6475,
10 F.S.; revising criteria for reinsuring
11 individuals under an individual health
12 reinsurance program; 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. 627.667, F.S.;
18 deleting an exception to an extension of
19 benefits application provision for out of state
20 group policies; amending s. 627.6692, F.S.;
21 extending a time period for premium payment for
22 continuation of coverage; amending s. 627.6699,
23 F.S.; revising definitions; allowing carriers
24 to separate the experience of small employer
25 groups with fewer than two employees;
26 authorizing certain small employers to enroll
27 with alternate carriers under certain
28 circumstances; revising the rating factors that
29 may be used by small employer carriers;
30 deleting a prohibition against charging certain
31 adjustments in rates to individual employees or

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1 dependents; revising certain criteria of the
2 small employer health reinsurance program;
3 requiring the Insurance Commissioner to appoint
4 a health benefit plan committee to modify the
5 standard, basic, and limited health benefit
6 plans; revising the disclosure that a carrier
7 must make to a small employer upon offering
8 certain policies; prohibiting small employer
9 carriers from using certain policies,
10 contracts, forms, or rates unless filed with
11 and approved by the Department of Insurance
12 pursuant to certain provisions; restricting
13 application of certain laws to limited benefit
14 policies under certain circumstances;
15 authorizing offering or delivering limited
16 benefit policies or contracts to certain
17 employers; providing requirements for benefits
18 in limited benefit policies or contracts for
19 small employers; amending s. 627.911, F.S.;
20 including health maintenance organizations
21 under certain information reporting
22 requirements; amending s. 627.9175, F.S.;
23 revising health insurance reporting
24 requirements for insurers; amending s.
25 627.9403, F.S.; clarifying application of
26 exceptions to certain long term care insurance
27 policy requirements for certain limited benefit
28 policies; amending s. 627.9408, F.S.;
29 authorizing the department to adopt by rule
30 certain provisions of the Long-Term Care
31 Insurance Model Regulation, as adopted by the

1 National Association of Insurance
2 Commissioners; amending s. 641.31, F.S.;
3 exempting contracts of group health maintenance
4 organizations covering a specified number of
5 persons from the requirements of filing with
6 the department; specifying the standards for
7 department approval and disapproval of a change
8 in rates by a health maintenance organization;
9 providing alternative rate filing requirements
10 for organizations with less than a specified
11 number of subscribers; amending s. 641.3111,
12 F.S.; revising extension of benefits
13 requirements for group health maintenance
14 contracts; providing an effective date.
15
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 state residents are not able to obtain affordable
21 health insurance coverage. Therefore, it is the intent of the
22 Legislature to expand the availability of health care options
23 for lower-income uninsured state residents by encouraging
24 health insurers, health maintenance organizations, health care
25 provider-sponsored organizations, local governments, health
26 care districts, and other public or private community-based
27 organizations to develop alternative approaches to traditional
28 health insurance which emphasize coverage for basic and
29 preventive health care services. To the maximum extent
30 possible, these options should be coordinated with existing
31 governmental or community-based health services programs in a

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

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1 health flex plan may limit or exclude benefits otherwise
2 required by law for insurers offering coverage in this state,
3 cap the total amount of claims paid per year per enrollee, or
4 limit the number of enrollees covered.
5 (a) The agency shall develop guidelines for the review
6 of health flex plan applications and shall not approve, or
7 shall withdraw approval of, any plan that does not meet, or
8 that no longer meets, minimum quality of care standards and
9 access to care standards.
10 (b) The department shall develop guidelines for the
11 review of health flex plan applications and shall not approve,
12 or shall withdraw approval of, any plan that:
13 1. Contains any ambiguous, inconsistent, or misleading
14 provisions or any exceptions or conditions that deceptively
15 affect or limit the benefits purported to be assumed in the
16 general coverage provided by the health flex plan;
17 2. Provides benefits that are unreasonable in relation
18 to the premium charged, contain provisions that are unfair or
19 inequitable or contrary to the public policy of this state,
20 that encourage misrepresentation, or that result in unfair
21 discrimination in sales practices; or
22 3. Cannot demonstrate that the health flex plan is
23 financially sound and that the applicant has the ability to
24 underwrite or finance the health care coverage provided.
25 (4) LICENSE NOT REQUIRED.--A health flex plan approved
26 under this section shall not be subject to the licensing
27 requirements of the Florida Insurance Code or chapter 641,
28 Florida Statutes, relating to health maintenance
29 organizations, unless expressly made applicable. However, for
30 the purposes of prohibiting unfair trade practices, health
31 flex plans shall be considered insurance subject to the

1 applicable provisions of part IX of chapter 626, Florida
2 Statutes, except as otherwise provided in this section.
3 (5) ELIGIBILITY.--Eligibility to enroll in an approved
4 health flex plan is limited to Florida residents who:
5 (a) Are less than 65 years of age;
6 (b) Have a family income equal to or less than 200
7 percent of the federal poverty level;
8 (c) Are not covered by a private insurance policy and
9 are not eligible for coverage through a public health
10 insurance program such as Medicare or Medicaid or another
11 public health care program, including, but not limited to,
12 KidCare; and have not been covered at any time during the
13 preceding 6 months; and
14 (d) Have applied for health care benefits through an
15 approved health flex plan and agree to make any payments
16 required for participation, including, but not limited to,
17 periodic payments or payments due at the time health care
18 services are provided.
19 (6) RECORDS.--Every health flex plan shall maintain
20 enrollment data and reasonable records of its loss, expense,
21 and claims experience and shall make such records reasonably
22 available to enable the department to monitor and determine
23 the financial viability of the health flex plan, as necessary.
24 Provider networks and total enrollment by area shall be
25 reported to the agency biannually to enable the agency to
26 monitor access to care.
27 (7) NOTICE.--The denial of coverage by a health flex
28 plan, or nonrenewal or cancellation of coverage, must be
29 accompanied by the specific reasons for denial, nonrenewal, or
30 cancellation. Notice of nonrenewal or cancellation shall be
31 provided at least 45 days in advance of such nonrenewal or

