CHAMBER ACTION

Senate		House
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ORIGINAL STAMP BELOW

Representative(s) Murman and Berfield offered the following:

Amendment (with title amendment)

On page 2, lines 6 and 7,
remove from the bill: all of said lines,

and insert in lieu thereof:

Section 2. Paragraph (a) of subsection (6) of section 627.410, Florida Statutes, is amended, and paragraph (f) is added to subsection (7) of said section, to read:

627.410 Filing, approval of forms.--

(6)(a) An insurer shall not deliver or issue for delivery or renew in this state any health insurance policy form until it has filed with the department a copy of every applicable rating manual, rating schedule, change in rating manual, and change in rating schedule; if rating manuals and rating schedules are not applicable, the insurer must file with the department applicable premium rates and any change in applicable premium rates. This paragraph does not apply to group health insurance policies insuring groups of 51 or more persons, except for Medicare supplement insurance, long-term

care insurance, and any coverage under which the increase in claims costs over the lifetime of the contract due to advancing age or duration is prefunded in the premium.

(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(5). 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 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 that ~~which~~ are unreasonable in relation to the premium charged;~~,~~

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

3. Contains provisions that ~~which~~ apply rating practices that ~~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.;~~in sales practices~~.

Section 4. Subsection (9) is added to section 627.6515, Florida Statutes, to read:

627.6515 Out-of-state groups.--

(9) For purposes of this section, any insurer that issues any group health insurance policy or group certificate for health insurance to a resident of this state and requires individual underwriting to determine coverage eligibility or premium rates to be charged shall combine the experience of all association-based group policies or association-based group certificates which are substantially similar with respect to type and level of benefits and marketing method issued in this state after the policy form has been in force for a period of 5 years to calculate uniform percentage rate increases. For purposes of this section, policy forms that have different cost-sharing arrangements or different riders are considered to be different policy forms. Nothing in this subsection shall be construed to require uniform rates for policies or certificates after their fifth duration, it being the intent and purpose of this law to require uniform percentage rate increases for such policies or certificates. Furthermore, nothing in this subsection shall be construed to eliminate changes in rates by age for attained age policies or certificates. The provisions of this subsection shall apply to policies or certificates issued after July 1, 2001. For purposes of this subsection, a group health policy or group certificate for health insurance means any hospital or medical policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber

1 contract. The term does not include accident-only, specified
2 disease, individual hospital indemnity, credit, dental-only,
3 vision-only, Medicare supplement, long-term care, or
4 disability income insurance; similar supplemental plans
5 provided under a separate policy, certificate, or contract of
6 insurance, which cannot duplicate coverage under an underlying
7 health plan and are specifically designed to fill gaps in the
8 underlying health plan, coinsurance, or deductibles; coverage
9 issued as a supplement to liability insurance; workers'
10 compensation or similar insurance; or automobile
11 medical-payment insurance.
12 Section 5. Paragraph (n) of subsection (3) and
13 paragraph (b) of subsection (6) of section 627.6699, Florida
14 Statutes, are amended to read:
15 627.6699 Employee Health Care Access Act.--
16 (3) DEFINITIONS.--As used in this section, the term:
17 (n) "Modified community rating" means a method used to
18 develop carrier premiums which spreads financial risk across a
19 large population; allows the use of separate rating factors
20 for age, gender, family composition, tobacco usage, and
21 geographic area as determined under paragraph (5)(j); and
22 allows adjustments for~~: claims experience, health status, or~~
23 ~~duration of coverage as permitted under subparagraph (6)(b)5.;~~
24 ~~and~~ administrative and acquisition expenses as permitted under
25 subparagraph (6)(b)5. A carrier may separate the experience of
26 small employer groups with less than 2 eligible employees from
27 the experience of small employer groups with 2 through 50
28 eligible employees.
29 (6) RESTRICTIONS RELATING TO PREMIUM RATES.--
30 (b) For all small employer health benefit plans that
31 are subject to this section and are issued by small employer

