By Senator Fasano

11-1311A-05

A bill to be entitled

An act relating to health insurance; amending s. 408.909, F.S.; requiring disapproval of health flex plans that cannot be shown to meet general eligibility standards for insurer certificate of authority; amending s. 627.411, F.S.; prescribing a limit on rate increases for closed forms; amending s. 627.413, F.S.; authorizing insurers and health maintenance organizations to issue high deductible insurance plans that meet certain criteria; creating s. 627.4141, F.S.; prohibiting mandatory arbitration clauses in life insurance and health insurance policies; amending s. 627.6487, F.S.; redefining the term "eligible individual" for purposes of guaranteed availability of individual health insurance coverage to eligible individuals; amending s. 627.64872, F.S.; revising definitions relating to the Florida Health Insurance Plan; providing for the Commissioner of Insurance Regulation to serve on the plan's board of directors; deleting obsolete provisions relating to an interim report; revising qualifications for eligibility; revising sources of additional revenue for the plan; prescribing a limit on health care provider reimbursement; amending s. 627.6515, F.S.; providing that out-of-state group health insurance policies are subject to the prohibition on mandatory arbitration clauses; amending s. 627.6692, F.S.; extending

time limits for giving certain notice with respect to health insurance coverage continuation; amending s. 627.6699, F.S.; requiring health insurance small employer carriers to offer high deductible insurance plans that meet certain criteria; reconstituting the board of the Florida Small Employer Health Reinsurance Program; changing the date by which the board must take certain actions; prescribing duties of the board with respect to advising the Office of Insurance Regulation and other entities on health insurance issues; amending s. 641.27, F.S.; increasing the interval at which the office must examine health maintenance organizations; deleting authority of the office to accept a report of an independent certified public accountant; deleting a limit on examination expenses; amending s. 641.31, F.S.; providing that health maintenance organization contracts are subject to the prohibition on mandatory arbitration clauses; providing applicability; providing an effective date.

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

Section 1. Paragraph (b) of subsection (3) of section 408.909, Florida Statutes, is amended to read:

408.909 Health flex plans.--

(3) PROGRAM.--The agency and the office shall each approve or disapprove health flex plans that provide health

care coverage for eligible participants. A health flex plan may limit or exclude benefits otherwise required by law for insurers offering coverage in this state, may cap the total amount of claims paid per year per enrollee, may limit the number of enrollees, or may take any combination of those actions. A health flex plan offering may include the option of a catastrophic plan supplementing the health flex plan.

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

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

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

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

Section 2. Subsection (4) is added to section 627.411, Florida Statutes, to read:

627.411 Grounds for disapproval.--

(4) Notwithstanding subsections (1) and (2), an annual rate increase for a closed form, or a closed block of forms with similar benefits, may not exceed medical trend. For purposes of this subsection, the term "closed" means that the form, or all forms within the block of pooled forms, has not been actively offered for sale by the insurer in the previous 12 months.

Section 3. Subsection (6) is added to section 627.413, Florida Statutes, to read:

627.413 Contents of policies, in general; identification.--

(6) Notwithstanding any other provision of the Florida Insurance Code which is in conflict with the federal requirements for a health savings account qualified high deductible health plan, an insurer or health maintenance organization subject to part I of chapter 641 which is authorized to issue health insurance in this state may offer for sale an individual or group policy or contract that provides for a high deductible plan that meets the federal requirements of a health savings account plan and that is offered in conjunction with a health savings account.

Section 4. Section 627.4141, Florida Statutes, is created to read:

627.4141 Mandatory arbitration clauses prohibited.--An insurer or health maintenance organization may not deliver or issue for delivery a life or health insurance policy, including a group life or health contract or certificate of coverage issued to a resident of this state, or a health maintenance contract in this state which contains a provision requiring the resolution of claims or disputes between the

insured and the insurer or health maintenance organization through the use of mandatory binding arbitration.

