CHAMBER ACTION

Senate		House
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1 Representative Bean offered the following:

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3 **Amendment (with title amendment)**

4 Remove everything after the enacting clause and insert:

5 Section 1. Paragraph (d) of subsection (2) of section

6 112.363, Florida Statutes, is amended to read:

7 112.363 Retiree health insurance subsidy.--

8 (2) ELIGIBILITY FOR RETIREE HEALTH INSURANCE SUBSIDY.--

9 (d) Payment of the retiree health insurance subsidy shall

10 be made only after coverage for health insurance for the retiree

11 or beneficiary has been certified in writing to the Department

12 of Management Services. Participation in a former employer's

13 group health insurance program is not a requirement for

14 eligibility under this section. Coverage issued pursuant to s.

15 408.9091 is considered health insurance for the purposes of this

16 section.

17 Section 2. Subsections (5) and (10) of section 408.909,
18 Florida Statutes, are amended to read:
19 408.909 Health flex plans.--
20 (5) ELIGIBILITY.--Eligibility to enroll in an approved
21 health flex plan is limited to residents of this state who:
22 (a)1. Are 64 years of age or younger;
23 2.~~(b)~~ Have a family income equal to or less than 300~~200~~
24 percent of the federal poverty level;
25 ~~(c) Are eligible under a federally approved Medicaid~~
26 ~~demonstration waiver and reside in Palm Beach County or Miami-~~
27 ~~Dade County;~~
28 3. ~~(d)~~ Are not covered by a private insurance policy and
29 are not eligible for coverage through a public health insurance
30 program, such as Medicare or Medicaid, ~~unless specifically~~
31 ~~authorized under paragraph (c),~~ or another public health care
32 program, such as Kidcare, and have not been covered at any time
33 during the past 6 months, except that:
34 a. A person who was covered under an individual health
35 maintenance contract issued by a health maintenance organization
36 licensed under part I of chapter 641 that also was an approved
37 health flex plan on October 1, 2008, may apply for coverage in
38 the same health maintenance organization's health flex plan
39 without a lapse in coverage if all other eligibility
40 requirements are met; or
41 b. A person who was covered under Medicaid or Kidcare and
42 lost eligibility for the Medicaid or Kidcare subsidy due to
43 income restrictions within 90 days prior to applying for health
44 care coverage through an approved health flex plan may apply for

45 coverage in a health flex plan without a lapse in coverage if
46 all other eligibility requirements are met; and
47 4.(c) Have applied for health care coverage as an
48 individual through an approved health flex plan and have agreed
49 to make any payments required for participation, including
50 periodic payments or payments due at the time health care
51 services are provided; or
52 (b) Are part of an employer group at least 75 percent of
53 the employees of which have a family income equal to or less
54 than 300 percent of the federal poverty level and which employee
55 group is not covered by a private health insurance policy and
56 has not been covered at any time during the past 6 months. If
57 the health flex plan entity is a health insurer, health plan, or
58 health maintenance organization licensed under Florida law, only
59 50 percent of the employees must meet the income requirements
60 for the purpose of this paragraph.
61 (10) EXPIRATION.--This section expires July 1, 2013 2008.
62 Section 3. Section 408.9091, Florida Statutes, is created
63 to read:
64 408.9091 Cover Florida Health Care Access Program.--
65 (1) SHORT TITLE.--This section may be cited as the "Cover
66 Florida Health Care Access Program Act."
67 (2) LEGISLATIVE INTENT.--The Legislature finds that a
68 significant number of state residents are unable to obtain
69 affordable health insurance coverage. The Legislature also finds
70 that existing health flex plan coverage has had limited
71 participation due in part to narrow eligibility restrictions as
72 well as minimal benefit options for catastrophic and emergency

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73 care coverage. Therefore, it is the intent of the Legislature to
74 expand the availability of health care options for uninsured
75 residents by developing an affordable health care product that
76 emphasizes coverage for basic and preventive health care
77 services; provides inpatient hospital, urgent, and emergency
78 care services; and is offered statewide by approved health
79 insurers, health maintenance organizations, health-care-
80 provider-sponsored organizations, or health care districts.
81 (3) DEFINITIONS.--As used in this section, the term:
82 (a) "Agency" means the Agency for Health Care
83 Administration.
84 (b) "Cover Florida plan" means a consumer choice benefit
85 plan approved under this section that guarantees payment or
86 coverage for specified benefits provided to an enrollee.
87 (c) "Cover Florida plan coverage" means health care
88 services that are covered as benefits under a Cover Florida
89 plan.
90 (d) "Cover Florida plan entity" means a health insurer,
91 health maintenance organization, health-care-provider-sponsored
92 organization, or health care district that develops and
93 implements a Cover Florida plan and is responsible for
94 administering the plan and paying all claims for Cover Florida
95 plan coverage by enrollees.
96 (e) "Cover Florida Plus" means a supplemental insurance
97 product, such as for additional catastrophic coverage or dental,
98 vision, or cancer coverage, approved under this section and
99 offered to all enrollees.

