By the Committees on Health, Aging and Long-Term Care; Banking and Insurance; and Senators Latvala and King

317-1931-01

A bill to be entitled

An act relating to health care; making legislative findings and providing legislative intent; providing definitions; providing for a pilot program for health flex plans for certain uninsured persons; providing criteria; exempting approved health flex plans from certain licensing requirements; providing criteria for eligibility to enroll in a health flex plan; requiring health flex plan providers to maintain certain records; providing requirements for denial, nonrenewal, or cancellation of coverage; specifying that coverage under an approved health flex plan is not an entitlement; providing for civil actions against health plan entities by the Agency for Health Care Administration under certain circumstances; amending s. 627.410, F.S.; requiring certain group certificates for health insurance coverage to be subject to the requirements for individual health insurance policies; exempting group health insurance policies insuring groups of a certain size from rate filing requirements; providing alternative rate filing requirements for insurers with less than a specified number of nationwide policyholders or members; amending s. 627.411, F.S.; revising the grounds for the disapproval of insurance policy forms; providing that a health insurance policy form may be disapproved if it results in certain rate increases;

specifying allowable new business rates and renewal rates if rate increases exceed certain levels; authorizing the Department of Insurance to determine medical trend for purposes of approving rate filings; amending s. 627.6487, F.S.; revising the types of policies that individual health insurers must offer to persons eligible for guaranteed individual health insurance coverage; prohibiting individual health insurers from applying discriminatory underwriting or rating practices to eligible individuals; amending s. 627.6482, F.S.; amending definitions used in the Florida Comprehensive Health Association Act; amending s. 627.6486, F.S.; revising the criteria for eligibility for coverage from the association; providing for cessation of coverage; requiring all eligible persons to agree to be placed in a case-management system; amending s. 627.6487, F.S.; redefining the term "eligible individual" for purposes of guaranteed availability of individual health insurance coverage; providing that a person is not eligible if the person is eligible for coverage under the Florida Comprehensive Health Association; amending s. 627.6488, F.S.; revising the membership of the board of directors of the association; revising the reimbursement of board members and employees; requiring that the plan of the association be submitted to the department for approval on an annual basis; revising the

duties of the association related to administrative and accounting procedures; requiring an annual financial audit; specifying grievance procedures; establishing a premium schedule based upon an individual's family income; deleting requirements for categorizing insureds as low-risk, medium-risk, and high-risk; authorizing the association to place an individual with a case manager who determines the health care system or provider; requiring an annual review of the actuarial soundness of the association and the feasibility of enrolling new members; requiring a separate account for policyholders insured prior to a specified date; requiring appointment of an executive director with specified duties; authorizing the board to restrict the number of participants based on inadequate funding; limiting enrollment; specifying other powers of the board; amending s. 627.649, F.S.; revising the requirements for the association to use in selecting an administrator; amending s. 627.6492, F.S.; requiring insurers to be members of the association and to be subject to assessments for operating expenses; limiting assessments to specified maximum amounts; specifying when assessments are calculated and paid; allowing certain assessments to be charged by the health insurer directly to each insured, member, or subscriber and to not be subject to department

review or approval; amending s. 627.6498, F.S.; revising the coverage, benefits, covered expenses, premiums, and deductibles of the association; requiring preexisting condition limitations; providing that the act does not provide an entitlement to health care services or health insurance and does not create a cause of action; limiting enrollment in the association; repealing s. 627.6484, F.S., relating to a prohibition on the Florida Comprehensive Health Association from accepting applications for coverage after a certain date; making a legislative finding that the provisions of this act fulfill an important state interest; providing that the amendments to s. 627.6487(3), F.S., do not take effect unless approved by the U.S. Health Care Financing Administration; amending s. 627.6515, F.S.; requiring that coverage issued to a state resident under certain group health insurance policies issued outside the state be subject to the requirements for individual health insurance policies; amending s. 627.6699, F.S.; revising definitions used in the Employee Health Care Access Act; allowing carriers to separate the experience of small employer groups with fewer than two employees; revising the rating factors that may be used by small employer carriers; requiring the Insurance Commissioner to appoint a health benefit plan committee to modify the standard, basic, and

limited health benefit plans; revising the disclosure that a carrier must make to a small employer upon offering certain policies; prohibiting small employer carriers from using certain policies, contracts, forms, or rates unless filed with and approved by the Department of Insurance pursuant to certain provisions; restricting application of certain laws to limited benefit policies under certain circumstances; authorizing offering or delivering limited benefit policies or contracts to certain employers; providing requirements for benefits in limited benefit policies or contracts for small employers; amending s. 627.9408, F.S.; authorizing the department to adopt by rule certain provisions of the Long-Term Care Insurance Model Regulation, as adopted by the National Association of Insurance Commissioners; amending s. 641.31, F.S.; exempting contracts of group health maintenance organizations covering a specified number of persons from the requirements of filing with the department; specifying the standards for department approval and disapproval of a change in rates by a health maintenance organization; providing alternative rate filing requirements for organizations with less than a specified number of subscribers; providing an effective date.

WHEREAS, the Legislature recognizes that the increasing number of uninsured Floridians is due in part to small employers' and their employees' inability to afford comprehensive health insurance coverage, and

WHEREAS, the Legislature recognizes the need for small employers and their employees to have the opportunity to choose more affordable and flexible health insurance plans, and

WHEREAS, it is the intent of the Legislature that insurers and health maintenance organizations have maximum flexibility in health plan design or in developing a health plan design to complement a medical savings account program established by a small employer for the benefit of its employees, NOW, THEREFORE,

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

Section 1. Health flex plans.--

(1) INTENT.--The Legislature finds that a significant portion of state residents are not able to obtain affordable health insurance coverage. Therefore, it is the intent of the Legislature to expand the availability of health care options for lower-income uninsured state residents by encouraging health insurers, health maintenance organizations, health care provider-sponsored organizations, local governments, health care districts, and 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) "Approved plan" means a health flex plan approved under subsection (3) which guarantees payment by the health plan entity for specified health care services provided to the enrollee.