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1 cancellation, except that 10 days' written notice shall be
2 given for cancellation due to nonpayment of premiums. If the
3 health flex plan fails to give the required notice, the health
4 flex plan coverage shall remain in effect until notice is
5 appropriately given.
6 (8) NONENTITLEMENT.--Coverage under an approved health
7 flex plan is not an entitlement, and no cause of action shall
8 arise against the state, a local government entity or other
9 political subdivision of this state, or the agency for failure
10 to make coverage available to eligible persons under this
11 section.
12 (9) PROGRAM EVALUATION.--The agency and the department
13 shall evaluate the pilot program and its impact on the
14 entities that seek approval as health flex plans, the number
15 of enrollees, the scope of the health care coverage offered
16 under a health flex plan, and an assessment of the health flex
17 plans and their potential applicability in other settings, and
18 shall jointly submit a report to the Governor, the President
19 of the Senate, and the Speaker of the House of Representatives
20 no later than January 1, 2004.
21 (10) REPEAL.--Unless specifically reenacted by the
22 Legislature, this section is repealed July 1, 2004.
23 Section 2. Subsection (1) and paragraph (a) of
24 subsection (6) of section 627.410, Florida Statutes, are
25 amended, paragraphs (f) and (g) are added to subsection (6) of
26 that section, and paragraph (f) is added to subsection (7) of
27 that section, to read:
28 627.410 Filing, approval of forms.--
29 (1) No basic insurance policy or annuity contract
30 form, or application form where written application is
31 required and is to be made a part of the policy or contract,

1 or group certificates issued under a master contract delivered
2 in this state, or printed rider or endorsement form or form of
3 renewal certificate, shall be delivered or issued for delivery
4 in this state, unless the form has been filed with the
5 department at its offices in Tallahassee by or in behalf of
6 the insurer which proposes to use such form and has been
7 approved by the department. This provision does not apply to
8 surety bonds or to policies, riders, endorsements, or forms of
9 unique character which are designed for and used with relation
10 to insurance upon a particular subject (other than as to
11 health insurance), or which relate to the manner of
12 distribution of benefits or to the reservation of rights and
13 benefits under life or health insurance policies and are used
14 at the request of the individual policyholder, contract
15 holder, or certificateholder. As to group insurance policies
16 effectuated and delivered outside this state but covering
17 persons resident in this state, the group certificates to be
18 delivered or issued for delivery in this state shall be filed
19 with the department for information purposes only, except that
20 group certificates for health insurance coverage, as described
21 in s. 627.6561(5)(a)2., which require individual underwriting
22 to determine coverage eligibility for an individual or premium
23 rates to be charged to an individual, shall be considered
24 policies issued on an individual basis and are subject to and
25 must comply with the Florida Insurance Code in the same manner
26 as individual health insurance policies issued in this state.
27 (6)(a) An insurer shall not deliver or issue for
28 delivery or renew in this state any health insurance policy
29 form until it has filed with the department a copy of every
30 applicable rating manual, rating schedule, change in rating
31 manual, and change in rating schedule; if rating manuals and

1 rating schedules are not applicable, the insurer must file
2 with the department applicable premium rates and any change in
3 applicable premium rates. Changes in rates, rating manuals,
4 and rating schedules for individual health insurance policies
5 shall be filed for approval pursuant to this paragraph. Prior
6 approval shall not be required for an individual health
7 insurance policy rate filing which complies with the
8 requirements of paragraph (f). Nothing in this paragraph shall
9 be construed to interfere with the department's authority to
10 investigate suspected violations of this section or to take
11 necessary corrective action when a violation can be
12 demonstrated. Nothing in this paragraph shall prevent an
13 insurer from filing rates or rate changes for approval or from
14 deeming rate changes approved pursuant to an approved loss
15 ratio guarantee pursuant to subsection (8). This paragraph
16 does not apply to group health insurance policies, effectuated
17 and delivered in this state, insuring groups of 51 or more
18 persons, except for Medicare supplement insurance, long-term
19 care insurance, and any coverage under which the increase in
20 claim costs over the lifetime of the contract due to advancing
21 age or duration is prefunded in the premium.
22 (f) An insurer that files changes in rates, rating
23 manuals, or rating schedules with the department, for
24 individual health policies as described in s.
25 627.6561(5)(a)2., but excluding Medicare supplement policies,
26 according to this paragraph may begin providing required
27 notice to policyholders, and charging corresponding adjusted
28 rates in accordance with s. 627.6043, upon filing, provided
29 the insurer certifies that it has met the criteria of
30 subparagraphs 1., 2., and 3. Filings submitted pursuant to
31 this paragraph shall contain the same information and

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1 demonstrations and shall meet the same requirements as rate
2 filings submitted for approval under this section, including
3 the requirements of s. 627.411, except as indicated in this
4 paragraph.
5 1. The insurer has complied with annual rate filing
6 requirements then in effect pursuant to subsection (7) since
7 October 1, 2002, or for the previous 2 years, whichever is
8 less, and has filed and implemented actuarially justifiable
9 rate adjustments at least annually during such period. Nothing
10 in this subparagraph shall be construed to prevent an insurer
11 from filing rate adjustments more often than annually.
12 2. The insurer has pooled experience for applicable
13 individual health policy forms in accordance with the
14 requirements of subparagraph (6)(e)3. Rate changes used on a
15 form shall not vary by the experience of that form or the
16 health status of covered individuals on that form but shall be
17 based on the experience of all forms, including rating
18 characteristics as defined in this paragraph.
19 3. Rates for the policy form are anticipated to meet a
20 minimum loss ratio of 65 percent over the expected life of the
21 form.
22
23 Rates for all individual health policy forms issued on or
24 after October 1, 2002, shall use the same factors for each
25 rating characteristic. As used in this paragraph, the term
26 "rating characteristics" means demographic characteristics of
27 individuals, including, but not limited to, geographic area
28 factors, benefit design, smoking status, and health status at
29 issue.
30 (g) Subsequent to filing a change of rates for an
31 individual health policy pursuant to paragraph (f), an insurer

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may be required to furnish additional information to demonstrate compliance with this section. If the department finds that the adjusted rates are not reasonable in relation to premiums charged pursuant to the standards of this section, the department may order appropriate corrective action.