100 (f) "Enrollee" means an individual who has been determined
101 to be eligible for and is receiving health insurance coverage
102 under a Cover Florida plan.
103 (g) "Office" means the Office of Insurance Regulation of
104 the Financial Services Commission.
105 (4) PROGRAM.--The agency and the office shall jointly
106 establish and administer the Cover Florida Health Care Access
107 Program.
108 (a) General Cover Florida plan components must require
109 that:
110 1. Plans are offered on a guaranteed-issue basis to
111 enrollees, subject to exclusions for preexisting conditions
112 approved by the office and the agency.
113 2. Plans are portable such that the enrollee remains
114 covered regardless of employment status or the cost-sharing of
115 premiums.
116 3. Plans provide for cost containment through limits on
117 the number of services, caps on benefit payments, and copayments
118 for services.
119 4. A Cover Florida plan entity makes all benefit plan and
120 marketing materials available in English and Spanish.
121 5. In order to provide for consumer choice, Cover Florida
122 plan entities develop two alternative benefit option plans
123 having different cost and benefit levels, including at least one
124 plan that provides catastrophic coverage.
125 6. Plans without catastrophic coverage provide coverage
126 options for services including, but not limited to:

127 a. Preventive health services, including immunizations,
128 annual health assessments, well-woman and well-care services,
129 and preventive screenings such as mammograms, cervical cancer
130 screenings, and noninvasive colorectal or prostate screenings.
131 b. Incentives for routine preventive care.
132 c. Office visits for the diagnosis and treatment of
133 illness or injury.
134 d. Office surgery, including anesthesia.
135 e. Behavioral health services.
136 f. Durable medical equipment and prosthetics.
137 g. Diabetic supplies.
138 7. Plans providing catastrophic coverage, at a minimum,
139 provide coverage options for all of the services listed under
140 subparagraph 6.; however, such plans may include, but are not
141 limited to, coverage options for:
142 a. Inpatient hospital stays.
143 b. Hospital emergency care services.
144 c. Urgent care services.
145 d. Outpatient facility services, outpatient surgery, and
146 outpatient diagnostic services.
147 8. All plans offer prescription drug benefit coverage or
148 use a prescription drug manager such as the Florida Discount
149 Drug Card Program.
150 9. Plan enrollment materials provide information in plain
151 language on policy benefit coverage, benefit limits, cost-
152 sharing requirements, and exclusions and a clear representation
153 of what is not covered in the plan. The Cover Florida Health
154 Care Access Program shall require the following disclosure to be

155 reviewed and executed by all consumers purchasing program
156 options or insurance coverage through the program: "In
157 connection with the Cover Florida Health Care Access Program
158 authorized by s. 408.9091, Florida Statutes, agents and entities
159 offering products and services under the program shall inform
160 the named insured, applicant, or subscriber, on a form approved
161 by the Office of Insurance Regulation of the Financial Services
162 Commission, that the program is not an insurance program or, if
163 it is an insurance program, that benefits under the coverage are
164 limited under s. 408.9091, Florida Statutes, and that such
165 coverage is an alternative to coverage without such limitations.
166 If the form is signed by a named insured, applicant, or
167 subscriber, it shall be presumed that there was an informed,
168 knowing acceptance of such limitations."
169 10. Plans offered through a qualified employer meet the
170 requirements of s. 125 of the Internal Revenue Code.
171 (b) Guidelines shall be developed to ensure that Cover
172 Florida plans meet minimum standards for quality of care and
173 access to care. The agency shall ensure that the Cover Florida
174 plans follow standardized grievance procedures.
175 (c) Changes in Cover Florida plan benefits, premiums, and
176 policy forms are subject to regulatory oversight by the office
177 and the agency as provided under rules adopted by the Financial
178 Services Commission and the agency.
179 (d) The agency, the office, and the Executive Office of
180 the Governor shall develop a public awareness program to be
181 implemented throughout the state for the promotion of the Cover
182 Florida Health Care Access Program.

183 (e) Public or private entities may design programs to
184 encourage Floridians to participate in the Cover Florida Health
185 Care Access Program or to encourage employers to cosponsor some
186 share of Cover Florida plan premiums for employees.
187 (5) PLAN PROPOSALS.--The agency and the office shall
188 announce, no later than July 1, 2008, an invitation to negotiate
189 for Cover Florida plan entities to design a Cover Florida plan
190 proposal in which benefits and premiums are specified.
191 (a) The invitation to negotiate shall include guidelines
192 for the review of Cover Florida plan applications, policy forms,
193 and all associated forms and provide regulatory oversight of
194 Cover Florida plan advertisement and marketing procedures. A
195 plan shall be disapproved or withdrawn if the plan:
196 1. Contains any ambiguous, inconsistent, or misleading
197 provisions or any exceptions or conditions that deceptively
198 affect or limit the benefits purported to be assumed in the
199 general coverage provided by the plan;
200 2. Provides benefits that are unreasonable in relation to
201 the premium charged or contains provisions that are unfair or
202 inequitable, that are contrary to the public policy of this
203 state, that encourage misrepresentation, or that result in
204 unfair discrimination in sales practices;
205 3. Cannot demonstrate that the plan is financially sound
206 and that the applicant is able to underwrite or finance the
207 health care coverage provided;
208 4. Cannot demonstrate that the applicant and its
209 management are in compliance with the standards required under
210 s. 624.404(3); or

211 5. Does not guarantee that enrollees may participate in
212 the Cover Florida plan entity's comprehensive network of
213 providers, as determined by the office, the agency, and the
214 contract.
215 (b) The agency and the office may announce an invitation
216 to negotiate for the design of Cover Florida Plus products to
217 companies that offer supplemental insurance, discount medical
218 plan organizations licensed under part II of chapter 636, or
219 prepaid health clinics licensed under part II of chapter 641.
220 (c) The agency and office shall approve at least one Cover
221 Florida plan entity having an existing statewide network of
222 providers and may approve at least one regional network plan in
223 each existing Medicaid area.
224 (6) LICENSE NOT REQUIRED.--
225 (a) The licensing requirements of the Florida Insurance
226 Code and chapter 641 relating to health maintenance
227 organizations do not apply to a Cover Florida plan approved
228 under this section unless expressly made applicable. However,
229 for the purpose of prohibiting unfair trade practices, Cover
230 Florida plans are considered to be insurance subject to the
231 applicable provisions of part IX of chapter 626 except as
232 otherwise provided in this section.
233 (b) Cover Florida plans are not covered by the Florida
234 Life and Health Insurance Guaranty Association under part III of
235 chapter 631 or by the Health Maintenance Organization Consumer
236 Assistance Plan under part IV of chapter 631.

