A bill to be entitled

An act relating to affordable health coverage; amending s. 408.909; revising the definition of a health flex plan; revising program requirements for approving plans by the agency; revising eligibility requirements; eliminating the expiration date of the health flex plan program; creating s. 408.910; establishing the Florida Health Choices Program; providing legislative intent; providing definitions; providing for a single centralized market for the sale and purchase of products that enable individuals to pay for health care; providing for program components; providing for employer eligibility criteria; providing for individual eligibility criteria; providing for employer enrollment criteria; providing for vendor, product and service eligibility criteria; providing for participation regardless of subsequent job status or Medicaid eligibility; providing for individual enrollment criteria; providing for participation by health insurance agents; providing criteria for products available for purchase; providing criteria for product pricing; providing for an administrative surcharge; providing for an exchange process; providing for enrollment periods and changes in selected products; providing for the pooling of risk; providing for exemptions from mandated offerings and coverages and certain licensure requirements; creating the Florida Health Choices Corporation; providing for corporate governance and board membership; providing for powers and duties of the corporation; requiring the corporation to make eligibility determinations, establish procedures, collect employer and individual contributions,

arrange for premium payments, establish individual disenrollment and vendor exclusion criteria, and establish policies and procedures for participants; requiring the corporation to submit an annual report to the Governor, the President of the Senate, the Speaker of the Florida House of Representatives; requiring the corporation to establish and enforce program integrity measures; amending s. 409.811; amending definition of premium assistance payment; amending s. 627.602; revising policy requirements pertaining to dependent children; providing a cross-reference; amending s. 627.653; requiring participation of employees in group insurance policies or group health benefit plans issued or renewed after October 1, 2008 pursuant to this section; providing opt-out provisions for employers and employees related to such coverage; amending s. 627.6562; expanding types of insurance policies providing for dependent coverage; extending qualifying age for dependent coverage from 25 to 30 years; revising eligibility requirements for dependents to receive continued coverage; providing clarifications and limitations of dependent coverage; providing mechanisms for reinstatement of dependent coverage; providing for payment of premium; requiring approval of premium payment requirements by the Office of Insurance Regulation; providing notice requirements for reinstated coverage of dependents; providing exclusions of certain types of health coverage policies from the requirements of this section; specifying the types of health coverage policies governed by this section; amending s. 627.6699; requiring participation of employees in health maintenance

contracts or policies issued or renewed after October 1, 2008 pursuant to this section; providing opt-out provisions for employers and employees related to such coverage; amending s. 641.31; requiring participation of employees in policies or health maintenance contracts issued or renewed after October 1, 2008 pursuant to this section; providing opt-out provisions for employers and employees related to such coverage; requiring compliance with s. 627.6562, F.S. for all heath maintenance contracts that provide coverage for family members; amending s. 641.402; revising definition of basic services; providing a definition for "hospital inpatient services;" clarifying and deleting provisions consistent with amendment; providing an effective date.

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

Section 1. Paragraph (e) of subsection (2), and subsections (3), (5), and (10) of section 408.909, Florida Statutes, are amended to read:

408.909 Health flex plans.--

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

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

(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 or provider network requirements 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 or a catastrophic plan supplementing the health flex plan.

(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. The agency shall ensure that the health flex plans follow standardized grievance procedures similar to those required of health maintenance organizations.

(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;

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; or

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

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

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

(a)1. Are 64 years of age or younger;

2.~~(b)~~ Have a family income equal to or less than 300 ~~200~~ percent of the federal poverty level;

~~(c) Are eligible under a federally approved Medicaid demonstration waiver and reside in Palm Beach County or Miami-Dade County;~~

3.~~(d)~~ 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, ~~unless specifically authorized under paragraph (c),~~ or another public health care program, such as Kidcare, and have not been covered at any time during the past 6 months; and

4.~~(e)~~ Have applied for health care coverage as an individual 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; or

(b) Are part of an employer group where at least 75 percent of the employees have a family income equal to or less than 300 percent of the federal poverty level and the employee

group is not covered by a private health insurance policy and has not been covered at any time during the past six months. If the health flex plan entity is a health insurer, health plan, or health maintenance organization licensed under Florida law, only 50 percent of the employees must meet the income requirements for the purpose of this paragraph.

