

By Senator Sachs

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1 A bill to be entitled
2 An act relating to health flex plans; amending s.
3 408.909, F.S.; revising the expiration date to extend
4 the availability of health flex plans to low-income
5 uninsured state residents; providing an effective
6 date.

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

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10 Section 1. Section 408.909, Florida Statutes, is amended to
11 read:

12 408.909 Health flex plans.—

13 (1) INTENT.—The Legislature finds that a significant
14 proportion of the residents of this state are unable to obtain
15 affordable health insurance coverage. Therefore, it is the
16 intent of the Legislature to expand the availability of health
17 care options for low-income uninsured state residents by
18 encouraging health insurers, health maintenance organizations,
19 health-care-provider-sponsored organizations, local governments,
20 health care districts, or other public or private community-
21 based organizations to develop alternative approaches to
22 traditional health insurance which emphasize coverage for basic
23 and preventive health care services. To the maximum extent
24 possible, these options should be coordinated with existing
25 governmental or community-based health services programs in a
26 manner that is consistent with the objectives and requirements
27 of such programs.

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

29 (a) "Agency" means the Agency for Health Care

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30 Administration.

31 (b) "Office" means the Office of Insurance Regulation of
32 the Financial Services Commission.

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

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

42 (e) "Health flex plan" means a health plan approved under
43 subsection (3) which guarantees payment for specified health
44 care coverage provided to the enrollee who purchases coverage
45 directly from the plan or through a small business purchasing
46 arrangement sponsored by a local government.

47 (f) "Health flex plan entity" means a health insurer,
48 health maintenance organization, health-care-provider-sponsored
49 organization, local government, health care district, other
50 public or private community-based organization, or public-
51 private partnership that develops and implements an approved
52 health flex plan and is responsible for administering the health
53 flex plan and paying all claims for health flex plan coverage by
54 enrollees of the health flex plan.

55 (3) PROGRAM.—The agency and the office shall each approve
56 or disapprove health flex plans that provide health care
57 coverage for eligible participants. A health flex plan may limit
58 or exclude benefits otherwise required by law for insurers

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59 offering coverage in this state, may cap the total amount of
60 claims paid per year per enrollee, may limit the number of
61 enrollees, or may take any combination of those actions. A
62 health flex plan offering may include the option of a
63 catastrophic plan supplementing the health flex plan.

64 (a) The agency shall develop guidelines for the review of
65 applications for health flex plans and shall disapprove or
66 withdraw approval of plans that do not meet or no longer meet
67 minimum standards for quality of care and access to care. The
68 agency shall ensure that the health flex plans follow
69 standardized grievance procedures similar to those required of
70 health maintenance organizations.

71 (b) The office shall develop guidelines for the review of
72 health flex plan applications and provide regulatory oversight
73 of health flex plan advertisement and marketing procedures. The
74 office shall disapprove or shall withdraw approval of plans
75 that:

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

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

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

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88 4. Cannot demonstrate that the applicant and its management
89 are in compliance with the standards required under s.
90 624.404(3).

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

93 (4) LICENSE NOT REQUIRED.—Neither the licensing
94 requirements of the Florida Insurance Code nor chapter 641,
95 relating to health maintenance organizations, is applicable to a
96 health flex plan approved under this section, unless expressly
97 made applicable. However, for the purpose of prohibiting unfair
98 trade practices, health flex plans are considered to be
99 insurance subject to the applicable provisions of part IX of
100 chapter 626, except as otherwise provided in this section.

101 (5) ELIGIBILITY.—Eligibility to enroll in an approved
102 health flex plan is limited to residents of this state who:

103 (a)1. Have a family income equal to or less than 300
104 percent of the federal poverty level;

105 2. Are not covered by a private insurance policy and are
106 not eligible for coverage through a public health insurance
107 program, such as Medicare or Medicaid, or another public health
108 care program, such as Kidcare, and have not been covered at any
109 time during the past 6 months, except that:

110 a. A person who was covered under an individual health
111 maintenance contract issued by a health maintenance organization
112 licensed under part I of chapter 641 which was also an approved
113 health flex plan on October 1, 2008, may apply for coverage in
114 the same health maintenance organization's health flex plan
115 without a lapse in coverage if all other eligibility
116 requirements are met; or

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117 b. A person who was covered under Medicaid or Kidcare and
118 lost eligibility for the Medicaid or Kidcare subsidy due to
119 income restrictions within 90 days prior to applying for health
120 care coverage through an approved health flex plan may apply for
121 coverage in a health flex plan without a lapse in coverage if
122 all other eligibility requirements are met; and

123 3. Have applied for health care coverage as an individual
124 through an approved health flex plan and have agreed to make any
125 payments required for participation, including periodic payments
126 or payments due at the time health care services are provided;
127 or

128 (b) Are part of an employer group of which at least 75
129 percent of the employees have a family income equal to or less
130 than 300 percent of the federal poverty level and the employer
131 group is not covered by a private health insurance policy and
132 has not been covered at any time during the past 6 months. If
133 the health flex plan entity is a health insurer, health plan, or
134 health maintenance organization licensed under Florida law, only
135 50 percent of the employees must meet the income requirements
136 for the purpose of this paragraph.

137 (6) RECORDS.—Each health flex plan shall maintain
138 enrollment data and reasonable records of its losses, expenses,
139 and claims experience and shall make those records reasonably
140 available to enable the office to monitor and determine the
141 financial viability of the health flex plan, as necessary.
142 Provider networks and total enrollment by area shall be reported
143 to the agency biannually to enable the agency to monitor access
144 to care.

145 (7) NOTICE.—The denial of coverage by a health flex plan,

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146 or the nonrenewal or cancellation of coverage, must be
147 accompanied by the specific reasons for denial, nonrenewal, or
148 cancellation. Notice of nonrenewal or cancellation must be
149 provided at least 45 days in advance of the nonrenewal or
150 cancellation, except that 10 days' written notice must be given
151 for cancellation due to nonpayment of premiums. If the health
152 flex plan fails to give the required notice, the health flex
153 plan coverage must remain in effect until notice is
154 appropriately given.

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

161 (9) PROGRAM EVALUATION.—The agency and the office shall
162 evaluate the pilot program and its effect on the entities that
163 seek approval as health flex plans, on the number of enrollees,
164 and on the scope of the health care coverage offered under a
165 health flex plan; shall provide an assessment of the health flex
166 plans and their potential applicability in other settings; shall
167 use health flex plans to gather more information to evaluate
168 low-income consumer driven benefit packages; and shall, by
169 January 1, 2005, and annually thereafter, jointly submit a
170 report to the Governor, the President of the Senate, and the
171 Speaker of the House of Representatives.

172 (10) EXPIRATION.—This section expires July 1, 2018 ~~July 1,~~
173 ~~2013~~.

174 Section 2. This act shall take effect June 30, 2013.