1 carriers on or after January 1, 1994, premium rates for health
2 benefit plans subject to this section are subject to the
3 following:
4 1. Small employer carriers must use a modified
5 community rating methodology in which the premium for each
6 small employer must be determined solely on the basis of the
7 eligible employee's and eligible dependent's gender, age,
8 family composition, tobacco use, or geographic area as
9 determined under paragraph (5)(j) and in which the premium may
10 be adjusted as permitted by subparagraphs 6.~~5.~~and 7.~~6.~~
11 2. Rating factors related to age, gender, family
12 composition, tobacco use, or geographic location may be
13 developed by each carrier to reflect the carrier's experience.
14 The factors used by carriers are subject to department review
15 and approval.
16 3. If the modified community rate is determined from
17 two experience pools as authorized by paragraph (3)(n), the
18 rate to be charged to small employer groups of less than 2
19 eligible employees may not exceed 150 percent of the rate
20 determined for groups of 2 through 50 eligible employees;
21 however, the carrier may charge excess losses of the less than
22 2 eligible employee experience pool to the experience pool of
23 the 2 through 50 eligible employees so that all losses are
24 allocated and the 150-percent rate limit on the less than 2
25 eligible employee experience pool is maintained.
26 4.~~3.~~ Small employer carriers may not modify the rate
27 for a small employer for 12 months from the initial issue date
28 or renewal date, unless the composition of the group changes
29 or benefits are changed. However, a small employer carrier may
30 modify the rate one time prior to 12 months after the initial
31 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 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

1 small employer which deviates more than 15 percent from the
2 carrier's approved rate. Any such adjustment must be applied
3 uniformly to the rates charged for all employees and
4 dependents of the small employer. A small employer carrier may
5 make an adjustment to a small employer's renewal premium, not
6 to exceed 10 percent annually, due to the claims experience,
7 health status, or duration of coverage of the employees or
8 dependents of the small employer. Semiannually, small group
9 carriers shall report information on forms adopted by rule by
10 the department, to enable the department to monitor the
11 relationship of aggregate adjusted premiums actually charged
12 policyholders by each carrier to the premiums that would have
13 been charged by application of the carrier's approved modified
14 community rates. If the aggregate resulting from the
15 application of such adjustment exceeds the premium that would
16 have been charged by application of the approved modified
17 community rate by 5 percent for the current reporting period,
18 the carrier shall limit the application of such adjustments
19 only to minus adjustments beginning not more than 60 days
20 after the report is sent to the department. For any subsequent
21 reporting period, if the total aggregate adjusted premium
22 actually charged does not exceed the premium that would have
23 been charged by application of the approved modified community
24 rate by 5 percent, the carrier may apply both plus and minus
25 adjustments. A small employer carrier may provide a credit to
26 a small employer's premium based on administrative and
27 acquisition expense differences resulting from the size of the
28 group. Group size administrative and acquisition expense
29 factors may be developed by each carrier to reflect the
30 carrier's experience and are subject to department review and
31 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.

Section 6. Section 627.9408, Florida Statutes, is amended to read:

627.9408 Rules.--

(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 7. Paragraph (b) of subsection (3) of section 641.31, Florida Statutes, is 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)

1 and requires at least 30 days' advance written notice to the
2 subscriber. In the case of a group member, there may be a
3 contractual agreement with the health maintenance organization
4 to have the employer provide the required notice to the
5 individual members of the group. This paragraph does not apply
6 to a group contract covering 51 or more persons unless the
7 rate is for any coverage under which the increase in claim
8 costs over the lifetime of the contract due to advancing age
9 or duration is prefunded in the premium.
10 (f) A health maintenance organization with fewer than
11 1,000 covered subscribers under all individual or group
12 contracts, at the time of a rate filing, may file for an
13 annual rate increase limited to annual medical trend, as
14 adopted by the department. The filing is in lieu of the
15 actuarial memorandum otherwise required for the rate filing.
16 The filing must include forms adopted by the department and a
17 certification by an officer of the company that the filing
18 includes all similar forms.
19 Section 8. Paragraphs (a) and (b) of subsection (1) of
20 section 641.3155, Florida Statutes, are amended to read:
21 641.3155 Payment of claims.--
22 (1)(a) As used in this section, the term "clean claim"
23 for a noninstitutional provider means a claim submitted on a
24 HCFA 1500 form which has no defect or impropriety, including
25 lack of required substantiating documentation for
26 noncontracted providers and suppliers, or particular
27 circumstances requiring special treatment which prevent timely
28 payment from being made on the claim. A claim may not be
29 considered not clean solely because a health maintenance
30 organization refers the claim to a medical specialist within
31 the health maintenance organization for examination. If