~~(10) EXPIRATION. This section expires July 1, 2008.~~

Section 2. Section 408.910, Florida Statutes, is created to read:

408.910 The Florida Health Choices Program.—

(1) PROGRAM PURPOSE AND INTENT.--The Legislature finds that a significant number of the residents of this state do not have adequate access to affordable, quality health care. The Legislature further finds that increasing access to affordable, quality health care will be best accomplished by establishing a competitive market for purchasing health insurance and health services. It is therefore the intent of the Legislature to create the Florida Affordable Health Care Program to:

(a) Expand opportunities for Floridians to purchase affordable health insurance and health services.

(b) Preserve the benefits of employment sponsored insurance while easing the administrative burden for employers who offer these benefits.

(c) Enable individual choice in both the manner and amount of health care purchased.

(d) Provide for the purchase of individual, portable health care coverage.

(e) Disseminate information on price and quality of health services to consumers.

(f) Sponsor a competitive market that stimulates product

innovation, quality improvement, and efficiencies in the production and delivery of health services.

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

(a) "Corporation" means the Florida Health Choices, Inc., established by this section.

(b) "Health insurance agent" means an agent licensed under part IV of chapter 626.

(c) "Insurer" means an individual health insurance policy subject to this chapter, an insurer issuing a group health insurance policy or certificate pursuant to s. 627.651, a plan of self-insurance providing the health coverage benefits to residents of this state pursuant to s. 627.651, an insurer delivering a group health policy issued or delivered outside this state under which a resident of this state is provided coverage pursuant to s. 627.6515, a preferred provider organization as defined in s. 627.6471, an exclusive provider organization as defined in s. 627.6472.

(d) "Program" means the Florida Affordable Healthcare Program established by this section.

(3) PROGRAM PURPOSE AND COMPONENTS.--The Florida Affordable Health Care program is created as a single, centralized market for the sale and purchase of various products that enable individuals to pay for health care. These products include, but are not limited to, health insurance plans, health maintenance organizations, prepaid services, service contracts, and flexible spending accounts. The components of the program include:

(a) Enrollment of employers.

(b) Administrative services for participating employers, including:

1. Assistance for seeking federal approval of cafeteria plans.

2. Collection of premiums and other payments.

3. Management of individual benefit accounts.

4. Distribution of premiums to insurers and payments to other eligible vendors.

5. Assistance for participants in complying with reporting requirements.

(c) Services to individual participants, including:

1. Information about available products and participating vendors;

2. Assistance to participating individuals for assessing the benefits and limits of each product, including information necessary to distinguish between policies offering creditable coverage and other products available through the program;

3. Account information to assist individual participants to manage available resources; and,

4. Services that promote healthy behaviors.

(d) Recruitment of vendors, including insurers, health maintenance organizations, prepaid clinic service providers, provider service networks, and other providers.

(e) Certification of vendors to assure capability, reliability and validity of offerings.

(f) Collection of data, monitoring, assessment, and reporting of vendor performance.

(g) Information services for individuals and employers.

(h) Program evaluation.

(4) ELIGIBILITY AND PARTICIPATION.--Participation is voluntary and shall be available to employers, individuals, vendors, and health insurance agents as specified in this

subsection.

(a) Employers eligible to enroll in the program include:

1. Employers with one to 50 employees.

2. Fiscally constrained counties described in s. 218.67.

3. Municipalities with populations less than 50,000 residents.

4. School districts in fiscally constrained counties.

(b) Individuals eligible to participate in the program include the following:

1. Individual employees of enrolled employers.

2. State employees not eligible for state employee health benefits.

3. State retirees.

4. Medicaid reform participants who select the opt-out provision of reform.

5. Statutory rural hospitals.

(c) Employers who choose to participate in the program can enroll by complying with the procedures established by the corporation. These procedures shall include, but not be limited to, the following:

1. Submission of required information.

2. Compliance with federal tax requirements for the establishment of a cafeteria plan, pursuant to s. 125 of the Internal Revenue Code, including designation of the employer's plan as a premium payment plan, a salary reduction plan with flexible spending arrangements, or a salary reduction plan with a premium payment and flexible spending arrangements.

3. Determination of the employer's contribution, if any, per employee, provided that such contribution is equal for each eligible employee.

4. Establishment of payroll deduction procedures, subject to the agreement of each individual employee who voluntarily participates in the program.

5. Designation of the corporation as the third party administrator for the employer's health benefit plan.

6. Identification of eligible employees.

7. Arrangement for periodic payments.

(d) Eligible vendors and the products and services that they are permitted to sell include:

1. Insurers licensed under chapter 627, may sell health insurance policies, limited benefit policies, other risk-bearing coverage, and other products or services.