237 (7) ELIGIBILITY.--Eligibility to enroll in a Cover Florida
238 plan is limited to residents of this state who meet all of the
239 following requirements:
240 (a) Are between 19 and 64 years of age, inclusive.
241 (b) Are not covered by a private insurance policy and are
242 not eligible for coverage through a public health insurance
243 program, such as Medicare, Medicaid, or Kidcare, unless
244 eligibility for coverage lapses due to no longer meeting income
245 or categorical requirements.
246 (c) Have not been covered by any health insurance program
247 at any time during the past 6 months, unless coverage under a
248 health insurance program was terminated within the previous 6
249 months due to:
250 1. Loss of a job that provided an employer-sponsored
251 health benefit plan;
252 2. Exhaustion of coverage that was continued under COBRA
253 or continuation-of-coverage requirements under s. 627.6692;
254 3. Reaching the limiting age under the policy; or
255 4. Death of, or divorce from, a spouse who was provided an
256 employer-sponsored health benefit plan.
257 (d) Have applied for health care coverage through a Cover
258 Florida plan and have agreed to make any payments required for
259 participation, including periodic payments or payments due at
260 the time health care services are provided.
261 (8) RECORDS.--Each Cover Florida plan must maintain
262 enrollment data and provide network data and reasonable records
263 to enable the office and the agency to monitor plans and to

264 determine the financial viability of the Cover Florida plan, as
265 necessary.
266 (9) NONENTITLEMENT.--Coverage under a Cover Florida plan
267 is not an entitlement, and a cause of action does not arise
268 against the state, a local government entity, any other
269 political subdivision of the state, or the agency or the office
270 for failure to make coverage available to eligible persons under
271 this section.
272 (10) PROGRAM EVALUATION.--The agency and the office shall:
273 (a) Evaluate the Cover Florida Health Care Access Program
274 and its effect on the entities that seek approval as Cover
275 Florida plans, on the number of enrollees, and on the scope of
276 the health care coverage offered under a Cover Florida plan.
277 (b) Provide an assessment of the Cover Florida plans and
278 their potential applicability in other settings.
279 (c) Use Cover Florida plans to gather more information to
280 evaluate low-income, consumer-driven benefit packages.
281 (d) Jointly submit by March 1, 2009, and annually
282 thereafter, a report to the Governor, the President of the
283 Senate, and the Speaker of the House of Representatives that
284 provides the information specified in paragraphs (a)-(c) and
285 recommendations relating to the successful implementation and
286 administration of the program.
287 (11) RULEMAKING AUTHORITY.--The agency and the Financial
288 Services Commission may adopt rules pursuant to ss. 120.536(1)
289 and 120.54 as needed to administer this section.
290 Section 4. Section 408.910, Florida Statutes, is created
291 to read:

292 408.910 Florida Health Choices Program.--
293 (1) LEGISLATIVE INTENT.--The Legislature finds that a
294 significant number of the residents of this state do not have
295 adequate access to affordable, quality health care. The
296 Legislature further finds that increasing access to affordable,
297 quality health care will be best accomplished by establishing a
298 competitive market for purchasing health insurance and health
299 services. It is therefore the intent of the Legislature to
300 create the Florida Health Choices Program to:
301 (a) Expand opportunities for Floridians to purchase
302 affordable health insurance and health services.
303 (b) Preserve the benefits of employment-sponsored
304 insurance while easing the administrative burden for employers
305 who offer these benefits.
306 (c) Enable individual choice in both the manner and amount
307 of health care purchased.
308 (d) Provide for the purchase of individual, portable
309 health care coverage.
310 (e) Disseminate information to consumers on the price and
311 quality of health services.
312 (f) Sponsor a competitive market that stimulates product
313 innovation, quality improvement, and efficiency in the
314 production and delivery of health services.
315 (2) DEFINITIONS.--As used in this section:
316 (a) "Corporation" means the Florida Health Choices, Inc.,
317 established under this section.
318 (b) "Health insurance agent" means an agent licensed under
319 part IV of chapter 626.

320 (c) "Insurer" means an entity licensed under chapter 624
321 that offers an individual health insurance policy or a group
322 health insurance policy, a preferred provider organization as
323 defined in s. 627.6471, or an exclusive provider organization as
324 defined in s. 627.6472.
325 (d) "Program" means the Florida Health Choices Program
326 established by this section.
327 (3) PROGRAM PURPOSE AND COMPONENTS.--The Florida Health
328 Choices Program is created as a single, centralized market for
329 the sale and purchase of various products that enable
330 individuals to pay for health care. These products include, but
331 are not limited to, health insurance plans, health maintenance
332 organization plans, prepaid services, service contracts, and
333 flexible spending accounts. The components of the program
334 include:
335 (a) Enrollment of employers.
336 (b) Administrative services for participating employers,
337 including:
338 1. Assistance in seeking federal approval of cafeteria
339 plans.
340 2. Collection of premiums and other payments.
341 3. Management of individual benefit accounts.
342 4. Distribution of premiums to insurers and payments to
343 other eligible vendors.
344 5. Assistance for participants in complying with reporting
345 requirements.
346 (c) Services to individual participants, including:

347 1. Information about available products and participating
348 vendors.
349 2. Assistance to participating individuals for assessing
350 the benefits and limits of each product, including information
351 necessary to distinguish between policies offering creditable
352 coverage and other products available through the program.
353 3. Account information to assist individual participants
354 to manage available resources.
355 4. Services that promote healthy behaviors.
356 (d) Recruitment of vendors, including insurers, health
357 maintenance organizations, prepaid clinic service providers,
358 provider service networks, and other providers.
359 (e) Certification of vendors to ensure capability,
360 reliability, and validity of offerings.
361 (f) Collection of data, monitoring, assessment, and
362 reporting of vendor performance.
363 (g) Information services for individuals and employers.
364 (h) Program evaluation.
365 (4) ELIGIBILITY AND PARTICIPATION.--Participation in the
366 program is voluntary and shall be available to employers,
367 individuals, vendors, and health insurance agents as specified
368 in this subsection.
369 (a) Employers eligible to enroll in the program include:
370 1. Employers with 1 to 50 employees.
371 2. Fiscally constrained counties described in s. 218.67.
372 3. Municipalities with populations of fewer than 50,000
373 residents.
374 4. School districts in fiscally constrained counties.