(7)

(f) Insurers with fewer than 1,000 nationwide policyholders or insured group members or subscribers covered under any form or pooled group of forms with health insurance coverage, as described in s. 627.6561(5)(a)2., excluding Medicare supplement insurance coverage under part VIII, at the time of a rate filing made pursuant to subparagraph (b)1., may file for an annual rate increase limited to medical trend as adopted by the department pursuant to s. 627.411(4). The filing is in lieu of the actuarial memorandum required for a rate filing prescribed by paragraph (6)(b). 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 3. Paragraph (e) of subsection (1) of section 627.411, Florida Statutes, is amended, and subsections (3), (4), and (5) are added to said section, to read:

627.411 Grounds for disapproval.--

(1) The department shall disapprove any form filed under s. 627.410, or withdraw any previous approval thereof, only if the form:

(e) Is for health insurance, and:

1. Provides benefits which are unreasonable in relation to the premium charged, based on the original filed and approved loss ratio for the form and rules adopted by the department pursuant to s. 627.410(6)(b);~~,~~

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2. Contains provisions which are unfair or inequitable or contrary to the public policy of this state or which encourage misrepresentation;~~, or~~

3. Contains provisions which apply rating practices which result in ~~premium escalations that are not viable for the policyholder market or result in~~ unfair discrimination pursuant to s. 626.9541(1)(g)2.; or ~~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

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1 approved for new insureds or 10 percent until the two rate
2 schedules converge; or
3 c. In excess of the greater of 150 percent of annual
4 medical trend or 10 percent on a form or block of pooled forms
5 in which no form is currently available for sale. This
6 provision does not apply to prestandardized Medicare
7 supplement forms.
8 (3) If a health insurance rate filing changes the
9 established rate relationships between insureds, the aggregate
10 effect of such change shall be revenue neutral. The change to
11 the new relationship shall be phased in over a period not to
12 exceed 3 years as approved by the department. The rate filing
13 may also include increases based on overall experience or
14 annual medical trend, or both, which portions shall not be
15 phased in pursuant to this paragraph.
16 (4) Individual health insurance policies which are
17 subject to renewability requirements of s. 627.6425 shall be
18 deemed guaranteed renewable for purposes of establishing loss
19 ratio standards and shall comply with the same loss ratio
20 standards as other guaranteed renewable forms.
21 (5) In determining medical trend for application of
22 subparagraph (1)(e)4., the department shall semiannually
23 determine medical trend for each health care market, using
24 reasonable actuarial techniques and standards. The trend must
25 be adopted by the department by rule and determined as
26 follows:
27 (a) Trend must be determined separately for medical
28 expense, preferred provider organization, Medicare supplement,
29 health maintenance organization, and other coverage for
30 individual, small group, and large group, where applicable.
31

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(b) The department shall survey insurers and health maintenance organizations currently issuing products and representing at least an 80-percent market share based on premiums earned in the state for the most recent calendar year for each of the categories specified in paragraph (a).

(c) Trend must be computed as the average annual medical trend approved for the carriers surveyed, giving appropriate weight to each carrier's statewide market share of earned premiums.

(d) The annual trend is the annual change in claims cost per unit of exposure. Trend includes the combined effect of medical provider price changes, changes in utilization, new medical procedures, and technology and cost shifting.

Section 4. Paragraphs (b), (c), and (e) of subsection (7) of section 627.6475, Florida Statutes, are amended to read:

627.6475 Individual reinsurance pool.--

(7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.--

(b) A reinsuring carrier may reinsure with the program coverage of an eligible individual, subject to each of the following provisions:

1. A reinsuring carrier may reinsure an eligible individual within 90 ~~60~~ days after commencement of the coverage of the eligible individual.

2. The program may not reimburse a participating carrier with respect to the claims of a reinsured eligible individual until the carrier has paid incurred claims of an amount equal to the participating carrier's selected deductible level ~~at least $5,000~~ in a calendar year for benefits covered by the program. ~~In addition, the reinsuring carrier is responsible for 10 percent of the next $50,000 and~~

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1 ~~5 percent of the next $100,000 of incurred claims during a~~
2 ~~calendar year, and the program shall reinsure the remainder.~~
3 3. The board shall annually adjust the initial level
4 of claims and the maximum limit to be retained by the carrier
5 to reflect increases in costs and utilization within the
6 standard market for health benefit plans within the state. The
7 adjustment may not be less than the annual change in the
8 medical component of the "Commerce Price Index for All Urban
9 Consumers" of the Bureau of Labor Statistics of the United
10 States Department of Labor, unless the board proposes and the
11 department approves a lower adjustment factor.
12 4. A reinsuring carrier may terminate reinsurance for
13 all reinsured eligible individuals on any plan anniversary.
14 5. The premium rate charged for reinsurance by the
15 program to a health maintenance organization that is approved
16 by the Secretary of Health and Human Services as a federally
17 qualified health maintenance organization pursuant to 42
18 U.S.C. s. 300e(c)(2)(A) and that, as such, is subject to
19 requirements that limit the amount of risk that may be ceded
20 to the program, which requirements are more restrictive than
21 subparagraph 2., shall be reduced by an amount equal to that
22 portion of the risk, if any, which exceeds the amount set
23 forth in subparagraph 2., which may not be ceded to the
24 program.
25 6. The board may consider adjustments to the premium
26 rates charged for reinsurance by the program or carriers that
27 use effective cost-containment measures, including high-cost
28 case management, as defined by the board.
29 7. A reinsuring carrier shall apply its
30 case-management and claims-handling techniques, including, but
31 not limited to, utilization review, individual case

management, preferred provider provisions, other managed-care provisions, or methods of operation consistently with both reinsured business and nonreinsured business.

(c)1. The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring eligible individuals pursuant to this section. The methodology must include a system for classifying individuals which reflects the types of case characteristics commonly used by carriers in this state. The methodology must provide for the development of basic reinsurance premium rates, which shall be multiplied by the factors set for them in this paragraph to determine the premium rates for the program. The basic reinsurance premium rates shall be established by the board, subject to the approval of the department, and shall be set at levels that reasonably approximate gross premiums charged to eligible individuals for individual health insurance by health insurance issuers. The premium rates set by the board may vary by geographical area, as determined under this section, to reflect differences in cost. ~~An eligible individual may be reinsured for a rate that is five times the rate established by the board.~~

2. The board shall periodically review the methodology established, including the system of classification and any rating factors, to ensure that it reasonably reflects the claims experience of the program. The board may propose changes to the rates that are subject to the approval of the department.