2. Health maintenance organizations licensed under part I of chapter 641, may sell health insurance policies, limited benefit policies, other risk-bearing products, and other products or services.

3. Prepaid clinic service providers licensed under part II of chapter 641 may sell prepaid service contracts and other arrangements for a specified amount and type of health services or treatments.

4. Out-of-state insurers, may sell health insurance policies, limited benefit policies, other risk-bearing products, and other products or services.

5. Health care providers, including hospitals and other licensed health facilities, health care clinics, licensed health professionals, pharmacies, and other licensed health care providers, may sell service contracts, and arrangements for a specified amount and type of health services or treatments.

6. Provider organizations including service networks, group practices, professional associations, and other

incorporated organizations of providers, may sell service contracts, and arrangements for a specified amount and type of health services or treatments.

7. Corporate entities providing specific health services in accordance with applicable state laws, may sell service contracts, and arrangements for a specified amount and type of health services or treatments.

8. Otherwise eligible vendors may be excluded from participating in the program for deceptive or predatory practices, financial insolvency, failure to comply with the terms of the participation agreement or other standards set by the corporation.

(e) Eligible individuals may voluntarily continue participation in the program regardless of subsequent changes in job status or Medicaid eligibility. Individuals who join the program may participate by complying with the procedures established by the corporation. These procedures shall include but are not limited to:

1. Submission of required information;

2. Authorization for payroll deduction;

3. Compliance with federal tax requirements;

4. Arrangements for payment in the event of job changes; and

5. Selection of products and services.

(f) Vendors who choose to participate in the program can enroll by complying with the procedures established by the corporation. These procedures shall include, but are not limited to:

1. Submission of required information including complete description of the coverage, services, provider network, payment

restrictions, and other requirements of each product offered through the program.

2. Execution of an agreement to make all products offered through the program available to all individual participants.

3. Establishment of product prices based on age, gender and location of the individual participant.

4. Arrangements for receiving payment for enrolled participants.

5. Participation in ongoing reporting processes established by the corporation;

6. Compliance with grievance procedures established by the corporation.

(g) Health insurance agents licensed under part IV of chapter 626 are eligible to voluntarily participate as buyers' representatives. A buyer's representative acts on behalf of individuals purchasing health insurance and health services through the program by providing information about products and services available through the program and assisting the individual with both the decision and the procedure of selecting specific products. Serving as a buyer's representative does not constitute a conflict of interest with continuing responsibilities as a health insurance agent provided that the relationship between each agent and any participating vendor is disclosed prior to advising individual participants about the products and services available through the program. In order to participate, health insurance agent will comply with the procedures established by the corporation, including:

1. Completion of training requirements.

2. Execution of a participation agreement specifying the terms and conditions of participation.

3. Disclosure of any appointments to solicit insurance or procure applications for vendors participating in the program.

4. Arrangements to receive payment from the corporation for services as buyers' representatives.

(5) PRODUCTS.--

(a) The products that may be made available for purchase through the program include, but are not limited to:

1. Health insurance policies.

2. Limited benefit plans.

3. Prepaid clinic services.

4. Service contracts.

5. Arrangements for purchase of a specific amount and type of health services and treatments.

6. Flexible spending accounts.

(b) Health insurance policies, limited benefit plans, prepaid service contracts and other contracts for services must assure the availability of covered services and benefits to participating individuals for at least one full enrollment year.

(c) Products may be offered for multi-year periods provided that the price of the product is specified for the entire period or for each separately priced segment of the policy or contract.

(6) PRICING.--Prices for the products sold through the program will be transparent to participants and established by the vendors based on age, gender and location. Prior to making the product available to individual participants, the corporation shall ensure that the prices are analyzed to compare the expected health care costs for the covered services and benefits to the vendor's price for that coverage. The results shall be reported to individuals participating in the program.

Once established, the price set by the vendor must remain in force for at least one year and may only be re-determined by the vendor at the next annual enrollment period. The corporation shall annually set a load factor to each premium or price set by the participating vendors. This surcharge will be no more than 2.5 percent and will be used to generate funding for administrative services provided by the corporation and payments to buyers' representatives.

(7) EXCHANGE PROCESS.--The program shall provide a single, centralized market for purchase of health insurance and health services. Purchases may be made by participating individuals over the internet or through the services of a participating health insurance agent. Information about each product and service available through the program shall be made available through printed material and an interactive website. Participants needing personal assistance to select products and services will be referred to a participating agent in their area.

