A bill to be entitled

An act relating to health insurance; amending s. 112.363, F.S.; specifying that coverage provided through the Cover Florida Health Care Access Program is considered health insurance coverage for the purposes of determining eligibility for the state retiree health insurance subsidy; amending s. 408.909, F.S.; revising eligibility for enrollment in a health flex plan; revising the expiration date of the health flex plan program; creating s. 408.9091, F.S.; creating the Cover Florida Health Care Access Program; providing a short title; providing legislative intent; providing definitions; requiring the Agency for Health Care Administration and the Office of Insurance Regulation of the Financial Services Commission within the Department of Financial Services to jointly administer the program; providing program requirements; requiring the development of guidelines to meet minimum standards for quality care and access to care; requiring the agency to ensure that the Cover Florida plans follow standardized grievance procedures; requiring the Executive Office of the Governor, the agency, and the office to develop a public awareness program; authorizing public and private entities to design or extend incentives for participation in the Cover Florida Access Program; requiring the agency and the office to announce an invitation to negotiate for Cover Florida plan entities to design a coverage proposal; requiring the agency and the office to approve one plan entity; authorizing the agency and the office to approve one regional network plan in

each existing Medicaid area; requiring the invitation to negotiate to include certain guidelines; providing certain conditions in which plans are disapproved or withdrawn; authorizing the agency and the office to announce an invitation to negotiate for companies that offer supplemental insurance or discount medical plans; providing that certain licensing requirements or ch. 641, F.S., are not applicable to a Cover Florida plan; providing that Cover Florida plans are considered insurance under certain conditions; excluding Cover Florida plans from the Florida Life and Health Insurance Guaranty Association and the Health Maintenance Organization Consumer Assistance Plan; providing requirements for eligibility in a Cover Florida plan; requiring each Cover Florida plan to maintain and provide certain records; providing that coverage under a Cover Florida plan is not an entitlement and does not give rise to a cause of action; requiring the agency and the office to evaluate the Cover Florida program and submit an annual report to the Governor and the Legislature; requiring the agency and the Financial Services Commission to adopt rules; amending s. 624.91, F.S.; revising the duties of the Florida Healthy Kids Corporation; amending s. 409.814, F.S.; revising the eligibility requirements for participation in the Medikids program or the Florida Healthy Kids program; deleting certain limitations; amending s. 627.6562, F.S.; requiring insurance policies that provide dependent coverage to provide the policyholder with the option of insuring a child until the

age of 30 under certain circumstances; amending s. 627.6699, F.S.; redefining the term "small employer" for purposes of the Employee Health Care Access Act; providing an effective date.

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

Section 1. Paragraph (d) of subsection (2) of section 112.363, Florida Statutes, is amended to read:

112.363 Retiree health insurance subsidy.--

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

(d) Payment of the retiree health insurance subsidy shall be made only after coverage for health insurance for the retiree or beneficiary has been certified in writing to the Department of Management Services. Participation in a former employer's group health insurance program is not a requirement for eligibility under this section. Coverage issued pursuant to s. 408.9091 is considered health insurance for the purposes of this section.

Section 2. Subsections (5) and (10) of section 408.909, Florida Statutes, are amended to read:

408.909 Health flex plans.--

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

(a) Are 64 years of age or younger;

(b) Have a family income equal to or less than 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;~~

(c) ~~(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; who are covered under an individual contract issued by a health maintenance organization that is an approved health flex plan on October 1, 2008, and are applying for coverage in the same health flex plan without a lapse in coverage and all other eligibility requirements under this subsection are met; or who were covered under Medicaid or Kidcare and lost eligibility for Medicaid or a Kidcare subsidy due to income restrictions within 90 days before applying for health care coverage through an approved health flex plan; and

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

(10) EXPIRATION.--This section expires July 1, 2013 ~~2008~~.

Section 3. 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 state residents are unable to obtain affordable health insurance coverage. The Legislature also finds that existing "health flex" plan coverage has had limited participation due in part to narrow eligibility restrictions as

well as minimal benefit options for catastrophic and emergency care coverage. Therefore, it is the Legislature's intent to expand the availability of health care options for uninsured residents by developing an affordable health care product that emphasizes coverage for basic and preventive health care services; provides inpatient hospital, urgent, and emergency care services; and is offered statewide by approved health insurers, health maintenance organizations, health-care-provider-sponsored organizations, or health care districts.