(e)1. Before September ~~March~~ 1 of each calendar year, the board shall determine and report to the department the program net loss in the individual account for the previous

year, including administrative expenses for that year and the incurred losses for that year, taking into account investment income and other appropriate gains and losses.

2. Any net loss in the individual account for the year shall be recouped by assessing the carriers as follows:

a. The operating losses of the program shall be assessed in the following order subject to the specified limitations. The first tier of assessments shall be made against reinsuring carriers in an amount that may not exceed 5 percent of each reinsuring carrier's premiums for individual health insurance. If such assessments have been collected and additional moneys are needed, the board shall make a second tier of assessments in an amount that may not exceed 0.5 percent of each carrier's health benefit plan premiums.

b. Except as provided in paragraph (f), risk-assuming carriers are exempt from all assessments authorized pursuant to this section. The amount paid by a reinsuring carrier for the first tier of assessments shall be credited against any additional assessments made.

c. The board shall equitably assess reinsuring carriers for operating losses of the individual account based on market share. The board shall annually assess each carrier a portion of the operating losses of the individual account. The first tier of assessments shall be determined by multiplying the operating losses by a fraction, the numerator of which equals the reinsuring carrier's earned premium pertaining to direct writings of individual health insurance in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of all such premiums earned by reinsuring carriers in the state during that calendar year. The second tier of assessments

shall be based on the premiums that all carriers, except risk-assuming carriers, earned on all health benefit plans written in this state. The board may levy interim assessments against reinsuring carriers to ensure the financial ability of the plan to cover claims expenses and administrative expenses paid or estimated to be paid in the operation of the plan for the calendar year prior to the association's anticipated receipt of annual assessments for that calendar year. Any interim assessment is due and payable within 30 days after receipt by a carrier of the interim assessment notice. Interim assessment payments shall be credited against the carrier's annual assessment. Health benefit plan premiums and benefits paid by a carrier that are less than an amount determined by the board to justify the cost of collection may not be considered for purposes of determining assessments.

d. Subject to the approval of the department, the board shall adjust the assessment formula for reinsuring carriers that are approved as federally qualified health maintenance organizations by the Secretary of Health and Human Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent, if any, that restrictions are placed on them which are not imposed on other carriers.

3. Before September ~~March~~ 1 of each year, the board shall determine and file with the department an estimate of the assessments needed to fund the losses incurred by the program in the individual account for the previous calendar year.

4. If the board determines that the assessments needed to fund the losses incurred by the program in the individual account for the previous calendar year will exceed the amount specified in subparagraph 2., the board shall evaluate the

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operation of the program and report its findings and recommendations to the department in the format established in s. 627.6699(11) for the comparable report for the small employer reinsurance program.

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. Subsection (6) of section 627.667, Florida Statutes, is amended to read:

627.667 Extension of benefits.--

(6) This section also applies to holders of group certificates which are renewed, delivered, or issued for delivery to residents of this state under group policies effectuated or delivered outside this state~~, unless a succeeding carrier under a group policy has agreed to assume liability for the benefits~~.

Section 7. Paragraph (e) of subsection (5) of section 627.6692, Florida Statutes, is amended to read:

627.6692 Florida Health Insurance Coverage Continuation Act.--

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(5) CONTINUATION OF COVERAGE UNDER GROUP HEALTH PLANS.--

(e)1. A covered employee or other qualified beneficiary who wishes continuation of coverage must pay the initial premium and elect such continuation in writing to the insurance carrier issuing the employer's group health plan within 63 ~~30~~ days after receiving notice from the insurance carrier under paragraph (d). Subsequent premiums are due by the grace period expiration date. The insurance carrier or the insurance carrier's designee shall process all elections promptly and provide coverage retroactively to the date coverage would otherwise have terminated. The premium due shall be for the period beginning on the date coverage would have otherwise terminated due to the qualifying event. The first premium payment must include the coverage paid to the end of the month in which the first payment is made. After the election, the insurance carrier must bill the qualified beneficiary for premiums once each month, with a due date on the first of the month of coverage and allowing a 30-day grace period for payment.

2. Except as otherwise specified in an election, any election by a qualified beneficiary shall be deemed to include an election of continuation of coverage on behalf of any other qualified beneficiary residing in the same household who would lose coverage under the group health plan by reason of a qualifying event. This subparagraph does not preclude a qualified beneficiary from electing continuation of coverage on behalf of any other qualified beneficiary.

Section 8. Paragraphs (i), (m), and (n) of subsection (3), paragraph (c) of subsection (5), paragraph (b) of subsection (6), paragraphs (f), (g), (h), and (j) of

subsection (11), 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 geographic area as determined under paragraph (5)(j); and allows adjustments for~~: claims experience, health status, or duration of coverage as permitted under subparagraph (6)(b)5.; and~~ administrative and acquisition expenses as permitted under subparagraph(6)(b)6~~(6)(b)5~~. A carrier may separate the experience of small employer groups with less than 2 eligible employees from the experience of small employer groups with 2 through 50 eligible employees.

(5) AVAILABILITY OF COVERAGE.--

(c) Every small employer carrier must, as a condition of transacting business in this state:

1. Beginning July 1, 2000, offer and issue all small employer health benefit plans on a guaranteed-issue basis to every eligible small employer, with 2 to 50 eligible employees, that elects to be covered under such plan, agrees to make the required premium payments, and satisfies the other provisions of the plan. A rider for additional or increased benefits may be medically underwritten and may only be added to the standard health benefit plan. The increased rate charged for the additional or increased benefit must be rated in accordance with this section.