Section 5. 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; or

c. Whose most recent creditable coverage was with the Florida Health Insurance Plan specified in s. 627.64872, which coverage is terminated due to inadequate funding of the Florida Health Insurance Plan as provided in s. 627.64872(15);

(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 Health Insurance Plan as specified in s. 627.64872 and such plan is accepting new enrollment;

(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 6. Subsections (2), (3), (6), (9), and (15) of section 627.64872, Florida Statutes, are amended, present subsection (20) of that section is renumbered as subsection (21), and a new subsection (20) is added to that section to read:

627.64872 Florida Health Insurance Plan.--

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

(a) "Board" means the board of directors of the plan.

(b) "Commissioner" means the Commissioner of Insurance Regulation.

(c)~~(b)~~ "Dependent" means a resident spouse or resident unmarried child under the age of 19 years, a child who is a student under the age of 25 years and who is financially dependent upon the parent, or a child of any age who is disabled and dependent upon the parent.

~~(c) "Director" means the Director of the Office of Insurance Regulation.~~

(d) "Health insurance" means any hospital or medical expense incurred policy or health maintenance organization subscriber contract pursuant to chapter 641. The term does not include short-term, accident, dental-only, vision-only, fixed-indemnity, limited-benefit, or credit insurance; disability income insurance; coverage for onsite medical clinics; insurance coverage specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof, or other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191; benefits provided under a separate policy, certificate, or contract of insurance, under which there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor and the benefits are paid with respect to an event without regard to whether benefits are

provided with respect to such an event under any group health plan maintained by the same plan sponsor, such as for coverage only for a specified disease or illness; hospital indemnity or other fixed indemnity insurance; coverage offered as a separate policy, certificate, or contract of insurance, such as Medicare supplemental health insurance as defined under s. 1882(g)(1) of the Social Security Act; coverage supplemental to the coverage provided under chapter 55 of Title 10, U.S.C., the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); similar supplemental coverage provided to coverage under a group health plan; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(e) "Implementation" means the effective date after the first meeting of the board when legal authority and administrative ability exists for the board to subsume the transfer of all statutory powers, duties, functions, assets, records, personnel, and property of the Florida Comprehensive Health Association as specified in s. 627.6488.

(f) "Insurer" means any entity that provides health insurance in this state. For purposes of this section, insurer includes an insurance company with a valid certificate in accordance with chapter 624, a health maintenance organization with a valid certificate of authority in accordance with part I or part III of chapter 641, a prepaid health clinic authorized to transact business in this state pursuant to part II of chapter 641, multiple employer welfare arrangements

authorized to transact business in this state pursuant to ss. 624.436-624.45, or a fraternal benefit society providing health benefits to its members as authorized pursuant to chapter 632.

(g) "Medicare" means coverage under both Parts A and B of Title XVIII of the Social Security Act, 42 U.S.C. ss. 1395 et seq., as amended.

(h) "Medicaid" means coverage under Title XIX of the Social Security Act.

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

(j) "Participating insurer" means any insurer providing health insurance to citizens of this state.

(k) "Provider" means any physician, hospital, or other institution, organization, or person that furnishes health care services and is licensed or otherwise authorized to practice in the state.

(l) "Plan" means the Florida Health Insurance Plan created in subsection (1).

(m) "Plan of operation" means the articles, bylaws, and operating rules and procedures adopted by the board pursuant to this section.

(n) "Resident" means an individual who has been legally domiciled in this state for a period of at least 6 months <u>and who physically resides in this state not less than 185 days a year</u>.

(3) BOARD OF DIRECTORS.--

(a) The plan shall operate subject to the supervision and control of the board. The board shall consist of the <u>commissioner</u> ~~director~~ or his or her designated representative, who shall serve as a member of the board and shall be its

chair, and an additional eight members, five of whom shall be appointed by the Governor, at least two of whom shall be individuals not representative of insurers or health care providers, one of whom shall be appointed by the President of the Senate, one of whom shall be appointed by the Speaker of the House of Representatives, and one of whom shall be appointed by the Chief Financial Officer.