375 (b) Individuals eligible to participate in the program
376 include:
377 1. Individual employees of enrolled employers.
378 2. State employees not eligible for state employee health
379 benefits.
380 3. State retirees.
381 4. Medicaid reform participants who select the opt-out
382 provision of reform.
383 5. Statutory rural hospitals.
384 (c) Employers who choose to participate in the program may
385 enroll by complying with the procedures established by the
386 corporation. These procedures shall include, but not be limited
387 to, the following:
388 1. Submission of required information.
389 2. Compliance with federal tax requirements for the
390 establishment of a cafeteria plan, pursuant to s. 125 of the
391 Internal Revenue Code, including designation of the employer's
392 plan as a premium payment plan, a salary reduction plan with
393 flexible spending arrangements, or a salary reduction plan with
394 a premium payment and flexible spending arrangements.
395 3. Determination of the employer's contribution, if any,
396 per employee, provided that such contribution is equal for each
397 eligible employee.
398 4. Establishment of payroll deduction procedures, subject
399 to the agreement of each individual employee who voluntarily
400 participates in the program.
401 5. Designation of the corporation as the third-party
402 administrator for the employer's health benefit plan.

403 6. Identification of eligible employees.
404 7. Arrangement for periodic payments.
405 (d) Eligible vendors and the products and services that
406 they are permitted to sell are as follows:
407 1. Insurers licensed under chapter 624 may sell health
408 insurance policies, limited benefit policies, other risk-bearing
409 coverage, and other products or services.
410 2. Health maintenance organizations licensed under part I
411 of chapter 641 may sell health insurance policies, limited
412 benefit policies, other risk-bearing products, and other
413 products or services.
414 3. Prepaid health clinic service providers licensed under
415 part II of chapter 641 may sell prepaid service contracts and
416 other arrangements for a specified amount and type of health
417 services or treatments.
418 4. Health care providers, including hospitals and other
419 licensed health facilities, health care clinics, licensed health
420 professionals, pharmacies, and other licensed health care
421 providers, may sell service contracts and arrangements for a
422 specified amount and type of health services or treatments.
423 5. Provider organizations, including service networks,
424 group practices, professional associations, and other
425 incorporated organizations of providers, may sell service
426 contracts and arrangements for a specified amount and type of
427 health services or treatments.
428 6. Corporate entities providing specific health services
429 in accordance with applicable state law may sell service

430 contracts and arrangements for a specified amount and type of
431 health services or treatments.
432
433 A vendor described in subparagraphs 3.-6. may not sell products
434 that provide risk-bearing coverage unless that vendor is
435 authorized under a certificate of authority issued by the Office
436 of Insurance Regulation under the provisions of the Florida
437 Insurance Code. Otherwise eligible vendors may be excluded from
438 participating in the program for deceptive or predatory
439 practices, financial insolvency, or failure to comply with the
440 terms of the participation agreement or other standards set by
441 the corporation.
442 (e) Eligible individuals may voluntarily continue
443 participation in the program regardless of subsequent changes in
444 job status or Medicaid eligibility. Individuals who join the
445 program may participate by complying with the procedures
446 established by the corporation. These procedures shall include,
447 but are not limited to:
448 1. Submission of required information.
449 2. Authorization for payroll deduction.
450 3. Compliance with federal tax requirements.
451 4. Arrangements for payment in the event of job changes.
452 5. Selection of products and services.
453 (f) Vendors who choose to participate in the program may
454 enroll by complying with the procedures established by the
455 corporation. These procedures shall include, but are not limited
456 to:

457 1. Submission of required information, including a
458 complete description of the coverage, services, provider
459 network, payment restrictions, and other requirements of each
460 product offered through the program.
461 2. Execution of an agreement to make all products offered
462 through the program available to all individual participants.
463 3. Establishment of product prices based on age, gender,
464 and location of the individual participant.
465 4. Arrangements for receiving payment for enrolled
466 participants.
467 5. Participation in ongoing reporting processes
468 established by the corporation.
469 6. Compliance with grievance procedures established by the
470 corporation.
471 (g) Health insurance agents licensed under part IV of
472 chapter 626 are eligible to voluntarily participate as buyers'
473 representatives. A buyer's representative acts on behalf of an
474 individual purchasing health insurance and health services
475 through the program by providing information about products and
476 services available through the program and assisting the
477 individual with both the decision and the procedure of selecting
478 specific products. Serving as a buyer's representative does not
479 constitute a conflict of interest with continuing
480 responsibilities as a health insurance agent provided the
481 relationship between each agent and any participating vendor is
482 disclosed prior to advising an individual participant about the
483 products and services available through the program. In order to