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

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

(e) "Health plan entity" means a health insurer, health maintenance organization, health care provider-sponsored organization, local government, health care district, or other public or private community-based organization that develops and implements an approved plan and is responsible for financing and paying all claims by enrollees of the plan.

(3) PILOT PROGRAM.--The agency and the Department of Insurance shall jointly approve or disapprove health flex plans that provide health care coverage for eligible participants residing in the three areas of the state having the highest number of uninsured residents as determined by the agency. A plan may limit or exclude benefits otherwise

required by law for insurers offering coverage in this state, cap the total amount of claims paid in 1 year per enrollee, or limit the number of enrollees covered. The agency and the Department of Insurance shall not approve, or shall withdraw approval of, plans that:

(a) 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 plan;

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

(c) Cannot demonstrate that the plan is financially sound and that the applicant has the ability to underwrite or finance the benefits provided.

(4) LICENSE NOT REQUIRED.--A health flex plan approved under this section is not subject to the licensing requirements of the Florida Insurance Code or chapter 641, Florida Statutes, relating to health maintenance organizations, unless expressly made applicable. However, for the purposes of prohibiting unfair trade practices, health flex plans shall be considered insurance subject to the applicable provisions of part IX of chapter 626, Florida Statutes, except as otherwise provided in this section.

(5) ELIGIBILITY.--Eligibility to enroll in an approved health flex plan is limited to Florida residents who:

(a) Are 64 years of age or younger;

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

(c) Are not covered by a private insurance policy and are not eligible for coverage through a public health insurance program such as Medicare or Medicaid or another public health care program, including, but not limited to, KidCare; and have not been covered at any time during the preceding 6 months; and

(d) Have applied for health care benefits through an approved health flex plan and agree to make any payments required for participation, including, but not limited to, periodic payments or payments due at the time health care services are provided.

(6) RECORDS.--Every health plan entity shall maintain reasonable records of its loss, expense, and claims experience and shall make such records reasonably available to enable the agency and the Department of Insurance to monitor and determine the financial viability of the plan, as necessary.

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

(8) NONENTITLEMENT.--Coverage under an approved health flex plan is not an entitlement, and no cause of action shall arise against the state, a local government entity or other political subdivision of this state, or the agency for failure to make coverage available to eligible persons under this section.

(9) CIVIL ACTIONS.--In addition to an administrative action initiated under subsection (4), the agency may seek any remedy provided by law, including, but not limited to, the remedies provided in section 812.035, Florida Statutes, if the agency finds that a health plan entity has engaged in any act resulting in injury to an enrollee covered by a plan approved under this section.

Section 2. Subsection (1) and paragraph (a) of subsection (6) of section 627.410, Florida Statutes, are amended, and paragraph (f) is added to subsection (7) of that section, to read:

627.410 Filing, approval of forms.--

(1) No basic insurance policy or annuity contract form, or application form where written application is required and is to be made a part of the policy or contract, or group certificates issued under a master contract delivered in this state, or printed rider or endorsement form or form of renewal certificate, shall be delivered or issued for delivery in this state, unless the form has been filed with the department at its offices in Tallahassee by or in behalf of the insurer which proposes to use such form and has been approved by the department. This provision does not apply to surety bonds or to policies, riders, endorsements, or forms of unique character which are designed for and used with relation to insurance upon a particular subject (other than as to health insurance), or which relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or health insurance policies and are used at the request of the individual policyholder, contract holder, or certificateholder. As to group insurance policies effectuated and delivered outside this state but covering

persons resident in this state, the group certificates to be delivered or issued for delivery in this state shall be filed with the department for information purposes only, except that group certificates for health insurance coverage, as described in s. 627.6561(5)(a)2., which require individual underwriting to determine coverage eligibility for an individual or premium rates to be charged to an individual, shall be considered policies issued on an individual basis and are subject to and must comply with the Florida Insurance Code in the same manner as individual health insurance policies issued in this state.

(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, effectuated and delivered in this state, except for Medicare supplement insurance, long-term care insurance, and 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.

(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. 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:

(a) Is in any respect in violation of, or does not comply with, this code.

(b) Contains or incorporates by reference, where such incorporation is otherwise permissible, any inconsistent, ambiguous, or misleading clauses, or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract.

(c) Has any title, heading, or other indication of its provisions which is misleading.

(d) Is printed or otherwise reproduced in such manner as to render any material provision of the form substantially illegible.

(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.~~

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 approved for new insureds or 10 percent until the two rate schedules converge; or

c. In excess of the greater of 150 percent of annual medical trend or 10 percent on a form or block of pooled forms in which no form is currently available for sale. This sub-subparagraph does not apply to pre-standardized Medicare supplement forms.

(f) Excludes coverage for human immunodeficiency virus infection or acquired immune deficiency syndrome or contains limitations in the benefits payable, or in the terms or conditions of such contract, for human immunodeficiency virus infection or acquired immune deficiency syndrome which are different than those which apply to any other sickness or medical condition.

(2) In determining whether the benefits are reasonable in relation to the premium charged, the department, in accordance with reasonable actuarial techniques, shall consider:

(a) Past loss experience and prospective loss experience within and without this state.

(b) Allocation of expenses.

(c) Risk and contingency margins, along with justification of such margins.

(d) Acquisition costs.

(3) If a health insurance rate filing changes the established rate relationships between insureds, the aggregate effect of such change shall be revenue-neutral. The change to the new relationship shall be phased-in over a period not to exceed 3 years as approved by the department. The rate filing may also include increases based on overall experience or annual medical trend, or both, which portions shall not be phased-in pursuant to this paragraph.

(4) In determining medical trend for application of subparagraph (1)(e)4., the department shall semiannually determine medical trend for each health care market, using reasonable actuarial techniques and standards. The trend must be adopted by the department by rule and determined as follows:

(a) Trend must be determined separately for medical expense; preferred provider organization; Medicare supplement; health maintenance organization; and other coverage for individual, small group, and large group, where applicable.