(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 plan.

(d) "Cover Florida plan" means a consumer choice benefit plan approved under this section which guarantees payment or coverage for specified benefits provided to an enrollee.

(e) "Cover Florida plan coverage" means health care services that are covered as benefits under a Cover Florida 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 a Cover Florida plan and is responsible for administering the plan and paying all claims for Cover Florida plan coverage by enrollees.

(g) "Cover Florida Plus" plan means a supplemental

insurance product, such as for additional catastrophic coverage or dental, vision, or cancer coverage, approved under this section and offered to all enrollees.

(4) PROGRAM.--The agency and the office shall jointly establish and administer the Cover Florida Health Care Access Program.

(a) General Cover Florida plan components must require that:

1. Plans are offered as guaranteed issue to enrollees, subject to exclusions for preexisting conditions approved by the office and the agency.

2. Plans are portable, such that the enrollee remains covered regardless of employment status or the cost-sharing of premiums.

3. Plans may provide for cost containment through limits on the number of services, caps on benefit payments, and copayments for services.

4. A Cover Florida health plan entity makes all benefit plan and marketing materials available in English and Spanish.

5. In order to provide for consumer choice, Cover Florida health plan entities develop two alternative benefit option plans having different cost and benefit levels, including at least one plan that provides catastrophic coverage.

6. Plans without catastrophic coverage provide coverage options for the following services, including, but not limited to:

a. Preventive health services, including preventive screenings, annual health assessments, and well-care and well-woman services, including mammograms, screenings for cervical

cancer, noninvasive colorectal or prostate screenings, and immunizations.

b. Incentives for routine, preventive care.

c. Office visits for the diagnosis and treatment of illness or injury.

d. Office surgery, including anesthesia.

e. Services related to behavioral health services.

f. Durable medical equipment and prosthetics.

g. Diabetic supplies.

7. Plans providing catastrophic coverage, at a minimum, provide coverage options for all of the services listed under subparagraph 6., and in addition include, but are not limited to, coverage options for:

a. Inpatient hospital stays.

b. Hospital emergency care services.

c. Urgent care services.

d. Outpatient facility services, outpatient surgery, and outpatient diagnostic services.

8. Plans offer prescription drug benefit coverage on all plans, or use a prescription drug manager, such as the Florida Discount Drug Card Program.

9. Plans provide, in enrollment materials, plain-language information on policy benefit coverage, benefit limits, cost-sharing requirements, and exclusions and a clear representation of what is not covered in the plan.

10. Plans offered through a qualified employer meet the requirements of s. 125 of the Internal Revenue Code.

(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) Changes in Cover Florida plan benefits, premiums, and policy forms are subject to regulatory oversight by the office and agency as provided by rules adopted by the Financial Services Commission and the agency.

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

(e) Public or private entities may design programs to encourage Floridians to participate in the Cover Florida Health Access Program, or to encourage employers to cosponsor some share of Cover Florida plan premiums for employees.

(5) PLAN PROPOSALS.--The agency and the office shall announce, no later than July 1, 2008, an invitation to negotiate for Cover Florida plan entities to design a Cover Florida plan proposal in which benefits and premiums are specified.

(a) The invitation to negotiate shall include guidelines for the review of Cover Florida plan applications, policy forms, and all associated forms, and provide regulatory oversight of Cover Florida plan advertisement and marketing procedures. A plan shall be disapproved or withdrawn if the plan:

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

2. Provides benefits that are unreasonable in relation to the premium charged or contains provisions that are unfair or

inequitable, that are 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 plan is financially sound and that the applicant is able to underwrite or finance the health care coverage provided;

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

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

(b) The agency and the office may announce an invitation to negotiate for the design of Cover Florida Plus products to companies that offer supplemental insurance, discount medical plan organizations licensed under part II of chapter 636, or prepaid health clinics licensed under part II of chapter 641.

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

(6) LICENSE NOT REQUIRED.--

(a) The licensing requirements of the Florida Insurance Code and chapter 641, relating to health maintenance organizations, do not apply 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.