(b) The term to be served on the board by the commissioner ~~Director of the Office of Insurance Regulation~~ shall be determined by continued employment in such position. The remaining initial board members shall serve for a period of time as follows: two members appointed by the Governor and the members appointed by the President of the Senate and the Speaker of the House of Representatives shall serve a term of 2 years; and three members appointed by the Governor and the Chief Financial Officer shall serve a term of 4 years. Subsequent board members shall serve for a term of 3 years. A board member's term shall continue until his or her successor is appointed.

(c) Vacancies on the board shall be filled by the appointing authority, such authority being the Governor, the President of the Senate, the Speaker of the House of Representatives, or the Chief Financial Officer. The appointing authority may remove board members for cause.

(d) The commissioner ~~director~~, or his or her recognized representative, shall be responsible for any organizational requirements necessary for the initial meeting of the board which shall take place no later than September 1, 2004.

(e) Members shall not be compensated in their capacity as board members but shall be reimbursed for reasonable

expenses incurred in the necessary performance of their duties in accordance with s. 112.061.

(f) The board shall submit to the Financial Services Commission a plan of operation for the plan and any amendments thereto necessary or suitable to ensure the fair, reasonable, and equitable administration of the plan. The plan of operation shall ensure that the plan qualifies to apply for any available funding from the Federal Government that adds to the financial viability of the plan. The plan of operation shall become effective upon approval in writing by the Financial Services Commission consistent with the date on which the coverage under this section must be made available. If the board fails to submit a suitable plan of operation within 1 year after <u>implementation</u> ~~the appointment of the board of directors~~, or at any time thereafter fails to submit suitable amendments to the plan of operation, the Financial Services Commission shall adopt such rules as are necessary or advisable to effectuate the provisions of this section. Such rules shall continue in force until modified by the office or superseded by a plan of operation submitted by the board and approved by the Financial Services Commission.

(6) ~~INTERIM REPORT;~~ ANNUAL REPORT.--

~~(a) By no later than December 1, 2004, the board shall report to the Governor, the President of the Senate, and the Speaker of the House of Representatives the results of an actuarial study conducted by the board to determine, including, but not limited to:~~

~~1. The impact the creation of the plan will have on the small group insurance market and the individual market on premiums paid by insureds. This shall include an estimate of~~

~~the total anticipated aggregate savings for all small employers in the state.~~

~~2. The number of individuals the pool could reasonably cover at various funding levels, specifically, the number of people the pool may cover at each of those funding levels.~~

~~3. A recommendation as to the best source of funding for the anticipated deficits of the pool.~~

~~4. The effect on the individual and small group market by including in the Florida Health Insurance Plan persons eligible for coverage under s. 627.6487, as well as the cost of including these individuals.~~

~~The board shall take no action to implement the Florida Health Insurance Plan, other than the completion of the actuarial study authorized in this paragraph, until funds are appropriated for startup cost and any projected deficits.~~

~~(b)~~ No later than December 1, 2005, and annually thereafter, the board shall submit to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the substantive legislative committees of the Legislature a report which includes an independent actuarial study to determine, including, but not be limited to:

(a)~~1.~~ The impact the creation of the plan has on the small group and individual insurance market, specifically on the premiums paid by insureds. This shall include an estimate of the total anticipated aggregate savings for all small employers in the state.

(b)~~2.~~ The actual number of individuals covered at the current funding and benefit level, the projected number of individuals that may seek coverage in the forthcoming fiscal

year, and the projected funding needed to cover anticipated increase or decrease in plan participation.

~~3. A recommendation as to the best source of funding for the anticipated deficits of the pool.~~

(c)~~4.~~ A summarization of the activities of the plan in the preceding calendar year, including the net written and earned premiums, plan enrollment, the expense of administration, and the paid and incurred losses.

(d)~~5.~~ A review of the operation of the plan as to whether the plan has met the intent of this section.