(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. Subsections (4) and (8) of section 627.6487, Florida Statutes, are amended to read:

627.6487 Guaranteed availability of individual health insurance coverage to eligible individuals.--

(4)(a) The health insurance issuer may elect to limit the coverage offered under subsection (1) if the issuer offers at least two different policy forms of health insurance coverage, both of which:

1. Are designed for, made generally available to, actively marketed to, and enroll both eligible and other individuals by the issuer; and

2. Meet the requirement of paragraph (b).

For purposes of this subsection, policy forms that have different cost-sharing arrangements or different riders are considered to be different policy forms.

(b) The requirement of this subsection is met for health insurance coverage policy forms offered by an issuer in the individual market if the issuer offers the basic and standard health benefit plans as established pursuant to s. 627.6699(12) or policy forms for individual health insurance coverage with the largest, and next to largest, premium volume of all such policy forms offered by the issuer in this state or applicable marketing or service area, as prescribed in rules adopted by the department, in the individual market in the period involved. To the greatest extent possible, such rules must be consistent with regulations adopted by the United States Department of Health and Human Services.

(8) This section does not:

(a) Restrict the issuer from applying the same nondiscriminatory underwriting and rating practices that are applied by the issuer to other individuals applying for coverage ~~amount of the premium rates that an issuer may charge an individual for individual health insurance coverage~~; or

(b) Prevent a health insurance issuer that offers individual health insurance coverage from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

Section 5. Subsection (12) of section 627.6482, Florida Statutes, is amended, and subsections (15) and (16) are added to that section, to read:

627.6482 Definitions.--As used in ss. 627.648-627.6498, the term:

(12) "Premium" means the entire cost of an insurance plan, including the administrative fee, the risk assumption charge, and, in the instance of a minimum premium plan or stop-loss coverage, the incurred claims whether or not such claims are paid directly by the insurer. ~~"Premium" shall not include a health maintenance organization's annual earned premium revenue for Medicare and Medicaid contracts for any assessment due for calendar years 1990 and 1991. For assessments due for calendar year 1992 and subsequent years,~~A health maintenance organization's annual earned premium revenue for Medicare and Medicaid contracts is subject to assessments unless the department determines that the health maintenance organization has made a reasonable effort to amend its Medicare or Medicaid government contract ~~for 1992 and subsequent years~~ to provide reimbursement for any assessment on Medicare or Medicaid premiums paid by the health maintenance organization and the contract does not provide for such reimbursement.

(15) "Federal poverty level" means the most current federal poverty guidelines, as established by the federal Department of Health and Human Services and published in the Federal Register, and in effect on the date of the policy and its annual renewal.

(16) "Family income" means the adjusted gross income, as defined in s. 62 of the United States Internal Revenue Code, of all members of a household.

Section 6. Section 627.6486, Florida Statutes, is amended to read:

627.6486 Eligibility.--

(1) Except as provided in subsection (2), any person who is a resident of this state and has been a resident of this state for the previous 6 months is ~~shall be~~ eligible for coverage under the plan, including:

(a) The insured's spouse.

(b) Any dependent ~~unmarried~~ child of the insured, from the moment of birth. Subject to the provisions of ss.~~s.~~ 627.6041 and 627.6562, such coverage shall terminate at the end of the premium period in which the child ~~marries,~~ceases to be a dependent of the insured~~, or attains the age of 19, whichever occurs first. However, if the child is a full-time student at an accredited institution of higher learning, the coverage may continue while the child remains unmarried and a full-time student, but not beyond the premium period in which the child reaches age 23~~.

(c) The former spouse of the insured whose coverage would otherwise terminate because of annulment or dissolution of marriage, if the former spouse is dependent upon the insured for financial support. The former spouse shall have continued coverage and shall not be subject to waiting periods because of the change in policyholder status.

(2)(a) The board or administrator shall require verification of residency for the preceding 6 months and shall require any additional information or documentation, or statements under oath, when necessary to determine residency upon initial application and for the entire term of the policy. A person may demonstrate his or her residency by maintaining his or her residence in this state for the

preceding 6 months, purchasing a home that has been occupied by him or her as his or her primary residence for the previous 6 months, or having established a domicile in this state pursuant to s. 222.17 for the preceding 6 months.

(b) No person who is currently eligible for health care benefits under Florida's Medicaid program is eligible for coverage under the plan unless:

1. He or she has an illness or disease which requires supplies or medication which are covered by the association but are not included in the benefits provided under Florida's Medicaid program in any form or manner; and

2. He or she is not receiving health care benefits or coverage under Florida's Medicaid program.

(c) No person who is covered under the plan and terminates the coverage is again eligible for coverage.

(d) No person on whose behalf the plan has paid out the lifetime maximum benefit currently being offered by the association of $500,000 in covered benefits is eligible for coverage under the plan.

(e) The coverage of any person who ceases to meet the eligibility requirements of this section may be terminated immediately. If such person again becomes eligible for subsequent coverage under the plan, any previous claims payments shall be applied towards the $500,000 lifetime maximum benefit and any limitation relating to preexisting conditions in effect at the time such person again becomes eligible shall apply to such person. ~~However, no such person may again become eligible for coverage after June 30, 1991.~~

(f) No person is eligible for coverage under the plan unless such person has been rejected by two insurers for coverage substantially similar to the plan coverage and no

insurer has been found through the market assistance plan pursuant to s. 627.6484 that is willing to accept the application. As used in this paragraph, "rejection" includes an offer of coverage with a material underwriting restriction ~~or an offer of coverage at a rate greater than the association plan rate~~.

(g) No person is eligible for coverage under the plan if such person has, or is eligible for, on the date of issue of coverage under the plan, substantially similar coverage under another contract or policy, unless such coverage is provided pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82 (1986) (COBRA), as amended, or such coverage is provided pursuant to s. 627.6692 and such coverage is scheduled to end at a time certain and the person meets all other requirements of eligibility. Coverage provided by the association shall be secondary to any coverage provided by an insurer pursuant to COBRA or pursuant to s. 627.6692.