(a) Participation in the program may begin at any time during a year when the employer completes enrollment and meets the requirements specified by the corporation pursuant to subsection (4)(c).

(b) Initial selection of products and services must be made by individual participants within 60 days of the date on which the individual's employer qualified for participation. Individuals failing to enroll in products and services by the end of this period will be limited to participation in flexible spending account services until the next annual enrollment period.

(c) Initial enrollment periods for each product selected

by an individual participant must last a minimum of 12 months, unless the individual participant specifically agrees to a different period.

(d) When an individual has selected one or more products and enrolled in those products for at least 12 months or any other period specifically agreed to by the individual participants, changes in selected products and services are limited to the annual enrollment period established by the corporation.

(e) The limits established in paragraphs (b) through (d) apply to any risk-bearing product that promises future payment or coverage for a variable amount of benefits or services. The limits do not apply to initiation of flexible spending plans when those plans are not associated with specific high deductible insurance policies or to the use of spending accounts for any products offering individual participants a specific amount and type of health services and treatments at a contracted price.

(8) RISK POOLING.--The program shall utilize methods for pooling the risk of individual participants and preventing selection bias. These methods shall include, but may not be limited to, a post-enrollment risk adjustment of the premium payments to the vendors. The corporation shall establish a methodology for assessing the risk of enrolled individual participants based on data reported by the vendors about their enrollees. Monthly distributions of payments to the vendors shall be adjusted based on the assessed relative risk profile of the enrollees in each risk-bearing product for the most recent period for which data is available.

(9) EXEMPTIONS.--

(a) Policies sold as part of the program are not subject to the licensing requirements of the Florida Insurance Code, chapter 641, or the mandated offerings or coverages established in part VI of chapter 627,and chapter 641.

(b) The corporation is authorized to act as an administrator pursuant to s. 626.88. However the corporation shall not be subject to the licensing requirements of part VII of chapter 626.

(11) LIQUIDATION OR DISSOLUTION.--The Department of Financial Services shall supervise any liquidation or dissolution of the corporation and shall have, with respect to such liquidation or dissolution, all power granted to it pursuant to the insurance code.

(12) CORPORATION.--There is created the Florida Health Choices, Inc., which shall be registered, incorporated, organized, and operated in compliance with chapter 617. The purpose of the corporation is to administer the program created in this section and to conduct such other business as may further the administration of the program.

(a) The corporation shall be governed by a board of directors consisting of 15 individuals appointed in the following manner:

1. Five members appointed by and serving at the pleasure of the Governor, consisting of:

a. The Secretary of the Agency for Health Care Administration or a designee with expertise in health care services.

b. The Secretary of the Department of Management Services or a designee with expertise in state employee benefits.

c. Three representatives of eligible public employers.

2. Five members appointed by and serving at the pleasure of the President of the Senate, consisting of representatives of employers, insurers, health care providers, health insurance agents, and individual participants.

3. Five members appointed by and serving at the pleasure of the Speaker of the House of Representatives, consisting of representatives of employers, insurers, health care providers, health insurance agents, and individual participants.

(b) Members shall be appointed for terms of up to 3 years. Any member is eligible for reappointment. A vacancy on the board of directors shall be filled for the remainder of the unexpired term.

(c) The board shall select a chief executive officer for the corporation who shall be responsible for the selection of such other staff as may be authorized by the corporation's operating budget adopted by the board.

(d) Board members are entitled to receive, from funds of the corporation, reimbursement for per diem and travel expenses as provided by s. 112.061. No other compensation is authorized.

(e) There shall be no liability on the part of, and no cause of action shall arise against, any member of the board, or its employees or agents, for any action taken in the performance of their powers and duties under this section.

(f) The board shall develop and adopt bylaws and other corporate procedures as necessary for the operation of the corporation and carrying out the purposes of this section. The bylaws shall specify procedures for selection of officers and qualifications for reappointment provided that no director shall serve more than 8 consecutive years. The bylaws shall also require an annual membership meeting providing an opportunity

for input and interaction with individual participants in the program.

(g) The corporation may exercise all powers granted to it under chapter 617 necessary to carry out the purposes of this section, including, but not limited to, the power to receive and accept grants, loans, or advances of funds from any public or private agency and to receive and accept from any source contributions of money, property, labor, or any other thing of value, to be held, used, and applied for the purposes of this act.

(h) The corporation shall:

1. Determine eligibility of employers, vendors, individuals, and agents in accordance with subsection (4).

2. Establish procedures necessary for the operation of the program, including, but not limited to, procedures for application, enrollment, risk assessment, risk adjustment, plan administration, performance monitoring, and consumer education.