2. Beginning July 1, 2000, and until July 31, 2001, offer and issue basic and standard small employer health benefit plans on a guaranteed-issue basis to every eligible small employer which is eligible for guaranteed renewal, has less than two eligible employees, is not formed primarily for the purpose of buying health insurance, elects to be covered under such plan, agrees to make the required premium payments, and satisfies the other provisions of the plan. A rider for additional or increased benefits may be medically underwritten and may be added only to the standard benefit plan. The increased rate charged for the additional or increased benefit must be rated in accordance with this section. For purposes of this subparagraph, a person, his or her spouse, and his or her dependent children shall constitute a single eligible employee if that person and spouse are employed by the same small employer and either one has a normal work week of less than 25 hours.

3.a. Beginning August 1, 2001, offer and issue basic and standard small employer health benefit plans on a guaranteed-issue basis, during a 31-day open enrollment period of August 1 through August 31 of each year, to every eligible

1 small employer, with fewer than two eligible employees, which
2 small employer is not formed primarily for the purpose of
3 buying health insurance and which elects to be covered under
4 such plan, agrees to make the required premium payments, and
5 satisfies the other provisions of the plan. Coverage provided
6 under this subparagraph shall begin on October 1 of the same
7 year as the date of enrollment, unless the small employer
8 carrier and the small employer agree to a different date. A
9 rider for additional or increased benefits may be medically
10 underwritten and may only be added to the standard health
11 benefit plan. The increased rate charged for the additional
12 or increased benefit must be rated in accordance with this
13 section. For purposes of this subparagraph, a person, his or
14 her spouse, and his or her dependent children constitute a
15 single eligible employee if that person and spouse are
16 employed by the same small employer and either that person or
17 his or her spouse has a normal work week of less than 25
18 hours.
19 b. Notwithstanding the restrictions set forth in
20 sub-subparagraph a., when a small employer group is losing
21 coverage because a carrier is exercising the provisions of s.
22 627.6571(3)(b) or s. 641.31074(3)(b), the eligible small
23 employer, as defined in sub-subparagraph a., shall be entitled
24 to enroll with another carrier offering small employer
25 coverage within 63 days after the notice of termination or the
26 termination date of the prior coverage, whichever is later.
27 Coverage provided under this sub-subparagraph shall begin
28 immediately upon enrollment, unless the small employer carrier
29 and the small employer agree to a different date.
30 4. This paragraph does not limit a carrier's ability
31 to offer other health benefit plans to small employers if the

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standard and basic health benefit plans are offered and rejected.

(6) RESTRICTIONS RELATING TO PREMIUM RATES.--

(b) For all small employer health benefit plans that are subject to this section and are issued by small employer carriers on or after January 1, 1994, premium rates for health benefit plans subject to this section are subject to the following:

1. Small employer carriers must use a modified community rating methodology in which the premium for each small employer must be determined solely on the basis of the eligible employee's and eligible dependent's gender, age, family composition, tobacco use, or geographic area as determined under paragraph (5)(j) and in which the premium may be adjusted as permitted by subparagraphs 5., ~~and~~ 6., and 7.

2. Rating factors related to age, gender, family composition, tobacco use, or geographic location may be developed by each carrier to reflect the carrier's experience. The factors used by carriers are subject to department review and approval.

3. If the modified community rate is determined from two experience pools as authorized by paragraph (5)(n), the rate to be charged to small employer groups of less than 2 eligible employees may not exceed 150 percent of the rate determined for groups of 2 through 50 eligible employees; however, the carrier may charge excess losses of the less-than-2-eligible-employee experience pool to the experience pool of the 2 through 50 eligible employees so that all losses are allocated and the 150-percent rate limit on the less-than-2-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, 2002, 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 credit may not be based on different morbidity assumptions or on any other factor related to the health status or claims experience of any person covered under the policy. Nothing in this subparagraph exempts an alliance or group association from licensure for any activities that require licensure under

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the insurance code. A carrier issuing a group health insurance policy to a small employer health alliance or other group association shall allow any properly licensed and appointed agent of that carrier to market and sell the small employer health alliance or other group association policy. Such agent shall be paid the usual and customary commission paid to any agent selling the policy.

6.~~5. Any adjustments in rates for claims experience, health status, or duration of coverage may not be charged to individual employees or dependents. For a small employer's policy, such adjustments may not result in a rate for the small employer which deviates more than 15 percent from the carrier's approved rate. Any such adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer. A small employer carrier may make an adjustment to a small employer's renewal premium, not to exceed 10 percent annually, due to the claims experience, health status, or duration of coverage of the employees or dependents of the small employer. Semiannually, small group carriers shall report information on forms adopted by rule by the department, to enable the department to monitor the relationship of aggregate adjusted premiums actually charged policyholders by each carrier to the premiums that would have been charged by application of the carrier's approved modified community 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.

(11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.--

(f) The program has the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans

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1 directly to groups or individuals. In addition thereto, the
2 program has specific authority to:
3 1. Enter into contracts as necessary or proper to
4 carry out the provisions and purposes of this act, including
5 the authority to enter into contracts with similar programs of
6 other states for the joint performance of common functions or
7 with persons or other organizations for the performance of
8 administrative functions.
9 2. Sue or be sued, including taking any legal action
10 necessary or proper for recovering any assessments and
11 penalties for, on behalf of, or against the program or any
12 carrier.
13 3. Take any legal action necessary to avoid the
14 payment of improper claims against the program.
15 4. Issue reinsurance policies, in accordance with the
16 requirements of this act.
17 5. Establish rules, conditions, and procedures for
18 reinsurance risks under the program participation.
19 6. Establish actuarial functions as appropriate for
20 the operation of the program.
21 7. Assess participating carriers in accordance with
22 paragraph (j), and make advance interim assessments as may be
23 reasonable and necessary for organizational and interim
24 operating expenses. Interim assessments shall be credited as
25 offsets against any regular assessments due following the
26 close of the calendar year.
27 8. Appoint appropriate legal, actuarial, and other
28 committees as necessary to provide technical assistance in the
29 operation of the program, and in any other function within the
30 authority of the program.
31

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9. Borrow money to effect the purposes of the program. Any notes or other evidences of indebtedness of the program which are not in default constitute legal investments for carriers and may be carried as admitted assets.

10. To the extent necessary, increase the $5,000 deductible reinsurance requirement to adjust for the effects of inflation. The program may evaluate the desirability of establishing differing levels of deductibles. If differing levels of deductibles are established, such levels and the resulting premiums shall be approved by the department.