(h) A person is ineligible for coverage under the plan if such person is currently eligible for health care benefits under the Medicare program, except for a person who is insured by the Florida Comprehensive Health Association and enrolled under Medicare on July 1, 2001.~~All eligible persons who are classified as high-risk individuals pursuant to s. 627.6498(4)(a)4. shall, upon application or renewal, agree to be placed in a case management system when it is determined by the board and the plan case manager that such system will be cost-effective and provide quality care to the individual.~~

(i) A person is ineligible for coverage under the plan if such person's premiums are paid for or reimbursed under any

government-sponsored program or by any government agency or health care provider.

(j) An eligible individual, as defined in s. 627.6487, and his or her dependents, as described in subsection (1), are automatically eligible for coverage in the association unless the association has ceased accepting new enrollees under s. 627.6488. If the association has ceased accepting new enrollees, the eligible individual is subject to the coverage rights set forth in s. 627.6487.

(3) A person's coverage ceases:

(a) On the date a person is no longer a resident of this state;

(b) On the date a person requests coverage to end;

(c) Upon the date of death of the covered person;

(d) On the date state law requires cancellation of the policy; or

(e) Sixty days after the person receives notice from the association making any inquiry concerning the person's eligibility or place or residence to which the person does not reply.

(4) All eligible persons must, upon application or renewal, agree to be placed in a case-management system when the association and case manager find that such system will be cost-effective and provide quality care to the individual.

(5) Except for persons who are insured by the association on December 31, 2001, and who renew such coverage, persons may apply for coverage beginning January 1, 2002, and coverage for such persons shall begin on or after April 1, 2002, as determined by the board pursuant to s. 627.6488(4)(n).

Section 7. Subsection (3) of section 627.6487, Florida Statutes, is amended to read:

627.6487 Guaranteed availability of individual health insurance coverage to eligible individuals.--

(3) For the purposes of this section, the term "eligible individual" means an individual:

(a)1. For whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage, as defined in s. 627.6561(5) and (6), is 18 or more months; and

2.a. Whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan, or health insurance coverage offered in connection with any such plan; or

b. Whose most recent prior creditable coverage was under an individual plan issued in this state by a health insurer or health maintenance organization, which coverage is terminated due to the insurer or health maintenance organization becoming insolvent or discontinuing the offering of all individual coverage in the State of Florida, or due to the insured no longer living in the service area in the State of Florida of the insurer or health maintenance organization that provides coverage through a network plan in the State of Florida;

(b) Who is not eligible for coverage under:

1. A group health plan, as defined in s. 2791 of the Public Health Service Act;

2. A conversion policy or contract issued by an authorized insurer or health maintenance organization under s. 627.6675 or s. 641.3921, respectively, offered to an

individual who is no longer eligible for coverage under either an insured or self-insured employer plan;

3. Part A or part B of Title XVIII of the Social Security Act; ~~or~~

4. A state plan under Title XIX of such act, or any successor program, and does not have other health insurance coverage; or

5. The Florida Comprehensive Health Association, if the association is accepting and issuing coverage to new enrollees, provided that the 63-day period specified in s. 627.6561(6) shall be tolled from the time the association receives an application from an individual until the association notifies the individual that it is not accepting and issuing coverage to that individual;

(c) With respect to whom the most recent coverage within the coverage period described in paragraph (a) was not terminated based on a factor described in s. 627.6571(2)(a) or (b), relating to nonpayment of premiums or fraud, unless such nonpayment of premiums or fraud was due to acts of an employer or person other than the individual;

(d) Who, having been offered the option of continuation coverage under a COBRA continuation provision or under s. 627.6692, elected such coverage; and

(e) Who, if the individual elected such continuation provision, has exhausted such continuation coverage under such provision or program.

Section 8. Section 627.6488, Florida Statutes, is amended to read:

627.6488 Florida Comprehensive Health Association.--

(1) There is created a nonprofit legal entity to be known as the "Florida Comprehensive Health Association." All

insurers, as a condition of doing business, shall be members of the association.

(2)(a) The association shall operate subject to the supervision and approval of a five-member ~~three-member~~ board of directors consisting of the Insurance Commissioner, or his or her designee, who shall serve as chairperson of the board, and four additional members who must be state residents. At least one member must be a representative of an authorized health insurer or health maintenance organization authorized to transact business in this state.The board of directors shall be appointed by the Insurance Commissioner ~~as follows:~~

~~1. The chair of the board shall be the Insurance Commissioner or his or her designee.~~

~~2. One representative of policyholders who is not associated with the medical profession, a hospital, or an insurer.~~

~~3. One representative of insurers~~.

The administrator or his or her affiliate shall not be a member of the board. Any board member appointed by the commissioner may be removed and replaced by him or her at any time without cause.

(b) All board members, including the chair, shall be appointed to serve for staggered 3-year terms beginning on a date as established in the plan of operation.

(c) The board of directors may ~~shall have the power to~~ employ or retain such persons as are necessary to perform the administrative and financial transactions and responsibilities of the association and to perform other necessary and proper functions not prohibited by law. Employees of the association shall be reimbursed as provided in s. 112.061 from moneys of

the association for expenses incurred in carrying out their responsibilities under this act.

(d) Board members may be reimbursed as provided in s. 112.061 from moneys of the association for ~~actual and necessary~~ expenses incurred by them as members in carrying out their responsibilities under the Florida Comprehensive Health Association Act, but may not otherwise be compensated for their services.

(e) There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member insurer, or its agents or employees, agents or employees of the association, members of the board of directors of the association, or the departmental representatives for any act or omission taken by them in the performance of their powers and duties under this act, unless such act or omission by such person is in intentional disregard of the rights of the claimant.

(f) Meetings of the board are subject to s. 286.011.

(3) The association shall adopt a plan pursuant to this act and submit its articles, bylaws, and operating rules to the department for approval. If the association fails to adopt such plan and suitable articles, bylaws, and operating rules within 180 days after the appointment of the board, the department shall adopt rules to effectuate the provisions of this act; and such rules shall remain in effect until superseded by a plan and articles, bylaws, and operating rules submitted by the association and approved by the department. Such plan shall be reviewed, revised as necessary, and annually submitted to the department for approval.