3. Arrange for collection of contributions from participating employers and individuals.

4. Arrange for payment of premiums and other appropriate disbursements based on the selections of products and services by the individual participants.

5. Establish criteria for disenrollment of participating individuals based on failure to pay the individual's share of any contribution required to maintain enrollment in selected products.

6. Establish criteria for exclusion of vendors pursuant to subsection (4)(d).

7. Develop and implement a plan for promoting public awareness of and participation in the program.

8. Secure staff and consultant services necessary to the operation of the program.

9. The corporation shall establish policies and procedures regarding participation in the program for individuals, vendors, health insurance agents and employers.

10. Beginning in fiscal year 2009-2010, submit on February 1, an annual report to the Governor, the President of the Senate, the Speaker of the Florida House of Representatives. The report shall document the corporation's activities in compliance with the duties delineated in this section.

(j) To ensure program integrity and to safeguard the financial transactions made under the auspices of the program, the corporation is authorized to establish qualifying criteria and certification procedures for vendors; require performance bonds or other guarantees of ability to complete contractual obligations; monitor the performance of vendors; and enforce the agreements of the program through financial penalty or disqualification from the program.

Section 3. Subsection (22) of section 409.811, Florida Statutes, is amended to read:

409.811 Definitions relating to Florida Kidcare Act.--As used in ss. 409.810-409.820, the term:

(22) "Premium assistance payment" means the monthly consideration paid by the agency per enrollee in the Florida Kidcare program towards health insurance premiums and may include the direct payment of the premium for a qualifying child to be covered as a dependent under an employer sponsored group family plan, when such payment does not exceed the payment required for an enrollee in the Florida Kidcare program.

Section 4. Section 408.9091, Florida Statutes, is created to read:

408.9091 Cover Florida Health Care Access Act. --

(1) SHORT TITLE.--This section may be cited as the "Cover Florida Health Access Program Act".

(2) INTENT.--The Legislature finds that a significant proportion of the residents of this state are unable to obtain affordable health insurance coverage. The Legislature also finds that existing "health flex" plan coverage in Florida has had limited participation in part because of narrow eligibility restrictions as well as minimal benefit options for catastrophic and emergency care coverage. Therefore, it is the intent of the Legislature to expand the availability of health care options for uninsured state residents by developing an affordable health care product to be offered statewide by approved health insurers, health maintenance organizations, health-care-provider-sponsored organizations, or health care districts. The Cover Florida Health Access Program (herein referred to as "Cover Florida", or CFHAP) is designed to emphasize coverage for basic and preventive health care services as well as provide inpatient hospital, urgent, and emergency care services.

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

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

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

(c) "Enrollee" means an individual who has been determined to be eligible for and is receiving health insurance coverage under a Cover Florida Health Access Program plan approved under this section.

(d) "Health insurance" or "health care coverage" or "Cover Florida plan coverage" means health care services that are covered as benefits under an approved Cover Florida plan.

(e) "Cover Florida plan" means a consumer choice benefit plan approved under subsections (4) and (5) which guarantees payment for specified health insurance provided to the enrollee who purchases coverage directly from the plan.

(f) "Cover Florida plan entity" means a health insurer, health maintenance organization, health-care-provider-sponsored organization, or health care district, that develops and implements an approved Cover Florida plan and is responsible for administering the Cover Florida plan and paying all claims for Cover Florida plan coverage by enrollees of the Cover Florida plan, approved in this section.

(g) "Cover Florida Plus" plan means a supplemental insurance product, such as for additional catastrophic coverage, dental, vision or cancer coverage, approved under this section and offered to all Cover Florida plan enrollees.

(4) PROGRAM.--The agency and the office shall define general Cover Florida plan components, to require that:

(a) plans are offered as guarantee issue to enrollees;

(b) plans are portable, such that the enrollee remains covered regardless of employment status or cost-sharing of the premiums;

(c) insurers may provide for cost containment through limits on number of services, caps on benefit payments, and co-payments for services.

(d) Cover Florida health plan entities make all benefit plan and marketing materials available in both English and Spanish.

(e) insurers develop two alternative benefit option plans with different cost and benefit levels, including at least one plan with catastrophic coverage, to provide for additional consumer choice.

