By Senator Latvala

19-868A-02

A bill to be entitled

An act relating to health insurance; providing legislative findings and legislative intent; defining terms; 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 that certain group certificates for health insurance coverage 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 having fewer 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. 627.6475, F.S.; revising criteria for reinsuring individuals under an individual health reinsurance program; 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. 627.667, F.S.; deleting an exception to an extension-of-benefits application provision for out-of-state group policies; amending s. 627.6692, F.S.; extending a time period for premium payment for continuation of coverage; amending s. 627.6699, F.S.; redefining terms; allowing carriers to separate the experience of small-employer groups having fewer than two employees; authorizing certain small employers to enroll with alternate carriers under certain circumstances; revising the rating factors that may be used by small-employer carriers; eliminating a prohibition against charging certain adjustments in rates to individual employees or dependents; revising certain criteria of the small-employer health reinsurance program; 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. 627.911, F.S.; including health maintenance organizations under certain information-reporting requirements; amending s. 627.9175, F.S.; revising health insurance reporting requirements for insurers; amending s. 627.9403, F.S.; clarifying application of exceptions to certain long-term-care insurance policy requirements for certain limited-benefit policies; 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 having fewer than a specified number of subscribers; amending s. 641.3111, F.S.; revising extension-of-benefits requirements for group health maintenance contracts; providing an effective date.

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

Section 1. Health flex plans.--

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

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

(a) "Agency" means the Agency for Health Care Administration.

(b) "Department" means the Department of Insurance.

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

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

(e) "Health flex plan" means a health plan approved under subsection (3) which guarantees payment for specified health care coverage provided to the enrollee.

(f) "Health flex 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 health flex plan and is responsible for administering the health flex plan and paying all claims for health flex plan coverage by enrollees of the health flex plan.

(3) PILOT PROGRAM.--The agency and the department shall each approve or disapprove health flex plans that provide health care coverage for eligible participants who reside in the three areas of the state that have the highest number of uninsured persons, as identified in the Florida Health Insurance Study conducted by the agency. A health flex plan may limit or exclude benefits otherwise required by law

for insurers offering coverage in this state, may cap the total amount of claims paid per year per enrollee, may limit the number of enrollees, or may take any combination of those actions.

(a) The agency shall develop guidelines for the review of applications for health flex plans and shall disapprove or withdraw approval of plans that do not meet or no longer meet minimum standards for quality of care and access to care.

(b) The department shall develop guidelines for the review of health flex plan applications and shall disapprove or shall withdraw approval of plans that:

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

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

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

(4) LICENSE NOT REQUIRED.--Neither the licensing requirements of the Florida Insurance Code nor chapter 641, Florida Statutes, relating to health maintenance organizations, is applicable to a health flex plan approved under this section, unless expressly made applicable. However, for the purpose of prohibiting unfair trade practices, health flex plans are considered to be insurance subject to the

applicable provisions of part IX of chapter 626, Florida Statutes, except as otherwise provided in this section.

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

(a) 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, such as KidCare, and have not been covered at any time during the past 6 months; and

(d) Have applied for health care coverage through an approved health flex plan and have agreed to make any payments required for participation, including periodic payments or payments due at the time health care services are provided.

(6) RECORDS.--Each health flex plan shall maintain enrollment data and reasonable records of its losses, expenses, and claims experience and shall make those records reasonably available to enable the department to monitor and determine the financial viability of the health flex plan, as necessary. Provider networks and total enrollment by area shall be reported to the agency biannually to enable the agency to monitor access to care.

(7) NOTICE.--The denial of coverage by a health flex plan, or the nonrenewal or cancellation of coverage, must be accompanied by the specific reasons for denial, nonrenewal, or cancellation. Notice of nonrenewal or cancellation must be provided at least 45 days in advance of the nonrenewal or cancellation, except that 10 days' written notice must be given for cancellation due to nonpayment of premiums. If the

health flex plan fails to give the required notice, the health flex plan coverage must remain in effect until notice is appropriately given.

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

(9) PROGRAM EVALUATION.--The agency and the department shall evaluate the pilot program and its effect on the entities that seek approval as health flex plans, on the number of enrollees, and on the scope of the health care coverage offered under a health flex plan; shall provide an assessment of the health flex plans and their potential applicability in other settings; and shall, by January 1, 2004, jointly submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

(10) EXPIRATION.--This section expires July 1, 2004.