484 participate, a health insurance agent shall comply with the
485 procedures established by the corporation, including:
486 1. Completion of training requirements.
487 2. Execution of a participation agreement specifying the
488 terms and conditions of participation.
489 3. Disclosure of any appointments to solicit insurance or
490 procure applications for vendors participating in the program.
491 4. Arrangements to receive payment from the corporation
492 for services as a buyer's representative.
493 (5) PRODUCTS.--
494 (a) The products that may be made available for purchase
495 through the program include, but are not limited to:
496 1. Health insurance policies.
497 2. Limited benefit plans.
498 3. Prepaid clinic services.
499 4. Service contracts.
500 5. Arrangements for purchase of specific amounts and types
501 of health services and treatments.
502 6. Flexible spending accounts.
503 (b) Health insurance policies, limited benefit plans,
504 prepaid service contracts, and other contracts for services must
505 ensure the availability of covered services and benefits to
506 participating individuals for at least 1 full enrollment year.
507 (c) Products may be offered for multiyear periods provided
508 the price of the product is specified for the entire period or
509 for each separately priced segment of the policy or contract.
510 (d) The corporation shall require the following disclosure
511 to be reviewed and executed by all consumers purchasing program

512 options or insurance coverage through the corporation: "In
513 connection with the Florida Health Choices Program authorized by
514 s. 408.910, Florida Statutes, agents and entities offering
515 products and services under the program shall inform the named
516 insured, applicant, or subscriber, on a form approved by the
517 Office of Insurance Regulation of the Financial Services
518 Commission, that the products and services are not insurance or,
519 if they are insurance, that benefits under the coverage are
520 limited under s. 408.910, Florida Statutes, and that such
521 coverage is an alternative to coverage without such limitations.
522 If the form is signed by a named insured, applicant, or
523 subscriber, it shall be presumed that there was an informed,
524 knowing acceptance of such limitations."
525 (6) PRICING.--Prices for the products sold through the
526 program shall be transparent to participants and established by
527 the vendors based on age, gender, and location of participants.
528 The corporation shall develop a methodology to evaluate the
529 actuarial soundness of products offered through the program. The
530 methodology shall be reviewed by the Office of Insurance
531 Regulation prior to use by the corporation. Prior to making the
532 product available to individual participants, the corporation
533 shall use the methodology to compare the expected health care
534 costs for the covered services and benefits to the vendor's
535 price for that coverage. The results shall be reported to
536 individuals participating in the program. Once established, the
537 price set by the vendor must remain in force for at least 1 year
538 and may only be redetermined by the vendor at the next annual
539 enrollment period. The corporation shall annually assess a

540 surcharge for each premium or price set by a participating
541 vendor. This surcharge may not be more than 2.5 percent of the
542 price and shall be used to generate funding for administrative
543 services provided by the corporation and payments to buyers'
544 representatives.
545 (7) EXCHANGE PROCESS.--The program shall provide a single,
546 centralized market for purchase of health insurance and health
547 services. Purchases may be made by participating individuals
548 over the Internet or through the services of a participating
549 health insurance agent. Information about each product and
550 service available through the program shall be made available
551 through printed material and an interactive Internet website. A
552 participant needing personal assistance to select products and
553 services shall be referred to a participating agent in his or
554 her area.
555 (a) Participation in the program may begin at any time
556 during a year when the employer completes enrollment and meets
557 the requirements specified by the corporation pursuant to
558 paragraph (4)(c).
559 (b) Initial selection of products and services must be
560 made by an individual participant within 60 days after the date
561 on which the individual's employer qualified for participation.
562 An individual who fails to enroll in products and services by
563 the end of this period shall be limited to participation in
564 flexible spending account services until the next annual
565 enrollment period.
566 (c) Initial enrollment periods for each product selected
567 by an individual participant must last a minimum of 12 months,

568 unless the individual participant specifically agrees to a
569 different enrollment period.
570 (d) When an individual has selected one or more products
571 and enrolled in those products for at least 12 months or any
572 other period specifically agreed to by the individual
573 participant, changes in selected products and services may only
574 be made during the annual enrollment period established by the
575 corporation.
576 (e) The limits established in paragraphs (b)-(d) apply to
577 any risk-bearing product that promises future payment or
578 coverage for a variable amount of benefits or services. The
579 limits do not apply to initiation of flexible spending plans
580 when those plans are not associated with specific high-
581 deductible insurance policies or to the use of spending accounts
582 for any products offering individual participants specific
583 amounts and types of health services and treatments at a
584 contracted price.
585 (8) RISK POOLING.--The program shall utilize methods for
586 pooling the risk of individual participants and preventing
587 selection bias. These methods shall include, but not be limited
588 to, a postenrollment risk adjustment of the premium payments to
589 the vendors. The corporation shall establish a methodology for
590 assessing the risk of enrolled individual participants based on
591 data reported by the vendors about their enrollees. Monthly
592 distributions of payments to the vendors shall be adjusted based
593 on the assessed relative risk profile of the enrollees in each
594 risk-bearing product for the most recent period for which data
595 is available.

596 (9) EXEMPTIONS.--
597 (a) Policies sold as part of the program are not subject
598 to the licensing requirements of the Florida Insurance Code,
599 chapter 641, or the mandated offerings or coverages established
600 in part VI of chapter 627 and chapter 641.
601 (b) The corporation is authorized to act as an
602 administrator as defined in s. 626.88. However, the corporation
603 is not subject to the licensing requirements of part VII of
604 chapter 626.
605 (10) LIQUIDATION OR DISSOLUTION.--The Department of
606 Financial Services shall supervise any liquidation or
607 dissolution of the corporation and shall have, with respect to
608 such liquidation or dissolution, all power granted to it
609 pursuant to the Florida Insurance Code.
610 (11) CORPORATION.--There is created the Florida Health
611 Choices, Inc., which shall be registered, incorporated,
612 organized, and operated in compliance with chapter 617. The
613 purpose of the corporation is to administer the program created
614 in this section and to conduct such other business as may
615 further the administration of the program.
616 (a) The corporation shall be governed by a board of
617 directors consisting of 15 individuals appointed in the
618 following manner:
619 1. Five members appointed by and serving at the pleasure
620 of the Governor, consisting of:
621 a. The Secretary of Health Care Administration or a
622 designee with expertise in health care services.

