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CHAMBER ACTION

Senate	.	House
Comm: WD 4/8/2008	.	
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The Committee on Health Policy (Dean) recommended the following **amendment:**

Senate Amendment (with title amendment)

Between lines 96 and 97

and insert:

Section 4. Section 408.909, Florida Statutes, is amended to read:

408.909 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) "Office" means the Office of Insurance Regulation of the Financial Services Commission.

(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 a health flex plan 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 who purchases coverage directly from the plan <u>as an individual or as a small business,</u> or through a small business purchasing arrangement sponsored by a local government.

(f) "Health flex plan entity" means a health insurer, health maintenance organization, health-care-provider-sponsored organization, local government, health care district, other public or private community-based organization, or public-private

partnership 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) PROGRAM.--The agency and the office shall each approve or disapprove health flex plans that provide health care coverage for eligible participants. A health flex plan may limit or exclude benefits or provider network requirements 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 health flex plan offering may include the option of a catastrophic plan or a catastrophic plan supplementing the health flex plan.

(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. The agency shall ensure that the health flex plans follow standardized grievance procedures similar to those required of health maintenance organizations.

(b) The office shall develop guidelines for the review of health flex plan applications and provide regulatory oversight of health flex plan advertisement and marketing procedures. The office 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;

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; or

4. Cannot demonstrate that the applicant and its management are in compliance with the standards required under s. 624.404(3).

(c) The agency and the Financial Services Commission may adopt rules as needed to administer this section.

(4) LICENSE NOT REQUIRED.--Neither the licensing requirements of the Florida Insurance Code nor chapter 641, 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, 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)1. Are 64 years of age or younger;

2.~~(b)~~ Have a family income equal to or less than 300 ~~200~~ percent of the federal poverty level;

~~(c) Are eligible under a federally approved Medicaid demonstration waiver and reside in Palm Beach County or Miami-Dade County;~~

3.~~(d)~~ 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, ~~unless specifically authorized under paragraph (c),~~ or another public health care program, such as Kidcare, and have not been covered at any time during the past 6 months; and

4.~~(c)~~ 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.

(b) Are part of an employer group in which at least 75 percent of the employees have a family income equal to or less than 300 percent of the federal poverty level, and the employee group is not covered by a private health insurance policy and has not been covered at any time during the immediately preceding 6 months. If the health flex plan entity is a health insurer, health plan, or health maintenance organization properly licensed under Florida law, only 50 percent of the employees must meet the income requirements of this paragraph.

(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 office 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 office shall evaluate the pilot program and its effect on the entities that seek approval as health flex plans, on the number of enrollees, and on the scope of the health care coverage offered under a health flex plan; shall provide an assessment of the health flex plans and their potential applicability in other settings; shall use health flex plans to gather more information to evaluate low-income consumer driven benefit packages; and shall, by January 1, 2005, and annually thereafter, 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, 2008.~~

Section 5. Subsection (41) is added to section 641.31, Florida Statutes, to read:

641.31 Health maintenance contracts.--

(41) Unless the employer chooses otherwise, for all policies issued or renewed after October 1, 2008, all eligible

employees and their dependents shall be enrolled for coverage at the time of issuance or during the next open or special enrollment period, unless the employee provides written notice to the employer declining coverage. Such notice must include evidence of coverage under an existing group insurance policy or group health benefit plan, or reasons for declining coverage. Such notice shall be retained by the employer as part of the employee's employment or insurance file. An employer may require its employees to participate in its group health plan as a condition of employment.

Section 6. Present subsection (4) of section 627.653, Florida Statutes, is renumbered as subsection (5), and a new subsection (4) is added to that section, to read:

627.653 Employee groups.--

(4) Unless the employer chooses otherwise, for all policies issued or renewed after October 1, 2008, all eligible employees and their dependents shall be enrolled for coverage at the time of issuance or during the next open or special enrollment period, unless the employee provides written notice to the employer declining coverage. Such notice must include evidence of coverage under an existing group insurance policy or group health benefit plan, or reasons for declining coverage. Such notice shall be retained by the employer as part of the employee's employment or insurance file. An employer may require its employees to participate in its group health plan as a condition of employment.