(4) The association shall:

(a) Establish administrative and accounting procedures and internal controls for the operation of the association and provide for an annual financial audit of the association by an independent certified public accountant licensed pursuant to chapter 473.

(b) Establish procedures under which applicants and participants in the plan may have grievances reviewed by an impartial body and reported to the board. Individuals receiving care through the association under contract from a health maintenance organization must follow the grievance procedures established in ss. 408.7056 and 641.31(5).

(c) Select an administrator in accordance with s. 627.649.

(d) Collect assessments from all insurers to provide for operating losses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established by the board, as formulated in s. 627.6492(1). Annual assessment of the insurers for each calendar year shall occur as soon thereafter as the operating results of the plan for the calendar year and the earned premiums of insurers being assessed for that year are known. Annual assessments are due and payable within 30 days of receipt of the assessment notice by the insurer.

(e) Require that all policy forms issued by the association conform to standard forms developed by the association. The forms shall be approved by the department.

(f) Develop and implement a program to publicize the existence of the plan, the eligibility requirements for the plan, and the procedures for enrollment in the plan and to maintain public awareness of the plan.

(g) Design and employ cost containment measures and requirements which may include preadmission certification, home health care, hospice care, negotiated purchase of medical and pharmaceutical supplies, and individual case management.

~~(h) Contract with preferred provider organizations and health maintenance organizations giving due consideration to the preferred provider organizations and health maintenance organizations which have contracted with the state group health insurance program pursuant to s. 110.123. If cost-effective and available in the county where the policyholder resides, the board, upon application or renewal of a policy, shall place a high-risk individual, as established under s. 627.6498(4)(a)4., with the plan case manager who shall determine the most cost-effective quality care system or health care provider and shall place the individual in such system or with such health care provider. If cost-effective and available in the county where the policyholder resides, the board, with the consent of the policyholder, may place a low-risk or medium-risk individual, as established under s. 627.6498(4)(a)4., with the plan case manager who may determine the most cost-effective quality care system or health care provider and shall place the individual in such system or with such health care provider. Prior to and during the implementation of case management, the plan case manager shall obtain input from the policyholder, parent, or guardian.~~

(h)~~(i)~~ Make a report to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Minority Leaders of the Senate and the House of Representatives not later than March 1 ~~October 1~~ of each year. The report shall summarize the activities of the plan for the

prior fiscal ~~12-month period ending July 1 of that~~ year, including then-current data and estimates as to net written and earned premiums, the expense of administration, and the paid and incurred losses for the year. The report shall also include analysis and recommendations for legislative changes regarding utilization review, quality assurance, an evaluation of the administrator of the plan, access to cost-effective health care, and cost containment/case management policy ~~and recommendations concerning the opening of enrollment to new entrants as of July 1, 1992~~.

(i)~~(j)~~ Make a report to the Governor, the Insurance Commissioner, the President of the Senate, the Speaker of the House of Representatives, and the Minority Leaders of the Senate and House of Representatives, not later than 45 days after the close of each calendar quarter, which includes, for the prior quarter, current data and estimates of net written and earned premiums, the expenses of administration, and the paid and incurred losses. The report shall identify any statutorily mandated program that has not been fully implemented by the board.

(j)~~(k)~~ To facilitate preparation of assessments and for other purposes, the board shall engage an independent certified public account licensed pursuant to chapter 473 to conduct an annual financial audit of the association ~~direct preparation of annual audited financial statements~~ for each calendar year as soon as feasible following the conclusion of that calendar year, and shall, within 30 days after the issuance ~~rendition~~ of such statements, file with the department the annual report containing such information as required by the department to be filed on March 1 of each year.

(k)~~(l)~~ Employ a plan case manager or managers to supervise and manage the medical care or coordinate the supervision and management of the medical care, with the administrator, of specified individuals. The plan case manager, with the approval of the board, shall have final approval over the case management for any specific individual. If cost-effective and available in the county where the policyholder resides, the association, upon application or renewal of a policy, may place an individual with the plan case manager, who shall determine the most cost-effective quality care system or health care provider and shall place the individual in such system or with such health care provider. Prior to and during the implementation of case management, the plan case manager shall obtain input from the policyholder, parent or guardian, and the health care providers.

(l) Administer the association in a fiscally responsible manner that ensures that its expenditures are reasonable in relation to the services provided and that the financial resources of the association are adequate to meet its obligations.

(m) At least annually, but no more than quarterly, evaluate or cause to be evaluated the actuarial soundness of the association. The association shall contract with an actuary to evaluate the pool of insureds in the association and monitor the financial condition of the association. The actuary shall determine the feasibility of enrolling new members in the association, which must be based on the projected revenues and expenses of the association.

(n) Restrict at any time the number of participants in the association based on a determination by the board that the

revenues will be inadequate to fund new participants. However, any person denied participation solely on the basis of such restriction must be granted priority for participation in the succeeding period in which the association is reopened for participants. Effective April 1, 2002, the association may provide coverage for up to 500 persons for the period ending December 31, 2002. On or after January 1, 2003, the association may enroll an additional 1,500 persons. At no time may the association provide coverage for more than 2,000 persons. Except as provided in s. 627.6486(2)(j), applications for enrollment must be processed on a first-in, first-out basis.

(o) Establish procedures to maintain separate accounts and recordkeeping for policyholders prior to January 1, 2002, and policyholders issued coverage on and after January 1, 2002.

(p) Appoint an executive director to serve as the chief administrative and operational officer of the association and operate within the specifications of the plan of operation and perform other duties assigned to him or her by the board.

(5) The association may:

(a) Exercise powers granted to insurers under the laws of this state.

(b) Sue or be sued.

(c) In addition to imposing annual assessments under paragraph (4)(d), levy interim assessments against insurers 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 a calendar year prior to the association's anticipated receipt of annual assessments

for that calendar year. Any interim assessment shall be due and payable within 30 days after ~~of~~ receipt by an insurer of an interim assessment notice. Interim assessment payments shall be credited against the insurer's annual assessment. Such assessments may be levied only for costs and expenses associated with policyholders insured with the association prior to January 1, 2002.