(f) catastrophic plans provide coverage options for services 1-11 below, including but not limited to:

1. preventive health services, including preventive screenings, annual health assessments, Well Care and Well Woman services including mammograms, screenings for cervical cancer, non-invasive colorectal or prostate screenings, and immunizations;

2. incentives for routine, preventive care;

3. office visits for the diagnosis and treatment of illness or injury;

4. office surgery, including anesthesia;

5. services related to Behavioral Health Services;

6. durable medical equipment and prosthetics;

7. diabetic supplies;

8. inpatient hospital stays;

9. hospital emergency care services;

10. urgent care services; and

11. outpatient facility services, outpatient surgery, and outpatient diagnostic services,

(g) plans without catastrophic coverage provide coverage options for services 1-7 below, including but not limited to:

1. preventive health services, including preventive screenings, annual health assessments, Well Care and Well Woman services including mammograms, screenings for cervical cancer, non-invasive colorectal or prostate screenings, and immunizations;

2. incentives for routine, preventive care;

3. office visits for the diagnosis and treatment of illness or injury;

4. office surgery, including anesthesia;

5. services related to Behavioral Health Services;

6. durable medical equipment and prosthetics; and

7. diabetic supplies.

(h) plans shall offer prescription drug benefit coverage on all plans, or use the existing Florida Discount Drug Card Program for plan enrollees.

(i) plans provide, in enrollment materials, plain-language information on policy benefit coverage, benefit limits, cost-sharing requirements, exclusions, and a clear presentation of what is not covered in the plan.

(5) The agency and the office shall announce, no later than July 1, 2008, an Invitation to Negotiate ("ITN") for Cover Florida plan entities to design a Cover Florida coverage proposal in which benefits and premiums are defined.

(a) The agency and office shall approve at least one Cover Florida plan entity with an existing statewide network of providers, and may approve at least one regional network plan in each existing Medicaid Area.

(b) Guidelines shall be developed to ensure that Cover Florida plans meet minimum standards for quality of care and access to care. The agency shall ensure that the Cover Florida plans follow standardized grievance procedures.

(c) The ITN shall include guidelines for the review of Cover Florida plan applications and provide regulatory oversight of Cover Florida plan advertisement and marketing procedures. Plans shall be disapproved or withdrawn upon the following:

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 Cover Florida 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;

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

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

5. Does not guarantee that Cover Florida plan enrollees may participate in the Cover Florida plan entity's comprehensive network of providers, as determined by the office and the contract.

(d) The agency and the office may announce an Invitation to Negotiate ("ITN") for companies that offer supplemental insurance or discount medical plans licensed under Part II of s. 636, Florida Statutes, to design "Cover Florida Plus" supplemental coverage products, such as for additional catastrophic coverage, dental, vision or cancer coverage, to be offered to enrollees of Cover Florida plans.

(e) The agency, the office, and the Executive Office of the Governor, shall develop a public awareness and incentive campaign to be implemented throughout the state for the promotion of the Cover Florida Health Access Program.

(f) Public or private entities may design or extend incentives to encourage Floridians to participate in the Cover Florida Health Access Program, or to encourage employers to co-sponsor some share of Cover Florida premiums for employees.

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

(7) ELIGIBILITY.--Eligibility to enroll in an approved Cover Florida plan is limited to residents of this state who:

(a) Are 19-64 years of age;

(b) Are not covered by a private insurance policy and are not eligible for coverage through a public health insurance program, such as Medicare, Medicaid, or Kidcare.

(c) Have not been covered by any health insurance program at any time during the past six months; and

(d) Have applied for health care coverage through an approved Cover Florida 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.

(8) RECORDS.--Each Cover Florida plan shall maintain enrollment data and provide network data and reasonable records to enable the office to monitor plans and to determine the financial viability of the Cover Florida plan, as necessary.

(9) NONENTITLEMENT.--Coverage under an approved Cover Florida 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 or office, for failure to make coverage available to eligible persons under this section.

(10) PROGRAM EVALUATION.--The agency and the office shall evaluate the Cover Florida program and its effect on the entities that seek approval as Cover Florida plans, on the number of enrollees, and on the scope of the health care coverage offered under a Cover Florida plan; shall provide an assessment of the Cover Florida plans and their potential applicability in other settings; shall use Cover Florida plans to gather more information to evaluate low-income consumer driven benefit packages; and shall, by March 1, 2009, and annually thereafter, jointly submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

(11) RULE MAKING AUTHORITY.-- The agency and the Financial Services Commission may adopt rules as needed to administer this section.