(b) Cover Florida plans are not covered by the Florida Life and Health Insurance Guaranty Association under part III of chapter 631 or by the Health Maintenance Organization Consumer Assistance Plan under part IV of chapter 631.

(7) ELIGIBILITY.--Eligibility to enroll in a Cover Florida plan is limited to residents of this state who meet all of the following:

(a) Are 19 to 64 years of age.

(b) Are not covered by a private health insurance policy and are not eligible for coverage through a public health insurance program, such as Medicare, Medicaid, or Kidcare, unless eligibility for coverage lapses due to no longer meeting income or categorical requirements.

(c) Have not been covered by any health insurance program at any time during the past 6 months, unless coverage under a health insurance program was terminated within the previous 6 months due to:

1. Loss of a job that provided an employer-sponsored health benefit plan;

2. Exhaustion of coverage that was continued under COBRA or continuation-of-coverage requirements under s. 627.6692;

3. Reaching the limiting age under the policy; or

4. Death of, or divorce from, a spouse who was provided employer-sponsored health benefit plan.

(d) Have applied for health care coverage through a 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 must maintain enrollment data and provide network data and reasonable records to enable the office and agency to monitor plans and to determine the financial viability of the Cover Florida plan, as necessary.

(9) NONENTITLEMENT.--Coverage under a Cover Florida plan is not an entitlement, and a cause of action does not arise against the state, a local government entity, any other political subdivision of this state, or 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:

(a) 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;

(b) Provide an assessment of the Cover Florida plans and their potential applicability in other settings;

(c) Use Cover Florida plans to gather more information to evaluate low-income, consumer-driven benefit packages; and

(d) Jointly submit by March 1, 2009, and annually thereafter, a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives providing the information specified in paragraphs (a)-(c) and recommendations relating to the successful implementation and administration of the program.

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

Section 4. Paragraph (b) of subsection (5) of section 624.91, Florida Statutes, is amended to read:

624.91 The Florida Healthy Kids Corporation Act.--

(5) CORPORATION AUTHORIZATION, DUTIES, POWERS.--

(b) The Florida Healthy Kids Corporation shall:

1. Arrange for the collection of any family, local contributions, or employer payment or premium, in an amount to be determined by the board of directors, to provide for payment of premiums for comprehensive insurance coverage and for the actual or estimated administrative expenses.

2. Arrange for the collection of any voluntary contributions to provide for payment of premiums for children who are not eligible for medical assistance under Title XXI of the Social Security Act.

3. Subject to the provisions of s. 409.8134, accept voluntary supplemental local match contributions that comply with the requirements of Title XXI of the Social Security Act for the purpose of providing additional coverage in contributing counties under Title XXI.

4. Establish the administrative and accounting procedures for the operation of the corporation.

5. Establish, with consultation from appropriate professional organizations, standards for preventive health services and providers and comprehensive insurance benefits appropriate to children, provided that such standards for rural areas shall not limit primary care providers to board-certified pediatricians.

6. Determine eligibility for children seeking to participate in the Title XXI-funded components of the Florida Kidcare program consistent with the requirements specified in s. 409.814, as well as the non-Title-XXI-eligible children as

provided in subsection (3).

7. Establish procedures under which providers of local match to, applicants to and participants in the program may have grievances reviewed by an impartial body and reported to the board of directors of the corporation.

8. Establish participation criteria and, if appropriate, contract with an authorized insurer, health maintenance organization, or third-party administrator to provide administrative services to the corporation.

9. Establish enrollment criteria which shall include penalties or waiting periods of not fewer than 60 days for reinstatement of coverage upon voluntary cancellation for nonpayment of family premiums.

10. Contract with authorized insurers or any provider of health care services, meeting standards established by the corporation, for the provision of comprehensive insurance coverage to participants. Such standards shall include criteria under which the corporation may contract with more than one provider of health care services in program sites. Health plans shall be selected through a competitive bid process. The Florida Healthy Kids Corporation shall purchase goods and services in the most cost-effective manner consistent with the delivery of quality medical care. The maximum administrative cost for a Florida Healthy Kids Corporation contract shall be 15 percent. For health care contracts, the minimum medical loss ratio for a Florida Healthy Kids Corporation contract shall be 85 percent. For dental contracts, the remaining compensation to be paid to the authorized insurer or provider under a Florida Healthy Kids Corporation contract shall be no less than an amount which is 85

percent of premium; to the extent any contract provision does not provide for this minimum compensation, this section shall prevail. The health plan selection criteria and scoring system, and the scoring results, shall be available upon request for inspection after the bids have been awarded.