Section 2. Subsection (1) and paragraph (a) of subsection (6) of section 627.410, Florida Statutes, are amended, paragraphs (f) and (g) are added to subsection (6) of that section, 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. Changes in rates, rating manuals, and rating schedules for individual health insurance policies shall be filed for approval pursuant to this paragraph. Prior approval is not required for an individual health insurance policy rate filing that complies with the requirements of paragraph (f). This paragraph does not qualify the department's authority to investigate suspected violations of this section or to take necessary corrective action when a violation can be demonstrated. This paragraph does not prevent an insurer from filing rates or rate changes for approval or from deeming rate changes approved pursuant to an approved loss ratio guarantee under subsection (8). This paragraph does not apply to group health insurance policies, effectuated and delivered in this state, insuring groups of 51 or more persons, 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.

(f) An insurer that files changes in rates, rating manuals, or rating schedules with the department for individual health policies as described in s. 627.6561(5)(a)2., but excluding Medicare supplement policies, according to this paragraph may begin providing required notice to policyholders and charging corresponding adjusted rates in accordance with s. 627.6043, upon filing, if the insurer certifies that it has met the criteria of subparagraphs 1., 2., and 3. Filings submitted under this paragraph must contain the same information and demonstrations and must meet the same requirements as rate filings submitted for approval under this section, including the requirements of s. 627.411, except as indicated in this paragraph.

1. The insurer must have complied with annual rate-filing requirements then in effect pursuant to subsection (7) since October 1, 2002, or for the previous 2 years, whichever is less, and must have filed and implemented actuarially justifiable rate adjustments at least annually during this period. This subparagraph does not prevent an insurer from filing rate adjustments more often than annually.

2. The insurer must have pooled experience for applicable individual health policy forms in accordance with the requirements of subparagraph (6)(e)3. Rate changes used on a form must not vary by the experience of that form or the health status of covered individuals on that form but must be based on the experience of all forms, including rating characteristics as defined in this paragraph.

3. Rates for the policy form are anticipated to meet a minimum loss ratio of 65 percent over the expected life of the form.

Rates for all individual health policy forms issued on or after October 1, 2002, must be based upon the same factors for each rating characteristic. As used in this paragraph, the term "rating characteristics" means demographic characteristics of individuals, including, but not limited to, geographic area factors, benefit design, smoking status, and health status at issue.

(g) After filing a change of rates for an individual health policy under paragraph (f), an insurer may be required to furnish additional information to demonstrate compliance with this section. If the department finds that the adjusted rates are not reasonable in relation to premiums charged under

the standards of this section, the department may order appropriate corrective action.

(7)

(f) Insurers with fewer than 1,000 nationwide policyholders or insured group members or subscribers covered under any form or pooled group of forms with health insurance coverage, as described in s. 627.6561(5)(a)2., excluding Medicare supplement insurance coverage under part VIII, at the time of a rate filing made under subparagraph (b)1., may file for an annual rate increase limited to medical trend as adopted by the department under s. 627.411(4). The filing is in lieu of the actuarial memorandum required for a rate filing prescribed by paragraph (6)(b). The filing must include forms adopted by the department and a certification by an officer of the company that the filing includes all similar forms.

Section 3. Paragraph (e) of subsection (1) of section 627.411, Florida Statutes, is amended, and subsections (3), (4), and (5) are added to that section, to read:

627.411 Grounds for disapproval.--

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

(e) Is for health insurance, and:

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

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 under s. 626.9541(1)(g)2.; or ~~in sales practices~~

4. Results in actuarially justified annual rate increases:

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 must 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 which is equal to the rate increase otherwise allowed by this sub-subparagraph. Future annual rate increases for existing insureds are 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 provision does not apply to prestandardized Medicare supplement forms.

(3) If a health insurance rate filing changes the established rate relationships between insureds, the aggregate effect of such a change must be revenue-neutral. The change to the new relationship must 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 are not to be phased-in pursuant to this paragraph.

(4) Individual health insurance policies that are subject to renewability requirements of s. 627.6425 are guaranteed renewable for purposes of establishing loss ratio standards and must comply with the same loss ratio standards as other guaranteed renewable forms.