(g) A reinsuring carrier may reinsure with the program coverage of an eligible employee of a small employer, or any dependent of such an employee, subject to each of the following provisions:

1. With respect to a standard and basic health care plan, the program may ~~must~~ reinsure the level of coverage provided; and, with respect to any other plan, the program may ~~must~~ reinsure the coverage up to, but not exceeding, the level of coverage provided under the standard and basic health care plan. As an alternative to reinsuring the entire level of coverage provided, the program may develop corridors of reinsurance designed to coordinate with a reinsuring carrier's existing reinsurance. The corridors of reinsurance and resulting premiums must be approved by the department.

2. Except in the case of a late enrollee, a reinsuring carrier may reinsure an eligible employee or dependent within 90 ~~60~~ days after the commencement of the coverage of the small employer. A newly employed eligible employee or dependent of a small employer may be reinsured within 90 ~~60~~ days after the commencement of his or her coverage.

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3. A small employer carrier may reinsure an entire employer group within 90 ~~60~~ days after the commencement of the group's coverage under the plan. The carrier may choose to reinsure newly eligible employees and dependents of the reinsured group pursuant to subparagraph 1.

4. The program may evaluate the option of allowing a small employer carrier to reinsure an entire employer group or an eligible employee at the first or subsequent renewal date. Any such option and the resulting premium must be approved by the department.

5.~~4.~~ The program may not reimburse a participating carrier with respect to the claims of a reinsured employee or dependent until the carrier has paid incurred claims of an amount equal to the participating carrier's selected deductible level ~~at least $5,000~~ in a calendar year for benefits covered by the program. ~~In addition, the reinsuring carrier shall be responsible for 10 percent of the next $50,000 and 5 percent of the next $100,000 of incurred claims during a calendar year and the program shall reinsure the remainder.~~

6.~~5.~~ The board annually may ~~shall~~ adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the "Consumer Price Index for All Urban Consumers" of the Bureau of Labor Statistics of the Department of Labor, unless the board proposes and the department approves a lower adjustment factor.

1 7.~~6.~~ A small employer carrier may terminate
2 reinsurance for all reinsured employees or dependents on any
3 plan anniversary.
4 8.~~7.~~ The premium rate charged for reinsurance by the
5 program to a health maintenance organization that is approved
6 by the Secretary of Health and Human Services as a federally
7 qualified health maintenance organization pursuant to 42
8 U.S.C. s. 300e(c)(2)(A) and that, as such, is subject to
9 requirements that limit the amount of risk that may be ceded
10 to the program, which requirements are more restrictive than
11 subparagraph 4., shall be reduced by an amount equal to that
12 portion of the risk, if any, which exceeds the amount set
13 forth in subparagraph 4. which may not be ceded to the
14 program.
15 9.~~8.~~ The board may consider adjustments to the premium
16 rates charged for reinsurance by the program for carriers that
17 use effective cost containment measures, including high-cost
18 case management, as defined by the board.
19 10.~~9.~~ A reinsuring carrier shall apply its
20 case-management and claims-handling techniques, including, but
21 not limited to, utilization review, individual case
22 management, preferred provider provisions, other managed care
23 provisions or methods of operation, consistently with both
24 reinsured business and nonreinsured business.
25 (h)1. The board, as part of the plan of operation,
26 shall establish a methodology for determining premium rates to
27 be charged by the program for reinsuring small employers and
28 individuals pursuant to this section. The methodology shall
29 include a system for classification of small employers that
30 reflects the types of case characteristics commonly used by
31 small employer carriers in the state. The methodology shall

1 provide for the development of basic reinsurance premium
2 rates, which shall be multiplied by the factors set for them
3 in this paragraph to determine the premium rates for the
4 program. The basic reinsurance premium rates shall be
5 established by the board, subject to the approval of the
6 department, and shall be set at levels which reasonably
7 approximate gross premiums charged to small employers by small
8 employer carriers for health benefit plans with benefits
9 similar to the standard and basic health benefit plan. The
10 premium rates set by the board may vary by geographical area,
11 as determined under this section, to reflect differences in
12 cost. ~~The multiplying factors must be established as follows:~~
13 ~~a. The entire group may be reinsured for a rate that~~
14 ~~is 1.5 times the rate established by the board.~~
15 ~~b. An eligible employee or dependent may be reinsured~~
16 ~~for a rate that is 5 times the rate established by the board.~~
17 2. The board periodically shall review the methodology
18 established, including the system of classification and any
19 rating factors, to assure that it reasonably reflects the
20 claims experience of the program. The board may propose
21 changes to the rates which shall be subject to the approval of
22 the department.
23 (j)1. Before <u>September</u> ~~March~~ 1 of each calendar year,
24 the board shall determine and report to the department the
25 program net loss for the previous year, including
26 administrative expenses for that year, and the incurred losses
27 for the year, taking into account investment income and other
28 appropriate gains and losses.
29 2. Any net loss for the year shall be recouped by
30 assessment of the carriers, as follows:
31

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1 a. The operating losses of the program shall be
2 assessed in the following order subject to the specified
3 limitations. The first tier of assessments shall be made
4 against reinsuring carriers in an amount which shall not
5 exceed 5 percent of each reinsuring carrier's premiums from
6 health benefit plans covering small employers. If such
7 assessments have been collected and additional moneys are
8 needed, the board shall make a second tier of assessments in
9 an amount which shall not exceed 0.5 percent of each carrier's
10 health benefit plan premiums. Except as provided in paragraph
11 (n), risk-assuming carriers are exempt from all assessments
12 authorized pursuant to this section. The amount paid by a
13 reinsuring carrier for the first tier of assessments shall be
14 credited against any additional assessments made.
15 b. The board shall equitably assess carriers for
16 operating losses of the plan based on market share. The board
17 shall annually assess each carrier a portion of the operating
18 losses of the plan. The first tier of assessments shall be
19 determined by multiplying the operating losses by a fraction,
20 the numerator of which equals the reinsuring carrier's earned
21 premium pertaining to direct writings of small employer health
22 benefit plans in the state during the calendar year for which
23 the assessment is levied, and the denominator of which equals
24 the total of all such premiums earned by reinsuring carriers
25 in the state during that calendar year. The second tier of
26 assessments shall be based on the premiums that all carriers,
27 except risk-assuming carriers, earned on all health benefit
28 plans written in this state. The board may levy interim
29 assessments against carriers to ensure the financial ability
30 of the plan to cover claims expenses and administrative
31 expenses paid or estimated to be paid in the operation of the