623 b. The Secretary of Management Services or a designee with
624 expertise in state employee benefits.
625 c. The Commissioner of the Office of Insurance Regulation
626 or a designee with expertise in insurance regulation.
627 d. Two representatives of eligible public employers.
628 2. Five members appointed by and serving at the pleasure
629 of the President of the Senate, consisting of representatives of
630 employers, insurers, health care providers, health insurance
631 agents, and individual participants.
632 3. Five members appointed by and serving at the pleasure
633 of the Speaker of the House of Representatives, consisting of
634 representatives of employers, insurers, health care providers,
635 health insurance agents, and individual participants.
636 (b) Members shall be appointed for terms of up to 3 years.
637 Any member is eligible for reappointment. A vacancy on the board
638 shall be filled for the unexpired portion of the term in the
639 same manner as the original appointment.
640 (c) The board shall select a chief executive officer for
641 the corporation who shall be responsible for the selection of
642 such other staff as may be authorized by the corporation's
643 operating budget as adopted by the board.
644 (d) Board members are entitled to receive, from funds of
645 the corporation, reimbursement for per diem and travel expenses
646 as provided by s. 112.061. No other compensation is authorized.
647 (e) There shall be no liability on the part of, and no
648 cause of action shall arise against, any member of the board or
649 its employees or agents for any action taken by them in the
650 performance of their powers and duties under this section.

651 (f) The board shall develop and adopt bylaws and other
652 corporate procedures as necessary for the operation of the
653 corporation and carrying out the purposes of this section. The
654 bylaws shall:
655 1. Specify procedures for selection of officers and
656 qualifications for reappointment, provided that no board member
657 shall serve more than 9 consecutive years.
658 2. Require an annual membership meeting that provides an
659 opportunity for input and interaction with individual
660 participants in the program.
661 3. Specify policies and procedures regarding conflicts of
662 interest, including prohibiting a member from participating in
663 any decision that would inure to the benefit of the member or
664 the organization that employs the member. The policies and
665 procedures shall also require public disclosure of the interest
666 that prevents the member from participating in a decision on a
667 particular matter.
668 (g) The corporation may exercise all powers granted to it
669 under chapter 617 necessary to carry out the purposes of this
670 section, including, but not limited to, the power to receive and
671 accept grants, loans, or advances of funds from any public or
672 private agency and to receive and accept from any source
673 contributions of money, property, labor, or any other thing of
674 value to be held, used, and applied for the purposes of this
675 section.
676 (h) The corporation shall:
677 1. Determine eligibility of employers, vendors,
678 individuals, and agents in accordance with subsection (4).

679 2. Establish procedures necessary for the operation of the
680 program, including, but not limited to, procedures for
681 application, enrollment, risk assessment, risk adjustment, plan
682 administration, performance monitoring, and consumer education.
683 3. Arrange for collection of contributions from
684 participating employers and individuals.
685 4. Arrange for payment of premiums and other appropriate
686 disbursements based on the selections of products and services
687 by the individual participants.
688 5. Establish criteria for disenrollment of participating
689 individuals based on failure to pay the individual's share of
690 any contribution required to maintain enrollment in selected
691 products.
692 6. Establish criteria for exclusion of vendors pursuant to
693 paragraph (4)(d).
694 7. Develop and implement a plan for promoting public
695 awareness of and participation in the program.
696 8. Secure staff and consultant services necessary to the
697 operation of the program.
698 9. Establish policies and procedures regarding
699 participation in the program for individuals, vendors, health
700 insurance agents, and employers.
701 10. Develop a plan, in coordination with the Department of
702 Revenue, to establish tax credits or refunds for employers that
703 participate in the program. The corporation shall submit the
704 plan to the Governor, the President of the Senate, and the
705 Speaker of the House of Representatives no later than January 1,
706 2009.

707 11. Beginning in fiscal year 2009-2010, submit by February
708 1 an annual report to the Governor, the President of the Senate,
709 and the Speaker of the House of Representatives documenting the
710 corporation's activities in compliance with the duties
711 delineated in this section.
712 (i) To ensure program integrity and to safeguard the
713 financial transactions made under the auspices of the program,
714 the corporation is authorized to establish qualifying criteria
715 and certification procedures for vendors, require performance
716 bonds or other guarantees of ability to complete contractual
717 obligations, monitor the performance of vendors, and enforce the
718 agreements of the program through financial penalty or
719 disqualification from the program.
720 Section 5. Subsection (22) of section 409.811, Florida
721 Statutes, is amended to read:
722 409.811 Definitions relating to Florida Kidcare Act.--As
723 used in ss. 409.810-409.820, the term:
724 (22) "Premium assistance payment" means the monthly
725 consideration paid by the agency per enrollee in the Florida
726 Kidcare program towards health insurance premiums and may
727 include the direct payment of the premium for a qualifying child
728 to be covered as a dependent under an employer-sponsored group
729 family plan when such payment does not exceed the payment
730 required for an enrollee in the Florida Kidcare program.
731 Section 6. Section 624.1265, Florida Statutes, is created
732 to read:
733 624.1265 Nonprofit religious organization exemption;
734 authority; notice.--