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

627.6475 Individual reinsurance pool.--

(7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.--

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

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

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

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

4. A reinsuring carrier may terminate reinsurance for all reinsured eligible individuals on any plan anniversary.

5. The premium rate charged for reinsurance by the program to a health maintenance organization that is approved by the Secretary of Health and Human Services as a federally qualified health maintenance organization pursuant to 42 U.S.C. s. 300e(c)(2)(A) and that, as such, is subject to requirements that limit the amount of risk that may be ceded to the program, which requirements are more restrictive than subparagraph 2., shall be reduced by an amount equal to that portion of the risk, if any, which exceeds the amount set forth in subparagraph 2., which may not be ceded to the program.

6. The board may consider adjustments to the premium rates charged for reinsurance by the program or carriers that use effective cost-containment measures, including high-cost case management, as defined by the board.

7. A reinsuring carrier shall apply its case-management and claims-handling techniques, including, but not limited to, utilization review, individual case management, preferred provider provisions, other managed-care

provisions, or methods of operation consistently with both reinsured business and nonreinsured business.

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

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

(e)1. Before <u>September</u> ~~March~~ 1 of each calendar year, the board shall determine and report to the department the program net loss in the individual account for the previous year, including administrative expenses for that year and the

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

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

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

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

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

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

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

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

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

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

Section 5. Subsection (9) is added to section 627.6515, Florida Statutes, to read:

627.6515 Out-of-state groups.--

(9) Notwithstanding any other provision of this section, any group health insurance policy or group certificate for health insurance, as described in s. 627.6561(5)(a)2., which is issued to a resident of this state and requires individual underwriting to determine coverage eligibility for an individual or premium rates to be charged to an individual is considered a policy issued on an individual basis and is subject to and must comply with the Florida Insurance Code in the same manner as individual insurance policies issued in this state.

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

627.667 Extension of benefits.--

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

Section 7. Paragraph (e) of subsection (5) of section 627.6692, Florida Statutes, as amended by section 1 of chapter 2001-353, Laws of Florida, is amended to read:

627.6692 Florida Health Insurance Coverage Continuation Act.--

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

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

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

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

subsection (11), paragraphs (a), (d), and (e) of subsection (12), and paragraph (a) of subsection (15) of section 627.6699, Florida Statutes, are amended to read:

627.6699 Employee Health Care Access Act.--

(3) DEFINITIONS.--As used in this section, the term:

(i) "Established geographic area" means the county or counties~~, or any portion of a county or counties,~~within which the carrier provides or arranges for health care services to be available to its insureds, members, or subscribers.

(m) "Limited benefit policy or contract" means a policy or contract that provides coverage for each person insured under the policy for a specifically named disease or diseases or~~,~~a specifically named accident which~~, or a specifically named limited market that~~ fulfills a ~~an experimental or~~ reasonable need by providing more affordable health insurance~~, such as the small group market~~.

(n) "Modified community rating" means a method used to develop carrier premiums which spreads financial risk across a large population; allows the use of separate rating factors for age, gender, family composition, tobacco usage, and geographic area as determined under paragraph (5)(j); and allows adjustments for~~: claims experience, health status, or duration of coverage as permitted under subparagraph (6)(b)5.; and~~ administrative and acquisition expenses as permitted under subparagraph(6)(b)6~~(6)(b)5~~. A carrier may separate the experience of small employer groups that have fewer than 2 eligible employees from the experience of small employer groups that have 2 through 50 eligible employees.

(5) AVAILABILITY OF COVERAGE.--

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

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

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

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

small employer, with fewer than two eligible employees, which small employer is not formed primarily for the purpose of buying health insurance and which elects to be covered under such plan, agrees to make the required premium payments, and satisfies the other provisions of the plan. Coverage provided under this subparagraph shall begin on October 1 of the same year as the date of enrollment, unless the small employer carrier and the small employer agree to a different date. A rider for additional or increased benefits may be medically underwritten and may only be added to the standard health benefit plan. The increased rate charged for the additional or increased benefit must be rated in accordance with this section. For purposes of this subparagraph, a person, his or her spouse, and his or her dependent children constitute a single eligible employee if that person and spouse are employed by the same small employer and either that person or his or her spouse has a normal work week of less than 25 hours.

b. Notwithstanding the restrictions set forth in sub-subparagraph a., when a small employer group is losing coverage because a carrier is exercising the provisions of s. 627.6571(3)(b) or s. 641.31074(3)(b), the eligible small employer, as defined in sub-subparagraph a., is entitled to enroll with another carrier offering small employer coverage within 63 days after the notice of termination or the termination date of the prior coverage, whichever is later. Coverage provided under this sub-subparagraph begins immediately upon enrollment, unless the small employer carrier and the small employer agree to a different date.