1 plan for the calendar year prior to the association's
2 anticipated receipt of annual assessments for that calendar
3 year. Any interim assessment is due and payable within 30
4 days after receipt by a carrier of the interim assessment
5 notice. Interim assessment payments shall be credited against
6 the carrier's annual assessment. Health benefit plan premiums
7 and benefits paid by a carrier that are less than an amount
8 determined by the board to justify the cost of collection may
9 not be considered for purposes of determining assessments.
10 c. Subject to the approval of the department, the
11 board shall make an adjustment to the assessment formula for
12 reinsuring carriers that are approved as federally qualified
13 health maintenance organizations by the Secretary of Health
14 and Human Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to
15 the extent, if any, that restrictions are placed on them that
16 are not imposed on other small employer carriers.
17 3. Before September ~~March~~ 1 of each year, the board
18 shall determine and file with the department an estimate of
19 the assessments needed to fund the losses incurred by the
20 program in the previous calendar year.
21 4. If the board determines that the assessments needed
22 to fund the losses incurred by the program in the previous
23 calendar year will exceed the amount specified in subparagraph
24 2., the board shall evaluate the operation of the program and
25 report its findings, including any recommendations for changes
26 to the plan of operation, to the department within 240 ~~90~~ days
27 following the end of the calendar year in which the losses
28 were incurred. The evaluation shall include an estimate of
29 future assessments, the administrative costs of the program,
30 the appropriateness of the premiums charged and the level of
31 carrier retention under the program, and the costs of coverage

1 for small employers. If the board fails to file a report with
2 the department within 240 ~~90~~ days following the end of the
3 applicable calendar year, the department may evaluate the
4 operations of the program and implement such amendments to the
5 plan of operation the department deems necessary to reduce
6 future losses and assessments.
7 5. If assessments exceed the amount of the actual
8 losses and administrative expenses of the program, the excess
9 shall be held as interest and used by the board to offset
10 future losses or to reduce program premiums. As used in this
11 paragraph, the term "future losses" includes reserves for
12 incurred but not reported claims.
13 6. Each carrier's proportion of the assessment shall
14 be determined annually by the board, based on annual
15 statements and other reports considered necessary by the board
16 and filed by the carriers with the board.
17 7. Provision shall be made in the plan of operation
18 for the imposition of an interest penalty for late payment of
19 an assessment.
20 8. A carrier may seek, from the commissioner, a
21 deferment, in whole or in part, from any assessment made by
22 the board. The department may defer, in whole or in part, the
23 assessment of a carrier if, in the opinion of the department,
24 the payment of the assessment would place the carrier in a
25 financially impaired condition. If an assessment against a
26 carrier is deferred, in whole or in part, the amount by which
27 the assessment is deferred may be assessed against the other
28 carriers in a manner consistent with the basis for assessment
29 set forth in this section. The carrier receiving such
30 deferment remains liable to the program for the amount
31

1 deferred and is prohibited from reinsuring any individuals or
2 groups in the program if it fails to pay assessments.
3 (12) STANDARD, BASIC, AND LIMITED HEALTH BENEFIT
4 PLANS.--
5 (a)1. By May 15, 1993, the commissioner shall appoint
6 a health benefit plan committee composed of four
7 representatives of carriers which shall include at least two
8 representatives of HMOs, at least one of which is a staff
9 model HMO, two representatives of agents, four representatives
10 of small employers, and one employee of a small employer. The
11 carrier members shall be selected from a list of individuals
12 recommended by the board. The commissioner may require the
13 board to submit additional recommendations of individuals for
14 appointment.
15 2. The plans shall comply with all of the requirements
16 of this subsection.
17 3. The plans must be filed with and approved by the
18 department prior to issuance or delivery by any small employer
19 carrier.
20 4. Before October 1, 2002, and in every 4th year
21 thereafter, the commissioner shall appoint a new health
22 benefit plan committee in the manner provided in subparagraph
23 1. to determine whether modifications to a plan might be
24 appropriate and to submit recommended modifications to the
25 department for approval. Such determination shall be based
26 upon prevailing industry standards regarding managed care and
27 cost-containment provisions and shall be for the purpose of
28 ensuring that the benefit plans offered to small employers on
29 a guaranteed-issue basis are consistent with the low-priced to
30 mid-priced benefit plans offered in the large-group market.
31 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~~

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~~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 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 shall 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."

(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, ~~and~~ 627.411, and 641.31 and this section.

(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

1 law is made expressly applicable to such policies or
2 contracts. A law restricting or limiting deductibles,
3 copayments, or annual or lifetime maximum payments does not
4 apply to a limited benefit policy or contract offered or
5 delivered to a small employer unless such law is made
6 expressly applicable to such policy or contract. A limited
7 benefit policy or contract that is offered or delivered to a
8 small employer may also be offered or delivered to an employer
9 having 51 or more eligible employees. Any covered disease or
10 condition may be treated by any physician, without
11 discrimination, licensed or certified to treat the disease or
12 condition.
13 Section 9. Section 627.911, Florida Statutes, is
14 amended to read:
15 627.911 Scope of this part.--Any insurer or health
16 maintenance organization transacting insurance in this state
17 shall report information as required by this part.
18 Section 10. Section 627.9175, Florida Statutes, is
19 amended to read:
20 627.9175 Reports of information on health insurance.--
21 (1) Each authorized health insurer shall submit
22 annually to the department information concerning health
23 insurance coverage being issued or currently in force in this
24 state. The information shall include information related to
25 premium, number of policies, and covered lives for such
26 policies and other information necessary to analyze trends in
27 enrollment, premiums, and claim costs.as to policies of
28 individual health insurance:
29 (a) The required information shall be broken down by
30 market segment, to include:
31

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1. Health insurance issuer company contact information.