Section 7. Paragraph (h) of subsection (5) of section 627.6699, Florida Statutes, is amended to read:

627.6699 Employee Health Care Access Act.--

(5) AVAILABILITY OF COVERAGE.--

(h) All health benefit plans issued under this section must comply with the following conditions:

1. For employers who have fewer than two employees, a late enrollee may be excluded from coverage for no longer than 24 months if he or she was not covered by creditable coverage continually to a date not more than 63 days before the effective date of his or her new coverage.

2. Any requirement used by a small employer carrier in determining whether to provide coverage to a small employer group, including requirements for minimum participation of eligible employees and minimum employer contributions, must be applied uniformly among all small employer groups having the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier, except that a small employer carrier that participates in, administers, or issues health benefits pursuant to s. 381.0406 which do not include a preexisting condition exclusion may require as a condition of offering such benefits that the employer has had no health insurance coverage for its employees for a period of at least 6 months. A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

3. Unless the employer chooses otherwise, for all policies issued or renewed after October 1, 2008, all eligible employees and their dependents shall be enrolled for coverage at the time of issuance or during the next open or special enrollment period, unless the employee provides written notice to the employer declining coverage. Such notice must include evidence of coverage under an existing group insurance policy or group health benefit plan, or reasons for declining coverage. Such notice shall be

retained by the employer as part of the employee's employment or insurance file. An employer may require its employees to participate in its group health plan as a condition of employment.

4.~~3.~~ In applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider as an eligible employee employees or dependents who have qualifying existing coverage in an employer-based group insurance plan or an ERISA qualified self-insurance plan in determining whether the applicable percentage of participation is met. However, a small employer carrier may count eligible employees and dependents who have coverage under another health plan that is sponsored by that employer.

5.~~4.~~ A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage, unless the employer size has changed, in which case the small employer carrier may apply the requirements that are applicable to the new group size.

6.~~5.~~ If a small employer carrier offers coverage to a small employer, it must offer coverage to all the small employer's eligible employees and their dependents. A small employer carrier may not offer coverage limited to certain persons in a group or to part of a group, except with respect to late enrollees.

7.~~6.~~ A small employer carrier may not modify any health benefit plan issued to a small employer with respect to a small employer or any eligible employee or dependent through riders, endorsements, or otherwise to restrict or exclude coverage for

certain diseases or medical conditions otherwise covered by the health benefit plan.

8.~~7.~~ An initial enrollment period of at least 30 days must be provided. An annual 30-day open enrollment period must be offered to each small employer's eligible employees and their dependents. A small employer carrier must provide special enrollment periods as required by s. 627.65615.

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

On line 13, after the semicolon,

insert:

amending s. 408.909, F.S.; expanding the definition of "health flex plan" to include those who purchase coverage as an individual; authorizing a health flex plan to limit or exclude certain provider network requirements; providing that a health flex plan offering may include the option of a catastrophic plan supplementing the health flex plan; revising requirements for eligibility to enroll in a health flex plan; extending the date of expiration of certain provisions of state law regarding health flex plans; amending ss. 641.31, 627.653, and 627.6699, F.S.; requiring that all health maintenance contracts providing coverage for a member of the subscriber's family comply with certain provisions of state law; requiring that, for all policies issued or renewed after a specified date, all eligible employees and their dependents be enrolled for coverage at the time of issuance of a policy or during the next open or

special enrollment period, unless the employer chooses otherwise or the employee provides written notice to the employer declining coverage; requiring that such notice contain certain information; requiring that such notice be retained by the employer as part of the employee's employment or insurance file; authorizing an employer to require its employees to participate in its group health plan as a condition of employment;