735 (1) Any nonprofit religious organization that qualifies
736 under Title 26, s. 501 of the Internal Revenue Code of 1986, as
737 amended; that limits its participants to members of the same
738 religion; that acts as an organizational clearinghouse for
739 information between participants who have financial, physical,
740 or medical needs and participants with the ability to pay for
741 the benefit of those participants with financial, physical, or
742 medical needs; that provides for the financial or medical needs
743 of a participant through payments directly from one participant
744 to another; and that suggests amounts that participants may
745 voluntarily give with no assumption of risk or promise to pay
746 either among the participants or between the participants and
747 the organization are not subject to any requirements of the
748 Florida Insurance Code.
749 (2) Nothing in this section prevents the organization
750 described in subsection (1) from establishing qualifications of
751 participation relating to the health of a prospective
752 participant, prevents a participant from limiting the financial
753 or medical needs that may be eligible for payment, or prevents
754 the organization from canceling the membership of a participant
755 when such participant indicates his or her unwillingness to
756 participate by failing to make a payment to another participant
757 for a period in excess of 60 days.
758 (3) The organization described in subsection (1) shall
759 provide each prospective participant in the organizational
760 clearinghouse written notice that the organization is not an
761 insurance company, that membership is not offered through an
762 insurance company, and that the organization is not subject to

763 the regulatory requirements or consumer protections of the
764 Florida Insurance Code.
765 Section 7. Section 627.6562, Florida Statutes, is amended
766 to read:
767 627.6562 Dependent coverage.--
768 (1) If an insurer offers coverage that insures dependent
769 children of the policyholder or certificateholder, the policy
770 must insure a dependent child of the policyholder or
771 certificateholder at least until the end of the calendar year in
772 which the child reaches the age of 25, if the child meets all of
773 the following:
774 (a) The child is dependent upon the policyholder or
775 certificateholder for support.
776 (b) The child is living in the household of the
777 policyholder or certificateholder, or the child is a full-time
778 or part-time student.
779 (2) A policy that is subject to the requirements of
780 subsection (1) must also offer the policyholder or
781 certificateholder the option to insure a child of the
782 policyholder or certificateholder at least until the end of the
783 calendar year in which the child reaches the age of 30, if the
784 child:
785 (a) Is unmarried and does not have a dependent of his or
786 her own;
787 (b) Is a resident of this state or a full-time or part-
788 time student; and
789 (c) Is not provided coverage as a named subscriber,
790 insured, enrollee, or covered person under any other group,

791 blanket, or franchise health insurance policy or individual
792 health benefits plan, or entitled to benefits under Title XVIII
793 of the Social Security Act.
794 (3) If, pursuant to subsection (2), a child is provided
795 coverage under the parent's policy after the end of the calendar
796 year in which the child reaches age 25, and coverage for the
797 child is subsequently terminated, the child is not eligible to
798 be covered under the parent's policy unless the child was
799 continuously covered by other creditable coverage without a gap
800 in coverage of more than 63 days. For the purposes of this
801 subsection, the term "creditable coverage" has the same meaning
802 as defined in s. 627.6561(5).
803 (4)(2) Nothing in This section does not affect or preempt
804 affects or preempts an insurer's right to medically underwrite
805 or charge the appropriate premium. (b) Require coverage
806 for services provided to a dependent before October 1, 2008.
807 (c) Require an employer to pay all or part of the cost of
808 coverage provided for a dependent under this section.
809 (d) Prohibit an insurer or health maintenance organization
810 from increasing the limiting age for dependent coverage to age
811 30 in policies or contracts issued or renewed prior to the
812 effective date of this act.
813 (5) Until April 1, 2009, a dependent child who qualifies
814 for coverage under subsection (1) but whose coverage as a
815 dependent child under a covered person's plan terminated under
816 the terms of the plan before October 1, 2008, may make a written
817 election to reinstate coverage, without proof of insurability,
818 under that plan as a dependent child pursuant to this section.

819 All other dependent children who qualify for coverage under
820 subsection (1) shall be automatically covered at least until the
821 end of the calendar year in which the child reaches the age of
822 30, unless the covered person provides the group policyholder
823 with written evidence the dependent child is married, is not a
824 resident of the state, is covered under a separate comprehensive
825 health insurance policy or a health benefit plan, is entitled to
826 benefits under Title XVIII of the Social Security Act, Pub. L.
827 No. 89-97, 42 U.S.C. ss. 1935 et seq., or is eligible for
828 coverage as an employee under an employer-sponsored health plan.
829 (6) The covered person's plan may require the payment of a
830 premium by the covered person or dependent child, as
831 appropriate, subject to the approval of the Office of Insurance
832 Regulation, for any period of coverage relating to a dependent's
833 written election for coverage pursuant to subsection (3).
834 (7) Notice regarding the reinstatement of coverage for a
835 dependent child as provided under this section must be provided
836 to a covered person in the certificate of coverage prepared for
837 covered persons by the insurer or by the covered person's
838 employer. The notice shall be given as soon as practicable after
839 July 1, 2008, and such notice may be given through the group
840 policyholder.
841 (8) This section does not apply to accident only,
842 specified disease, disability income, Medicare supplement, or
843 long-term care insurance policies.
844 (9) This section applies to all group, blanket, and
845 franchise health insurance policies covering residents of this
846 state, including, but not limited to, policies in which the

847 carrier has reserved the right to change the premium. This
848 section applies to all individual, group, blanket, and franchise
849 health insurance policies and health maintenance contracts
850 issued, renewed, or amended after October 1, 2008.
851 Section 8. Subsections (1), (4), and (6) of section
852 641.402, Florida Statutes, are amended to read:
853 641.402 Definitions.--As used in this part, the term:
854 (1) "Basic services" includes any of the following:
855 limited hospital inpatient services, which may include hospital
856 inpatient physician services, up to a maximum of coverage
857 benefit of 5 days and a maximum dollar amount of coverage of
858 $15,000 per calendar year; emergency care;~~,~~ physician care other
859 than hospital inpatient physician services;~~,~~ ambulatory
860 diagnostic treatment;~~,~~ and preventive health care services.
861 (4) "Prepaid health clinic" means any organization
862 authorized under this part which provides, either directly or
863 through arrangements with other persons, basic services to
864 persons enrolled with such organization, on a prepaid per capita
865 or prepaid aggregate fixed-sum basis, including those basic
866 services described in this part which subscribers might
867 reasonably require to maintain good health. ~~However, no clinic~~
868 ~~that provides or contracts for, either directly or indirectly,~~
869 ~~inpatient hospital services, hospital inpatient physician~~
870 ~~services, or indemnity against the cost of such services shall~~
871 ~~be a prepaid health clinic.~~
872 (6) "Provider" means any physician or person ~~other than a~~
873 ~~hospital~~ that furnishes health care services under this part and
874 is licensed or authorized to practice in this state.