(d) Prepare or contract for a performance audit of the administrator of the association.

(e) Appear in its own behalf before boards, commissions, or other governmental agencies.

(f) Solicit and accept gifts, grants, loans, and other aid from any source or participate in any way in any government program to carry out the purposes of the Florida Comprehensive Health Association Act.

(g) Require and collect administrative fees and charges in connection with any transaction and impose reasonable penalties, including default, for delinquent payments or for entering into the association on a fraudulent basis.

(h) Procure insurance against any loss in connection with the property, assets, and activities of the association or the board.

(i) Contract for necessary goods and services; employ necessary personnel; and engage the services of private consultants, actuaries, managers, legal counsel, and independent certified public accountants for administrative or technical assistance.

(6) The department shall examine and investigate the association in the manner provided in part II of chapter 624.

Section 9. Paragraph (b) of subsection (3) of section 627.649, Florida Statutes, is amended to read:

627.649 Administrator.--

(3) The administrator shall:

(b) Pay an agent's referral fee as established by the board to each insurance agent who refers an applicant to the plan, if the applicant's application is accepted. The selling or marketing of plans shall not be limited to the administrator or its agents. Any agent must be licensed by the department to sell health insurance in this state.The referral fees shall be paid by the administrator from moneys received as premiums for the plan.

Section 10. Section 627.6492, Florida Statutes, is amended to read:

627.6492 Participation of insurers.--

(1)(a) As a condition of doing business in this state an insurer shall pay an assessment to the board, in the amount prescribed by this section. Subsections (1), (2), and (3) apply only to the costs and expenses associated with policyholders insured with the association prior to January 1, 2002, including renewal of coverage for such policyholders after that date. For operating losses incurred in any calendar year ~~on July 1, 1991, and thereafter~~, each insurer shall annually be assessed by the board in the following calendar year a portion of such incurred operating losses of the plan; such portion shall be determined by multiplying such operating losses by a fraction, the numerator of which equals the insurer's earned premium pertaining to direct writings of health insurance in the state during the calendar year preceding that for which the assessment is levied, and the denominator of which equals the total of all such premiums

earned by participating insurers in the state during such calendar year.

(b) ~~For operating losses incurred from July 1, 1991, through December 31, 1991, the total of all assessments upon a participating insurer shall not exceed .375 percent of such insurer's health insurance premiums earned in this state during 1990. For operating losses incurred in 1992 and thereafter,~~The total of all assessments upon a participating insurer shall not exceed 1 percent of such insurer's health insurance premium earned in this state during the calendar year preceding the year for which the assessments were levied.

~~(c) For operating losses incurred from October 1, 1990, through June 30, 1991, the board shall assess each insurer in the amount and manner prescribed by chapter 90-334, Laws of Florida. The maximum assessment against an insurer, as provided in such act, shall apply separately to the claims incurred in 1990 (October 1 through December 31) and the claims incurred in 1991 (January 1 through June 30). For operating losses incurred on January 1, 1991, through June 30, 1991, the maximum assessment against an insurer shall be one-half of the amount of the maximum assessment specified for such insurer in former s. 627.6492(1)(b), 1990 Supplement, as amended by chapter 90-334, Laws of Florida.~~

(c)~~(d)~~ All rights, title, and interest in the assessment funds collected shall vest in this state. However, all of such funds and interest earned shall be used by the association to pay claims and administrative expenses.

(2) If assessments and other receipts by the association, board, or administrator exceed the actual losses and administrative expenses of the plan, the excess shall be held at interest and used by the board to offset future

losses. As used in this subsection, the term "future losses" includes reserves for claims incurred but not reported.

(3) Each insurer's assessment shall be determined annually by the association based on annual statements and other reports deemed necessary by the association and filed with it by the insurer. Any deficit incurred under the plan shall be recouped by assessments against participating insurers by the board in the manner provided in subsection (1); and the insurers may recover the assessment in the normal course of their respective businesses without time limitation.

(4)(a) This subsection applies only to those costs and expenses of the association related to persons whose coverage begins after January 1, 2002. As a condition of doing business in this state, every insurer shall pay an amount determined by the board of up to 25 cents per month for each individual policy or covered group subscriber insured in this state, not including covered dependents, under a health insurance policy, certificate, or other evidence of coverage that is issued for a resident of this state and shall file the information with the association as required pursuant to paragraph (d). Any insurer who neglects, fails, or refuses to collect the fee shall be liable for and pay the fee. The fee shall not be subject to the provisions of s. 624.509.

(b) For purposes of this subsection, health insurance does not include accident only, specified disease, individual hospital indemnity, credit, dental-only, vision-only, Medicare supplement, long-term care, nursing home care, home health care, community-based care, or disability income insurance; similar supplemental plans provided under a separate policy, certificate, or contract of insurance, which cannot duplicate coverage under an underlying health plan and are specifically

designed to fill gaps in the underlying health plan, coinsurance, or deductibles; any policy covering medical-payment coverage or personal injury protection coverage in a motor vehicle policy; coverage issued as a supplement to liability insurance; or workers' compensation insurance. For the purposes of this subsection, the term "insurer" as defined in s. 627.6482(7) also includes administrators licensed pursuant to s. 626.8805, and any insurer defined in s. 627.6482(7) from whom any person providing health insurance to Florida residents procures insurance for itself in the insurer, with respect to all or part of the health insurance risk of the person, or provides administrative services only. This definition of insurer excludes self-insured, employee welfare benefit plans that are not regulated by the Florida Insurance Code pursuant to the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, as amended. However, this definition of insurer includes multiple employer welfare arrangements as provided for in the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, as amended. Each covered group subscriber, without regard to covered dependents of the subscriber, shall be counted only once with respect to any assessment. For that purpose, the board shall allow an insurer as defined by this subsection to exclude from its number of covered group subscribers those who have been counted by any primary insurer providing health insurance coverage pursuant to s. 624.603.