(9) ELIGIBILITY.--

(a) Any individual person who is and continues to be a resident of this state shall be eligible for coverage under the plan if:

1. Evidence is provided that the person received notices of rejection or refusal to issue substantially similar coverage for health reasons from at least two health insurers or health maintenance organizations. A rejection or refusal by an insurer offering only stop-loss, excess of loss, or reinsurance coverage with respect to the applicant shall not be sufficient evidence under this paragraph.

2. The person is enrolled in the Florida Comprehensive Health Association as of the date the plan is implemented.

3. The person is an eligible individual as defined in s. 627.6487(3), excluding s. 627.6487(3)(b)5.

(b) Each resident dependent of a person who is eligible for coverage under the plan shall also be eligible for such coverage.

(c) A person shall not be eligible for coverage under the plan if:

1. The person has or obtains health insurance coverage substantially similar to or more comprehensive than a plan policy, or would be eligible to obtain such coverage, unless a person may maintain other coverage for the period of time the person is satisfying any preexisting condition waiting period under a plan policy or may maintain plan coverage for the period of time the person is satisfying a preexisting condition waiting period under another health insurance policy intended to replace the plan policy.

2. The person is determined to be eligible for health care benefits under Medicaid, Medicare, the state's children's health insurance program, or any other federal, state, or local government program that provides health benefits;

3. The person voluntarily terminated plan coverage unless 12 months have elapsed since such termination;

4. The person is an inmate or resident of a public institution; or

5. The person's premiums are paid for or reimbursed under any government-sponsored program or by any government agency<u>,</u> ~~or~~ health care provider<u>, or health-care-provider-sponsored or affiliated organization</u>.

(d) Coverage shall cease:

1. On the date a person is no longer a resident of this state;

2. On the date a person requests coverage to end;

3. Upon the death of the covered person;

4. On the date state law requires cancellation or nonrenewal of the policy; ~~or~~

5. At the option of the plan, 30 days after the plan makes any inquiry concerning the person's eligibility or place of residence to which the person does not reply<u>; or</u>~~.~~

6. Upon failure of the insured to pay for continued coverage.

(e) Except under the circumstances described in this subsection, coverage of a person who ceases to meet the eligibility requirements of this subsection shall be terminated at the end of the policy period for which the necessary premiums have been paid.

(15) FUNDING OF THE PLAN.--

(a) Premiums.--

1. The plan shall establish premium rates for plan coverage as provided in this section. Separate schedules of premium rates based on age, sex, and geographical location may apply for individual risks. Premium rates and schedules shall be submitted to the office for approval prior to use.

2. Initial rates for plan coverage shall be limited to no more than 200 ~~300~~ percent of rates established for individual standard risks as specified in s. 627.6675(3)(c). Subject to the limits provided in this paragraph, subsequent rates shall be established to provide fully for the expected costs of claims, including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein, but in no event shall premiums exceed the 200-percent ~~300 percent~~ rate limitation provided in this section. Notwithstanding the 200-percent ~~300 percent~~ rate limitation, sliding scale premium surcharges based upon the insured's income may apply to all enrollees.

(b) Sources of additional revenue.--Any deficit incurred by the plan shall be ~~primarily~~ funded through amounts appropriated by the Legislature from general revenue sources, including, but not limited to, a portion of the amount of

~~annual growth in~~ existing net insurance premium taxes in an amount not less than the anticipated losses and reserve requirements for existing policyholders. The board shall operate the plan in such a manner that the estimated cost of providing health insurance during any fiscal year will not exceed total income the plan expects to receive from policy premiums and funds appropriated by the Legislature, including any interest on investments. After determining the amount of funds appropriated to the board for a fiscal year, the board shall estimate the number of new policies it believes the plan has the financial capacity to insure during that year so that costs do not exceed income. The board shall take steps necessary to ensure that plan enrollment does not exceed the number of residents it has estimated it has the financial capacity to insure.

(c) In the event of inadequate funding, the board may cancel policies on a nondiscriminatory basis as necessary to remedy the situation. A policy may not be canceled if a covered individual under that policy is currently on claim.