875 Section 9. This act shall take effect upon becoming a law.
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880 **T I T L E A M E N D M E N T**
881 Remove the entire title and insert:
882 Remove the entire title and insert:
883 A bill to be entitled
884 An act relating to affordable health coverage; amending s.
885 112.363, F.S.; specifying that coverage provided through
886 the Cover Florida Health Care Access Program is considered
887 health insurance coverage for the purposes of determining
888 eligibility for the state retiree health insurance
889 subsidy; amending s. 408.909, F.S.; revising eligibility
890 requirements; providing cetain exemptions from the 6-month
891 lapse in coverage requirement; extending the expiration
892 date of the health flex plan; creating s. 408.9091, F.S.;
893 creating the Cover Florida Health Care Access Program;
894 providing a short title; providing legislative intent;
895 providing definitions; requiring the agency and the Office
896 of Insurance Regulation of the Financial Services
897 Commission within the Department of Financial Services to
898 jointly administer the program; providing program
899 requirements; requiring the development of guidelines to
900 meet minimum standards for quality of care and access to
901 care; requiring the agency to ensure that the Cover
902 Florida plans follow standardized grievance procedures;

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903 requiring the office and the agency to oversee changes to
904 plan benefits; requiring the Executive Office of the
905 Governor, the agency, and the office to develop a public
906 awareness program; authorizing public and private entities
907 to design programs to encourage or extend incentives for
908 participation in the Cover Florida Health Care Access
909 Program; requiring the agency and the office to announce
910 an invitation to negotiate for Cover Florida plan entities
911 to design a coverage proposal; requiring the invitation to
912 negotiate to include certain guidelines; providing certain
913 conditions under which plans are disapproved or withdrawn;
914 authorizing the agency and the office to announce an
915 invitation to negotiate for companies that offer
916 supplemental insurance or discount medical plans;
917 requiring the agency and the office to approve at least
918 one plan entity; authorizing the agency and the office to
919 approve one regional network plan in each existing
920 Medicaid area; providing that certain licensing
921 requirements are not applicable to a Cover Florida plan;
922 providing that Cover Florida plans are considered
923 insurance under certain conditions; excluding Cover
924 Florida plans from the Florida Life and Health Insurance
925 Guaranty Association and the Health Maintenance
926 Organization Consumer Assistance Plan; providing
927 requirements for eligibility for a Cover Florida plan;
928 requiring each Cover Florida plan to maintain and provide
929 certain records; providing that coverage under a Cover
930 Florida plan is not an entitlement and does not give rise

931 to a cause of action; requiring the agency and the office
932 to evaluate the program and submit an annual report to the
933 Governor and the Legislature; authorizing the agency and
934 the Financial Services Commission to adopt rules; creating
935 s. 408.910, F.S.; establishing the Florida Health Choices
936 Program; providing legislative intent; providing
937 definitions; providing program purpose and components;
938 providing employer eligibility criteria; providing
939 individual eligibility criteria; providing employer
940 enrollment criteria; providing vendor, product, and
941 service eligibility criteria; providing for individual
942 participation regardless of subsequent job status or
943 Medicaid eligibility; providing individual enrollment
944 criteria; providing vendor enrollment criteria; providing
945 for participation by health insurance agents; providing
946 criteria for products available for purchase; providing
947 criteria for product pricing; providing for an
948 administrative surcharge; providing for an exchange
949 process; providing for enrollment periods and changes in
950 selected products; providing methods for the pooling of
951 risk; providing for exemptions from certain statutory
952 provisions, mandated offerings and coverages, and
953 licensing requirements; creating the Florida Health
954 Choices, Inc.; requiring the department to supervise any
955 liquidation or dissolution of the corporation; providing
956 for corporate governance and board membership and terms;
957 providing for reimbursement for per diem and travel
958 expenses; providing for powers and duties of the

959 corporation; requiring the corporation to coordinate with
960 the Department of Revenue to develop a plan by January 1,
961 2009, for creating tax exemptions or refunds for
962 participating in the program; requiring the corporation to
963 submit an annual report to the Governor and Legislature;
964 authorizing the corporation to establish and enforce
965 certain program integrity measures; amending s. 409.811,
966 F.S.; revising the definition of the term "premium
967 assistance payment"; creating s. 624.1265, F.S.; exempting
968 certain nonprofit religious organizations from
969 requirements of the Florida Insurance Code; preserving
970 certain authority of such organizations; requiring such
971 organizations to provide certain notice to prospective
972 participants; providing notice requirements; amending s.
973 627.6562, F.S.; requiring insurance policies that provide
974 dependent coverage to provide the policyholder with the
975 option of insuring a child until the age of 30 under
976 certain circumstances; amending s. 627.6699, F.S.;
977 requiring participation of employees in health maintenance
978 contracts or policies issued or renewed after a specified
979 date; providing conditions for employers and employees to
980 opt out of such coverage; amending s. 641.402, F.S.;
981 revising the definition of the term "basic services" to
982 include certain hospital inpatient services; revising the
983 definitions of the terms "prepaid health clinic" and
984 "provider"; providing an effective date.
985