11. Establish disenrollment criteria in the event local matching funds are insufficient to cover enrollments.

12. Develop and implement a plan to publicize the Florida Healthy Kids Corporation, the eligibility requirements of the program, and the procedures for enrollment in the program and to maintain public awareness of the corporation and the program.

13. Secure staff necessary to properly administer the corporation. Staff costs shall be funded from state and local matching funds and such other private or public funds as become available. The board of directors shall determine the number of staff members necessary to administer the corporation.

14. Provide a report annually to the Governor, Chief Financial Officer, Commissioner of Education, Senate President, Speaker of the House of Representatives, and Minority Leaders of the Senate and the House of Representatives.

15. Provide information on a quarterly basis to the Legislature and the Governor which compares the costs and utilization of the full-pay enrolled population and the Title XXI-subsidized enrolled population in the KidCare program. The information, at a minimum, must include:

a. The monthly enrollment and expenditure for full-pay enrollees in the Medikids and Florida Healthy Kids programs compared to the Title XXI-subsidized enrolled population; and

b. The costs and utilization by service of the full-pay

enrollees in the Medikids and Florida Healthy Kids programs and the Title XXI-subsidized enrolled population.

By February 1, 2009, the Florida Healthy Kids Corporation shall provide a study to the Legislature and the Governor on premium impacts to the subsidized portion of the program from the inclusion of the full-pay program, which shall include recommendations on how to eliminate or mitigate possible impacts to the subsidized premiums.

16.~~15.~~ Establish benefit packages which conform to the provisions of the Florida Kidcare program, as created in ss. 409.810-409.820.

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 may ~~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. Effective upon this act becoming law and applicable to policies issued or renewed on or after October 1, 2008, section 627.6562, Florida Statutes, is amended to read:

627.6562 Dependent coverage.--

(1) If an insurer offers 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 25, if the child meets all of the following:

(a) The child is dependent upon the policyholder or

certificateholder for support.

(b) The child is living in the household of the policyholder or certificateholder, or the child is a full-time or part-time student.

(2) A policy that is subject to the requirements of subsection (1) must also offer the policyholder or certificateholder the option to insure a child of the policyholder or certificateholder at least until the end of the calendar year in which the child reaches the age of 30, if the child:

(a) Is unmarried and does not have a dependent of his or her own;

(b) Is a resident of this state or a full-time or part-time student; and

(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.

(3) If, pursuant to subsection (2), a child is provided coverage under the parent's policy after the end of the calendar year in which the child reaches age 25, and coverage for the child is subsequently terminated, the child is not eligible to be covered under the parent's policy unless the child was continuously covered by other creditable coverage without a gap in coverage of more than 63 days. For the purposes of this subsection, the term "creditable coverage" has the same meaning as defined in s. 627.6561(5).

(4)~~(2)~~ ~~Nothing in~~ This section does not affect or preempt

~~affects or preempts~~ an insurer's right to medically underwrite or charge the appropriate premium.

Section 7. Effective upon this act becoming a law and applicable to policies issued or renewed on or after that date, paragraph (v) of subsection (3) of section 627.6699, Florida Statutes, is amended to read:

627.6699 Employee Health Care Access Act.--

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

(v) "Small employer" means, in connection with a health benefit plan with respect to a calendar year and a plan year, any person, sole proprietor, self-employed individual, independent contractor, firm, corporation, partnership, or association that is actively engaged in business, has its principal place of business in this state, employed an average of at least 1 but not more than 50 eligible employees on business days during the preceding calendar year, the majority of whom were employed within this state, ~~and~~ employs at least 1 employee on the first day of the plan year, and is not formed primarily for the purpose of purchasing health insurance. In determining the number of eligible employees, companies that are an affiliated group as defined in s. 1504(a) of the Internal Revenue Code shall be considered one employer. For purposes of this section, a sole proprietor, an independent contractor, or a self-employed individual is considered a small employer only if all of the conditions and criteria established in this section are met.

Section 8. This act shall take effect upon becoming a law.