4. This paragraph does not limit a carrier's ability to offer other health benefit plans to small employers if the

standard and basic health benefit plans are offered and rejected.

(6) RESTRICTIONS RELATING TO PREMIUM RATES.--

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

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

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.

<u>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 having fewer than 2 eligible employees may not exceed 150 percent of the rate determined for groups having 2 through 50 eligible employees; however, the carrier may charge excess losses of the less-than-2-eligible-employee experience pool to the experience pool of the 2-through-50-eligible-employee pool so that all losses are allocated and the 150-percent rate limit on the less-than-2-eligible-employee experience pool is maintained. Notwithstanding s. 627.411(1)(e)4. and (3), the</u>

rate to be charged to a small employer group having fewer than 2 eligible employees insured as of July 1, 2002, may be up to 125 percent of the rate determined for groups having 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 duration of coverage may not be charged to individual employees or dependents. For a small employer's policy, such adjustments may not result in a rate for the small employer which deviates more than 15 percent from the carrier's approved rate. Any such adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer. A small employer carrier may make an adjustment to a small employer's renewal premium, not to exceed 10 percent annually, due to the claims experience, health status, or duration of coverage of the employees or dependents of the small employer. Semiannually, small group carriers shall report information on forms adopted by rule by the department, to enable the department to monitor the relationship of aggregate adjusted premiums actually charged policyholders by each carrier to the premiums that would have been charged by application of the carrier's approved modified community rates. If the aggregate resulting from the application of such adjustment exceeds the premium that would have been charged by application of the approved modified community rate by 5 percent for the current reporting period, the carrier shall limit the application of such adjustments only to minus adjustments beginning not more than 60 days after the report is sent to the department. For any subsequent~~

~~reporting period, if the total aggregate adjusted premium actually charged does not exceed the premium that would have been charged by application of the approved modified community rate by 5 percent, the carrier may apply both plus and minus adjustments.~~A small employer carrier may provide a credit to a small employer's premium based on administrative and acquisition expense differences resulting from the size of the group. Group size administrative and acquisition expense factors may be developed by each carrier to reflect the carrier's experience and are subject to department review and approval.

7.~~6.~~ A small employer carrier rating methodology may include separate rating categories for one dependent child, for two dependent children, and for three or more dependent children for family coverage of employees having a spouse and dependent children or employees having dependent children only. A small employer carrier may have fewer, but not greater, numbers of categories for dependent children than those specified in this subparagraph.

8.~~7.~~ Small employer carriers may not use a composite rating methodology to rate a small employer with fewer than 10 employees. For the purposes of this subparagraph, a "composite rating methodology" means a rating methodology that averages the impact of the rating factors for age and gender in the premiums charged to all of the employees of a small employer.

(11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.--

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

directly to groups or individuals. In addition thereto, the program has specific authority to:

1. Enter into contracts as necessary or proper to carry out the provisions and purposes of this act, including the authority to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions.

2. Sue or be sued, including taking any legal action necessary or proper for recovering any assessments and penalties for, on behalf of, or against the program or any carrier.

3. Take any legal action necessary to avoid the payment of improper claims against the program.

4. Issue reinsurance policies, in accordance with the requirements of this act.

5. Establish rules, conditions, and procedures for reinsurance risks under the program participation.

6. Establish actuarial functions as appropriate for the operation of the program.

7. Assess participating carriers in accordance with paragraph (j), and make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Interim assessments shall be credited as offsets against any regular assessments due following the close of the calendar year.

8. Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the program, and in any other function within the authority of the program.

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

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

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

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

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

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

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

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

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

7.~~6.~~ A small employer carrier may terminate reinsurance for all reinsured employees or dependents on any plan anniversary.

8.~~7.~~ The premium rate charged for reinsurance by the program to a health maintenance organization that is approved by the Secretary of Health and Human Services as a federally qualified health maintenance organization pursuant to 42 U.S.C. s. 300e(c)(2)(A) and that, as such, is subject to requirements that limit the amount of risk that may be ceded to the program, which requirements are more restrictive than subparagraph 4., shall be reduced by an amount equal to that portion of the risk, if any, which exceeds the amount set forth in subparagraph 4. which may not be ceded to the program.