(c) The calculation shall be determined as of December 31 of each year and shall include all policies and covered subscribers, not including covered dependents of the subscribers, insured at any time during the year, calculated for each month of coverage. The payment is payable to the

association no later than April 1 of the subsequent year. The first payment shall be forwarded to the association no later than April 1, 2002, covering the period of October 1, 2001, through December 31, 2001.

(d) The payment of such funds shall be submitted to the association accompanied by a form prescribed by the association and adopted in the plan of operation. The form shall identify the number of covered lives for different types of health insurance products and the number of months of coverage.

(e) Beginning October 1, 2001, the fee paid to the association may be charged by the health insurer directly to each policyholder, insured member, or subscriber and is not part of the premium subject to the department's review and approval. Nonpayment of the fee shall be considered nonpayment of premium for purposes of s. 627.6043.

Section 11. Section 627.6498, Florida Statutes, is amended to read:

627.6498 Minimum benefits coverage; exclusions; premiums; deductibles.--

(1) COVERAGE OFFERED.--

(a) The plan shall offer in an annually ~~a semiannually~~ renewable policy the coverage specified in this section for each eligible person. ~~For applications accepted on or after June 7, 1991, but before July 1, 1991, coverage shall be effective on July 1, 1991, and shall be renewable on January 1, 1992, and every 6 months thereafter. Policies in existence on June 7, 1991, shall, upon renewal, be for a term of less than 6 months that terminates and becomes subject to subsequent renewal on the next succeeding January 1 or July 1, whichever is sooner.~~

~~(b) If an eligible person is also eligible for Medicare coverage, the plan shall not pay or reimburse any person for expenses paid by Medicare.~~

~~(c) Any person whose health insurance coverage is involuntarily terminated for any reason other than nonpayment of premium may apply for coverage under the plan. If such coverage is applied for within 60 days after the involuntary termination and if premiums are paid for the entire period of coverage, the effective date of the coverage shall be the date of termination of the previous coverage.~~

(b)~~(d)~~ The plan shall provide that, upon the death or divorce of the individual in whose name the contract was issued, every other person then covered in the contract may elect within 60 days to continue under the same or a different contract.

(c)~~(e)~~ No coverage provided to a person who is eligible for Medicare benefits shall be issued as a Medicare supplement policy as defined in s. 627.672.

(2) BENEFITS.--

(a) The plan must offer coverage to every eligible person subject to limitations set by the association. The coverage offered must pay an eligible person's covered expenses, subject to limits on the deductible and coinsurance payments authorized under subsection (4). The lifetime benefits limit for such coverage shall be $500,000. However, policyholders of association policies issued prior to 1992 are entitled to continued coverage at the benefit level established prior to January 1, 2002. Only the premium, deductible, and coinsurance amounts may be modified as determined necessary by the board.~~The plan shall offer major medical expense coverage similar to that provided by the state~~

~~group health insurance program as defined in s. 110.123 except as specified in subsection (3) to every eligible person who is not eligible for Medicare. Major medical expense coverage offered under the plan shall pay an eligible person's covered expenses, subject to limits on the deductible and coinsurance payments authorized under subsection (4), up to a lifetime limit of $500,000 per covered individual. The maximum limit under this paragraph shall not be altered by the board, and no actuarially equivalent benefit may be substituted by the board.~~

(b) The plan shall provide that any policy issued to a person eligible for Medicare shall be separately rated to reflect differences in experience reasonably expected to occur as a result of Medicare payments.

(3) COVERED EXPENSES.--

(a) The board shall establish the coverage to be issued by the association.

(b) If the coverage is being issued to an eligible individual as defined in s. 627.6487, the individual shall be offered, at the option of the individual, the basic and the standard health benefit plan as established in s. 627.6699. ~~The coverage to be issued by the association shall be patterned after the state group health insurance program as defined in s. 110.123, including its benefits, exclusions, and other limitations, except as otherwise provided in this act. The plan may cover the cost of experimental drugs which have been approved for use by the Food and Drug Administration on an experimental basis if the cost is less than the usual and customary treatment. Such coverage shall only apply to those insureds who are in the case management system upon the approval of the insured, the case manager, and the board.~~

(4) PREMIUMS AND~~,~~DEDUCTIBLES~~, AND COINSURANCE~~.--

~~(a)~~ The plan shall provide for annual deductibles for major medical expense coverage in the amount of $1,000 or any higher amounts proposed by the board and approved by the department, plus the benefits payable under any other type of insurance coverage or workers' compensation. The schedule of premiums and deductibles shall be established by the board ~~association~~. ~~With regard to any preferred provider arrangement utilized by the association, the deductibles provided in this paragraph shall be the minimum deductibles applicable to the preferred providers and higher deductibles, as approved by the department, may be applied to providers who are not preferred providers.~~

1. Separate schedules of premium rates based on age may apply for individual risks.

2. Rates are subject to approval by the department pursuant to ss. 627.410 and 627.411, except as provided by this section. The board shall revise premium schedules annually, beginning January 2002.

~~3. Standard risk rates for coverages issued by the association shall be established by the department, pursuant to s. 627.6675(3).~~

3.~~4.~~ The board shall establish three premium schedules based upon an individual's family income:

a. Schedule A is applicable to an individual whose family income exceeds the allowable amount for determining eligibility under the Medicaid program, up to and including 200 percent of the Federal Poverty Level. Premiums for a person under this schedule may not exceed 150 percent of the standard risk rate.

b. Schedule B is applicable to an individual whose family income exceeds 200 percent but is less than 300 percent of the Federal Poverty Level. Premiums for a person under this schedule may not exceed 250 percent of the standard risk rate.

c. Schedule C is applicable to an individual whose family income is equal to or greater than 300 percent of the Federal Poverty Level. Premiums for a person under this schedule may not exceed 300 percent of the standard risk rate. ~~establish separate premium schedules for low-risk individuals, medium-risk individuals, and high-risk individuals and shall revise premium schedules annually beginning January 1999.~~