(12) APPROPRIATIONS.-- The sum of $500,000 is appropriated for implementation of a statewide public awareness and incentive campaign for the promotion of the Cover Florida Health Access Program, to be directed by the agency.

Section 5. Subsection (5) of section 409.814, Florida Statutes, is amended to read:

409.814 Eligibility.--A child who has not reached 19 years of age whose family income is equal to or below 200 percent of the federal poverty level is eligible for the Florida Kidcare

program as provided in this section. For enrollment in the Children's Medical Services Network, a complete application includes the medical or behavioral health screening. If, subsequently, an individual is determined to be ineligible for coverage, he or she must immediately be disenrolled from the respective Florida Kidcare program component.

(5) A child whose family income is above 200 percent of the federal poverty level or a child who is excluded under the provisions of subsection (4) may participate in the Medikids program as provided in s. 409.8132 or, if the child is ineligible for Medikids by reason of age, in the Florida Healthy Kids program, subject to the following provisions:

(a) The family is not eligible for premium assistance payments and must pay the full cost of the premium, including any administrative costs.

~~(b) The agency is authorized to place limits on enrollment in Medikids by these children in order to avoid adverse selection. The number of children participating in Medikids whose family income exceeds 200 percent of the federal poverty level must not exceed 10 percent of total enrollees in the Medikids program.~~

(b) ~~(c)~~ The board of directors of the Florida Healthy Kids Corporation is authorized to ~~place limits on enrollment of these children in order to avoid adverse selection. In addition, the board is authorized to~~ offer a reduced benefit package to these children in order to limit program costs for such families. ~~The number of children participating in the Florida Healthy Kids program whose family income exceeds 200 percent of the federal poverty level must not exceed 10 percent of total enrollees in the Florida Healthy Kids program.~~

Section 6. Paragraph (c) of subsection (1) of section 627.602, Florida Statutes, is amended to read:

627.602 Scope, format of policy.--

(1) Each health insurance policy delivered or issued for delivery to any person in this state must comply with all applicable provisions of this code and all of the following requirements:

(c) The policy may purport to insure only one person, except that upon the application of an adult member of a family, who is deemed to be the policyholder, a policy may insure, either originally or by subsequent amendment, any eligible members of that family, including husband, wife, any children or any person dependent upon the policyholder. If an insurer offers coverage that insures dependent children of the policyholder, the policy must comply with the provisions of s. 627.6562, F.S.

Section 7. Subsection (4) of section 627.653, Florida Statutes, is renumbered as subsection (5) and a new subsection (4) is added to said section to read:

627.653 Employee groups.--

(4) Unless the employer chooses otherwise, for all policies issued or renewed after October 1, 2008, all eligible employees and their dependents shall be enrolled for coverage at the time of issuance or during the next open or special enrollment period, unless the employee provides written notice to the employer declining coverage, which notice shall include evidence of coverage under an existing group insurance policy or group health benefit plan, or other reasons for declining coverage. Such notice shall be retained by the employer as part of the employee's employment or insurance file. An employer may require

its employees to participate in its group health plan as a condition of employment.

Section 8. Section 627.6562, Florida Statutes, is amended to read:

627.6562 Dependent coverage.--

(1) If an insurer offers under a group, blanket, or franchise health insurance policy coverage that insures dependent children of the policyholder or certificateholder, the policy must insure a dependent child of the policyholder or certificateholder at least until the end of the calendar year in which the child reaches the age of 30 ~~25~~, if the child ~~meets all of the following~~:

(a) Is unmarried and does not have a dependent of his or her own. ~~The child is dependent upon the policyholder or certificateholder for support.~~

(b) Is a resident of this state~~The child is living in the household of the policyholder or certificateholder, or the child is a full time or part time student~~.

(c) Is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan or entitled to benefits under Title XVIII of the Social Security Act, Pub. L. No. 89-97 (42 U.S.C. s. 1395 et seq.).

(2) ~~Nothing in~~ This ~~this~~ section does not:

(a) Affect ~~affects~~ or preempt~~s~~ an insurer's right to medically underwrite or charge the appropriate premium.

(b) Require coverage for services provided before October 1, 2008, to a dependent.

(c) Require that an employer pay all or part of the cost of coverage provided for a dependent under this section.

(d) Prohibit an insurer or health maintenance organization from increasing the limiting age for dependent coverage to age 30 in policies or contracts issued or renewed prior to the effective date of this act.