9.~~8.~~ The board may consider adjustments to the premium rates charged for reinsurance by the program for carriers that use effective cost containment measures, including high-cost case management, as defined by the board.

10.~~9.~~ A reinsuring carrier shall apply its case-management and claims-handling techniques, including, but not limited to, utilization review, individual case management, preferred provider provisions, other managed care provisions or methods of operation, consistently with both reinsured business and nonreinsured business.

(h)1. The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall

provide for the development of basic reinsurance premium rates, which shall be multiplied by the factors set for them in this paragraph to determine the premium rates for the program. The basic reinsurance premium rates shall be established by the board, subject to the approval of the department, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard and basic health benefit plan. The premium rates set by the board may vary by geographical area, as determined under this section, to reflect differences in cost. ~~The multiplying factors must be established as follows:~~

~~a. The entire group may be reinsured for a rate that is 1.5 times the rate established by the board.~~

~~b. An eligible employee or dependent may be reinsured for a rate that is 5 times the rate established by the board.~~

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

(j)1. Before September ~~March~~ 1 of each calendar year, the board shall determine and report to the department the program net loss for the previous year, including administrative expenses for that year, and the incurred losses for the year, taking into account investment income and other appropriate gains and losses.

2. Any net loss for the year shall be recouped by assessment of the carriers, as follows:

a. The operating losses of the program shall be assessed in the following order subject to the specified limitations. The first tier of assessments shall be made against reinsuring carriers in an amount which shall not exceed 5 percent of each reinsuring carrier's premiums from health benefit plans covering small employers. If such assessments have been collected and additional moneys are needed, the board shall make a second tier of assessments in an amount which shall not exceed 0.5 percent of each carrier's health benefit plan premiums. Except as provided in paragraph (n), risk-assuming carriers are exempt from all assessments authorized pursuant to this section. The amount paid by a reinsuring carrier for the first tier of assessments shall be credited against any additional assessments made.

b. The board shall equitably assess carriers for operating losses of the plan based on market share. The board shall annually assess each carrier a portion of the operating losses of the plan. The first tier of assessments shall be determined by multiplying the operating losses by a fraction, the numerator of which equals the reinsuring carrier's earned premium pertaining to direct writings of small employer health benefit plans in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of all such premiums earned by reinsuring carriers in the state during that calendar year. The second tier of assessments shall be based on the premiums that all carriers, except risk-assuming carriers, earned on all health benefit plans written in this state. The board may levy interim assessments against carriers to ensure the financial ability of the plan to cover claims expenses and administrative expenses paid or estimated to be paid in the operation of the

plan for the calendar year prior to the association's anticipated receipt of annual assessments for that calendar year. Any interim assessment is due and payable within 30 days after receipt by a carrier of the interim assessment notice. Interim assessment payments shall be credited against the carrier's annual assessment. Health benefit plan premiums and benefits paid by a carrier that are less than an amount determined by the board to justify the cost of collection may not be considered for purposes of determining assessments.

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

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

4. If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified in subparagraph 2., the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the department within 240 ~~90~~ days following the end of the calendar year in which the losses were incurred. The evaluation shall include an estimate of future assessments, the administrative costs of the program, the appropriateness of the premiums charged and the level of carrier retention under the program, and the costs of coverage

for small employers. If the board fails to file a report with the department within 240 ~~90~~ days following the end of the applicable calendar year, the department may evaluate the operations of the program and implement such amendments to the plan of operation the department deems necessary to reduce future losses and assessments.

5. If assessments exceed the amount of the actual losses and administrative expenses of the program, the excess shall be held as interest and used by the board to offset future losses or to reduce program premiums. As used in this paragraph, the term "future losses" includes reserves for incurred but not reported claims.

6. Each carrier's proportion of the assessment shall be determined annually by the board, based on annual statements and other reports considered necessary by the board and filed by the carriers with the board.

7. Provision shall be made in the plan of operation for the imposition of an interest penalty for late payment of an assessment.