(20) PROVIDER REIMBURSEMENT.--Notwithstanding any statute to the contrary, the maximum reimbursement rate to health care providers for all covered, medically necessary services shall be 100 percent of Medicare's allowed payment amount for that particular provider and service. All providers licensed in this state shall accept assignment of plan benefits and consider the Medicare allowed payment amount as payment in full.

Section 7. Subsection (2) of section 627.6515, Florida Statutes, is amended to read:

627.6515 Out-of-state groups.--

(2) Except as otherwise provided in this part, this part does not apply to a group health insurance policy issued or delivered outside this state under which a resident of this state is provided coverage if:

(a) The policy is issued to an employee group the composition of which is substantially as described in s. 627.653; a labor union group or association group the composition of which is substantially as described in s. 627.654; an additional group the composition of which is substantially as described in s. 627.656; a group insured under a blanket health policy when the composition of the group is substantially in compliance with s. 627.659; a group insured under a franchise health policy when the composition of the group is substantially in compliance with s. 627.663; an association group to cover persons associated in any other common group, which common group is formed primarily for purposes other than providing insurance; a group that is established primarily for the purpose of providing group insurance, provided the benefits are reasonable in relation to the premiums charged thereunder and the issuance of the group policy has resulted, or will result, in economies of administration; or a group of insurance agents of an insurer, which insurer is the policyholder;

(b) Certificates evidencing coverage under the policy are issued to residents of this state and contain in contrasting color and not less than 10-point type the following statement: "The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida"; ~~and~~

(c) The policy provides the benefits specified in ss. 627.419, 627.6574, 627.6575, 627.6579, 627.6612, 627.66121,

627.66122, 627.6613, 627.667, 627.6675, 627.6691, and 627.66911 and is in compliance with s. 627.4141; and.

(d) Applications for certificates of coverage offered to residents of this state must contain, in contrasting color and not less than 12-point type, the following statement on the same page as the applicant's signature:

"This policy is primarily governed by the laws of ...insert state where the master policy if filed.... As a result, all of the rating laws applicable to policies filed in this state do not apply to this coverage, which may result in increases in your premium at renewal that would not be permissible under a Florida-approved policy. Any purchase of individual health insurance should be considered carefully, as future medical conditions may make it impossible to qualify for another individual health policy. For information concerning individual health coverage under a Florida-approved policy, consult your agent or the Florida Department of Financial Services."

This paragraph applies only to group certificates providing health insurance coverage which require individualized underwriting to determine coverage eligibility for an individual or premium rates to be charged to an individual except for the following:

1. Policies issued to provide coverage to groups of persons all of whom are in the same or functionally related

licensed professions, and providing coverage only to such licensed professionals, their employees, or their dependents;

2. Policies providing coverage to small employers as defined by s. 627.6699. Such policies shall be subject to, and governed by, the provisions of s. 627.6699;

3. Policies issued to a bona fide association, as defined by s. 627.6571(5), provided that there is a person or board acting as a fiduciary for the benefit of the members, and such association is not owned, controlled by, or otherwise associated with the insurance company; or

4. Any accidental death, accidental death and dismemberment, accident-only, vision-only, dental-only, hospital indemnity-only, hospital accident-only, cancer, specified disease, Medicare supplement, products that supplement Medicare, long-term care, or disability income insurance, or similar supplemental plans provided under a separate policy, certificate, or contract of insurance, which cannot duplicate coverage under an underlying health plan, coinsurance, or deductibles or coverage issued as a supplement to workers' compensation or similar insurance, or automobile medical-payment insurance.

Section 8. Paragraphs (d) and (j) of subsection (5) of section 627.6692, Florida Statutes, are amended to read:

627.6692 Florida Health Insurance Coverage Continuation Act.--

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

(d)1. A qualified beneficiary must give written notice to the insurance carrier within <u>63</u> ~~30~~ days after the occurrence of a qualifying event. Unless otherwise specified in the notice, a notice by any qualified beneficiary

constitutes notice on behalf of all qualified beneficiaries. The written notice must inform the insurance carrier of the occurrence and type of the qualifying event giving rise to the potential election by a qualified beneficiary of continuation of coverage under the group health plan issued by that insurance carrier, except that in cases where the covered employee has been involuntarily discharged, the nature of such discharge need not be disclosed. The written notice must, at a minimum, identify the employer, the group health plan number, the name and address of all qualified beneficiaries, and such other information required by the insurance carrier under the terms of the group health plan or the commission by rule, to the extent that such information is known by the qualified beneficiary.