1 additional substantiating documentation, such as the medical
2 record or encounter data, is required from a source outside
3 the health maintenance organization, the claim is considered
4 not clean. This paragraph does not apply to claims which
5 include potential coordination of benefits for third-party
6 liability or subrogation, as evidenced by the information
7 provided on the claim form related to coordination of
8 benefits.This definition of "clean claim" is repealed on the
9 effective date of rules adopted by the department which define
10 the term "clean claim."
11 (b) Absent a written definition that is agreed upon
12 through contract, the term "clean claim" for an institutional
13 claim is a properly and accurately completed paper or
14 electronic billing instrument that consists of the UB-92 data
15 set or its successor with entries stated as mandatory by the
16 National Uniform Billing Committee. This paragraph does not
17 apply to claims which include potential coordination of
18 benefits for third-party liability or subrogation, as
19 evidenced by the information provided on the claim form
20 related to coordination of benefits.
21 Section 9. Health flex plans.--
22 (1) INTENT.--The Legislature finds that a significant
23 portion of the residents of this state are not able to obtain
24 affordable health insurance coverage. Therefore, it is the
25 intent of the Legislature to expand the availability of health
26 care options for lower income uninsured state residents by
27 encouraging health insurers, health maintenance organizations,
28 health care provider sponsored organizations, local
29 governments, health care districts, or other public or private
30 community-based organizations to develop alternative
31 approaches to traditional health insurance which emphasize

1 coverage for basic and preventive health care services. To
2 the maximum extent possible, such options should be
3 coordinated with existing governmental or community-based
4 health services programs in a manner that is consistent with
5 the objectives and requirements of such programs.
6 (2) DEFINITIONS.--As used in this section:
7 (a) "Agency" means the Agency for Health Care
8 Administration.
9 (b) "Approved plan" means a health flex plan approved
10 under subsection (3) which guarantees payment by the health
11 plan entity for specified health care services provided to the
12 enrollee.
13 (c) "Enrollee" means an individual who has been
14 determined eligible for and is receiving health benefits under
15 a health flex plan approved under this section.
16 (d) "Health care coverage" means payment for health
17 care services covered as benefits under an approved plan or
18 that otherwise provides, either directly or through
19 arrangements with other persons, covered health care services
20 on a prepaid per-capita basis or on a prepaid aggregate
21 fixed-sum basis.
22 (e) "Health plan entity" means a health insurer,
23 health maintenance organization, health care provider
24 sponsored organization, local government, health care
25 districts, or other public or private community-based
26 organization that develops and implements an approved plan and
27 is responsible for financing and paying all claims by
28 enrollees of the plan.
29 (3) PILOT PROGRAM.--The agency and the Department of
30 Insurance shall jointly approve or disapprove health flex
31 plans which provide health care coverage for eligible

1 participants residing in the three areas of the state having
2 the highest number of uninsured residents as determined by the
3 agency. A plan may limit or exclude benefits otherwise
4 required by law for insurers offering coverage in this state,
5 cap the total amount of claims paid in 1 year per enrollee, or
6 limit the number of enrollees covered. The agency and the
7 Department of Insurance shall not approve or shall withdraw
8 approval of a plan which:
9 (a) Contains any ambiguous, inconsistent, or
10 misleading provisions, or exceptions or conditions that
11 deceptively affect or limit the benefits purported to be
12 assumed in the general coverage provided by the plan;
13 (b) Provides benefits that are unreasonable in
14 relation to the premium charged, contains provisions that are
15 unfair or inequitable or contrary to the public policy of this
16 state or that encourage misrepresentation, or result in unfair
17 discrimination in sales practices; or
18 (c) Cannot demonstrate that the plan is financially
19 sound and the applicant has the ability to underwrite or
20 finance the benefits provided.
21 (4) LICENSE NOT REQUIRED.--A health flex plan approved
22 under this section shall not be subject to the licensing
23 requirements of the Florida Insurance Code or chapter 641,
24 Florida Statutes, relating to health maintenance
25 organizations, unless expressly made applicable. However, for
26 the purposes of prohibiting unfair trade practices, health
27 flex plans shall be considered insurance subject to the
28 applicable provisions of part IX of chapter 626, Florida
29 Statutes, except as otherwise provided in this section.
30 (5) ELIGIBILITY.--Eligibility to enroll in an approved
31 health flex plan is limited to residents of this state who:

1 (a) Are 64 years of age or younger;
2 (b) Have a family income equal to or less than 200
3 percent of the federal poverty level;
4 (c) Are not covered by a private insurance policy and
5 are not eligible for coverage through a public health
6 insurance program such as Medicare or Medicaid, or other
7 public health care program, including, but not limited to,
8 Kidcare, and have not been covered at any time during the past
9 6 months; and
10 (d) Have applied for health care benefits through an
11 approved health flex plan and agree to make any payments
12 required for participation, including, but not limited to,
13 periodic payments and payments due at the time health care
14 services are provided.
15 (6) RECORDS.--Every health flex plan provider shall
16 maintain reasonable records of its loss, expense, and claims
17 experience and shall make such records reasonably available to
18 enable the agency and the Department of Insurance to monitor
19 and determine the financial viability of the plan, as
20 necessary.
21 (7) NOTICE.--The denial of coverage by the health plan
22 entity shall be accompanied by the specific reasons for
23 denial, nonrenewal, or cancellation. Notice of nonrenewal or
24 cancellation shall be provided at least 45 days in advance of
25 such nonrenewal or cancellation except that 10 days' written
26 notice shall be given for cancellation due to nonpayment of
27 premiums. If the health plan entity fails to give the
28 required notice, the plan shall remain in effect until notice
29 is appropriately given.
30 (8) NONENTITLEMENT.--Coverage under an approved health
31 flex plan is not an entitlement and no cause of action shall

1 arise against the state, local governmental entity, or other
2 political subdivision of this state or the agency for failure
3 to make coverage available to eligible persons under this
4 section.
5 (9) CIVIL ACTIONS.--In addition to an administrative
6 action initiated under subsection (4), the agency may seek any
7 remedy provided by law, including, but not limited to, the
8 remedies provided in s. 812.035, Florida Statutes, if the
9 agency finds that a health plan entity has engaged in any act
10 resulting in injury to an enrollee covered by a plan approved
11 under this section.
12 Section 10. The Legislature finds that the
13 affordability and availability of health insurance is one of
14 the most important and complex issues in this state and that
15 coverage issued to a state resident under group health
16 insurance policies issued outside the state is an important
17 factor in meeting the needs of the citizens of this state.
18 The Legislature also finds that it is important to ensure that
19 those policies are adequately regulated in order to maintain
20 the quality of the coverage offered to citizens of this state.
21 Therefore, the Workgroup on Out of State Group Policies is
22 hereby created to study the regulatory environment in which
23 these policies are now offered and recommend any statutory
24 changes that may be necessary to maintain the quality of the
25 insurance offered in this state. There shall be four members
26 from the House of Representatives appointed by the Speaker of
27 the House of Representatives and four members from the Senate
28 appointed by the President of the Senate. The group shall
29 begin its meetings by July 1, 2001, and complete its meetings
30 by November 15, 2001. Recommendations for suggested
31 legislation shall be delivered to the Speaker of the House of

1 Representatives and the President of the Senate by December
2 15, 2001. At its first meeting, the group shall elect a chair
3 from among its members.
4 Section 11. This act shall take effect July 1, 2001.
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6
7 =============== T I T L E A M E N D M E N T ===============
8 And the title is amended as follows:
9 On page 1, line 9, after the semicolon,
10
11 insert:
12 amending s. 627.410, F.S.; exempting group
13 health insurance policies insuring groups of a
14 certain size from rate filing requirements;
15 providing alternative rate filing requirements
16 for insurers with less than a specified number
17 of nationwide policyholders or members;
18 amending s. 627.411, F.S.; revising the grounds
19 for the disapproval of insurance policy forms;
20 amending s. 627.6515, F.S.; providing
21 additional experience requirements and
22 limitations for out-of-state groups; providing
23 construction; amending s. 627.6699, F.S.;
24 revising a definition; allowing carriers to
25 separate the experience of small employer
26 groups with fewer than two employees; revising
27 the rating factors that may be used by small
28 employer carriers; 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; providing alternative rate
7 filing requirements for organizations with less
8 than a specified number of subscribers;
9 amending s. 641.3155, F.S.; specifying
10 nonapplication of certain provisions to certain
11 claims; providing for certain health flex
12 plans; providing legislative intent; providing
13 definitions; providing for a pilot program for
14 health flex plans for certain uninsured
15 persons; providing criteria; exempting approved
16 health flex plans from certain licensing
17 requirements; providing criteria for
18 eligibility to enroll in a health flex plan;
19 requiring health flex plan providers to
20 maintain certain records; providing
21 requirements for denial, nonrenewal, or
22 cancellation of coverage; specifying that
23 coverage under an approved health flex plan is
24 not an entitlement; providing for civil actions
25 against health plan entities by the Agency for
26 Health Care Administration under certain
27 circumstances; providing legislative findings;
28 creating the Workgroup on Out of State Group
29 Policies; providing for membership; providing
30 purposes; requiring recommendations for
31 proposed legislation; providing an effective

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