8. A carrier may seek, from the commissioner, a deferment, in whole or in part, from any assessment made by the board. The department may defer, in whole or in part, the assessment of a carrier if, in the opinion of the department, the payment of the assessment would place the carrier in a financially impaired condition. If an assessment against a carrier is deferred, in whole or in part, the amount by which the assessment is deferred may be assessed against the other carriers in a manner consistent with the basis for assessment set forth in this section. The carrier receiving such deferment remains liable to the program for the amount

deferred and is prohibited from reinsuring any individuals or groups in the program if it fails to pay assessments.

(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, 2002, 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 a determination must be based upon prevailing industry standards regarding managed care and cost-containment provisions and is to serve the purpose of ensuring that the benefit plans offered to small employers on a guaranteed-issue basis are consistent with the low-priced 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 information sufficient to provide 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 was ~~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 he or she ~~the prospective policyholder had~~ rejected that coverage.

~~A copy of such written statement shall be provided to the prospective policyholder no later than at the time of delivery of the policy or contract, and the original of such written statement shall be retained in the files of the small employer carrier for the period of time that the policy or contract remains in effect or for 5 years, whichever period is longer.~~

~~3. Any material statement made by an applicant for coverage under a health benefit plan which falsely certifies~~

~~as to the applicant's eligibility for coverage serves as the basis for terminating coverage under the policy or contract.~~

3.~~4.~~ Each marketing communication that is intended to be used in the marketing of a health benefit plan in this state must be submitted for review by the department prior to use and must contain the disclosures stated in this subsection.

4. The contract, policy, and certificates evidencing coverage under a limited benefit policy or contract and the application for coverage under such plans must state in not less than 10-point type on the first page in contrasting color the following: "The benefits provided by this health plan are limited and may not cover all of your medical needs. You should carefully review the benefits offered under this health plan."

(e) A small employer carrier may not use any policy, contract, form, or rate under this section, including applications, enrollment forms, policies, contracts, certificates, evidences of coverage, riders, amendments, endorsements, and disclosure forms, until the insurer has filed it with the department and the department has approved it under ss. 627.410~~,~~ ~~and~~ 627.411, and 641.31 and this section.

(15) APPLICABILITY OF OTHER STATE LAWS.--

(a) Except as expressly provided in this section, a law requiring coverage for a specific health care service or benefit, or a law requiring reimbursement, utilization, or consideration of a specific category of licensed health care practitioner, does not apply to a standard or basic health benefit plan policy or contract or a limited benefit policy or contract offered or delivered to a small employer unless that

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 the law is made expressly applicable to such a 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. Any covered disease or condition may be treated by any physician, without discrimination, who is licensed or certified to treat the disease or condition.

Section 9. Section 627.911, Florida Statutes, is amended to read:

627.911 Scope of this part.--Any insurer or health maintenance organization transacting insurance in this state shall report information as required by this part.

Section 10. Section 627.9175, Florida Statutes, is amended to read:

627.9175 Reports of information on health insurance.--

(1) Each authorized health insurer shall submit annually to the department information concerning health insurance coverage being issued or currently in force in this state. The information must include information related to premium, number of policies, and covered lives for such policies and other information necessary for analyzing trends in enrollment, premiums, and claim costs.~~as to policies of individual health insurance:~~

(a) The required information must be broken down by market segment, to include:

1. Health insurance issuer company contact information.

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

a. Direct premiums earned.

b. Direct losses incurred.

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

d. Number of policies.

e. Number of certificates.

f. Number of total covered lives.

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

~~1. The deductible amount;~~

~~2. The coinsurance percentage;~~

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

~~4. Outpatient benefits;~~

~~5. Inpatient benefits; and~~

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

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

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

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

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

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

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

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

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

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

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

627.9408 Rules.--

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

(2) The department may adopt by rule the provisions of the Long-Term Care Insurance Model Regulation adopted by the National Association of Insurance Commissioners in the second quarter of the year 2000 which are not in conflict with the Florida Insurance Code.

Section 13. Paragraphs (b) and (d) of subsection (3) of section 641.31, Florida Statutes, are amended, and paragraph (f) is added to 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 that has fewer than 1,000 covered subscribers under all individual or group contracts at the time of a rate filing may file for an annual rate increase limited to annual medical trend, as adopted by the department. The filing is in lieu of the actuarial memorandum otherwise required for the rate filing. The filing must include forms adopted by the department and a certification by an officer of the company that the filing includes all similar forms.

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

641.3111 Extension of benefits.--

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

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

(a) The expiration of 12 months.

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

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

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

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

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

****

LEGISLATIVE SUMMARY

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