4. The standard risk rate shall be determined by the department pursuant to s. 627.6675(3). The rate shall be adjusted for benefit differences.~~No rate shall exceed 200 percent of the standard risk rate for low-risk individuals, 225 percent of the standard risk rate for medium-risk individuals, or 250 percent of the standard risk rate for high-risk individuals. For the purpose of determining what constitutes a low-risk individual, medium-risk individual, or high-risk individual, the board shall consider the anticipated claims payment for individuals based upon an individual's health condition.~~

~~(b) If the covered costs incurred by the eligible person exceed the deductible for major medical expense coverage selected by the person in a policy year, the plan shall pay in the following manner:~~

~~1. For individuals placed under case management, the plan shall pay 90 percent of the additional covered costs incurred by the person during the policy year for the first $10,000, after which the plan shall pay 100 percent of the covered costs incurred by the person during the policy year.~~

~~2. For individuals utilizing the preferred provider network, the plan shall pay 80 percent of the additional covered costs incurred by the person during the policy year for the first $10,000, after which the plan shall pay 90 percent of covered costs incurred by the person during the policy year.~~

~~3. If the person does not utilize either the case management system or the preferred provider network, the plan shall pay 60 percent of the additional covered costs incurred by the person for the first $10,000, after which the plan shall pay 70 percent of the additional covered costs incurred by the person during the policy year.~~

(5) PREEXISTING CONDITIONS.--An association policy shall ~~may~~ contain provisions under which coverage is excluded during a period of 12 months following the effective date of coverage with respect to a given covered individual for any preexisting condition, as long as:

(a) The condition manifested itself within a period of 6 months before the effective date of coverage; or

(b) Medical advice or treatment was recommended or received within a period of 6 months before the effective date of coverage.

This subsection does not apply to an eligible individual as defined in s. 627.6487.

(6) OTHER SOURCES PRIMARY.--

(a) No amounts paid or payable by Medicare or any other governmental program or any other insurance, or self-insurance maintained in lieu of otherwise statutorily required insurance, may be made or recognized as claims under such policy or be recognized as or towards satisfaction of

applicable deductibles or out-of-pocket maximums or to reduce the limits of benefits available.

(b) The association has a cause of action against a participant for any benefits paid to the participant which should not have been claimed or recognized as claims because of the provisions of this subsection or because otherwise not covered.

(7) NONENTITLEMENT.--The Florida Comprehensive Health Association Act does not provide an individual with an entitlement to health care services or health insurance. A cause of action does not arise against the state, the board, or the association for failure to make health services or health insurance available under the Florida Comprehensive Health Association Act.

Section 12. The Legislature finds that the provisions of this act fulfill an important state interest.

Section 13. The amendments in this act to section 627.6487(3), Florida Statutes, shall not take effect unless the Health Care Financing Administration of the U.S. Department of Health and Human Services approves this act as providing an acceptable alternative mechanism, as provided in the Public Health Service Act.

Section 14. Effective January 1, 2002, section 627.6484, Florida Statutes, is repealed.

Section 15. 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 16. Paragraphs (i), (m), and (n) of subsection (3), paragraph (b) of subsection (6), 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 credits based on the duration that the ~~of~~ coverage has been in force as permitted under subparagraph (6)(b)6.~~subparagraph~~

~~(6)(b)5.~~; and administrative and acquisition expenses as permitted under subparagraph (6)(b)5. A carrier may separate the experience of small employer groups with less than two eligible employees from the experience of small employer groups with two through 50 eligible employees.

(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 two eligible employees may not exceed 150 percent of the rate determined for groups of two through 50 eligible employees; however, the carrier may charge excess losses of the less-than-two-eligible-employee experience pool to the experience pool of the two through 50 eligible employees so

that all losses are allocated and the 150-percent rate limit on the less-than-two-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, 2001, 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 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 credits based on the 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 credits based on the 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.

(12) STANDARD, BASIC, AND LIMITED HEALTH BENEFIT PLANS.--

(a)1. By May 15, 1993, the commissioner shall appoint a health benefit plan committee composed of four representatives of carriers which shall include at least two representatives of HMOs, at least one of which is a staff model HMO, two representatives of agents, four representatives of small employers, and one employee of a small employer. The carrier members shall be selected from a list of individuals recommended by the board. The commissioner may require the board to submit additional recommendations of individuals for appointment.

2. The plans shall comply with all of the requirements of this subsection.

3. The plans must be filed with and approved by the department prior to issuance or delivery by any small employer carrier.

4. Before October 1, 2001, and in every 4th year thereafter, the commissioner shall appoint a new health benefit plan committee in the manner provided in subparagraph 1. to determine whether modifications to a plan might be appropriate and to submit recommended modifications to the department for approval. Such determination shall be based upon prevailing industry standards regarding managed care and cost-containment provisions and shall be for the purpose of ensuring that the benefit plans offered to small employers on a guaranteed-issue basis are consistent with the low to mid-priced benefit plans offered in the large-group market. 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 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 the ~~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 must 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."

(d)~~(c)~~ 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. 627.31,627.410, 627.4106, and 627.411.

(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 law is made expressly applicable to such policies or contracts. A law restricting or limiting deductibles, copayments, or annual or lifetime maximum payments does not

apply to a limited benefit policy or contract offered or delivered to a small employer unless such law is made expressly applicable to such policy or contract. A limited benefit policy or contract that is offered or delivered to a small employer may also be offered or delivered to an employer having 51 or more eligible employees.

Section 17. 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 18. Paragraphs (b) and (d) of subsection (3) of section 641.31, Florida Statutes, are amended, and paragraph (f) is added to that 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 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 19. This act shall take effect October 1, 2001.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR
CS for SB 1960 & 1760

The Committee Substitute for the Committee Substitute for Senate Bills 1960 and 1760 reopens the Florida Comprehensive Health Association for enrollment on January 1, 2002, caps new enrollment in the association at 500 for calendar year 2002 and allows an additional 1,500 members, effective January 1, 2003, and makes changes to procedures, structure and eligibility for the program.