(3) Until April 1, 2009, a dependent child who qualifies for coverage under subsection (1) but whose coverage as a dependent child under a covered person's plan terminated under the terms of the plan before October 1, 2008, may make a written election to reinstate coverage, without proof of insurability, under that plan as a dependent child pursuant to this section. All other dependent children who qualify for coverage under subsection (1) shall be automatically covered at least until the end of the calendar year in which the child reaches the age of 30, unless the covered person provides the group policyholder with written evidence the dependent child is married, not a resident of Florida, or is covered under a separate comprehensive health insurance policy, a health benefit plan, or is entitled to benefits Title XVIII of the Social Security Act, Pub. L. No. 89-97 (42 U.S.C. s. 1935, et seq.).

(4) The covered person's plan may require the payment of a premium by the covered person or dependent child, as appropriate, subject to the approval of the Office of Insurance Regulation, for any period of coverage relating to a dependent's written election for coverage pursuant to paragraph (3).

(5) Notice regarding the reinstatement of coverage for a dependent child as provided under this section must be provided to a covered person:

(a) In the certificate of coverage prepared for covered

persons by the insurer; or

(b) By the covered person's employer.

(c) The notice regarding the opportunity for reinstatement of coverage for a dependent child shall be given as soon as practicable after July 1, 2008 and such notice may be given through the group policyholder.

(6) This section does not apply to accident only, specified-disease, disability income, Medicare supplement, or long-term care insurance policies.

(7) This section applies to all group, blanket, or franchise health insurance policies covering residents of this state, including, but not limited to, policies in which the carrier has reserved the right to change the premium.

Section 9. Subparagraphs 3. through 7. of paragraph (h) of subsection (5) of section 627.6699, Florida Statutes, are renumbered as subparagraphs 4. through 8. respectively, and a new subparagraph 3. is added to said section to read:

627.6699 Employee Health Care Access Act.--

(5) AVAILABILITY OF COVERAGE.--

(h) All health benefit plans issued under this section must comply with the following conditions:

3. Unless the employer chooses otherwise, for all policies or health maintenance contracts issued or renewed after the October 1, 2008, all eligible employees and their dependents shall be enrolled for coverage at the time of issuance or during the next open or special enrollment period, unless the employee provides written notice to the employer declining coverage, which notice shall include evidence of coverage under an existing group insurance policy or group health benefit plan, or other reasons for declining coverage. Such notice shall be

retained by the employer as part of the employee's employment or insurance file. An employer may require its employees to participate in its group health plan as a condition of employment.

Section 10. Subsections (41) and (42)of section 641.31, Florida Statutes, are added to read:

641.31 Health maintenance contracts.--

(41) Unless the employer chooses otherwise, for all policies or health maintenance contracts issued or renewed after the October 1, 2008, all eligible employees and their dependents shall be enrolled for coverage at the time of issuance or during the next open or special enrollment period, unless the employee provides written notice to the employer declining coverage, which notice shall include evidence of coverage under an existing group insurance policy or group health benefit plan, or other reasons for declining coverage. Such notice shall be retained by the employer as part of the employee's employment or insurance file. An employer may require its employees to participate in its group health plan as a condition of employment.

(42) All health maintenance contracts that provide coverage for a member of the family of the subscriber shall comply with the provisions of s. 627.6562, F.S.

Section 11. Subsections (1), (4) and (6) of section 641.402, Florida Statutes, are amended to read:

641.402 Definitions.--As used in this part, the term:

(1) "Basic services" includes any of the following: limited hospital inpatient services, which may include hospital inpatient physician services, up to a maximum of coverage benefit of five days and a maximum dollar amount of coverage of

$15,000 per calendar year; emergency care; physician care other than hospital inpatient physician services; ambulatory diagnostic treatment, and preventive health care services.

(4) "Prepaid health clinic" means any organization authorized under this part which provides, either directly or through arrangements with other persons, basic services to persons enrolled with such organization, on a prepaid per capita or prepaid aggregate fixed-sum basis, including those basic services described in this part which subscribers might reasonably require to maintain good health. ~~However, no clinic that provides or contracts for, either directly or indirectly, inpatient hospital services, hospital inpatient physician services, or indemnity against the cost of such services shall be a prepaid health clinic.~~

(6) "Provider" means any physician or person ~~other than a hospital~~ that furnishes health care services under this part and is licensed or authorized to practice in this state.

Section 12. This act shall take effect upon becoming law, except that sections 3, 4, 5 and 7 of this act shall take effect October 1, 2008, and shall apply to all individual, group, blanket, franchise health insurance policies and health maintenance contracts issued, renewed, or amended after October 1, 2008.