2. Within 14 days after the receipt of written notice under subparagraph 1., the insurance carrier shall send each qualified beneficiary by certified mail an election and premium notice form, approved by the office, which form must provide for the qualified beneficiary's election or nonelection of continuation of coverage under the group health plan and the applicable premium amount due after the election to continue coverage. This subparagraph does not require separate mailing of notices to qualified beneficiaries residing in the same household, but requires a separate mailing for each separate household.

(j) Notwithstanding paragraph (b), if a qualified beneficiary in the military reserve or National Guard has elected to continue coverage and is thereafter called to active duty and the coverage under the group plan is terminated by the beneficiary or the carrier due to the qualified beneficiary becoming eligible for TRICARE (the

health care program provided by the United States Defense Department), the 18-month period or such other applicable maximum time period for which the qualified beneficiary would otherwise be entitled to continue coverage is tolled during the time that he or she is covered under the TRICARE program. Within 63 ~~30~~ days after the federal TRICARE coverage terminates, the qualified beneficiary may elect to continue coverage under the group health plan, retroactively to the date coverage terminated under TRICARE, for the remainder of the 18-month period or such other applicable time period, subject to termination of coverage at the earliest of the conditions specified in paragraph (b).

Section 9. Paragraph (c) of subsection (5) and subsection (11) of section 627.6699, Florida Statutes, are amended to read:

627.6699 Employee Health Care Access Act.--

(5) AVAILABILITY OF COVERAGE.--

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

1. 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. In the absence of enrollment availability in the Florida Health Insurance Plan, offer and issue basic and

standard small employer health benefit plans, and a high-deductible plan that meets the requirements of a health savings account plan as defined by federal law, 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. Any right to an open enrollment of health benefit coverage for groups of fewer than two employees, pursuant to this section, shall remain in full force and effect in the absence of the availability of new enrollment into the Florida Health Insurance Plan.

3. 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.

(11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.--

(a) There is created a nonprofit entity to be known as the "Florida Small Employer Health Reinsurance Program."

(b)1. The program shall operate subject to the supervision and control of the board.

2. Effective upon this act becoming a law, the board shall consist of the director of the office or his or her designee, who shall serve as the chairperson, and 13 additional members who are representatives of carriers and insurance agents and are appointed by the director of the office and serve as follows:

a. Five members must be representatives of health insurers licensed under chapters 624 and 641. Two members must be agents who are actively engaged in the sale of health insurance. Four members must be employers or representatives. One member must be a person covered under an individual health insurance policy issued by an insurer licensed in this state. One member must represent the Agency for Health Care Administration and be recommended by the secretary. ~~The director of the office shall include representatives of small employer carriers subject to assessment under this subsection. If two or more carriers elect to be risk assuming carriers, the membership must include at least two representatives of risk assuming carriers; if one carrier is risk assuming, one member must be a representative of such carrier. At least one member must be a carrier who is subject to the assessments, but is not a small employer carrier. Subject to such restrictions, at least five members shall be selected from individuals recommended by small employer carriers pursuant to procedures provided by rule of the commission. Three members shall be selected from a list of health insurance carriers~~

~~that issue individual health insurance policies. At least two of the three members selected must be reinsuring carriers. Two members shall be selected from a list of insurance agents who are actively engaged in the sale of health insurance.~~

b. A member appointed under this subparagraph shall serve a term of 4 years and shall continue in office until the member's successor takes office, except that, in order to provide for staggered terms, the director of the office shall designate two of the initial appointees under this subparagraph to serve terms of 2 years and shall designate three of the initial appointees under this subparagraph to serve terms of 3 years.