2. Information on all health insurance products issued or in force. Such information shall include:

a. Direct premiums earned.

b. Direct losses incurred.

c. Direct premiums earned for new business issued during the year.

d. Number of policies.

e. Number of certificates.

f. Number of total covered lives.

~~A summary of typical benefits, exclusions, and limitations for each type of individual policy form currently being issued in the state. The summary shall include, as appropriate:~~

~~1. The deductible amount;~~

~~2. The coinsurance percentage;~~

~~3. The out-of-pocket maximum;~~

~~4. Outpatient benefits;~~

~~5. Inpatient benefits; and~~

~~6. Any exclusions for preexisting conditions.~~

~~The department shall determine other appropriate benefits, exclusions, and limitations to be reported for inclusion in the consumer's guide published pursuant to this section.~~

(b) The department may adopt rules to administer this section, including, but not limited to, rules governing compliance and provisions implementing electronic methodologies for use in furnishing such records or documents. ~~A schedule of rates for each type of individual policy form reflecting typical variations by age, sex, region of the~~

~~state, or any other applicable factor which is in use and is determined to be appropriate for inclusion by the department.~~

The department may ~~shall~~ provide by rule a uniform format for the submission of this information in order to allow for meaningful comparisons ~~of premiums charged for comparable benefits. The department shall publish annually a consumer's guide which summarizes and compares the information required to be reported under this subsection~~.

(2)~~(a)~~ The department shall publish annually a consumer's guide ~~Every insurer transacting health insurance in this state shall report annually to the department, not later than April 1, information relating to any measure the insurer has implemented or proposes to implement during the next calendar year for the purpose of containing health insurance costs or cost increases~~. ~~The reports shall identify each measure and the forms to which the measure is applied, shall provide an explanation as to how the measure is used, and shall provide an estimate of the cost effect of the measure.~~

~~(b) The department shall promulgate forms to be used by insurers in reporting information pursuant to this subsection and shall utilize such forms to analyze the effects of health care cost containment programs used by health insurers in this state.~~

~~(c) The department shall analyze the data reported under this subsection and shall annually make available to the public a summary of its findings as to the types of cost containment measures reported and the estimated effect of these measures.~~

Section 11. Section 627.9403, Florida Statutes, is amended to read:

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

627.9403 Scope.--The provisions of this part shall apply to long-term care insurance policies delivered or issued for delivery in this state, and to policies delivered or issued for delivery outside this state to the extent provided in s. 627.9406, by an insurer, a fraternal benefit society as defined in s. 632.601, a health maintenance organization as defined in s. 641.19, a prepaid health clinic as defined in s. 641.402, or a multiple-employer welfare arrangement as defined in s. 624.437. A policy which is advertised, marketed, or offered as a long-term care policy and as a Medicare supplement policy shall meet the requirements of this part and the requirements of ss. 627.671-627.675 and, to the extent of a conflict, be subject to the requirement that is more favorable to the policyholder or certificateholder. The provisions of this part shall not apply to a continuing care contract issued pursuant to chapter 651 and shall not apply to guaranteed renewable policies issued prior to October 1, 1988. Any limited benefit policy that limits coverage to care in a nursing home or to one or more lower levels of care required or authorized to be provided by this part or by department rule must meet all requirements of this part that apply to long-term care insurance policies, except ss. 627.9407(3)(c) and (d), (9), (10)(f), and (12) and 627.94073(2). ~~If the limited benefit policy does not provide coverage for care in a nursing home, but does provide coverage for one or more lower levels of care, the policy shall also be exempt from the requirements of s. 627.9407(3)(d).~~

Section 12. Section 627.9408, Florida Statutes, is amended to read:

627.9408 Rules.--

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

(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.

Section 13. Paragraphs (b) and (d) of subsection (3) of section 641.31, Florida Statutes, are amended, and paragraph (f) is added to said 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. This paragraph does not apply to a group contract covering 51 or more persons unless the 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

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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 14. Subsections (1) and (3) of section 641.3111, Florida Statutes, are amended to read:

641.3111 Extension of benefits.--

(1) Every group health maintenance contract shall provide that termination of the contract shall be without prejudice to any continuous loss which commenced while the contract was in force, but any extension of benefits beyond the period the contract was in force may be predicated upon the continuous total disability of the subscriber ~~and may be limited to payment for the treatment of a specific accident or illness incurred while the subscriber was a member~~. The extension is required regardless of whether the group contract holder or other entity secures replacement coverage from a new insurer or health maintenance organization or foregoes the provision of coverage. The required provision must provide for

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continuation of contract benefits in connection with the treatment of a specific accident or illness incurred while the contract was in effect. Such extension of benefits may be limited to the occurrence of the earliest of the following events:

(a) The expiration of 12 months.

(b) Such time as the member is no longer totally disabled.

(c) A succeeding carrier elects to provide replacement coverage without limitation as to the disability condition.

(d) The maximum benefits payable under the contract have been paid.

(3) In the case of maternity coverage, ~~when not covered by the succeeding carrier,~~ a reasonable extension of benefits or accrued liability provision is required, which provision provides for continuation of the contract benefits in connection with maternity expenses for a pregnancy that commenced while the policy was in effect. The extension shall be for the period of that pregnancy and shall not be based upon total disability.

Section 15. This act shall take effect October 1, 2002.

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1 **

2 HOUSE SUMMARY

3

Provides for a pilot program for health flex plans for uninsured persons, exempts approved health flex plans from licensing requirements, provides criteria for eligibility to enroll in a health flex plan, requires health flex plan providers to maintain records, provides requirements for denial, nonrenewal, or cancellation of coverage, specifies that coverage under an approved health flex plan is not an entitlement, and provides for civil actions against health flex plan entities by the Agency for Health Care Administration. Revises various other health insurance provisions relating to group health insurance policies, alternative rate filing requirements, insurance policy forms, allowable new business rates and renewal rates, medical trend determinations in rate filing approvals, reinsurance, extensions of benefits, continuations of coverage, the Employee Health Care Access Act, disclosure requirements, limited benefit policies, health insurance reporting requirements for insurers, long-term care insurance policy requirements for limited benefit policies, Department of Insurance rulemaking authority, and health maintenance organizations. See bill for details.

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