3. The director of the office may remove a member for cause.

4. Vacancies on the board shall be filled in the same manner as the original appointment for the unexpired portion of the term.

~~5. The director of the office may require an entity that recommends persons for appointment to submit additional lists of recommended appointees.~~

(c)1. The board shall submit to the office a plan of operation to assure the fair, reasonable, and equitable administration of the program. The board may at any time submit to the office any amendments to the plan that the board finds to be necessary or suitable.

2. The office shall, after notice and hearing, approve the plan of operation if it determines that the plan submitted by the board is suitable to assure the fair, reasonable, and equitable administration of the program and provides for the sharing of program gains and losses equitably and proportionately in accordance with paragraph (j).

3. The plan of operation, or any amendment thereto, becomes effective upon written approval of the office.

(d) The plan of operation must, among other things:

1. Establish procedures for handling and accounting for program assets and moneys and for an annual fiscal reporting to the office.

2. Establish procedures for selecting an administering carrier and set forth the powers and duties of the administering carrier.

3. Establish procedures for reinsuring risks.

4. Establish procedures for collecting assessments from participating carriers to provide for claims reinsured by the program and for administrative expenses, other than amounts payable to the administrative carrier, incurred or estimated to be incurred during the period for which the assessment is made.

5. Provide for any additional matters at the discretion of the board.

(e) The board shall recommend to the office market conduct requirements and other requirements for carriers and agents, including requirements relating to:

1. Registration by each carrier with the office of its intention to be a small employer carrier under this section;

2. Publication by the office of a list of all small employer carriers, including a requirement applicable to agents and carriers that a health benefit plan may not be sold by a carrier that is not identified as a small employer carrier;

3. The availability of a broadly publicized, toll-free telephone number for access by small employers to information concerning this section;

4. Periodic reports by carriers and agents concerning health benefit plans issued; and

5. Methods concerning periodic demonstration by small employer carriers and agents that they are marketing or issuing health benefit plans to small employers.

(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.

(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 must reinsure the level of coverage provided; and, with respect to any other plan, the program must reinsure the coverage up to, but not exceeding, the level of coverage provided under the standard and basic health care plan.

2. Except in the case of a late enrollee, a reinsuring carrier may reinsure an eligible employee or dependent within 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 60 days after the commencement of his or her coverage.

3. A small employer carrier may reinsure an entire employer group within 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 not reimburse a participating carrier with respect to the claims of a reinsured employee or dependent until the carrier has paid incurred claims of 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.

5. The board annually 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 office approves a lower adjustment factor.

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

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.

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.

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 office, 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 office.

(i) If a health benefit plan for a small employer issued in accordance with this subsection is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued must be consistent with the requirements relating to premium rates set forth in this section.

(j)1. Before <u>July</u> ~~March~~ 1 of each calendar year, the board shall determine and report to the office 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 office, 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 July ~~March~~ 1 of each year, the board shall determine and file with the office 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 office within 180 ~~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 office within 180 ~~90~~ days following the end of the applicable calendar year, the office may evaluate the operations of the program and implement such amendments to the

plan of operation the office 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 office, a deferment, in whole or in part, from any assessment made by the board. The office may defer, in whole or in part, the assessment of a carrier if, in the opinion of the office, 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.

(k) Neither the participation in the program as reinsuring carriers, the establishment of rates, forms, or procedures, nor any other joint or collective action required

by this act, may be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its carriers either jointly or separately.

(l) The board, as part of the plan of operation, shall develop standards setting forth the manner and levels of compensation to be paid to agents for the sale of basic and standard health benefit plans. In establishing such standards, the board shall take into consideration the need to assure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide ongoing service to the small employer, the levels of compensation currently used in the industry, and the overall costs of coverage to small employers selecting these plans.

(m) The board shall monitor compliance with this section, including the market conduct of small employer carriers, and shall report to the office any unfair trade practices and misleading or unfair conduct by a small employer carrier that has been reported to the board by agents, consumers, or any other person. The office shall investigate all reports and, upon a finding of noncompliance with this section or of unfair or misleading practices, shall take action against the small employer carrier as permitted under the insurance code or chapter 641. The board is not given investigatory or regulatory powers, but must forward all reports of cases or abuse or misrepresentation to the office.

(n) Notwithstanding paragraph (j), the administrative expenses of the program shall be recouped by assessment of risk-assuming carriers and reinsuring carriers and such amounts shall not be considered part of the operating losses of the plan for the purposes of this paragraph. Each

carrier's portion of such administrative expenses shall be determined by multiplying the total of such administrative expenses by a fraction, the numerator of which equals the carrier's earned premium pertaining to direct writing 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 such premiums earned by all carriers in the state during such calendar year.

(o) The board shall advise the office, the agency, the department, and other executive and legislative entities on health insurance issues. Specifically, the board shall:

1. Provide a forum for stakeholders, including insurers, agents, consumers, and regulators, in the private health insurance market in this state.

2. Review and recommend strategies to improve the functioning of the health insurance markets in this state, with a specific focus on market stability, access, and pricing.

3. Make recommendations of the office for legislation addressing health insurance market issues and provide comment on health insurance legislation proposed by the office.

4. Meet at least three times each year. One meeting shall be held to hear reports and to secure public comment on the health insurance market, to develop any legislation needed to address health insurance market issues, and to provide comment on health insurance legislation proposed by the office.

5. By September 1 of each year, issue a report to the office on the state of the health insurance market. The report must include recommendations for changes in the health

insurance market, results from implementation of previous recommendations, and information on health insurance markets.

Section 10. Subsection (1) of section 641.27, Florida Statutes, is amended to read:

641.27 Examination by the department.--

(1) The office shall examine the affairs, transactions, accounts, business records, and assets of any health maintenance organization as often as it deems it expedient for the protection of the people of this state, but not less frequently than once every 5 ~~3~~ years. ~~In lieu of making its own financial examination, the office may accept an independent certified public accountant's audit report prepared on a statutory accounting basis consistent with this part.~~ However, except when the medical records are requested and copies furnished pursuant to s. 456.057, medical records of individuals and records of physicians providing service under contract to the health maintenance organization shall not be subject to audit, although they may be subject to subpoena by court order upon a showing of good cause. For the purpose of examinations, the office may administer oaths to and examine the officers and agents of a health maintenance organization concerning its business and affairs. The examination of each health maintenance organization by the office shall be subject to the same terms and conditions as apply to insurers under chapter 624. ~~In no event shall expenses of all examinations exceed a maximum of $20,000 for any 1 year period.~~ Any rehabilitation, liquidation, conservation, or dissolution of a health maintenance organization shall be conducted under the supervision of the department, which shall have all power with respect thereto granted to it under the laws governing the rehabilitation,

liquidation, reorganization, conservation, or dissolution of life insurance companies.

Section 11. Paragraph (c) of subsection (3) of section 641.31, Florida Statutes, is amended to read:

641.31 Health maintenance contracts.--

(3)

(c) The office shall disapprove any form filed under this subsection, or withdraw any previous approval thereof, if the form:

1. Is in any respect in violation of, or does not comply with, any provision of this part or rule adopted thereunder.

2. 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.

3. Has any title, heading, or other indication of its provisions which is misleading.

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

5. Contains provisions which are unfair, inequitable, or contrary to the public policy of this state or which encourage misrepresentation.

6. 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.

7. Is not in compliance with s. 627.4141.

Section 12. This act shall take effect July 1, 2005, and applies to all policies and contracts issued on or after that date.

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SENATE SUMMARY

Prohibits mandatory arbitration clauses in life insurance and health insurance policies. Authorizes high deductible health insurance plans that meet certain requirements of a health savings account. Revises duties of the Office of Insurance Regulation in examinations of health maintenance organizations. Extends the time within which eligible employees may apply for health insurance coverage continuation.